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Abstract

The purpose of this chapter was to examine the impact of healthcare reform in the USA on LGBT elders, especially the Affordable Care Act (ACA). Attention is given to health disparities and coming out risk factors for LGBT elders, health systems challenges for LGBT elders, advantages and disadvantages of healthcare reform on LGBT elders, and future directions of healthcare reform in the USA. Where appropriate, discussion from an international perspective is included, especially Canada and the UK. It is not the intent of this chapter to endorse any point of view over the other or to be advisory about healthcare issues. The intent is to present multiple perspectives concerning the benefits and debates of healthcare reform on seniors, especially LGBT elders.

Keywords

Healthcare reform · LGBT elders' health · LGBT health disparities

Overview

Health policy is a set of decisions taken by governments or healthcare organizations to achieve a desired health outcome (Cherry and Trotter Betts 2005). Navarro (2007) contends that the scope of health policy is beyond medical care and extends to any action that affects health.

Health policy planning and reform can be achieved at the international level through regulations that guide communities in preventing and responding to acute public health risks that have the potential to threaten people worldwide, at national levels with legislation, or on local levels with internal guidelines for patient caseloads in local clinics (An et al. 2015). An et al. suggest that it is necessary to consider the context in which policies are made or implemented because the setting often includes policy challenges. These challenges include but are not limited to (a) a dearth of societal resources, (b) different needs and competing interests from consumers

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and stakeholders, (c) conflict between efficiency and fairness, (d) deep uncertainty about the future, and (e) political, social, and cultural issues with regard to policy design and implementation (An et al. 2015). In the USA, healthcare reform has an extensive history with limited change and impact until recently. In 2010, two major federal statutes became law, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (H.R. 4872), which amended the PPACA. The purpose of this chapter was to examine the impact of healthcare reform in the USA, especially PPACA (more commonly referred to as the Affordable Care Act [ACA]) on LGBT elders. In this discussion of the ACA, the term “Obama care” is not used due to its negative political and bipartisan connotation, because it detracts from an examination of what is both beneficial and challenging about this legislation. Attention is given to health disparities and coming out risk factors for LGBT elders, health systems challenges for LGBT elders, advantages and disadvantages of healthcare reform on LGBT elders, and future directions of healthcare reform for LGBT elders. Although the primary focus of this chapter is on healthcare reform in the USA, whenever possible, discussion from an international perspective, especially Canada and the United Kingdom, is also included. In addition, this author does not intend to endorse any particular point of view or to be advisory about healthcare issues, but rather to present multiple perspectives concerning the benefits and debates of healthcare reform on older adults, especially those who are LGBT.

Learning Objectives

By the end of the chapter, the reader should be able to:

1. Identify health risk and challenges for LGBT elders.
2. Understand the advantages and disadvantages of healthcare reform legislation for LGBT elders.

3. Identify gaps in healthcare reform for LGBT elders.
4. Identify future areas of need in healthcare reform and implementation for LGBT elders.

Introduction

Although the focus of this chapter is on healthcare reform, some discussion of healthcare concerns and disparities of LGBT elders is referenced throughout. LGBT elders are at risk of health disparities from several perspectives, including minority stress as a sexual minority; a life course perspective in which events at each stage of life influence subsequent stages; legal, political, and social issues; an intersectionality perspective because of multiple identities and the ways in which they interact; and the social–ecological perspective in which older adults are surrounded by spheres of influence such as families, communities, and society (Ard and Makadon 2012; Institute of Medicine [IOM] 2011). Overall, research on the LGBT population and its health status throughout the life course is limited, with more research focusing on gay men and lesbians than on bisexual and transgender persons, to a lesser extent on racial and ethnic minority groups, and even less attention on LGBT elders (IOM). In 2012, Health and Human Services Secretary Kathleen Sebelius applauded the ACA as “the strongest foundation we have ever created to begin to closing LGBT health disparities.” There is a consensus in the literature that LGBT populations have unique health experiences and needs; however, in the USA, we have not quantified the experiences and needs to know exactly what they are (IOM; SAGE 2012). Nevertheless, we do know that LGBT persons are more likely than their heterosexual counterparts to experience difficulty in accessing health care (Ard and Makadon 2012).

Before the passage of the ACA, the healthcare system in the USA was the most expensive in the world, yet delivered lower quality outcomes than systems of other industrialized countries (Saul 2009). The US counterpart, Canada, has the

second most expensive healthcare system among industrialized countries with universal health care (Barua and Clemens 2014). Once the majority of the provisions of the ACA are implemented, it is estimated that approximately thirty million previously uninsured Americans will have access to health care (Congressional Budget Office 2012). A key component of the ACA, the Community Living Assistance Services and Supports (CLASS) Act, was designed to provide public voluntary long-term care insurance, which could have helped to shield elderly people from catastrophic out-of-pocket costs, but was dropped in 2011. The primary reason for discontinuing CLASS was challenges about financial viability (Kelley et al. 2013).

The healthcare reform debate includes arguments representing the benefits and disadvantages as well as mixed implications of healthcare reform legislation. The view of those who espouse mixed implications suggests that one has to expect negative aspects to any plan that takes monies out of Medicare and that such a plan will invariably go to cut some people's benefits. In addition, the claim that ACA will close the "doughnut hole" in Medicare Part D is not as generous as originally portrayed (Kaplan 2011). In essence, ACA lowers a patient's cost obligation for co-payment (i.e., the benefit), but it is not the same as saying that individuals will not have any cost exposure whatsoever (Kaplan). Kaplan stresses that enrollees in managed care (MC) plans are likely to be less satisfied with the new law because MC plans will raise premiums or may discontinue their participation in the program altogether. In either case, the result will likely be higher costs, reduced benefits, and fewer options for enrollees in Medicare managed care plans.

Health Disparities and Coming Out Risk Factors for LGBT Elders

This section examines **implications** of health disparities for LGBT elders. Overwhelmingly, the literature confirms the existence of health disparities for LGBT elders and adverse

consequences in healthcare services and other sociocultural aspects. The first step in addressing LGBT Americans' health disparities is ensuring that policymakers, medical professionals, healthcare workers, and social service providers have a clear understanding of those disparities. Federal health surveys are an essential tool in determining how disparities and differences are recognized and addressed in subpopulations (Rosenthal 2009). Healthcare reform legislation contains a number of provisions to address healthcare disparities (e.g., advisory councils, prioritize the elimination of health disparities, develop a public health insurance option, expand health data collection). Rosenthal stresses that LGBT health disparities in each of these areas should be considered along with racial, ethnic, and geographic disparities.

Health disparities are increased with revealing one's sexual orientation and sexual identity to healthcare providers because of discrimination, stigma, and poor quality of care. LGBT elders and their caregivers have faced discrimination in the healthcare system for most of their lives. Both historical hostilities and current prejudices against LGBT populations have resulted in many LGBT elders not revealing their identities to healthcare providers or delaying or avoiding seeking medical or mental health intervention (Ard and Makadon 2012). Chapter 20 further discusses the risk factors associated with both disclosure and non-disclosure of sexual orientation and gender identity in the USA.

According to Baker and Krehely (2012), governments and service providers rarely track health data on LGBT persons, resulting in its limited availability, which suggests that later life carries unique health challenges for LGBT persons, particularly in areas that have a high concentration of HIV/AIDS, mental health, and chronic health conditions. See Chaps. 20, 23, and 32 for further discussion on healthcare and sexual practices, mental health counseling, and disabilities among LGBT elders. In the study and discussion of LGBT health disparities, the specific needs of transgender persons are seldom explored separately. From the 2011 *National Healthcare Disparities Report* findings,

transgender persons (a) are more likely to be uninsured and less likely to have employer-based health insurance than the general population; (b) postpone care when sick or injured and postpone preventive health care due to cost, discrimination, and disrespect by providers, with female-to-male transgender persons being most likely to postpone care due to discrimination; and (c) one in five has been denied services by a doctor or other provider due to their gender, with racial and ethnic minority transgender persons being more likely to be denied services (Agency for Healthcare Research and Quality 2012). Of LGBT populations, transgender persons are at greater risk of receiving inferior health care or being denied health care because of their sexual identity (Fredriksen-Goldsen et al. 2011). In addition, the number of clinicians who have had knowledge or have received training about health issues pertinent to transgender persons further exacerbates their risk factors (Kaufman 2010). Healthcare practitioners, for example, may not realize that physical examinations or intimate care are sources of extreme anxiety to transgender adults, be unfamiliar with the outcomes of less refined surgical techniques, which may result in appearance of genitalia that are “abnormal,” and may not understand that physical examinations and screening tests should be predicated on the organs actually presented instead of the appearance of the person (Feldman 2010; Kaufman 2010).

LGBT elders and their caregivers face discrimination in the healthcare system, and heterosexism effectively works to create obstacles to achieving full equality for LGBT persons (Brotman et al. 2006). Greenesmith et al. (2013) offer a guide to understanding the benefits of ACA and LGBT families. The guide provides a basic overview of the ACA, a review of how the act helps LGBT persons and their families, and an explanation of how the person and his or her family can access affordable health insurance (see the “Resources” section of this chapter under the Center for American Progress for the location of the guide). In Canada, two notable organizations that are run by lesbian and gay community groups are the 519 Community Centre in

Toronto and The Centre in Vancouver that have highly organized and advanced programs for gay and lesbian elders and their caregivers (Brotman et al. 2007). Brotman et al. (2007) acknowledge that even with the efforts, policies, and practices of these organizations in addressing issues facing gay and lesbian elders in Canada, they remain marginalized within mainstream health and social service agencies. The result is isolation and invisibility of both LGBT persons and caregivers in environments often marked by intolerance and avoidance.

Health Systems Challenges for LGBT Elders

Over 50 years ago, both the USA and Canadian healthcare systems were similar. Over time, Canada moved toward a universal single-payer system that covers the majority of expenditures and without co-payment or user fees for all medically necessary hospital and physician care for all fully insured persons as required by the Canada Health Act. Over 90 % of hospital expenditures and almost 100 % of total physician services are funded by the public sector (Library of Parliament Research, n.d.). It is important to note that the Canadian system provides public coverage from a combination of public and private delivery and is not a system of socialized medicine, but rather one of universal health care (Barua and Esmail 2013). The USA and Turkey are the only two members of the Organization for Economic Cooperation and Development (OECD) without some form of formal universal health coverage. The OECD is an organization that acts as a meeting ground for 30 countries that believe in the free market system. The OECD provides a forum for discussing issues and reaching agreements (www.oecd.org).

One of the major challenges the Canadian healthcare system facing is lengthy wait times for treatment, often months long and sometimes stretching over a year (Barua and Esmail 2013). Wait times are not a characteristic of universal healthcare countries. Other countries with

universal health care (e.g., Belgium, France, Germany, Japan, Luxembourg, Korea, Switzerland, the Netherlands) typically report few problems with wait times (Barua and Clemens 2014). Canadians faced with long periods of wait times have resorted to seeking non-emergency treatment outside of Canada. Among the 12 major medical specialties surveyed by the Fraser Institute, the most patients receiving care outside Canada were in urology, general surgery, and ophthalmology, and the least likely were in cardiovascular surgeries, radiation treatment for cancer, and chemotherapy for cancer (Barua and Esmail 2013). Unfortunately, the survey did not distinguish the age cohorts of these patients.

In addition to concerns and challenges that confront individuals as they age, LGBT elders face at least three unique barriers and inequities that impact their health and access to health care, positive engagement with their communities, and psychosocial adjustment. These barriers include (a) social stigma and prejudice, past and present; (b) reliance on informal families of choice for social connections, care, and support; and (c) laws and programs that fail to address or create barriers to better health and well-being for LGBT elders (Baker and Krehely 2012). Although there are no LGBT-specific diseases, numerous health disparities affect LGBT persons, especially older adults. For example, LGBT persons have higher rates of depression, anxiety, suicidal ideation, and substance abuse than their heterosexual counterparts (IOM 2011; Ruble and Forstein 2008; see Chaps. 23, 24). These higher rates of pathology are attributed to the minority stress they experience on the basis of sexual orientation and gender identity, and when these identities intersect with the inequalities associated with race, ethnicity, and social class, their trauma is magnified (see Chaps. 5–10). In addition, the lack of knowledge and cultural competency about LGBT populations in the healthcare system further discourage LGBT elders from seeking care. See Chap. 20 for further discussion about cultural competency of healthcare providers.

In both the USA and Canada, the inclusion of LGBT persons in health and well-being initiatives has been overwhelmingly from the

perspective of an illness-based focus, such as HIV/AIDS, and from an oppressive and one-dimensional analysis (Berkelman 2012; Mule et al. 2009). A similar approach is seen throughout the world (World Health Organization 2012). Mule et al. make several observations about similarities in public health between the USA and Canada. First, although both the USA and Canada recognize health determinants that comprise four health fields: biology, lifestyle, environments, and health care, they downplay the impact of social structures in health while focusing on individual relational action and responsibility. Second, in the case of LGBT persons, a microlevel or individualized lifestyle approach continues to dominate health promotion by targeting high-risk populations through large-scale campaigns in which interventions promote risk reduction through behavior change (Mule et al. 2009). Finally, illness and behavior remain the primary focus and sexual orientation and gender identity, as social locations in the broader social health structures, simply do not register. In Canada, LGBT persons are included in human rights protection, inclusive of healthcare services, but for the most part, they have not been recognized as an identifiable population within the healthcare sector (Mule 2007), and gender identity is absent from most human rights legislation across Canada with the exception of the Northwest Territories and the City of Toronto (Rainbow Health Network 2008).

In Uganda, health workers could become the frontline enforcers of the newly passed Anti-Homosexuality Act of 2014. The *Draft Guidelines for Health Workers Regarding Health Services for Homosexuals* suggests that healthcare facilities would be made more dangerous for LGBT persons. The guidelines specify that health workers could break confidentiality of gay and lesbian patients, even when not required by law in cases when a person has been sodomized or in cases of “aggravated homosexuality” (i.e., same-sex intercourse repeatedly, same-sex intercourse with a minor or persons with a disability or a persons who has HIV) as defined by the Anti-Homosexuality Act (Feder 2014). In addition, under the provisions of the draft guidelines,

Table 19.1 Practices by nurses to improve quality of care of LGBT patients

Realize that they already have LGBT patients or residents
Change the way information is gathered from the patient
Ask questions about sexual orientation and gender identity separately
Questions such as marital status may need to be amended
If an adult identifies as transgender, the nurse must ask how the client wishes to be addressed
Ask what surgeries have been completed, as it may directly affect the care needed

Adapted from Jablonski et al. (2013)

healthcare workers might be in a vulnerable position of being charged with promoting homosexuality, even in cases where they have been approved to provide services or conduct research with lesbian and gay persons. Researchers, health workers, or health facilities are solely responsible to ensure that no acts of promotion or recruitment of subjects into acts of homosexuality, as stipulated by the Anti-Homosexuality Act, occurs. In fact, one clause of the act reads, “In the event of promotion or recruitment, they shall be held accountable” (Feder 2014).

In the healthcare system, nurses are typically the first point of contact for patients, and as the front line of care, they can directly impact the quality of care of LGBT elders’ experience (Jablonski et al. 2013). Jablonski et al. recommend practices that nurses can follow to improve the quality of care they provide to LGBT patients (see Table 19.1). Although all clinicians and service providers should be trained in culturally appropriate knowledge and skills in working with LGBT elders, it is essential for those who initially have contact with patients.

Rosenthal (2009) indicates that health information technology will significantly reduce costs and increase coordinated care, but it can also put LGBT persons at risk. For example, comprehensive care requires that a primary care provider to know about a patient’s sexual behavior, gender history, and other sensitive information. However, not all providers need access to all

information (e.g., there is not need for an orthopedist to know that a person is gay). The result might be the exposure of too much information, which in turn could expose LGBT persons to discrimination by healthcare providers (Rosenthal 2009).

Impact of Healthcare Legislation on LGBT Elders

Healthcare legislation for older adults in the USA has its origins in the passage of the Medicare legislation enacted in 1965. At that time, President Lyndon Johnson signed the legislation, declaring that no longer will older Americans lose their life savings due to illness (Beschloss 2006). The intent of Medicare was to provide healthcare coverage to persons aged 65 and older and to protect elders from financial risks. However, Medicare does not cover the full financial cost of poor health among elders, requiring many enrollees to pay significant out-of-pocket co-payments and deductibles. In addition, Medicare does not cover a variety of services particularly valuable for those with chronic diseases or a lifelong illness (Kelley et al. 2013). Alternatives to ACA have focused on voucher plans with greater cost sharing; however, such plans would most likely increase, not decrease, out-of-pocket medical expenditures for Medicare recipients (e.g., the bipartisan options for the future, *Choices to Strengthen Medicare and Health Security for All*, by Senator Ron Wyden of Oregon and Senator Paul Ryan of Wisconsin, www.budget.house.gov/uploadedfiles/wydenryan.pdf). The primary goal of this plan was “to strengthen traditional Medicare by permanently maintaining it as a guaranteed and viable option for all of the nation’s retirees” and simultaneously “expanding choice for seniors by allowing the private sector to compete with Medicare in an effort to offer seniors better quality and more affordable healthcare choice” (p. 1). The plan included the following components: (a) choice, (b) affordability, (c) protecting the guarantee, (d) protecting seniors, (e) protecting the safety net, and

(f) lifelong choices. The Wyden–Ryan plan seek to respond to the fast-paced growth of Medicare spending, which is growing more than twice as fast as the economy.

Throughout the twentieth century, healthcare coverage was too expensive and difficult to obtain for many Americans and more so for LGBT persons. Michael Adams, Executive Director of SAGE, in 2009 described the lack of attention of federal policy on LGBT issues in the past eight years (i.e., President George W. Bush’s administration) as a “wasteland” (SAGE Matters 2009, p. 3). Kerry Eleveld, Senior Political Correspondent for The Advocate magazine, added, with the attempt of President Obama and the Congress “to overhaul our health care system and bring more Americans into the fold, older Americans will undoubtedly be a high-priority constituency” (SAGE Matters 2009, p. 5). Moreover, SAGE (2012) asserts that health reform has dramatically improved healthcare coverage for LGBT elders who face health disparities, aggravated by a lifetime of discrimination and higher economic insecurity, in several ways (a) by expanding coverage, (b) strengthening consumer rights and protections, and (c) improving data collection efforts and a host of other benefits.

In general, most people agree that healthcare reform is a step in the right direction in equalizing access to and improving the quality of health care for LGBT persons. The point of division or disagreement is about the extent to which reform is effective beyond access. On the one hand, Baker and Krehely (2012) consider the Affordable Care Act (ACA) as “the most significant and far-reaching reform of America’s health system since the creation of Medicare and Medicaid in the 1960s” (p. 21). Baker and Krehely espouse two major advantages of the ACA to include (a) the introduction of new protections and options for patients in the private health insurance market and (b) expansion of access to more comprehensive benefits and services that focus on improving our nation’s health and lowering healthcare cost by investing in keeping people healthy in the first place. The ACA also includes provisions such as

expanding cultural competency in the healthcare workforce to include LGBT issues, improving data collection to better identify and address health disparities, and recognizing the increasing diversity of America’s families (Baker and Krehely 2011). The ACA has implications for LGBT elders from an intersectionality perspective as well: Sexual minorities, elderly, and persons overrepresented with HIV (SAGE 2014).

According to SAGE, for older LGBT persons, poor health represents the cumulative effect of a lifetime of discrimination, and the ACA prevents health insurers from denying coverage or charging higher premiums based on preexisting conditions, or a person’s sexual orientation or gender identity. The significance of this provision is that access to care is expanded for transgender persons and those living with HIV/AIDS, who often face life-threatening discrimination in healthcare coverage. For older persons who already have coverage through Medicare, the ACA has provisions that improve the benefits available through adding free wellness checkups and prevention services. For persons with HIV, the benefits include prescription drug coverage, laboratory services, and chronic disease management. The ACA ended lifetime dollar limits on essential health benefits, cracked down on frivolous cancellations of policies, and made it illegal to arbitrarily cancel health insurance simply because the policyholder got sick (SAGE 2014). See Table 19.2 for ways in which ACA impact on elders.

Chance (2013) acknowledges that the ACA’s reformatory focus on increasing access to care will likely work to remedy some of the discrimination that results in the LGBT community’s disparate access to care. However, Chance believes that the ACA “fails to comprehensively combat the broader LGBT healthcare discrimination because it will do nothing to remedy the stigma that results in lower quality care” (p. 376). Chance identifies the major disadvantages of the ACA, which result in gaps in access to quality medical services that include failure to address the social stigma associated with a patient’s LGBT status and failure to address specific needs of the LGBT community. The recommended

Table 19.2 Affordable Care Act's impact on elders

Reduce prescription drug cost in Medicare Part D
Provide a free annual wellness visit for all Medicare beneficiaries
Provide free Medicare coverage of vital preventive services
Encourage better care coordination
Expand coverage for seniors under age 65
Protect patent rights and lower costs in the private health insurance market
Provide new options for long-term care
Increase access to home-based care
Nursing home transparency
Protecting seniors from abuse and neglect
Implement the Elder Justice Act

Adapted from Baker and Krehely (2012), Medicare.org (2013)

reforms include a national legislative and regulatory effort for training competent providers for LGBT patients. Chance recommends “amending the ACA to include provisions requiring applicable agencies to issue rules aimed at increasing implementation and utilization of LGBT-specific cultural competence training provides a convenient vehicle for such reform” (p. 399). In addition, Congress should amend the ACA to require agencies that administer research funding to place a condition on receipt of those funds to treat disadvantaged persons such as those who LGBT (e.g., medical schools). Finally, although not directly related to the ACA, LGBT-specific cultural competence can also be achieved at the state level, stipulating that licensing boards require a certain number of hours of LGBT cultural competence training as a condition of renewed licensure. Chance suggests amending the ACA to address discriminatory attitudes is a better choice for such reform than other avenues.

Those who argue that healthcare reform legislation may have potential negative consequences for seniors suggest several disadvantages. First, health reform will not shore up Medicare's financing, despite claims to the contrary (The Senior Citizen League [TSCL] www.seniorsleague.org). The assurance by

lawmakers that healthcare reform would keep the Medicare trust in the black for several additional years is challenged by the Congressional Budget office (CBO), which claims the government is “double counting.” In 2009, a CBO memo stated that “the saving to the health insurance trust would be received by the government only once, thus they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on other parts of the legislation or on other programs” (<http://www.cbo.gov/publications/25017>). Second, as providers experience cuts and go out of business, seniors may have reduced access to medical care (TSCL). To support this notion of the long-term assumption for Medicare and aggregate national health expenditures, reference is made to the Chief Actuary of the government's Centers for Medicare and Medicaid services who connotes that providers for whom Medicare constitutes is a substantive portion of their business could find it difficult to remain profitable, and without legislation intervention, might end their participation in the program, possibly jeopardizing access to care for beneficiaries (www.cms.gov/Research-Statistics-Data-and-System/Statistics-Trend-and-reports/ReportsTrustFunds/downloads/2010TRAlternativeScenario.pdf).

Many LGBT elders are classified as having low socioeconomic status and limited resources and, as such, may be eligible for the Medicaid program. For persons who are eligible for full Medicaid coverage, Medicare healthcare coverage is supplemented by services (e.g., nursing facility care beyond the 100-day limited covered by Medicare, eyeglasses, hearing aids) that are available under their state's Medicaid program. For persons enrolled in both programs, any services covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program because Medicaid is always the payer of last resort (Annual Statistical Supplement 2011). Even so, Medicare does not cover all of a senior's medical expenses.

Older adults who qualify for the federal government program have several options to purchase additional health insurance called Medicare

Advantage plans, which is classified into three basic categories: Private-Fee-for-Service, Health Maintenance Organization (HMO), or Preferred Provider Organization (PPO). According to the Centers for Medicare and Medicaid Services, the most recent addition to the lineup to help manage the health care of senior Americans is the Accountable Care Organizations (ACO). ACO is a collection of healthcare providers who come together and assume responsibility for the care, quality, and cost of healthcare services for a specified group of people. ACO is not an insurance plan. The ACO model is designed to (a) deliver accountable care, (b) emphasize quality of care (a point that Chance (2013) argues is a shortcoming of ACA), (c) coordinate care for patients, and (d) reduce costs by reducing waste (Botek 2015).

Future Directions of Healthcare Reform

The future direction of healthcare reform is uncertain. It is also uncertain whether healthcare reform will regress to something previously known and tried or to something innovative and exploratory. However, several certainties do exist. First, there will continue to be opponents to whatever type of healthcare reform and healthcare legislation is proposed, and second, increases in health care spending along with fiscal pressures created by an aging population and increasing prevalence of debility and chronic conditions make it likely that out-of-pocket expense will continue to rise (Kelley et al. 2013). In addition, an ongoing challenge for healthcare delivery and healthcare reform is related to increasing costs and the ability of the government to continue to fund Medicare and Medicaid in the USA and universal health care in Canada, the ability of individuals to be able to afford health insurance, and the quality of care for LGBT elders. According to Kelley et al., the “average” elder will pay approximately \$39,000 in out-of-pocket medical cost during the final five years of life, and a “typical” elder in the top 25 %

of medical expenditures will pay about \$101,791 in the five years preceding their death (see Research Box 19.1).

Research Box 19.1 Out-of-Pocket Medical Costs

Keyyey, A. S., McGarry, K., Fahle, S., Marshall, S. M., Du, Q., & Skinner, J. S. (2013). Out-of-pocket spending in the last five years of life. *Journal of General Internal Medicine*, 28(2), 304–309.

Objective: To determine the cumulative financial risks arising from out-of-pocket healthcare expenditures faced by older adults, particularly near the end of life.

Method: Retrospective analyses of Medicare beneficiaries’ total out-of-pocket healthcare expenditures over the last five years of life were conducted using the nationally representative Health and retirement Study (HRS) cohort. The subjects were HRS decedents between 2002 and 2008, using each subject’s date of death to define a 5-year study period and excluding those without Medicare coverage at the beginning of this period ($n = 3209$). The total out-of-pocket healthcare expenditures in the last 5 years of life and expenditures as a percentage of baseline household assets were examined. Then, stratified results by marital status and cause of death. All measurements were adjusted for inflation to 2008 US dollars.

Results: Average out-of-pocket expenditures in the 5 years prior to death were \$38,688 (95 % confidence interval \$36,868, \$40,508) for individuals and \$51,030 (95 % CI \$47,649, \$54,412) for couples in which one spouse/partner dies. Spending was skewed, with the median and 90th percentile equal to \$22,885 and \$89,106, respectively, for individuals, and \$39,759 and \$94,823, respectively, for couples. Overall, 25 % of subjects’ expenditures exceeded baseline total household assets and 43 % of subjects’ spending surpassed their non-housing

assets. Among those survived by a spouse, 10 % exceeded total baseline assets and 24 % exceeded non-housing assets. By cause of death, average spending ranged from \$31,069 for gastrointestinal disease to \$66,155 for Alzheimer's disease.

Conclusion: Even with Medicare coverage, elderly households face considerable financial risk from out-of-pocket healthcare expenses at the end of life. Disease-related differences in this risk complicate efforts to anticipate or plan for health-related expenditures in the last 5 years of life.

Questions

1. What are the limitations to this study?
2. Overall, what does this study demonstrate about health-related financial costs?
3. What does this study suggest about out-of-pocket expenditures for an aging population and increasing prevalence of chronic illness?

As the USA discusses, debates, and determines the next steps for healthcare reform, Barua and Clemens (2014) suggest consulting the Canadian model in terms of what to avoid rather than as a model for reform or replication. In reality, the Canadian healthcare model “is comparatively expensive and imposes enormous costs on Canadians in the form of waiting for services, and limited access to physicians and medical technology” (p. 2). Moreover, evidence indicates that excessive wait times lead to poorer health outcomes and, in some cases, death. Arguably, for many LGBT persons who frequently delay receiving health care, increased wait times further comprise their health outcomes. Conversely, Friedman (2013) argues that a Canadian-style, single-payer health plan would reap huge savings realized from reduced paperwork and negotiated drug prices that will pay for quality coverage for all and at less cost to families and businesses. Friedman advocates for The

Table 19.3 Ways single-payer program would improve health system

Extend coverage to all uninsured Americans
Reduce barriers to access for the currently insured by eliminating burdensome co-payments, deductibles, and other out-of-pocket spending for medical care
Improve benefits by covering services such as dental and long-term care
Eliminate inequity in the treatment of less affluent patients by paying providers the same fee for each patient regardless of income or employment
No financial barriers or financial harm resulting from seeking care
Patients have their choice of physicians, providers, hospitals, clinics, and practices

Adapted from Friedman (2013), Physicians for a National Health Program (2011)

Expanded & Improved Medicare For All Act (H. R. 676) as progressive taxation to “replace regressive and obsolete funding sources including federal, state, and local government spending on private health insurance for government employees, and state and local government spending on Medicaid and other health programs” (p. 1). See Table 19.3 for ways in which a single-payer program would improve the healthcare system in the USA.

The goal of The Expanded and Improved Medicare For All Act is to ensure that all Americans will have access, guaranteed by law, to the highest quality and most cost-effective healthcare services regardless of their employment, income, or healthcare status. Essentially, health care becomes a fundamental human right without financial barriers or hardship resulting from obtaining care (Physicians for a National Health Program 2011). Clearly, the focus of H.R. 676 aligns with the needs of and respect and dignity for LGBT elders in the healthcare system. Its intent is to provide every person living or visiting in the USA and the US Territories with a Medicare For All Card and identification number once they enroll at the appropriate location. H.R. 676 will cover all medically necessary services (see Table 19.4) (Physicians for a National Health Program 2011).

Table 19.4 Medically necessary service covered by H. R. 676

Primary care
Medically approved diet and nutrition services
Inpatient care
Outpatient care
Emergency care
Prescription drugs
Durable medical equipment
Hearing services
Oral surgery
Eye care
Chiropractic
Long-term care
Palliative care
Podiatric care
Mental health services
Dentistry
Substance abuse treatment

Adapted from Physicians for a National Health Program (2011)

Since 2003, H.R. 676 has been introduced in every Congressional session. The bill, if adopted, would usher the USA into a single-payer model for healthcare financing, mirroring the rest of the industrialized world. Supporters of the bill see it as the only way to guarantee quality care and sustainably cut costs (Federal Information & News Dispatch 2015). This view is consistent with that of Chance's (2013) position for amending the ACA to ensure the quality of care, not only access for LGBT persons. Ironically, reintroduction of H.R. 676 came on the same day as House Republicans voted for the 56th time to repeal the ACA (Federal Information & News Dispatch 2015).

The future of healthcare policy will need to address health disparities of LGBT elders. Importantly, LGBT elders themselves are emerging as active participants in the debate on reform—they are forging ahead with their own healthcare planning and are increasingly vocal about LGBT-specific and appropriate services. Just as policy and legislation have changed to

include legal protections for LGBT elders that prohibit discrimination based on sexual orientation and gender identity by hospital participating in Medicare and Medicaid (Fredriksen-Goldsen et al. 2012), the future of healthcare reform must follow suit.

Summary

Health care is becoming increasingly expensive, particularly for persons with chronic conditions, which disproportionately affects LGBT elders. Decisions about financing strategies for the health care of all persons in the USA rests in the hands of political forces divided not only along party lines, but also along judgments about the rights of LGBT persons. Regardless of the direction that healthcare reform takes, cost containment, access to care, and quality of care should be the hallmark. Many LGBT elders have been and continue to be victimized by inadequacies in the present healthcare system, all the more problematic because the USA spends more per person on health care as any other country, yet lags behind on key indicators such as life expectancy and preventable deaths.

Learning Activities

Self-Check Questions

1. What is the relationship between Medicaid and Medicare for LGBT elders?
2. What are the reasons for LGBT elders' health disparities?
3. What are the advantages and disadvantages of the Affordable Care Act for LGBT persons?
4. What are some of the challenges to policy implementation of healthcare reform?
5. How are health disparities for LGBT populations consistent across different countries?

Experiential Exercises

1. Interview a healthcare provider to discover their knowledge level in working with LGBT elders. In addition, ask questions to determine the service providers' comfort working with LGBT population. See whether they are more or less comfortable working with a particular subgroup of LGBT persons.
2. Imagine yourself as an LGBT elder who now has to decide upon a health insurance plan. What are some questions would you ask?
3. Volunteer to work with LGBT elders to develop a personalized self-advocacy health strategy.

Multiple-Choice Questions

1. Which of the following is the payer of last resort for individuals enrolled in both Medicare and Medicaid?
 - (a) Medicare
 - (b) Medicaid
 - (c) Supplemental Security Income
 - (d) Social Security Disability Income
2. Which key component was dropped from the Affordable Care Act?
 - (a) Elder Care Assistance
 - (b) Independent Living Assurance
 - (c) Community Living Assistance Services and Supports
 - (d) Fairness Assurance and Community-Based Supports
3. Which of the following is considered the strongest foundation in closing health disparities for LGBT persons?
 - (a) Medicare
 - (b) Medicaid
 - (c) Americans With Disabilities Act
 - (d) Affordable Care Act
4. Which of the following is the most recent addition to the options for managing health care for older Americans?
 - (a) Private-Fee-for-Service
 - (b) Preferred Provider Organizations
 - (c) Accountable Care Organizations
 - (d) Health Maintenance Organizations
5. Which of the following law can hold healthcare workers, their facilities, or researchers accountable for "promoting homosexuality"?
 - (a) Ugandan Anti-Homosexuality Act
 - (b) International Gay Protection Act
 - (c) Canadian Anti-Sodomy Law
 - (d) Universal Human Rights Law
6. What is a disadvantage of health information technology for LGBT persons?
 - (a) May expose too much information about a person's sexual identity to providers who do not need to know
 - (b) May expose an LGBT person to discrimination by healthcare providers in certain situations
 - (c) All of the above
 - (d) None of the above
7. Canada has which of the following type of healthcare system?
 - (a) Socialized
 - (b) Universal
 - (c) Medicare
 - (d) Medicaid
8. From which type of perspective in most parts of the world has been the inclusion of LGBT persons in health and well-being initiatives?
 - (a) Illness based
 - (b) One-dimensional
 - (c) Oppressive analysis
 - (d) All of the above
 - (e) None of the above
9. Which of the following is a criticism of the comprehensiveness of the Affordable Care Act for LGBT persons?
 - (a) Fails to remedy the stigma that results in lower quality care
 - (b) Discourages improved data collection to better identify and address health disparities
 - (c) Decreases access to free wellness checkups and prevention services
 - (d) Fails to crack down on frivolous cancellations of policies
10. Which of the following statements most accurately reflect the government and service providers' data collection on the health of LGBT persons?

- (a) They collect data every 10 years with the Census
- (b) They rarely track health data
- (c) They will violate HIPPA in so doing
- (d) They prioritize type of data collected

Key

- 1-b
- 2-c
- 3-d
- 4-c
- 5-a
- 6-c
- 7-b
- 8-d
- 9-a
- 10-b

Resources

- Advancing Effective Communication, Cultural Competence, and patient-and-Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide (The Joint Commission): <http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf>
- Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care staff: http://www.lgbthealtheducation.org/wp-content/uploads/13-017_TransBestPracticesforFrontlineStaff_v9_04-30-13.pdf
- Agency for Healthcare Research and Quality: www.ahrq.gov/
- Center for American Progress- The Affordable Care Act and LGBT Families: Everything You Need to Know: www.familyequality.org/asset/5gqpf/FEC-CAP-LGBT-AVA-Families-Guide.pdf
- Do Ask, Do Tell: Talking to your provider about being LGBT: http://www.lgbthealtheducation.org/wp-content/uploads/COM13-067_LGBT_HAWbrochure_v4.pdf

- Fenway Health/National LGBT Health Education Center: www.lgbthealtheducation.org
- LGBT Training Curricula for Behavioral Health and Primary Care Practitioners: www.hrsa.gov/LGBT/lgbtcurricula.pdf
- Medicare.org: www.medicare.org
- National Resource Center on LGBT Aging: www.lgbtagingcenter.org
- Optimizing LGBT Health Under the Affordable Care Act: Strategies for Health Centers: <http://www.lgbthealtheducation.org/wp-content/uploads/Brief-Optimizing-LGBT-Health-Under-ACA-FINAL-12-06-2013.pdf>
- Rainbow Health Ontario (RHO): www.rainbowhealthontario.ca
- The ACA and LGBT Older Adults Discussion Guide: www.issues.com/lgbtagingcenter/doc/affordablecareactandlgbtolderadults

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