Differences in Healthcare Access, Use, and Experiences Within a Community Sample of Racially Diverse Lesbian, Gay, Bisexual, Transgender, and Questioning Emerging Adults

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Abstract

Purpose: Health services research involving lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) individuals has focused on differences in healthcare access, use, and experiences between cisgender, heterosexual adults and LGBTQ adults. Yet these factors may differ within the LGBTQ community and have not been well-studied among emerging adults (18–29 years), a group with unique barriers to healthcare. We sought to characterize healthcare challenges within a sample of LGBTQ emerging adults.

Methods: From 2012 to 2013, 206 participants aged 18–27 (86% racial/ethnic minority, 10% transgender) completed questionnaires assessing healthcare access, use, and experiences during a longitudinal study. Descriptive statistics established patterns of healthcare access, use, and experiences, and nonparametric tests examined differences related to sociodemographic variables, HIV status, sexual orientation identity, and gender identity.

Results: Overall, 68% of participants reported relatively easy access to care. White and bisexual participants reported higher rates of insurance than racial/ethnic minority ($P=0.01$) and gay or lesbian participants ($P=0.005$), respectively. Although most participants did not report having negative experiences in healthcare settings related to their LGBTQ identity, transgender participants were more likely to delay care ($P<0.001$) and report negative effects of disclosure to their provider ($P<0.001$) compared with cisgender participants. Participants who identified as queer or were questioning their sexual orientation identity reported negative healthcare experiences more frequently than LGB-identified participants ($P=0.001$).

Conclusions: Although LGBTQ emerging adults experienced fewer barriers to care than observed in previous studies on LGBTQ adults, the results suggest that queer, questioning, and transgender individuals may face additional healthcare challenges compared with their LGB and cisgender counterparts.

Keywords: discrimination, healthcare disparities, health services, minority health, young adult

Introduction

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, and questioning (LGBTQ) people in the United States experience numerous health disparities (e.g., HIV, mental health, substance use) relative to cisgender heterosexual people.^{1–3} Potential contributors to these disparities include lack of access to healthcare and low healthcare utilization among LGBTQ individuals.^{4–6} In addition, perceived and actual discrimination in healthcare settings related to sexual orientation or gender identities hinders health-seeking behaviors, especially among LGBTQ people of color.^{7,8}

LGBTQ emerging adults aged 18 to 29⁹ face additional challenges related to their developmental stage¹⁰ and evolving gender and sexual orientation identities.¹¹ Emerging adults as a group demonstrate lower rates of healthcare use than other age groups.¹² These problems may be compounded for LGBTQ emerging adults who may experience difficulties disclosing their sexual orientation and/or gender identities to providers and learning to advocate for LGBTQ-specific health needs. Indeed, research on LGBTQ emerging adults indicates that they more commonly endorse having unmet health needs^{13–15} and skipping needed medical care¹³ compared with cisgender heterosexual people.

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However, most research on healthcare use and experiences among LGBTQ people has not distinguished emerging adults from adolescents or adults, rendering the healthcare status of emerging adults difficult to discern.

Most health services research to date has focused on differences between non-LGBTQ and LGBTQ individuals, failing to recognize the diversity within this population. Yet, evidence suggests that healthcare access, use, and experiences differ systematically among LGBTQ subgroups. For instance, compared with cisgender LGB individuals, transgender people report difficulties accessing care and lower rates of insurance coverage with insurance plans often failing to cover gender-confirming treatments.^{4,16} Moreover, while LGB persons experience negative encounters in healthcare settings such as discrimination or invalidation of their identity, transgender individuals are more likely to report these concerns.⁷ Such experiences are thought to contribute to worse mental (e.g., depression) and physical health outcomes (e.g., HIV) among transgender people.¹⁷

Regarding sexual orientation identity, bisexual adults are less likely to have access to care, a usual place for healthcare and insurance,⁶ and less likely to disclose their sexual orientation identities to healthcare providers.^{18,19} As such, providers may not address health concerns relevant to bisexual people, such as safer sex with same-sex partners, or mental health and substance use issues that disproportionately affect them (e.g., depression, alcohol use).^{19,20}

In addition, research on the healthcare experiences of individuals who identify as queer, are questioning their sexual orientation identities, or engage in same-sex sexual activity, but do not use an LGB label is in its infancy.²¹ Health disparities in this group may be under-recognized due to difficulties in accessing and identifying those who do not identify with these labels. For example, men who have sex with men (MSM) who identify as heterosexual or people questioning their sexual orientation identity may be reluctant to report behaviors that may “out” them to providers. In turn, providers may fail to inquire about health concerns for which sexual or gender minorities and/or people who engage in same-sex sexual behaviors are at risk.

Finally, with the exception of some studies,²² sexual minority women and LGBTQ people of color report worse health status, more unmet healthcare needs, and perceived and actual discrimination or substandard care than sexual minority men and White, LGBTQ people, respectively, yet few have examined these patterns in emerging adult samples.^{7,15,23–25} In addition, while HIV-positive MSM have higher rates of healthcare use once linked into care,²⁶ these rates are much lower among young adult, MSM of color. These findings indicate that intersecting minority identities (e.g., race, ethnicity, sexual orientation, gender, health status) shape LGBTQ individuals’ experiences in healthcare, often in disadvantageous ways.

Taken together, LGBTQ emerging adults are at disproportionate risk for negative healthcare experiences and underutilization of care, which may ultimately contribute to health disparities in this group.^{10,11} However, evaluations of healthcare experiences in this population are lacking, as existing work on younger individuals is largely focused on White, cisgender adolescents^{11,13–15} using surveys which have not collected data on sexual orientation and gender identities systematically until recently,⁶ or which combine emerging

adults with adults over age 30. As such, these studies may underestimate disparities in healthcare access, utilization, and experiences among LGBTQ emerging adults who may be at a higher risk for negative health outcomes. Furthermore, there is limited information on potential disparities within LGBTQ young adults. We addressed these knowledge gaps by evaluating healthcare access, use, and experiences in a diverse, predominantly racial and ethnic minority sample of LGBTQ emerging adults in this exploratory study.

Methods

A community sample of emerging adults in a large, Midwestern city participated in a longitudinal study examining the health and development of LGBTQ youth.² At baseline, participants were 13 to 24 years old and identified as LGBT, queer, or questioning (i.e., reporting some degree of same-sex attraction or behavior, but unsure of or questioning their sexual orientation identity). Recruitment occurred through incentivized snowball sampling and community outreach.

Data analyzed in this article were from the 206 participants who answered questions about their healthcare experiences at the 48-month follow-up assessment from June 2012 to March 2013. After arriving at the study site, participants provided written informed consent, completed study measures using computer-assisted self-interviewing software, and participated in diagnostic mental health interviews conducted by trained research assistants. Two participants who had moved away completed an abbreviated study visit, which did not include several healthcare variables. Participants were compensated \$30. Northwestern University’s Institutional Review Board approved all study procedures.

Measures

Sociodemographic characteristics, including race, ethnicity, sexual orientation (attraction, identity, and behavior), residence, education, and employment, were assessed at each study visit. Birth sex and current gender identity were also assessed using two separate items. The PROMIS Global Short Form²⁷ measured overall physical and mental health status; higher T-scores indicated better health. HIV status and illicit drug use in the past 6 months (never vs. ever) were self-reported. Alcohol use was measured using the Alcohol Use Disorders Identification Test.²⁸ Current DSM-IV major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) were assessed using the Diagnostic Interview Schedule.²⁹

Items assessing healthcare access, use, and experiences were drawn from several public health surveys^{4,30,31} or developed by the study team. Response options were dichotomized or condensed into three categories to increase power to detect between-group effects. Four items assessed participants’ healthcare access and use patterns. Ease of access to healthcare was rated on a 4-point scale condensed into “somewhat to very difficult” and “somewhat to very easy.” Time since last checkup, was dichotomized into “less than 1 year” and “more than 1 year.” Usual source of healthcare was reduced to three categories: private, public (e.g., community-based clinics), and no regular source of care (e.g., emergency services). Health insurance was reduced to two categories: insured (which included private and public coverage) and uninsured.

TABLE 1. DEMOGRAPHIC DESCRIPTION OF SAMPLE ($N=206$)

	M (SD)
Age (years)	23.0 (1.6)
PROMIS physical health T-score	50.9 (8.4)
PROMIS mental health T-score	48.3 (9.8)
	% (n)
Birth sex	
Female	55.3 (114)
Male	44.7 (92)
Race/ethnicity	
Black	56.3 (116)
Multiracial/other	15.6 (32)
White	13.6 (28)
Hispanic/Latino	12.1 (25)
Asian/Pacific Islander	1.5 (3)
Native American	1.0 (2)
Sexual orientation identity ^a	
Gay	30.6 (63)
Lesbian/gay woman	30.6 (63)
Bisexual	25.2 (52)
Questioning	7.3 (15)
Not listed/do not want to answer	2.9 (6)
Queer	2.4 (5)
Heterosexual	1.0 (2)
Gender identity	
Cisgender woman	51.9 (107)
Cisgender man	36.9 (76)
Transgender woman	6.8 (14)
Transgender man	2.9 (6)
Do not want to answer	1.0 (2)
Transgender (nonbinary gender)	0.5 (1)
Living situation	
With family	35.0 (72)
Other stable housing	60.2 (124)
Unstable housing	4.4 (9)
Do not want to answer	0.5 (1)
Education	
Less than high school	10.7 (22)
High school	29.1 (60)
Partial college	39.3 (81)
College graduate	20.4 (42)
Do not want to answer	0.5 (1)
Student status	
Yes	35.0 (72)
No	64.6 (133)
Do not want to answer	0.5 (1)
Employed	
Yes	54.4 (112)
No	44.7 (92)
Do not want to answer	1.0 (2)
HIV status	
Negative	80.1 (165)
Positive	7.8 (16)
Do not know/do not want to answer	12.1 (25)
Mental health status ^b	
No MDD or PTSD	68.4 (141)
Has MDD or PTSD	30.6 (63)
Missing	1.0 (2)

(continued)

TABLE 1. (CONTINUED)

	% (n)
Alcohol and drug use	
Yes	55.8 (115)
No	35.9 (74)
Do not want to answer	8.3 (17)

^aThe term “questioning” refers to participants who reported some degree of same-sex attraction or behavior but identified as questioning or unsure of their sexual orientation. Two transgender participants reported a heterosexual sexual orientation with respect to their experienced gender identity.

^bMissing data reflect two participants who completed an abbreviated study visit that did not include these questions.

MDD, major depressive disorder; PTSD, posttraumatic stress disorder; SD, standard deviation.

Other items assessed healthcare experiences related to participants' LGBTQ identity. Three items assessed whether participants experienced denial of service or equal treatment, or were verbally harassed due to their sexual orientation or gender identities across different healthcare settings. These were collapsed into one item (experienced vs. never experienced). Two items assessed whether participants had ever postponed or did not seek medical care when sick or injured due to LGBTQ-related discrimination and were collapsed into one variable (experienced vs. never experienced). Finally, one item assessed disclosure of LGBTQ identity to a primary healthcare provider. The five response options were dichotomized for analyses (no vs. yes). Those who had disclosed were then asked about the perceived effect of disclosure on the subsequent healthcare received (negative, neutral, or positive).

Statistical analysis

Descriptive statistics were computed for all variables. ANOVAs examined differences in overall physical and mental health, and chi-square and Fisher's exact tests examined healthcare access, use, and experiences by birth sex (male, female), race/ethnicity (non-Hispanic White, racial/ethnic minority), HIV status (positive, negative), sexual orientation identity (gay/lesbian, bisexual, queer/questioning), and gender identity (transgender, cisgender). Follow-up analyses were also conducted to examine differences between gay men and lesbians, bisexual men and women, and transgender men and women; as no significant findings emerged among bisexual and transgender individuals, only results between gay men and lesbians will be described in the results.

Results

Table 1 provides sample characteristics and Table 2 provides descriptive statistics regarding participant healthcare access, use, and experiences. Participants were 18 to 27 years old (mean = 23.0, SD = 1.6 years). Most identified as a racial or ethnic minority (86%), assigned female at birth (55%), and gay or lesbian (61%). Two cisgender women who identified as gay were recoded as lesbian for the purpose of the analyses. Transgender individuals comprised 10% of the sample (14 transgender women, 6 transgender men, 1 person who identified as transgender and nonbinary). With the exception of two transgender women who identified as heterosexual with respect to their experienced gender identity, the remaining transgender participants identified as LGBTQ.

TABLE 2. HEALTHCARE ACCESS AND EXPERIENCES (N=206)

	% (N)
Ease of access	
Somewhat/very difficult	30.6 (63)
Somewhat/very easy	68.4 (141)
Missing	1.0 (2)
Insurance type	
Public	24.3 (50)
Private	32.0 (66)
None (self-pay)	42.7 (88)
Missing	1.0 (2)
Time since last checkup	
<1 year	68.4 (141)
>1 year	30.1 (62)
Do not know/not sure	0.5 (1)
Missing	1.0 (2)
Usual place of care	
Public	46.1 (95)
Private	27.2 (56)
ER/no regular care	25.7 (53)
Missing	1.0 (2)
Had negative healthcare experiences due to LGBTQ status (denied service/equal treatment/verbally harassed)	
No	84.0 (173)
Yes	15.0 (31)
Missing	1.0 (2)
Postponed or did not seek preventive care, or postponed or did not get needed medical care when sick or injured, due to LGBTQ discrimination	
No	88.3 (182)
Yes	8.3 (17)
N/A	3.4 (7)
Told healthcare provider about sexual orientation/gender identity	
Yes, participant was asked about it	35.0 (72)
Yes, participant was not asked about it	28.2 (58)
No, even when asked about it	2.9 (6)
No, but participant would like to	14.6 (30)
No, and participant would prefer not to	19.4 (40)
Effect of disclosing LGBTQ status to provider on subsequent healthcare ^a	
Positive	30.8 (40)
Neutral	61.5 (80)
Negative	7.7 (10)

^aThis item was asked of the 130 participants who indicated that they had disclosed their sexual orientation or gender identity to their provider. Missing data reflect two participants who completed an abbreviated study visit that did not include these questions.

LGBTQ, lesbian, gay, bisexual, transgender, queer, and questioning.

Sixteen participants (8%) were HIV-positive. Nearly half were uninsured (43%), and 26% had no usual place of care. Most reported having a medical checkup in the last year (68%), and having disclosed their LGBTQ identity to their primary healthcare provider (63%).

Over half reported having used drugs or alcohol (56%), and 31% met criteria for MDD or PTSD in the past 6 months. Participants rated their physical health and mental health as average, as indicated by mean T-scores on the PROMIS scales. HIV-positive individuals reported somewhat poorer mental health ($M=43.8$, $SD=9.2$) than HIV-negative indi-

viduals ($M=49.1$, $SD=10.1$), $F(1,179)=4.15$, $P=0.043$, and participants assigned male at birth were more likely to report an HIV-positive status (88%) than were participants assigned female at birth (13%), $\chi^2(1, N=206)=12.90$, $P=0.002$. Otherwise, there were no significant differences in health status, mental health outcomes, or drug and alcohol use by sociodemographic characteristics, sexual orientation identity, or gender identity.

Given the exploratory nature of the study, below we have reported findings that are significant at traditional cutoffs (i.e., two-tailed $P<0.05$). For each set of seven tests examining group differences in healthcare experiences (e.g., by race, sexual orientation), we applied a Holm–Bonferroni correction using an adjusted P -value of 0.007 to account for multiple comparisons. Findings below this threshold are not significant and are noted in Table 3.

Healthcare access and use

Overall, most participants (68.4%) reported somewhat to very easy access to care (Table 2). Participants assigned male at birth were more likely to endorse easier access than those assigned female at birth ($P=0.006$) (Table 3). Follow-up analyses indicated that this finding was likely driven by the fact that gay men reported easier access to care than lesbians (76.2% vs. 52.4%, $\chi^2[1, N=126]=7.778$, $P=0.005$). There were no other significant differences between gay men and lesbians regarding the remaining healthcare access and use outcomes.

Over half of participants (56.3%) reported having private or public insurance (Table 2). There were differences in insurance coverage between races, with participants who identified as both non-Hispanic White and LGBTQ being more likely than those who identified as both a racial/ethnic minority and LGBTQ to report having insurance ($P=0.01$). Insurance coverage also differed by sexual orientation identity ($P=0.005$), with bisexual participants being more likely to be insured than gay/lesbian and queer/questioning participants. HIV-positive participants were more likely to be uninsured than HIV-negative participants ($P=0.03$) (Table 3).

Approximately half of participants (46.1%) reported public or community clinics as their usual place of care (Table 2). Participants who identified as a racial/ethnic minority and LGBTQ tended to lack a regular place of care and more often used public rather than private health services compared with those who identified as non-Hispanic White and LGBTQ ($P=0.003$); there were no other significant differences in healthcare variables between LGBTQ people of color and their non-Hispanic White counterparts. Also, HIV-positive participants most often sought care from public healthcare settings, whereas HIV-negative participants more often reported having no regular source of care ($P=0.01$) (Table 3).

Most participants (68.4%) reported having had a medical checkup in the last 12 months (Table 2). Gay and lesbian participants were less likely to have received a medical checkup in the last 12 months compared with bisexual and queer/questioning participants ($P=0.02$). In addition, compared with HIV-negative participants, HIV-positive participants were more likely to have received a medical checkup in the last 12 months ($P=0.02$) (Table 3).

TABLE 3. CHI-SQUARE AND FISHER'S EXACT TEST ANALYSES OF GROUP DIFFERENCES IN HEALTHCARE ACCESS, USE, AND EXPERIENCES (N=206)

	<i>Ease of access, n (%)</i>		<i>Insurance coverage, n (%)</i>		<i>Usual place of care, n (%)</i>			<i>Time since last checkup, n (%)</i>	
	<i>Somewhat to very difficult</i>	<i>Somewhat to very easy</i>			<i>ER/No regular source</i>	<i><12 months</i>	<i>>12 months</i>		
			<i>Insured</i>	<i>Uninsured</i>				<i>Public</i>	<i>Private</i>
Birth sex	$\chi^2=7.70, P=0.006$		$\chi^2=2.67, P=0.10$		$\chi^2=0.57, P=0.75$			$\chi^2=0.14, P=0.71$	
Male	19 (20.9)	72 (79.1)	46 (50.5)	45 (49.5)	45 (49.5)	24 (26.4)	22 (24.2)	62 (68.1)	29 (31.9)
Female	44 (38.9)	69 (61.1)	70 (61.9)	43 (38.1)	50 (44.2)	32 (28.3)	31 (27.4)	79 (70.5)	33 (29.5)
Gender identity ^a	$\chi^2=0.60, P=0.44$		$\chi^2=3.39, P=0.07$		$\chi^2=2.58, P=0.28$			$\chi^2=0.007, P=0.93$	
Cisgender	58 (32.0)	123 (68.0)	107 (59.1)	74 (40.9)	82 (45.3)	52 (28.7)	47 (26.0)	125 (69.1)	56 (30.9)
Transgender	5 (23.8)	16 (76.2)	8 (38.1)	13 (61.9)	13 (61.9)	3 (14.3)	5 (23.8)	14 (70.0)	6 (30.0)
Race/ethnicity	$\chi^2=1.36, P=0.24$		$\chi^2=6.24, P=0.01^b$		$\chi^2=11.79, P=0.003$			$\chi^2=0.01, P=0.91$	
Non-Hispanic White	6 (21.4)	22 (78.6)	22 (78.6)	6 (21.4)	10 (35.7)	15 (53.6)	3 (10.7)	19 (70.4)	8 (29.6)
Racial/ethnic minority	57 (32.4)	119 (67.6)	94 (53.4)	82 (46.6)	85 (48.3)	41 (23.3)	50 (28.4)	122 (69.3)	54 (30.7)
HIV status ^c	FET, $P=0.78$		$\chi^2=4.97, P=0.03^b$		FET, $P=0.01^b$			FET, $P=0.02^b$	
Negative	51 (31.3)	112 (68.7)	98 (60.1)	65 (39.9)	72 (44.2)	44 (27.0)	47 (28.8)	107 (65.6)	56 (34.4)
Positive	4 (25.0)	12 (75.0)	5 (31.3)	11 (68.8)	12 (75.0)	4 (25.0)	0 (0.0)	15 (93.8)	1 (6.3)
Sexual orientation identity ^d	$\chi^2=4.39, P=0.11$		$\chi^2=10.56, P=0.005$		$\chi^2=6.52, P=0.16$			$\chi^2=7.74, P=0.02^b$	
Gay/lesbian	45 (35.7)	81 (64.3)	63 (50.0)	63 (50.0)	51 (40.5)	37 (29.4)	38 (30.2)	78 (61.9)	48 (38.1)
Bisexual	10 (19.6)	41 (80.4)	39 (76.5)	12 (23.5)	27 (52.9)	13 (25.5)	11 (21.6)	41 (80.4)	10 (19.6)
Queer/questioning	6 (31.6)	13 (68.4)	10 (52.6)	9 (47.4)	13 (68.4)	3 (15.8)	3 (15.8)	15 (83.3)	3 (16.7)
	<i>Negative healthcare experience related to LGBTQ identity, n (%)</i>		<i>Postponed/did not get care due to LGBTQ identity-based discrimination, n (%)</i>		<i>Effect of disclosing LGBTQ identity to provider on healthcare, n (%)</i>				
	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>Neutral or positive</i>		<i>Negative</i>		
Birth sex	$\chi^2=1.55, P=0.21$		$\chi^2=1.61, P=0.21$		FET, $P=0.53$				
Male	74 (81.3)	17 (18.7)	78 (88.6)	10 (11.4)	62 (93.9)		4 (6.1)		
Female	99 (87.6)	14 (12.4)	104 (93.7)	7 (6.3)	58 (90.6)		6 (9.4)		
Gender identity ^a	$\chi^2=13.65, P<0.001$		$\chi^2=12.89, P<0.001$		$\chi^2=14.26, P<0.001$				
Cisgender	159 (87.8)	22 (12.2)	166 (93.8)	11 (6.2)	109 (95.6)		5 (4.4)		
Transgender	12 (57.1)	9 (42.9)	14 (70.0)	6 (30.0)	11 (68.8)		5 (31.3)		
Race/ethnicity	$\chi^2=0.98, P=0.32$		FET, $P=0.71$		FET, $P=1.00$				
Non-Hispanic White	22 (78.6)	6 (21.4)	24 (88.9)	3 (11.1)	23 (92.0)		2 (8.0)		
Racial/ethnic minority	151 (85.8)	25 (14.2)	158 (91.9)	14 (8.1)	97 (92.4)		8 (7.6)		
HIV status ^c	FET, $P=1.00$		FET, $P=0.34$		FET, $P=0.60$				
Negative	139 (85.3)	24 (14.7)	147 (93.0)	11 (7.0)	91 (91.0)		9 (9.0)		
Positive	14 (87.5)	2 (12.5)	14 (87.5)	2 (12.5)	15 (100.0)		0 (0.0)		
Sexual orientation identity ^d	FET, $P=0.001$		FET, $P=0.038^b$		FET, $P=0.001$				
Gay/lesbian	109 (86.5)	17 (13.5)	116 (93.5)	8 (6.5)	85 (95.5)		4 (4.5)		
Bisexual	49 (96.1)	2 (3.9)	45 (91.8)	4 (8.2)	25 (100.0)		0 (0.0)		
Queer/questioning	10 (52.6)	9 (47.4)	15 (75.0)	5 (25.0)	7 (53.8)		6 (46.2)		

Two participants completed an abbreviated study visit that did not include healthcare access and experiences items.

^aExcludes participants who did not want to answer item on gender identity.

^bSignificant at conventional cutoff ($P < 0.05$), but not at adjusted threshold ($P < 0.007$).

^cAnalyses excluded participants who did not know or did not want to answer item on HIV status; including these participants did not alter the pattern of results.

^dAnalyses excluded participants who reported a heterosexual sexual orientation, those who indicated that their sexual orientation identity was not listed and did not provide a write-in response, and those who did not want to answer the questions about their sexual orientation identity.

FET, Fisher's exact test.

Healthcare experiences

Overall, most participants (84.0%) were not denied service or equal treatment and were not verbally harassed/disrespected in healthcare settings because of their LGBTQ identity (Table 2). Transgender participants were more likely than cisgender participants to experience these events ($P < 0.001$), and queer/questioning individuals reported them at higher rates compared with gay/lesbian and bisexual individuals ($P = 0.001$) (Table 3).

In addition, most participants (88.3%) denied postponing or not seeking healthcare due to LGBTQ-based discrimination (Table 2). Transgender participants were more likely than cisgender participants to delay care ($P < 0.001$) (Table 3). There was a significant difference for sexual orientation identity, with queer/questioning participants reporting this experience more frequently than gay/lesbian and bisexual participants ($P = 0.038$) (Table 3). Moreover, gay men were more likely than lesbians to endorse having postponed care due to discrimination (11.5% vs. 1.6%, Fisher's exact test $P = 0.031$). There were no other significant differences between gay men and lesbians regarding healthcare experiences.

Most participants reported that disclosing their LGBTQ identity to healthcare providers had a neutral (61.5%) or positive effect on their healthcare (30.8%) (Table 2). Transgender participants were more likely to endorse a negative outcome than cisgender participants ($P < 0.001$). Similarly, queer/questioning participants reported negative effects at higher rates than did gay/lesbian and bisexual participants ($P = 0.001$) (Table 3).

Discussion

This article is among the first to describe differences in racially diverse LGBTQ emerging adults' healthcare access, use, and experiences. We found several similarities and differences between this sample and national samples of emerging adults. The findings provide further evidence that different subgroups of the LGBTQ community experience greater barriers to care related to their sexual orientation or gender identities.

In interpreting the results of the present study, it can be informative to make comparisons with other reports that include demographically similar populations given the absence of data on LGBTQ young adults. When compared with emerging adults 19–25 years in the Centers for Disease Control and Prevention's National Health Interview Survey (NHIS),^{12,31} we found similar rates of healthcare use. For example, 70.3% of those in the NHIS had a usual place of care, and 70.0% reported visiting their healthcare provider in the past 12 months; among our participants, these rates were 73.3% and 68.4%, respectively.

In other respects, important differences were noted. Our participants were more frequently uninsured (LGBTQ: 42.7%; NHIS: 20.4%) with lower rates of private insurance (LGBTQ: 32.0%; NHIS: 61.5%).³² One explanation may be that LGBTQ young adults may have lost access to insurance coverage due to parental rejection of their sexual orientation or gender identities.¹ These differences also may be driven by race and ethnicity, as LGBTQ participants of color were somewhat more likely to be uninsured. However, these comparisons should be interpreted with great caution given differences in methodology and sample size. Further work on healthcare access and use is needed to identify driv-

ers of these important differences between LGBTQ and heterosexual, cisgender emerging adults, especially among more demographically diverse samples.

In contrast to previous findings,⁷ a minority of participants reported having experienced LGBTQ-related discrimination in healthcare settings. Moreover, most reported that disclosing their sexual orientation or gender identities to their provider resulted in a neutral to positive effect on their care.³³ These findings may reflect the fact that our participants were seeking healthcare in a progressive urban area, with at least 15% reporting an LGBT- or HIV-serving community health center as their usual place of care.

Although overall rates of discrimination were lower than in previous research, there were systematic differences in negative healthcare experiences and postponing care. As in past work on transgender adults,⁴ transgender emerging adults were more likely to be uninsured, experience discrimination in healthcare settings, and postpone care due to discrimination compared with cisgender people. In addition, they were more likely to perceive that disclosing their gender identity to a healthcare provider had a negative effect on their care than cisgender individuals. Worth noting is that the transgender participants all identified as persons of color, and it is possible their racial/ethnic backgrounds also played a role in their interactions with the healthcare system.

A similar pattern of adverse outcomes was observed among participants who identified as queer and/or were questioning their sexual orientation identity, echoing findings from one study of 19 queer women's healthcare experiences.²¹ Past research has shown that adolescents questioning their sexual orientation identity were at higher risk for negative health outcomes relative to LGB and heterosexual youth.^{34,35} These findings may be explained in part by internalized homonegativity, whereby shame regarding one's sexual orientation identity could worsen both subjective and actual experiences in healthcare and health status.^{36,37} Another possible explanation is that healthcare providers generally receive scant training in LGBT health, including education about transgender people and sexual orientation identities outside of the LGB umbrella,^{38,39} which may render them ill-equipped to meet the needs of queer, questioning, and transgender patients.^{38,40}

Unlike past research, bisexual people in this study were not more likely to experience lower rates of healthcare access or use, nor did they report higher rates of negative healthcare experiences than their gay and lesbian counterparts.^{6,18–20} This may be related to the fact that bisexual emerging adults may come out later than gay or lesbian youth^{41,42} and be more likely to remain on their parents' health insurance relative to "out" peers who may be removed from insurance due to parental rejection. Indeed, bisexual people were more likely to be insured than gay/lesbian participants and as such may have had access to better healthcare.

We found that young adult cisgender lesbians reported more difficult access to care than cisgender gay men, which reflects previous work that reported disparities in healthcare experiences between sexual minority women and men.^{15,24,25} In addition, gay men were more likely than lesbians to postpone care due to negative experiences related to their sexual orientation identity. Young women may be more reluctant to disclose their sexual orientation identity to providers and as such feel limited in their ability to access affirming care, whereas young men may be more

open about their sexual orientation identity in healthcare, which may increase the potential for negative experiences. Moreover, with regard to HIV status, HIV-positive individuals were no more likely to have negative healthcare experiences related to their sexual orientation or gender identities; this is not necessarily surprising, as sexual and gender minority patients are likely overrepresented in clinics that serve people living with HIV.

Finally, LGBTQ participants of color were more likely to be uninsured and report no regular source of care than their non-Hispanic White counterparts. However, few other racial or ethnic differences in healthcare experiences were observed. In contrast with past work,^{7,23} participants of color were not any more likely to have had negative healthcare experiences or to postpone care due to LGBTQ-related discrimination.

These findings should be interpreted with care, as they do not necessarily mean that the intersections of race, ethnicity, sexual orientation, and gender identity do *not* impact LGBTQ emerging adults' interactions with the healthcare system. Other more likely possibilities are (1) that the findings may reflect that our study was situated in a large, very racially and ethnically diverse urban area with several health centers that serve the LGBTQ community, as well as several major public and private hospital systems recognized as leaders in providing equitable, inclusive care for LGBTQ patients during the years data were collected,⁴³ and (2) that the sample size—while powered to detect simple between-group differences—was underpowered to disentangle more nuanced interactions.

Relative to prior studies, this sample was highly diverse, including a substantial minority of transgender, queer, and questioning individuals, relative to national estimates (0.3% transgender; 0.7%–1.2% “not sure” of sexual attraction)^{44,45} who are underrepresented in LGBTQ health services research. In addition, our sample was diverse in its composition of a majority of racial or ethnic minority individuals, unlike past work that largely focused on healthcare experiences of non-Hispanic White LGBTQ persons. Moreover, while past work has largely compared LGBTQ individuals to heterosexual, cisgender people, this study examined within-group differences.

Despite these strengths, there were several limitations. First, participants were recruited from a single urban area. As such, these findings may not generalize to LGBTQ emerging adults in different geographic areas with limited access to LGBT-inclusive healthcare. Second, relative to national health surveys, our sample size limited the ability to conduct adequately powered analyses to examine potential differences within sexual orientation identity (e.g., bisexual men vs. bisexual women) or within gender identity (e.g., transgender men vs. transgender women), as well as how intersections between race, ethnicity, sexual orientation identity, and gender identity may have contributed to participants' healthcare experiences. Third, the study was based on participants' perceptions of healthcare experiences rather than objective measures. Fourth, a comparison sample of cisgender heterosexual emerging adults was not recruited for this study; instead comparisons were made to existing national data.

The results point to several implications for public health and future research. As the LGBTQ community is comprised of a diversity of subgroups with different vulnerabilities and needs, routine assessment of sexual orientation and gender identities across national, state, and local health surveys

would better capture the magnitude of healthcare access and use disparities. These studies should consider LGBTQ emerging adults as a group separate from adolescents and adults over age 30 to better understand their distinct healthcare experiences. Such large-scale surveys would enable examinations of intersections between race/ethnicity, sexual orientation identity, and gender identity on young adults' healthcare experiences.

In addition, regular assessment of LGBTQ identity in healthcare settings may increase providers' awareness of when sexual or gender identity issues may play a role in a patient's presenting problem.⁴⁶ Although participants in this sample reported low rates of negative healthcare experiences, providing respectful care for LGBTQ persons remains imperative⁴⁷ given that our sample may not represent the experiences of all LGBTQ communities. Finally, qualitative research is needed to enrich our understanding of the healthcare experiences of contemporary samples of sexual and gender minority youth—especially the conditions that yield more positive experiences—which can inform affirming models of care.

Conclusion

These findings indicate that certain subgroups, particularly transgender, queer, and questioning populations, within LGBTQ emerging adults are more vulnerable to experiencing sexual orientation identity and/or gender identity-related discrimination in healthcare, as well as more limited access to and use of health services. These factors may further compound the health disparities experienced by LGBTQ emerging adults and need to be addressed to optimize health outcomes for this vulnerable population.

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