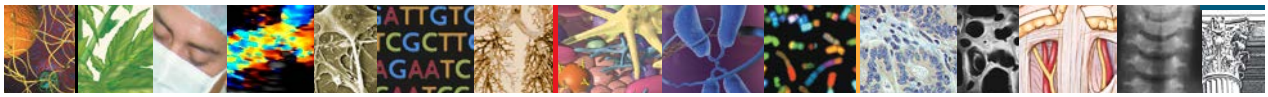

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Perspective

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Same-Sex Marriage — A Prescription for Better Health

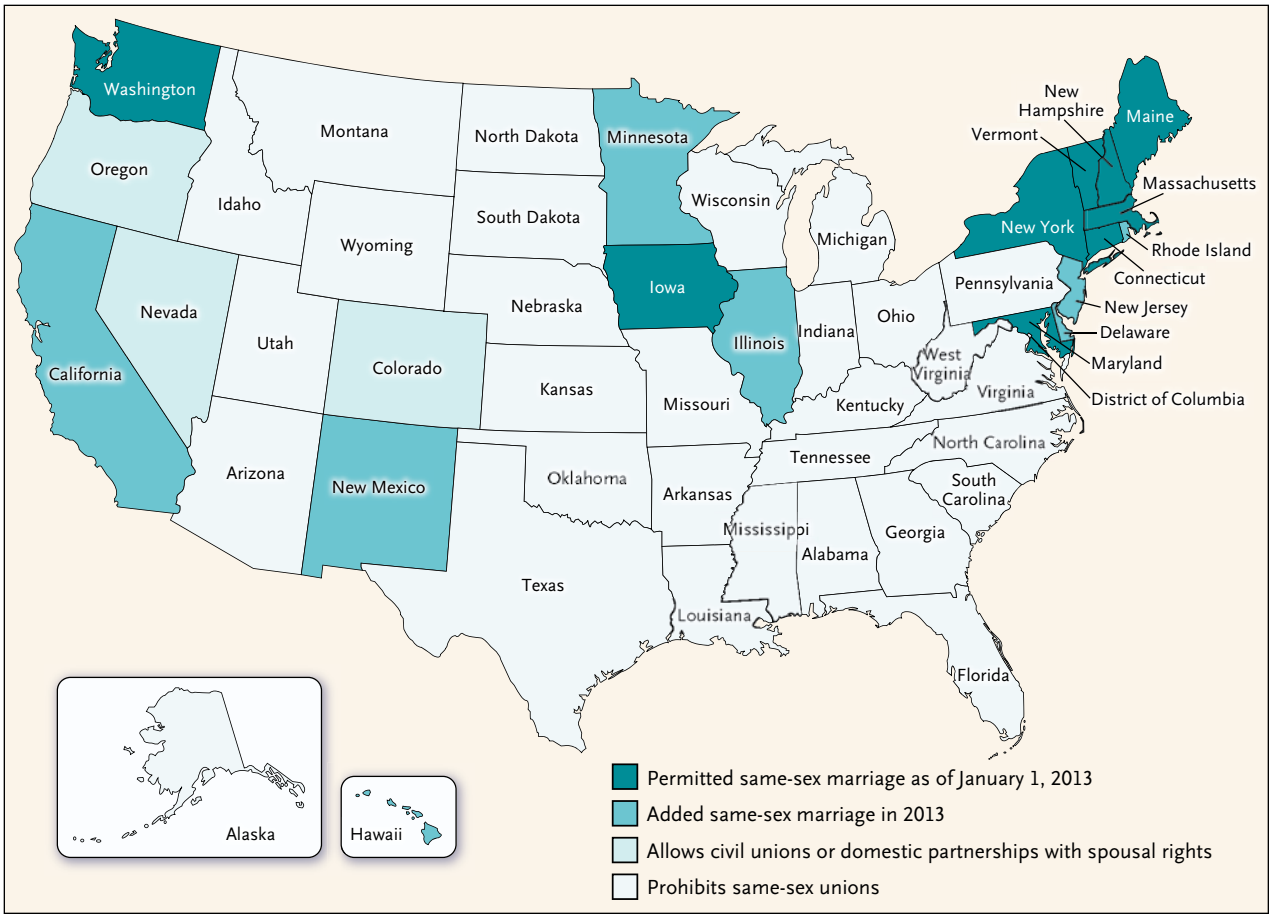
Gilbert Gonzales, M.H.A.

The past year has proved to be a pivotal one for lesbian, gay, bisexual, and transgender (LGBT) Americans. When 2013 began, same-sex couples were allowed to marry only in 9 states plus Washington, D.C., and even when they were legally married by states, the federal government did not recognize their relationships, in accordance with the Defense of Marriage Act (DOMA). As of February 2014, same-sex couples can legally wed in 17 states (and enter civil unions or domestic partnerships in 3 others), and their unions are federally recognized, thanks to a set of court decisions and new laws passed by state legislatures legalizing same-sex marriage (see map).

Nevertheless, approximately 60% of the population and many LGBT people live in the 33 states that still deny same-sex couples the right to marry. Though the issue remains stuck in political gridlock in Washington, growing public opinion in support of same-sex marriage is expected to lead to its reconsideration by more states in 2014. Shifting attitudes may reflect the fact that a growing number of Americans now have a close friend or family member who identifies as LGBT. Although the most central issues raised by the public discourse regarding marriage are moral and rights-oriented, there are also health-related issues at stake: legalizing same-sex marriage can improve health and access to health care for LGBT people.

A 2011 report by the Institute of Medicine on the health of LGBT persons identified substantial disparities in health and access to health care for sexual and gender minorities. Many LGBT people of all ages report worse physical and mental health outcomes than heterosexual and nontransgender populations, largely as a result of the stress caused by being a member of a stigmatized minority group or because of discrimination due to sexual orientation or gender nonconformity. Discriminatory environments and public policies stigmatize LGBT people and engender feelings of rejection, shame, and low self-esteem, which can negatively affect people's health-related behavior as well as their mental health. LGBT people living in states that ban same-sex marriage, for instance, are more likely than their counterparts in other states to report symptoms of depression, anxiety, and alcohol use disorder.[1]

Public health research has suggested not only that discriminatory environments and bans on



Status of Same-Sex Marriage Laws.

Data are from the Human Rights Campaign and news reports. Marriage licenses in California were first issued in June 2008, but Proposition 8 banned same-sex marriage in November 2008; the U.S. Supreme Court decision in *Hollingsworth v. Perry* reinstated same-sex marriage in 2013. A U.S. District Court ruled Utah's same-sex marriage ban unconstitutional in December 2013, but the Supreme Court placed a hold on additional marriages in January 2014 while the decision was appealed. Similar decisions in Virginia, Kentucky, Oklahoma, and Texas are on hold until further appeal.

same-sex marriage are detrimental to health but also that legalizing same-sex marriage (among other policies expanding protections) contributes to better health for LGBT people. For example, data from Massachusetts[2] and California,[3] respectively, indicate that same-sex marriage led to fewer mental health care visits and expenditures for gay men and that it reduced psychological distress among lesbian, gay, and bisexual adults in legally recognized same-sex relationships.

And of course, legalizing same-sex marriage also improves access to health insurance for LGBT people. About 55% of Americans are covered through their own or a family member's employer-sponsored health insurance plan, but many employers do not extend coverage to same-sex partners or children of same-sex partners. Even among companies with more than 200 employees, only 42% offer health benefits to same-sex partners, according to the 2012 Employer Health Benefits Survey conducted by the Kaiser Family Foundation and Health Research and Educational Trust. Thus, adults in same-sex relationships are less likely than their heterosexual counterparts to have health insurance and may therefore delay or forgo necessary medical care.[4] When states legalize same-sex marriage, some workplaces that offer employer-sponsored insurance are required to treat married same-sex couples just as they treat married opposite-sex couples. Therefore, disparities in insurance coverage are narrower in states that permit same-sex marriage or civil unions

that guarantee complete spousal rights to same-sex couples.[4]

Same-sex marriage also strengthens access to health insurance for the 220,000 children who are being raised by same-sex parents in the United States.[5] Employers who offer health insurance to dependent children often require that minors be related to the employee by birth, legal marriage, or legal adoption, so children with LGBT parents are left with diminished protections in states that deny legal marriages and adoptions to same-sex couples. As a result, children with same-sex parents are less likely than children with married opposite-sex parents to have private health insurance. These disparities diminish when LGBT families live in states with marriage equality or laws supporting adoptions for same-sex parents.[5]

Like other vulnerable populations with limited access to affordable health insurance, LGBT families can find some good news in the Affordable Care Act (ACA). The subsidies provided through the new insurance marketplaces will help LGBT families gain coverage, so more same-sex households with family incomes between 138 and 400% of the federal poverty level will now have better options for purchasing private health insurance. The ACA also prohibits health insurance companies from denying coverage because of sexual orientation, transgender identity, or preexisting conditions such as HIV infection. However, the law does not require that employers offer equal coverage to same-sex partners and their children in states where same-sex marriage is not legal. Nor does it require states to cover families earning less than 138% of the federal poverty level, so low-income LGBT Americans living in states that are not expanding their Medicaid programs will continue to have limited access to health insurance.

The 2013 Supreme Court decision in *United States v. Windsor* makes it easier for LGBT workers and their partners to enroll in employer-sponsored insurance plans. Before *Windsor*, Section 3 of DOMA defined marriage, for federal purposes, as a union between one man and one woman. Thus, same-sex couples were disadvantaged under federal laws, particularly through tax policy. For instance, the Internal Revenue Service (IRS) does not tax employer contributions to an opposite-sex spouse's health benefits, but under Section 3 of DOMA, a same-sex partner's health benefits were taxed as if the employer's contribution were taxable income. According to estimates from the Williams Institute, a research center focused on LGBT public policy, LGBT employees paid, on average, $1,069 in additional federal income taxes when they added their same-sex spouse to employer-sponsored insurance plans. In writing the opinion of the court that ruled Section 3 unconstitutional, Justice Anthony Kennedy agreed: DOMA "raises the cost of health care for families by taxing health benefits provided by employers to their workers' same-sex spouses."

In August 2013, the IRS announced that it will treat legally married same-sex couples just as it treats married opposite-sex couples. Although same-sex couples may live in any state, they must be issued a marriage license — not a civil union or domestic partnership — from a state where same-sex marriage is legal. This policy change permits LGBT workers to add a same-sex spouse and their spouse's children to employer-sponsored insurance plans without tax penalties — but only if they are legally married.

Same-sex marriage, therefore, remains an important health policy issue and relevant to the public policy goal of expanding access to health care through employer-sponsored health plans. Given the partisan divide in Washington, individual states are better positioned to advance protections for LGBT families in 2014. Though public opinion is rapidly evolving toward widespread support of same-sex marriage, not all states are likely to adopt same-sex marriage in the immediate future. Until they do, states could take measures to adopt legislation that protects LGBT people from discrimination in housing, employment, and health care.

Achieving marriage equality may require a two-step approach in more conservative states — beginning with civil unions that include full spousal rights and protections for LGBT couples, and later transitioning to same-sex marriage. Alternatively, state attorneys general may refuse to defend same-sex marriage bans when they are challenged in federal courts. But regardless of the pathway chosen, I believe that the health benefits associated with same-sex marriage should be considered in the ongoing debates occurring in legislative chambers, election contests, and federal and state courtrooms.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Division of Health Policy and Management and the State Health Access

Data Assistance Center, University of Minnesota, Minneapolis.

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Transforming Specialty Practice — The Patient-Centered Medical Neighborhood

Xiaoyan Huang, M.D., and Meredith B. Rosenthal, Ph.D.

The patient-centered medical home (PCMH) is a well accepted primary care delivery vehicle in the United States.[1] The National Committee for Quality Assurance (NCQA) has recognized nearly 27,000 clinicians at more than 5000 sites throughout the country in its PCMH program. State and private payers have their own certification criteria. As PCMH efforts have spread and met with mixed success, some observers have noted that refurbishing primary care is probably necessary but not sufficient for addressing the fragmentation of care and underlying cost growth. Primary care services themselves account for only 6% of total health care spending. Moreover, attempts to make primary care solely accountable for global costs raise the specter of gatekeeping.[2]

The term "medical neighborhood" has been coined to capture an expanded notion of patient-centered care, in which the PCMH is located (virtually or otherwise) centrally and is surrounded by specialty clinics, ancillary service providers, and hospitals.[1] The concept of the medical neighborhood, however, has been based almost entirely on the notion of primary care practices as integrators of downstream specialty care. Despite widespread reform of primary care practice, specialty practices have remained largely unchanged.

Many PCMH initiatives have wrestled with building effective partnerships with specialty practices that lack the capabilities and orientation to support care collaboration. In a patient-centered medical neighborhood, specialty practices risk being relegated to the periphery, with patients' access to them restricted by primary care providers, if the specialists do not embrace a more population-based approach and provide better value. The success of the medical neighborhood rests on alignment between the medical home and its neighbors in their long-term goals for their shared patient population. One possible blueprint is the specialty analogue and complement to the PCMH concept: the patient-centered specialty practice (PCSP).

In March 2013, building on the success of its PCMH program, the NCQA established PCSP standards for specialty practices engaged in a patient-centered care model (see box). These standards aim to reinforce care coordination, improve access to specialty care, reduce the use of unnecessary and duplicative tests, enhance communication, and measure and improve performance. Nationally, 64 organizations have enrolled as early adopters, and the first round of NCQA recognition has begun. Participating clinics come from diverse geographic areas and specialty backgrounds. Like Lego pieces of differing shapes, sizes, and colors, primary care and specialty clinics must have interlocking mechanisms with standard specifications. To that end, the NCQA standards have focused largely on care coordination: establishing referral agreements, having tracking systems and feedback loops for referral, defining key elements in referral responses, and keeping patients informed. Standardizing care coordination by using a single set of specifications for all specialties can improve connectivity not only vertically, between primary and specialty care practices, but also horizontally, among specialties.

The "remodeling" of specialty clinics to make them more capa-