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RESEARCH REPORT

Mapping the Health Divide

LGBTQIA+ Oral Health and the Role of Policy Inclusion

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RESEARCH REPORT

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LGBTQIA+ Oral Health and the Role of Policy Inclusion

Introduction and Purpose

Lesbian, gay, bisexual, transgender, queer, intersex, agender/asexual, and other gender/sexual identities (LGBTQIA+) have faced historical exclusion and discrimination from US health care systems, including dental and oral health care.[1] Fear of stigma and discrimination can prevent queer people from utilizing health care, as they seek to avoid uncomfortable, dismissive, or traumatizing encounters with health care providers.[2] Ongoing discrimination, lack of culturally affirming care, and overt homophobia or transphobia cause LGBTQIA+ adults to delay oral health care or avoid it completely.[2] These delays in care make routine health issues worse, exacerbating dental problems for LGBTQIA+ adults that result in increased emergency department visits and poorer outcomes.[3]

LGBTQIA+ adults' oral health issues are further compounded by unique health care needs shaped by social drivers. Queer adults reported feeling self-conscious or embarrassed about their oral health.[3] Social drivers of health such as financial instability significantly impact LGBTQIA+ adults' health and oral health outcomes, along with mental health issues, substance use, chronic illnesses, and social isolation.[4] Of the limited available research on queer people and oral health outcomes, results consistently conclude poorer access and utilization among queer people, resulting in worse outcomes than their cisgender heterosexual counterparts.[2–5] These outcomes are concerning and require additional evaluation of individual, community, and systemic drivers of oral health outcomes to include policy influencers.

The purpose of this report is to provide a state-level analysis of transgender and cisgender queer people's access to dental care, general health indicators, oral health indicators, and social drivers of health in the United States. More specifically, this research aims to evaluate the following:

1. How do state policies that protect or exclude queer people impact health outcomes?
2. Is dental care utilization influenced by inclusive or exclusionary state health policies for queer people?
3. Are there differences in social, mental, and oral health indicators by state and by age group?

This report focuses on filling the current gaps in knowledge and providing research findings to stakeholders who are working to improve the oral health of LGBTQIA+ communities in their state. By examining state-level policies and key indicators, this report will contribute to improving poor oral health outcomes for LGBTQIA+ adults.

An Overview of the LGBTQIA+ Health Policy Landscape

A combination of state and federal policies determines the practice and implementation of health care throughout the United States. Policies such as scope of work, insurance coverage, and care delivery systems are often defined by state policy, while policies such as patient rights, public health infrastructure, and rules for public policy implementation are defined at the federal level. As both state and federal policies are influenced by governing bodies at each level, policies can shift and change with an evolving political landscape.

Health care access and utilization by marginalized and historically excluded communities are often influenced by both state and federal law. For example, the reinstatement of federal sexual orientation and gender identity (SOGI) nondiscrimination laws in 2021 served as a significant milestone for LGBTQIA+ communities to gain important legal protections in the process of health care delivery. Similarly, the Affordable Care Act improved health insurance access for LGBTQIA+ adults and prevented coverage discrimination toward them. While these federal policies have reduced discrimination and improved legal support for queer people, health disparities persist.[6]

States often have more latitude in applying health care policies, including how providers are legally obligated to deliver health care. While state law cannot supersede federal law, states can make decisions as to how health care is practiced in their state, including whether a queer person can be protected from health care discrimination and the recourse available should discrimination occur. Regardless of specific policies, the culture and political climate in a state or community can influence feelings of safety within marginalized communities. In certain states, the health care and even the existence of LGBTQIA+ communities are framed as socially and politically divisive.[7–10] These anti-LGBTQIA+ policies contribute to the erasure of queer identities, which further impacts the access and availability of health care.[11,12]

States with Inclusive Policies

States across the country have passed inclusive gender identity laws that specifically protect transgender and nonbinary people from discrimination in health care delivery. For example, Colorado has some of the strongest policies in the United States supporting transgender people, which ensure nondiscrimination in health care, family rights, and gender-affirming care.[8,9] Other states with similarly supportive health care policies include New York, Maine, New Jersey, Maryland, Washington, Oregon, Nevada, Minnesota, Vermont, and Rhode Island.[9] States like Colorado, California, Maine, Nevada, New York, Illinois, Maryland, Connecticut, and New Jersey have passed policies that list sexual orientation as a protected class in health care, such as relationship and parental recognition, nondiscrimination, religious exemption, LGBTQIA+ youth, and health care laws.[11,12]

States with Exclusionary Policies

While some states have strengthened their protection of queer people over time, other states have simultaneously passed policies that restrict rights or exclude queer people from health care protections. Tennessee has enacted the most anti-LGBTQIA+ policies in the country, impacting queer Tennesseans' education, gender-affirming health care, and familial rights such as adoption and foster care.[10] Other states vary in the type and level of exclusionary laws: Some states focus on sexual orientation; others specifically target transgender, nonbinary, and other gender-diverse people. Florida and Missouri have primarily targeted transgender communities, while states like South Dakota and Wyoming have more discriminatory laws pertaining to sexual orientation. Tennessee, Alabama, Arkansas, Mississippi, South Carolina, Louisiana, Oklahoma, and Idaho have led the US in comprehensive anti-LGTBQIA+ health care policies.[9]

Analyzing the Impact of State Policies on Health Outcomes

Limited research exists examining the impact of anti-LGBTQIA+ policies on the oral health and well-being of queer people. In general, the purpose of the current research is to analyze trends associated with state policies related to health care, social support, and legal protections on health care outcomes and utilization. As such, data from the Youth Risk Behavior Survey (YRBS) and the Behavioral Risk Factor and Surveillance System (BRFSS) were analyzed to assess state-level differences in general health indicators, oral health indicators, and social drivers of health within LGBTQIA+ communities. These surveillance data were evaluated to understand the outcomes of queer youth and adults, since state policies impact both age groups in school, work, and family life.

Section One

Analyzing Access, General Health, Oral Health, and Social Drivers of Health for LGBTQIA+ Youth

YRBS is a national survey conducted by the Centers for Disease Control and Prevention (CDC) that assesses health-related behaviors and experiences in youth in the United States.[13] Data from 2021 and 2023 YRBS were combined and analyzed to examine demographic and general health indicators among transgender youth. This analysis included three primary aims: (1) assess the mental health impact of health care policies, (2) understand oral health outcomes and access, and (3) analyze social indicators related to feelings of safety and bullying. These results were analyzed for trends associated with health care outcomes and access in alignment with statewide policy approaches for LGBTQIA+ youth using data from the Movement Advancement Project (MAP).

States were selected by utilizing MAP's overall LGBTQIA+ policy tallies and gender identity policy tallies. States with the highest tallies indicate more negative policies, and states with the lowest tallies indicate more positive or protective policies.[9] The states with exclusionary policies used in the analysis included Oklahoma, Indiana, Mississippi, and Florida. The states with inclusive policies used in the analysis included New Jersey, Maryland, Illinois, and Nevada. Chi-square tests were conducted to determine the relationship between gender identity and sexual orientation and demographics, general health, oral health, and social indicators.

Demographics

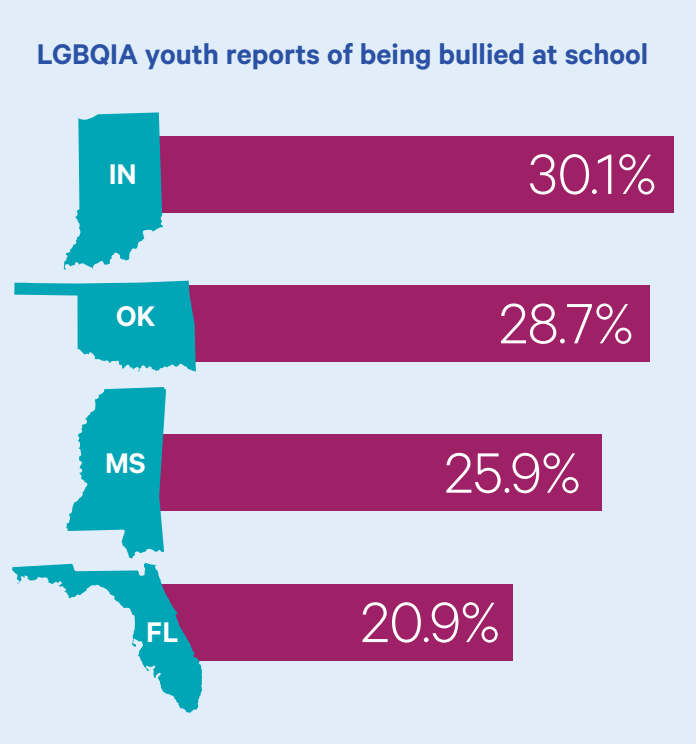
From 2020 to 2023, over 43 million youths aged 10 to 19 resided in the United States.[14] Out of the total number of youths in the sample, approximately 2.5% identified as transgender. Among transgender youth, 83% were 15 years old or older while 17% were 12 to 14 years old. An estimated 24.1% of the total youth population identified as LGBQIA+. Out of the total number of LGBQIA youth, 82% were 15 years old or older while 18% were 12 to 14 years old. Most of the transgender

youth were white (47%), followed by Hispanic/Latino (19%), American Indian/Alaska Native (14%), Black (9%), Asian (2%), and Native Hawaiian/Pacific Islander (1%). LGBQIA youth were predominantly white (48%), Hispanic/Latino (18%), American Indian/Alaska Native (12%), Black (8%), Asian (1%), and Native Hawaiian/Pacific Islander (1%).

Social Indicators

Social indicators such as safety at school and bullying were analyzed to assess the impact on oral, mental, and general health. Transgender youth in Florida had the highest reports of feeling unsafe at school (18.8%) and being bullied at school (16.6%), as well as the lowest grades compared to their non-transgender counterparts (60% had Cs or lower compared to 39.9% for LGBQIA and 30.6% cisgender or heterosexual). Florida and Oklahoma had the highest incidence of electronic bullying (both 13.6%). In comparison, states with inclusive policies had the lowest rates of transgender youth reporting feeling unsafe at school, with New Jersey and Illinois with the lowest reports (6.6% and 12.3%, respectively).

LGBQIA youth (queer cisgender) also reported feeling unsafe in states with more exclusionary policies. In all the states with exclusionary policies (Oklahoma, Indiana, Mississippi, and Florida), LGBQIA youth reported high rates of being bullied at school and electronic bullying. Indiana had the most LGBQIA youth reports of being bullied at school (30.1%), followed by Oklahoma (28.7%), Mississippi (25.9%), and Florida (20.9%). Queer cisgender youth in these states also reported higher rates of electronic bullying.



In general, even among states with protective policies in place for queer students, LGBQIA youth still reported high rates of unsafe feelings at school, even compared to transgender youth.

In general, even among states with protective policies in place for queer students, LGBQIA youth still reported high rates of unsafe feelings at school, even compared to transgender youth. Nevada had the highest number of cisgender queer students reporting unsafe feelings at school (18.3%), while 16.3% of transgender students reported not feeling safe at school. Two out of three states with inclusive policies had higher reports from LGBQIA youth being bullied at school compared to transgender youth. Illinois had the greatest number of queer cisgender youth report bullying at school (24.3%), followed by Nevada (18.4%). New Jersey had the lowest incidence of bullying reported overall (13.2% among queer cisgender youth and 6.6% among transgender youth).

Mental Health

Transgender youth who resided in states with a high number of exclusionary gender identity policies had the highest rates of reporting feeling sad and hopeless, attempting suicide, not getting eight or more hours of sleep, trying substances, and currently using substances. Indiana had the highest proportion of transgender youth who reported feeling sad and hopeless (39.4%), attempting suicide (18.9%), and not getting enough sleep (78.8%). Out of all the gender and sexual orientation groups (transgender, cisgender LGBQIA, and cisgender heterosexual), cisgender LGBQIA had the largest proportion of youth reporting feeling sad and hopeless. Among the states with exclusionary policies, Indiana had the largest group reporting feeling sad and hopeless (74%). Indiana also had the largest group who self-reported attempting suicide (54.4%) and not getting eight hours or more of sleep (87.1%).

Indiana had the highest proportion of transgender youth who reported feeling sad and hopeless (39.4%), attempting suicide (18.9%), and not getting enough sleep (78.8%).

In states with inclusive policies, Maryland had the lowest proportion of transgender youth who reported feeling sad or hopeless (31%). New Jersey had the lowest rate of youth reporting suicide attempts (10%). Generally, cisgender queer youth had higher rates of feeling sad and hopeless compared to transgender youth in states with inclusive policies. For LGBQIA youth in states with inclusive policies, Maryland had the lowest number of reports of feeling sad and hopeless (59%, compared to 31.1% of transgender respondents). Nevada had the highest number of LGBQIA youth who reported feeling sad and hopeless (66% compared to 31.9% of transgender respondents).

Florida (56.5%) and Mississippi (30.6%) had the largest percentage of transgender youth reporting that they had not seen a dentist in the past 12 months.

Key Takeaways for YRBS LGBTQIA+ Youth Analysis

- Across the board, states with discriminatory policies had more negative outcomes for social, mental, and oral health among transgender youth compared to states with protective policies.
- Queer cisgender youth reported high rates of bullying and feeling unsafe in schools, which consequently impacted their social, mental, and oral health, similar to transgender youth. In some states, reports of negative experiences were higher among queer cisgender students.
- Even among states with protective and inclusive policies for queer youth, high rates of negative social and mental health indicators were still reported.
- Queer youth, and transgender youth in particular, in states with discriminatory policies report lower dental utilization rates compared to states with inclusive or protective policies.

Oral Health

Dental care access and utilization were analyzed among queer youth by state. Among states with exclusionary policies, Florida (56.5%) and Mississippi (30.6%) had the largest percentage of transgender youth reporting that they had not seen a dentist in the past 12 months. Transgender youth had higher rates of not visiting a dentist in the past year compared to LGBQIA and cisgender heterosexual youth. LGBQIA youth in Florida had the highest reports of not visiting the dentist in the past 12 months (42.5%), followed by those in Mississippi (37.2%), Oklahoma (36.3%), and Indiana (35.9%). In all states with exclusionary policies, cisgender heterosexual youth had the lowest rates of not visiting the dentist in the past 12 months. Out of these states, Indiana (21.4%) and Oklahoma (24.1%) had the lowest, followed by Mississippi (26.9%) and Florida (33.7%).

The national average for visiting a dentist in the past year among all youth is 78%. States with inclusive policies had lower rates of not visiting a dentist in the past 12 months. Transgender youth in Illinois (21.4%) and New Jersey (27.8%) had the lowest rates of not visiting a dentist in the past year. In three out of the four states with inclusive policies, cisgender heterosexual youth had the lowest rate for youth who had not seen a dentist in the past year (New Jersey, Maryland, and Nevada).

States with inclusive policies had lower rates of not visiting a dentist in the past 12 months. Transgender youth in Illinois (21.4%) and New Jersey (27.8%) had the lowest rates of not visiting a dentist in the past year.

Section Two

Analyzing Access, General Health, Oral Health, and Social Drivers of Health for LGBTQIA+ Adults

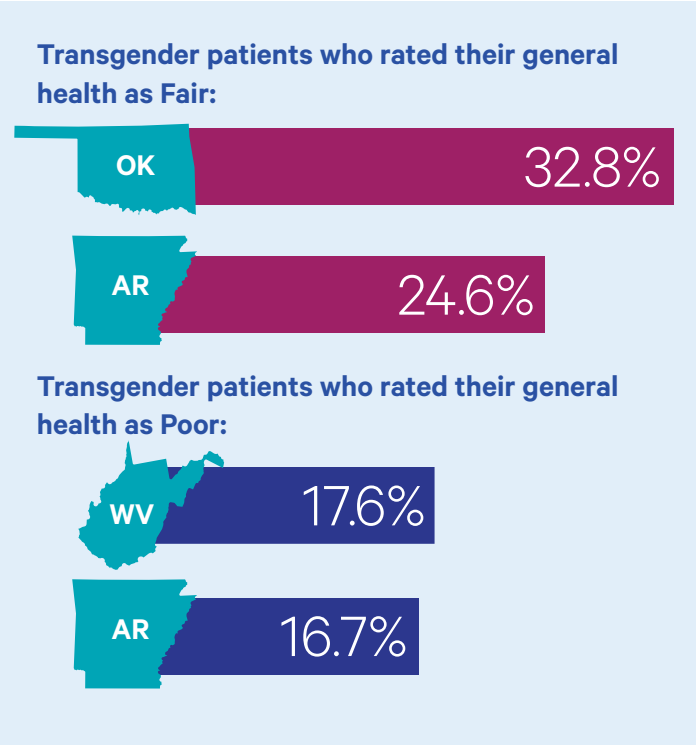
The Behavioral Risk Factor and Surveillance System (BRFSS) is a national telephone-based survey administered by the CDC to collect state-level data on chronic health conditions, preventive services, and health risk behaviors.[15] These data were evaluated to assess the oral, mental, and general health of transgender adults. Five BRFSS questions were used to capture general health including health status, physical health status, mental health status, length of time since the last routine health checkup, and health insurance coverage. Both oral health questions (number of permanent teeth removed and time since last dental visit) were analyzed to assess oral health status. Similarly to the YRBS analysis, variables were sorted into two groups: states with exclusionary gender identity policies and states with inclusive policies.

States for this analysis were selected by using the Movement Advancement Project's overall tallies and gender identity policies and available BRFSS state data.[9,15] The states with exclusionary policies that were used for this analysis included Arkansas, Oklahoma, Missouri, Texas, Indiana, Montana, West Virginia, South Carolina, Louisiana, and Idaho. The states with inclusive policies that were used for this analysis included California, New York, New Jersey, Massachusetts, Maryland, Colorado, Illinois, Vermont, Nevada, and Rhode Island.

Self-Reported General Health

Generally, patients who had visited a dentist tended to have higher rates of perceiving their general health as Excellent and Very Good. This finding supports that dental health care is intimately tied to broader health care. When looking closer

at patients' self-reported health, results indicated that in seven out of 10 states with exclusionary policies, transgender patients had a higher proportion who ranked their general health as Very Good compared to Excellent. Six out of the 10 states had more transgender patients rate their general health as Good compared to Very Good. These ratings show that most transgender patients in states with exclusionary policies tended to perceive their general health as Good or Very Good, a lower rating than their cisgender counterparts. Oklahoma (32.8%) and Arkansas (24.6%) had the highest proportion of transgender patients who rated their general health as Fair. West Virginia (17.6%) and Arkansas (16.7%) had the highest proportion of transgender patients who rated their general health as Poor. Transgender patients had higher ratings of perceiving general health as Poor compared to LGBQIA and cisgender heterosexual patients, with ratings for transgender patients ranging from 3.7% to 17.6% compared to LGBQIA ranging from 3.8% to 7.3% and cisgender heterosexual ranging from 3.8% to 7.8%.



In eight out of 10 states with inclusive policies, transgender patients had a higher percentage who rated their general health as Very Good compared to Excellent. Eight out of the 10 states had higher rates of patients rating their general health as Good compared to Very Good. Colorado (23.3%) and Massachusetts (18.8%) had the highest proportion of transgender patients who rated their general health as Fair. Illinois (22.3%) and Rhode Island (12.1%) had the largest proportion of transgender patients who rated their general health as Poor. Overall, transgender patients' ratings of their general health being Poor followed by cisgender heterosexual patients. Cisgender heterosexual patients (ranging from 3.8% to 5.9%) had higher proportions of poor general health compared to LGBQIA patients (ranging from 2.6% to 5.2%).

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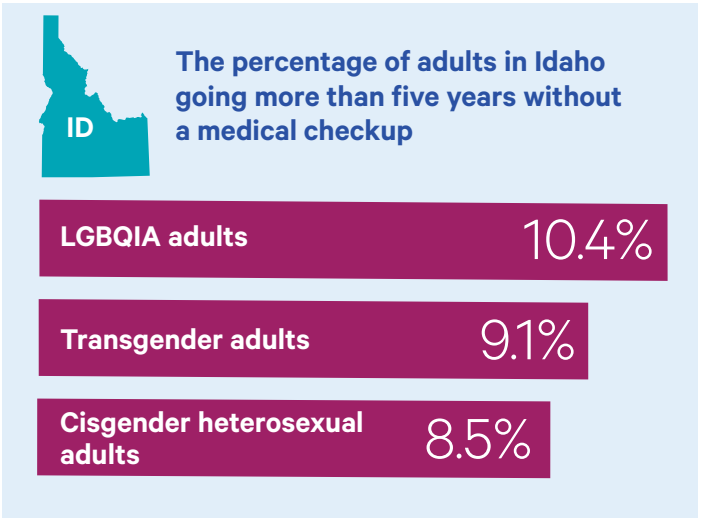
Medical Care Utilization

Medical care utilization was strongly associated with patients visiting the dentist. Those who had utilized medical care also tended to utilize dental and oral health care, indicating that patients who go to the doctor generally go to the dentist. When looking at the frequency with which adults had attended routine medical checkups, states with exclusionary policies were split. Three states had transgender or LGBQIA adults report that they had not attended a routine medical appointment in over five years. Missouri had the highest percentage of transgender respondents (16.3%) reporting that they had not been to a routine checkup in five years or more, followed by cisgender queer adults (9.4%) compared to cisgender heterosexual adults (6.3%). Idaho had the largest proportion of LGBQIA adults (10.4%) who reported that they had not attended a medical checkup in five years or more, followed by transgender adults (9.1%), with cisgender heterosexual adults having the lowest percentage (8.5%) of adults going more than five years without a visit. Similar to



Texas (74% compared to 71.3% for transgender and 63.9% for LGBQIA adults) and Louisiana (79.7% compared to 67% for transgender and 75.9% for LGBQIA adults), cisgender heterosexual adults in Missouri (77.9%) and Idaho (71.4%) had the highest percentage of people who attended their last routine checkup within a year or less. There is an almost 9% gap between Missouri's cisgender heterosexual and transgender adults and a 6.5% gap between Missouri cisgender heterosexual and LGBTQIA+ adults. The overall gap between cisgender heterosexual and LGBQIA adults was slightly larger (9.3%).

Experiences of Extended Poor Mental Health

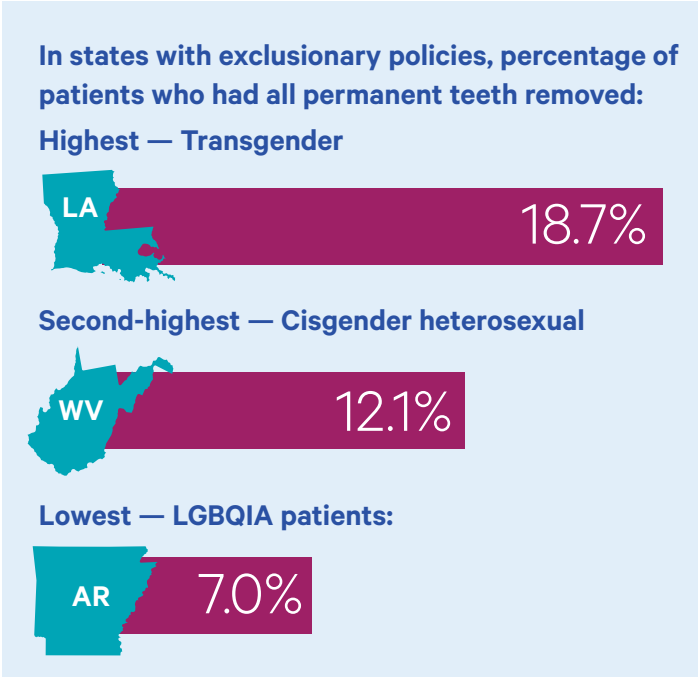
Extended periods of poor mental health were also strongly associated with patients visiting the dentist. Those who visited the dentist tended to have higher rates of experiencing zero days of poor mental health. After investigating states with exclusionary policies, Missouri, Texas, Arkansas, Louisiana, and Oklahoma had the highest rates of transgender adults reporting poor mental health for at least 14 days of the month. Missouri had the highest rate of transgender adults reporting extended poor mental health (48.4% compared to 39.2% for LGBQIA adults and 15.2% for cisgender heterosexual adults), while Oklahoma had the lowest rate (39.4% compared to 36.5% LGBQIA adults and 14.8% cisgender heterosexual adults). South Carolina (14.1% compared to 2.5% transgender adults and 33.5% LGBQIA adults) and Idaho (11.1% compared to 28.8% transgender adults and 4.1% LGBQIA adults) had the highest rates of cisgender queer adults reporting their mental health as poor for more than 14 days of the month.

After investigating states with exclusionary policies, Missouri, Texas, Arkansas, Louisiana, and Oklahoma had the highest rates of transgender adults reporting poor mental health for at least 14 days of the month.

The observed trend of both transgender and cisgender queer adults reporting extended poor mental health stayed consistent even in states with inclusive policies. Maryland had the highest proportion of transgender adults (19.6%) reporting extended poor mental health, followed by LGBQIA adults (14.0%), and cisgender heterosexual adults (10.0%). Among states with inclusive policies, California (25.4%) had the lowest proportion of transgender adults reporting extended poor mental health. Transgender adults in California (63.3%) also had the highest percentage of people who reported that they did not experience poor mental health, followed by cisgender queer adults (62.6%).

Dental Care Utilization and Oral Health Outcomes

In states with exclusionary policies, Arkansas (50.8%) and Louisiana (32.8%) had the highest proportion of transgender patients who had one to five permanent teeth removed. For LGBQIA patients, there were lower rates of having one to five permanent teeth removed (ranging from 19.9% to 29.6%) compared to transgender patients (ranging from 8.4% to 50.8%). Cisgender heterosexual patients also had lower rates of having one to five permanent teeth removed (ranging from 26% to 30%) compared to transgender patients. However, cisgender heterosexual patients had higher rates of having one to five permanent teeth removed compared to LGBQIA patients.
In states with exclusionary policies, transgender patients in Louisiana (18.7%) had the highest proportion of patients who had all permanent teeth removed. Cisgender heterosexual patients followed (with West Virginia having the highest percentage of 12.1%), and LGBQIA patients had the lowest out of the states with the largest proportion of patients who had all permanent teeth removed (with Arkansas having the highest percentage at 7.0%).



In states with inclusive policies, Maryland (38.6%) and New Jersey (27.3%) had the highest proportion of transgender patients who had from one to five permanent teeth removed. Cisgender heterosexual patients in Texas (29.7%) had the

second-highest proportion of patients who had one to five permanent teeth removed. LGBQIA patients across states with inclusive policies had the lowest proportions of patients who had six or more — but not all — of their permanent teeth removed. Cisgender heterosexual patients had the highest proportion of patients who had six or more, but not all permanent teeth removed. Cisgender heterosexual patients also had the highest proportion of patients who had all their permanent teeth removed (ranging from 4.8% to 12.1%) followed by LGBQIA patients (ranging from 1.4% to 5.6%). Transgender patients had the lowest rates of patients who had all permanent teeth removed (ranging from 0% to 11.2%).

Visiting a Dentist, Dental Hygienist, or Dental Clinic Within the Past Year

The time of last dental appointment was also strongly associated with dental care utilization. For all states with exclusionary policies, there were higher rates of attending the dentist within the past two years compared to those who attended within the past five years. However, when looking at the comparison between patients who had attended within the past five years and those whose visit was five or more years ago, the percentage of patients who visited five or more years ago was higher for nine out of 10 states (ranging from a 1.6% to 17.2% difference). This strong association between the time of last dental appointment and dental care utilization was present for all states with inclusive policies. Those who utilized dental care were most often the patients who also visited a dentist within the past year, as compared to those who visited within the past two years, within five years, five or more years, or never.

Missouri had the most transgender adults (59.1% compared to 44.9% LGBQIA adults and 37.9% cisgender heterosexual adults) who reported that they had not seen a dental practitioner within a year, followed by Oklahoma (56.4% compared to 42.7% LGBQIA adults and 39.9% cisgender heterosexual adults). Out of the states with exclusionary policies, Louisiana had the lowest proportion of transgender adults (45.1% compared to 39.5% LGBQIA adults and 39.8% cisgender heterosexual adults) who had not seen an oral health practitioner within the past year. In five out of seven of these states (Missouri, Texas, Louisiana, Oklahoma, and South Carolina), cisgender heterosexual adults made up the top two groups who visited a dental practitioner within the past year.

Transgender and cisgender queer adults had the lowest dental utilization rates across all states with inclusive policies. In four of seven of the states, transgender adults had the higher rate, while LGBQIA adults had the highest rate in the remaining three. California had the highest proportion of poor utilization, with 86.1% of transgender Californians, 35.3% of cisgender queer adults, and 35.2% cisgender heterosexual adults reporting having not visited a dental practitioner within the past year. Transgender adults (41%) in Colorado had the second-highest reported low dental utilization, followed by LGBQIA adults (39.1%). In 13 out of 19 states, regardless of policies, cisgender heterosexual adults were the most likely to have visited a dental practitioner in the past year.

Transgender and cisgender queer adults had the lowest dental utilization rates across all states with inclusive policies. In four of seven of the states, transgender adults had the higher rate, while LGBQIA adults had the highest rate in the remaining three.

Key Takeaways for BRFSS LGBTQIA+ Adult Analysis

- Both transgender and cisgender queer adults self-reported their health as Fair or Poor compared to cisgender heterosexual respondents.
- Even within states that have inclusive policies and protections, transgender people were more likely to self-report having Fair or Poor health outcomes.
- Both inclusive and exclusionary states had high self-reported mental health concerns from transgender and cisgender queer people.
- Utilizing dental care was strongly associated with people's general health, general health care utilization, mental health, and dental care utilization.
- Transgender adults consistently experience the highest rates of tooth loss, especially in states with exclusionary policies.
- LGBQIA adults generally have better oral health outcomes than transgender adults but still face disparities compared to cisgender heterosexual adults.

Conclusions and Strategic Recommendations

This report explores how state policies impact social, mental, general, and oral health outcomes for transgender and queer people. Importantly, these trends are explored in relation to states with protective or inclusive policies for queer people, such as protections from discrimination and codifying access to health care, versus states that have exclusionary or discriminatory policies. Data were analyzed to observe and report whether policies that banned health care or diminished social protections for queer people might influence dental care utilization and oral health outcomes. In general, mental health, general health, and oral health were poorer for queer people, and transgender people particularly, among states with exclusionary policies; however, in most cases, queer adults and youth still had worse outcomes compared to their cisgender heterosexual counterparts regardless of protective state policies. This observation was more pronounced among transgender and cisgender queer youth. These findings highlight some key differences between youth and adults related to their oral health and overall welfare.

Social, Mental, and Oral Health Trends among Queer Youth

- Transgender youth reported not visiting a dentist in the past 12 months more frequently compared to cisgender queer and cisgender heterosexual youth in states with exclusionary policies.
- Cisgender queer youth had higher rates of feeling sad and hopeless and reporting substance use in states with exclusionary policies compared to their transgender and cisgender heterosexual counterparts. Even in inclusive states, LGBQIA youth continued to report high rates of mental health concerns, including feeling sad or hopeless.
- LGBQIA youth residing in states with inclusive gender identity and sexual orientation policies had lower rates of depression and suicide attempts compared to transgender and cisgender heterosexual youth in states with exclusive policies.

- In general, across all states, transgender and cisgender queer youth reported lower dental care utilization compared to their cisgender heterosexual counterparts. Dental care utilization was lower in states with discriminatory policies.
- Dental care utilization was lowest for transgender youth in states with exclusionary policies, especially in Florida and Mississippi.
- States with inclusive policies had the highest dental care utilization rates for youth, particularly among transgender youth in Illinois and New Jersey.

Mental, General, and Oral Health Trends among Queer Adults

- In four out of seven states with exclusionary gender and sexualities policies (Missouri, South Carolina, Arkansas, and Louisiana), transgender adults had the highest percentage of reporting their health as Fair or Poor. LGBQIA adults had the highest percentage of Fair or Poor health reports in the remaining three states (Texas, Idaho, and Oklahoma).
- In five of these seven states (Missouri, Texas, Arkansas, Louisiana, and Oklahoma), transgender adults had the highest number of reports that their mental health was Poor for 14 days or longer.
- Missouri and Louisiana had the highest proportion of transgender adults who did not have health insurance.
- Texas and Arkansas had the highest proportions of transgender adults who were at risk of having permanent teeth extracted.
- Missouri had the most transgender adults who reported that they had not seen a dental practitioner within a year, followed by transgender adults in Oklahoma.
- In five out of seven states with inclusive gender and sexualities policies (Colorado, Massachusetts, Maryland, New York, and New Jersey), transgender adults had the highest proportion of people reporting their health as Fair or Poor.
- In all states with inclusive policies, transgender adults had the highest percentage of people reporting that their mental health status was Poor for 14 days or longer.
- In states with inclusive policies, transgender and cisgender heterosexual adults were the groups with the highest percentages of people who had health insurance.
- In six of the seven states with inclusive policies (California, Colorado, Massachusetts, New York, New Jersey, and Rhode Island), transgender and LGBQIA respondents had the highest percentages of adults who were not at risk of having their permanent teeth removed.
- Transgender and LGBQIA adults had the highest rates of not having visited a dental practitioner within the past year across all states with inclusive policies.

These key findings highlight the disparities that transgender and LGBQIA adults face regarding their dental and oral health. These disparities shape these groups' dental and oral health outcomes. The following strategic recommendations were developed to advocate and promote oral health equity for transgender and LGBQIA adults.

Recommendations for Policy Interventions

States with inclusive policies help queer people — but also help everyone.

In almost every circumstance, states with policy protections in place had higher care utilization and better outcomes for medical, mental, and oral health. Similarly, these states generally had better health outcomes for queer people — and, in some cases, for all constituents — when strong, inclusive policies were adopted. Taken together, these data indicate that inclusive policies help everyone live healthier lives. All states should strive to adopt nondiscrimination laws that explicitly protect queer people within their health care systems, and states with existing nondiscrimination laws should ensure they are enforced. States with inclusive laws should also prioritize the durability of those protections by codifying them into regulatory frameworks, shielding LGBTQIA+ health programs from potential reversals that jeopardize access to care. In this sense, legal protections affirm human rights but also serve as public health interventions that improve outcomes across the board.

Strong infrastructure for oral health access and utilization can improve medical and mental health outcomes.

Investments in oral health infrastructure support stronger medical and mental health systems. The results of this analysis indicate that dental care utilization is closely linked to medical care utilization, better general health outcomes, and fewer mental health challenges. States and federal agencies can build robust oral health systems that include integrated care delivery, accessible public dental programs, mobile and school-based services, and expanded workforce capacity. States should expand dental coverage under Medicaid and other public health programs to include robust preventive, restorative, and specialty services. LGBTQIA+ people, particularly transgender adults and queer youth, are disproportionately affected by low dental utilization, untreated dental disease, and tooth loss, especially in states with exclusionary policies. By investing in comprehensive dental coverage, states can directly address the oral health inequities that emerge from broader social marginalization with positive impacts on mental and physical health as a result. Federal agencies can continue supporting states through technical assistance, demonstration projects,

and funding for oral health expansion, while states can enact policy changes to improve reimbursement rates and incentivize provider education.

Expand and strengthen SOGI patient data to examine LGBTQIA+ oral health outcomes.

The Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey remain the strongest and most comprehensive state-based health data sources and only include two questions related to oral health. Demographic data assessing sexual orientation and gender identity (SOGI) were incorporated in the 2020 and 2022 versions of these systems. As the results indicate, these data systems are crucial to understanding the health and well-being of marginalized groups, including queer people. It is imperative that SOGI identifiers be included during data collection to continue accurately tracking and analyzing LGBTQIA+ general and oral health outcomes. Oral health indicators should be expanded to assess other critical oral health indicators, such as dental pain, emergency department use, dental insurance coverage, etc. Outside of federal systems, state health agencies could mandate SOGI data collection across all publicly funded health systems and surveys, including Medicaid enrollment forms, oral health screenings, and school-based health records. The absence of SOGI data limits the effectiveness of health equity interventions and weakens systems-level accountability. Mandating SOGI data collection would ensure that disparities in oral health outcomes, such as those observed in BRFSS and YRBS data, can be monitored and addressed with accuracy and transparency. Effective data collection allows states to establish mechanisms for evaluating how their policies affect health outcomes among LGBTQIA+ populations, including oral health disparities. Public health departments should monitor implementation and report on equity outcomes tied to nondiscrimination, Medicaid access, and provider protections to ensure the efficacy of their policies and set goals for improvement.

Recommendations for Clinical Care Delivery

Dental providers should be trained in culturally affirming care to reduce feelings of stigma and discrimination.

Clinicians and staff should be trained and held accountable for implementing gender-affirming practices, including using correct names and pronouns, avoiding assumptions about gender or sexual orientation, and creating inclusive intake forms. Transgender patients in both youth and adult datasets reported significantly worse general, mental, and oral health outcomes, often linked to avoidance of care due to fear or past experiences of discrimination. Normalizing gender-affirming and culturally affirming care within existing academic training and continuing education increases provider confidence in culturally appropriate care delivery. In the same vein, trauma-informed clinical practices should be adopted by dental providers, particularly when working with youth and transgender patients, who report high rates of bullying, mental health distress, and substance use. Trauma-informed care not only supports patient dignity but could also increase the likelihood that LGBTQIA+ patients will return for preventive care. Ultimately, trauma-informed practices help all patients feel more comfortable during dental visits and more empowered to address their oral health needs through self-care. Lastly, visible indicators like inclusive signage, pronoun buttons, rainbow symbols, or LGBTQIA+ health posters can signal safety and support. These visible cues, combined with trained, affirming staff, can reduce anxiety and foster trust. This is particularly important in dental settings, which many LGBTQIA+ people already avoid due to feelings of anxiety or stigma.

Include SOGI information in electronic records and strengthen patient privacy.

Clinical practices should include SOGI data collection in patient records, such as pronouns and affirmed name, to understand and address disparities in care delivery and outcomes. Providers can be trained in asking questions respectfully to improve patient connection, establish rapport, and indicate a safe clinical care environment. Accurate SOGI data at the practice level allows clinicians to monitor disparities, tailor care plans, and advocate for additional services or referrals. Data collection via inclusive forms and patient interviews increases feelings of privacy and safety but also signals to patients that a provider cares about their lived experience. Strong protections for this data, including privacy policies provided to patients, ensure that SOGI data is stored securely, shared only with consent, and never used inappropriately. Finally, standardizing SOGI fields within EHR platforms enables better tracking of health equity indicators across populations, supports continuity of care, and allows for meaningful quality improvement at the practice and system level.

Integrated care environments can address holistic health care needs for queer patients.

Given the strong association between dental care utilization and improved mental health outcomes, dental providers should establish clear pathways for mental health referrals and for referrals to dental care. This may include partnerships with LGBTQIA+ affirming mental health professionals, school-based programs, or FQHC behavioral health teams. Colocated services are especially important for transgender youth and adults, who may face multiple access barriers. Medical and dental providers should integrate routine screening for social drivers of health that are disproportionately experienced by queer communities, such as housing insecurity, bullying, food insecurity, and unsafe home or school environments. The data in this report suggest a strong connection between social

indicators (e.g., feeling unsafe at school) and both mental and oral health outcomes. These screenings should be paired with resource navigation, warm handoffs, and community partnerships to address needs beyond the clinical setting. Integrated care settings also facilitate interdisciplinary learning, increasing opportunities for dental practitioners to understand the specific needs of LGBTQIA+ adults, such as hormone therapy and gender-affirming surgeries. Given disparities across youth and adult populations, integrated training should include trauma-informed communication, inclusive clinical workflows, and strategies to increase patient adherence and satisfaction.

Our Call to Action

The evidence presented throughout this report clearly indicates that LGBTQIA+ people, particularly transgender and queer youth, face significant and persistent barriers to achieving optimal oral, mental, and general health.

These disparities are deeply influenced by the policy environments in which individuals live, with states that adopt inclusive policies consistently demonstrating better health outcomes and higher care utilization. Even in states with strong protections, queer patients continue to report disproportionate levels of unmet need, underscoring the reality that legal protections alone are not enough. As access to medically necessary care and public health resources comes under increasing scrutiny, it is essential that health care systems, providers, policymakers, and public health institutions act decisively to protect queer patients from further harm. While protective laws and affirming clinical practices are essential, they remain vulnerable to political volatility and ideological efforts that seek to dismantle access to care for queer communities. As such, health care providers, policymakers, public health professionals, and researchers must act with urgency and resolve to uphold the dignity, rights, and health of LGBTQIA+ people. This includes not only protecting and expanding inclusive policies, but also transforming care delivery systems to ensure safety, visibility, and belonging for queer patients. In the face of rising cultural and legislative threats, oral health professionals have a responsibility to advance evidence-based, affirming, and equitable care.

Appendix 1 — Methodology Description

Limitations

The BRFSS study had a relatively small sample size of transgender patients due to underreporting among transgender patients and underrepresentation in the surveillance system. Due to this, interpretations are limited. Additionally, patient self-reported data may be biased due to individuals' perceptions. However, this report remains one of the first to report on patient perceptions among queer communities. The benefits and contribution outweigh the limitations to provide a foundation to further investigate queer communities and their oral health.

YRBS Methodology

The first aim was to assess the mental health impact of health care policies. Mental health was captured by questions on health behaviors and substance abuse behaviors. Mental health questions asked respondents if they felt sad or hopeless, if they ever attempted suicide, and about their average number of hours of sleep. Substance abuse behaviors included smoking tobacco, vaping, and using marijuana. Findings on substance abuse behaviors can be found in the appendix.

The second aim was to investigate transgender youth oral health. Oral health was assessed by looking at three questions. The questions addressed how often youth visited the dentist and their oral health habits, such as drinking fruit juice and soda. The findings from fruit juice and soda drinking habits can be found in the appendix.

The third aim was to analyze social indicators regarding safety and bullying. YRBS asked multiple questions regarding youth safety and bullying at school.

Chi-square tests were conducted to determine the relationship between gender identity and sexual orientation and demographic, general health, oral health, and social indicators. However, because the tests were exploratory and due to smaller subpopulations, frequencies are reported on and presented as cross-tabulations.

Respondents were asked multiple questions about their substance use and mental health. These questions were used to assess youth general health/general health behavior. YRBS used seven questions on substance abuse. In this analysis, all substance behavior variables were converted into dummy variables, "1" meaning yes and "0" meaning no. The substance abuse questions asked if youth had ever smoked before, if they currently smoked, if they ever vaped, currently vaped, currently used tobacco, ever tried marijuana, and if they currently used marijuana. Mental health questions were also converted into dummy variables. These questions asked youth if they felt sad and hopeless, if they ever attempted suicide, about their mental health status, and about their sleep.

The question that asked respondents how often they visited the dentist's office was converted into a dummy variable where "1" meant youth had visited the dentist and "0" meant they had not. There were two questions that asked youth about the frequency of drinking fruit juice and soda. These variables were also converted into dummy variables to easily see who drank these types of drinks versus those who did not.

The safety and bullying questions included how often school was missed due to feeling unsafe, if youth had been bullied at school in the last 12 months, if youth had been electronically bullied at school in the last 12 months, and how youth described their grades. The bullying questions already had binary responses. The "unsafe at school" question was converted to indicate if youth had ever missed school due to bullying. Grades were converted into two groups: those who had mostly As and Bs versus those who had lower grades. All variables were analyzed and sorted into two categories: states with exclusionary gender identity and sexual orientation policies and states with inclusive policies.

State Selection

States were selected by utilizing the Movement Advancement Project's overall tallies and gender identity policy tallies (states with highest and lowest tallies where high indicated more policies and low meant fewer) and available YRBS state data.[13] The states with exclusionary policies used in the analysis included Oklahoma, Indiana, Mississippi, and Florida. The states with inclusive policies used in the analysis included New Jersey, Maryland, Illinois, and Nevada.

BRFSS Methodology

BRFSS data from 2020, 2021, and 2022 were used. Survey weights were adjusted to reflect the proportion of the total population. Six questions were used to capture adults' general health outcomes. The first question asked adults to rate their health status. This question had seven categories ranging from Poor to Excellent. Categories were collapsed into two main categories: Good/Better and Fair/Poor. The second question asked adults to report on their physical health and the frequency in which their physical health was not good. The categories of "0 days," "1–13 days," and "14 or more days" remained the same. The third question asked adults to recall when their last routine checkup was. This question had seven responses ranging from "within the past year" to "never." Adults who responded with "don't know" and "refused" were

dropped from the analysis. Categories were also collapsed into the five categories "<1 year," "1–2 years," "2–5 years," and "never." People were also asked about their mental health status. The categories were the same as the physical health question and remained the same ("0 days," "1–13 days," and "13 or more days"). The fifth question asked adults about the typical amount of sleep they get each day. The number of hours ranged from 1 to 24 and averages were reported. The final question asked adults about health care coverage. This question had binary responses where "1" indicated yes — that a patient was covered — and "2" indicated no coverage.

There were two questions that specifically asked adults about their oral health. The first question asked adults if they were at risk for having their permanent teeth extracted. This question had binary response options, where "1" indicated adults not being at risk and "2" indicated adults being at risk. The second question asked adults if they had visited a dentist, dental hygienist, or dental clinic within the past year. This question also had two options — "1" indicating yes, a patient had visited, and "2" indicating no, they had not visited within the past year.

The social indicator that was captured was employment. The question asked adults if they were employed, with nine options. Adults who refused to answer were dropped from the analysis, leaving eight categories. The categories were as follows: employed for wages, self-employed, out of work for one year or more, out of work for less than one year, homemaker, student, retired, and unable to work.

Due to low transgender and LBGQIA subpopulation numbers, the 2019 BRFSS dataset was combined for the general health and number of permanent teeth removed. This dataset was added since this year included SOGI demographic characteristics. As mentioned above, the remainder of the indicators utilized 2020 to 2022 datasets.

Appendix 2 — Terminology

The terms "transgender," "LGBQIA ," "cisgender," and "heterosexual" are used throughout the paper. Definitions are provided below.

Transgender is "an umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc."[16]

LGBQIA is an acronym that represents lesbian, gay, bisexual, queer/questioning, intersex, and agender/asexual/ally members. For this paper, LGBQIA adults were analyzed separately to investigate outcomes compared to transgender and cisgender heterosexual adults.[16]

Cisgender refers to people whose gender identity aligns with their sex assigned to them at birth.[17]

Heterosexual refers to people who are attracted to people of different gender or sex from their own. Heterosexual is also known as straight.[17]

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