



THE LIVES & LIVELIHOODS OF MANY IN THE LGBTQ COMMUNITY ARE AT RISK AMIDST COVID-19 CRISIS¹

As COVID-19 sweeps the world, hundreds of thousands of people have contracted the virus, and every community has been affected. The LGBTQ community in the U.S. — along with many communities around the globe — will face unique challenges.

As the pandemic gained increased public awareness in the U.S., the National LGBT Cancer Network, GLMA: Health Professionals Advancing LGBTQ Equality and other LGBTQ-supportive groups² led an effort to bring awareness to the unique health needs LGBTQ people will have throughout the COVID-19 crisis. More than 100 LGBTQ-supportive organizations, including the Human Rights Campaign, joined in a call to health care providers and policymakers to be keenly aware of the community's needs. Underlying many of the LGBTQ communities' vulnerabilities are economic disparities that will compound the realities of this global pandemic.

HRC Foundation estimates there are nearly 14 million LGBTQ adults³ and 2 million LGBTQ youth⁴ in the United States. Based on HRC Foundation's analyses of General Social Survey (GSS) data, more than 5 million work in jobs that are more likely to be impacted by COVID-19. This includes those working in restaurants and food services, hospitals, K-12 and higher education, and retail industries.

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Little is known about COVID-19's impact on the global economy. In addition, the extent of COVID-19's economic impact on LGBTQ people as well as the ways in which LGBTQ people are at increased risk of infection and health complications are mostly unknown. This brief will summarize the ways in which COVID-19 could adversely affect the lives and livelihoods of the LGBTQ community at disproportionate rates.⁵

As this research brief makes clear, in addition to the greater risk of health complications as a result of COVID-19, LGBTQ Americans are more likely than the general population to live in poverty and lack access to adequate medical care, paid medical leave, and basic necessities during the pandemic.

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2 Additional organizations in this effort include are, but not limited to, Whitman-Walker Health, SAGE, New York Transgender Advocacy Group and National Queer Asian Pacific Islander Alliance.

3 Estimate is based on 2018 General Social Survey data.

4 Estimate is based on 2017 Youth Risk Behavior System data.

5 Analyses of primary data in this brief use two sources: The 2018 National Opinion Research Center's General Social Survey (GSS) dataset, and data from 29 states in the core section of the 2018 Centers for Disease Control and Prevention's Behavior Risk Factor Surveillance System (BRFSS). While BRFSS data analysis results are generally limited to these 29 states, they are a representative set of states in that states not included are similar to some states that are included.

INCREASED EXPOSURE, ECONOMIC DISPARITIES AND BARRIERS TO CARE

Many LGBTQ people are employed in sectors that will be heavily impacted by the COVID-19 crisis. LGBTQ people also face significant economic disparities compared to their non-LGBTQ peers, which means they will more often lack the resources they need to stay afloat during the COVID-19 crisis.

LGBTQ PEOPLE WORK IN HIGHLY AFFECTED INDUSTRIES

LGBTQ people are more likely to work in jobs in highly affected industries, often with more exposure and/or higher economic sensitivity to the COVID-19 crisis. HRC Foundation's analysis of data from the 2018 GSS found the top five industries in which LGBTQ adults in the United States are most likely to work. Making up about 40%⁶ of all industries where LGBTQ people work, the top five are comprised of:

1. **2 MILLION** who work in restaurants and food services (15%)
2. **1 MILLION** who work in hospitals (7.5%)
3. **ALMOST 1 MILLION** who work in K-12 education (7%)
4. **ALMOST 1 MILLION** who work in colleges and universities (7% of LGBTQ adults)
5. **HALF A MILLION** who work in retail (4% of LGBTQ adults)

These statistics suggest that more than 5 million LGBTQ workers in these industries could be heavily impacted by the COVID-19 pandemic.⁷ These 5 industries, for comparison, only make up 22% of the industries where people who are non-LGBTQ work. As of March 19, 2020, the media reports that at least 15 state governors have ordered all dine-in restaurant services to stop, which means these workers could lose shifts or their jobs. Meanwhile, hospital workers, who serve at the frontlines of this crisis, are at increased risk of exposure. Moreover, many teachers and professors have also had their work lives fundamentally changed by COVID-19, navigating new demands around virtual classrooms with little to no support.

LGBTQ PEOPLE ARE POORER

Nearly one in ten LGBTQ people are unemployed and are more likely to live in poverty than straight and cisgender people, meaning they cannot always afford the health care that they need or afford to engage in preventative health care measures. According to a 2019 Williams Institute analysis of Behavioral Risk Factor Surveillance System (BRFSS) data, about one in five LGBTQ adults in the United States (22%) live in poverty, compared to an estimated 16% poverty rate among their straight and cisgender counterparts. In particular, the poverty rates of transgender adults (29%) and cisgender bisexual women (29%) in the U.S. tower over those of other groups. Furthermore, Black (40%) and Latinx (45%) transgender adults are more likely to live in poverty than transgender people of any other race.

In addition to higher rates of poverty, HRC Foundation's analysis of the Behavioral Risk Factor Surveillance System (BRFSS) found that one in five LGBTQ adults have not seen a doctor when needed because they could not afford it. To make matters worse, Black LGBTQ adults (23%), Latinx LGBTQ adults (24%), and all transgender women (29%) are most likely to have avoided going to the doctor because of costs.

These high rates of unemployment and poverty may be linked to discrimination. Despite recent advances in equality, LGBTQ individuals and families across the country continue to experience discrimination across their lives including at work. The Center for American Progress reported that anywhere from 11% to 28% of LGBTQ people reported they lost a promotion because of their sexual orientation, and 27% of transgender workers reported having been fired, not hired or denied a promotion due to their transgender identity. Discrimination like this leads to an increased risk for poverty and economic struggle among the most vulnerable in the LGBTQ community.

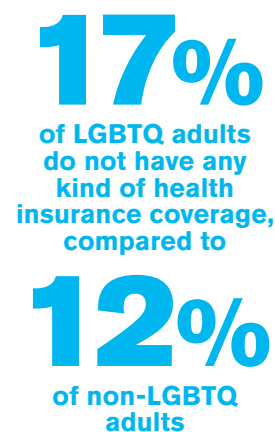
⁶ [28%, 52%] 95% CI. Percentage of employed LGBTQ adults (88%) came from the Movement Advancement Project. Confidence interval provided to account for a smoother industry distribution among LGBTQ adults.

⁷ Standard errors may be larger than normal due to smaller sample sizes across industry, as there are multiple industries which a respondent could have been coded.

LGBTQ people still fight every day to have their families recognized, and thousands of LGBTQ families — including families being led by same-sex couples⁸ that are raising 2 to 3.7 million children across the U.S. — live in states without explicit protection from discrimination. This systemic discrimination results in an increased risk for poverty and housing insecurity, and exacerbates health disparities and social isolation among the LGBTQ community's most vulnerable. Same-sex couples raising children are twice as likely to be living near the poverty line. For single LGBTQ parents the risk is even higher. For families living at the intersection of multiple marginalized identities this daily, systemic discrimination not only degrades individual dignity, but threatens their financial bottom line.

HEALTH COVERAGE GAPS EXIST

Being able to afford and access medical care is essential to testing for COVID-19, as well as treating the symptoms of the disease. However, LGBTQ people are more likely than their non-LGBTQ peers to lack health coverage or the monetary resources to visit a doctor, even when medically necessary. According to HRC Foundation's analysis of the 2018 BRFSS, 17% of LGBTQ adults do not have any kind of health insurance coverage, compared to 12% of non-LGBTQ adults. Furthermore, 23% of LGBTQ adults of color, 22% of transgender adults, and 32% of transgender adults of color have no form of health coverage. This can lead to avoidance of medical care even when medically necessary, and to severe economic hardship when medical care is ultimately accessed.



PAID LEAVE IS NOT AVAILABLE TO MANY

Caregiving can strain a family's bottom line. Whether it's welcoming a new child, caring for a sick family member, or facing their own serious illness, workers are too often forced to choose between the time they need and the job they depend on. Access to uniform paid leave is essential to closing the gaps created by these major life events and helping families stay healthy.

When it comes to paid medical and family leave, the U.S. lags far behind other industrialized countries. We are also the only industrialized country to offer no paid leave to working adults (such as leave that would allow an employee to take care of an ill family member or to welcome a new child). The lack of comprehensive paid leave is a universal experience across all walks of life in the United States. However, LGBTQ individuals and their families are uniquely impacted by these harsh policies. HRC Foundation's 2018 LGBTQ Paid Leave Survey found that fewer than half of respondents reported that their employer's policies cover new parents of all genders equally and only 49% said that employer policies are equally inclusive of the many ways families can welcome a child, including childbirth, adoption, or foster care.

LGBTQ individuals who take time off face heightened challenges in accessing paid leave policies even where they do exist. We know that LGBTQ workers facing a major life event are often left with leave policies that are under-inclusive at best. Even for LGBTQ workers whose employers have a formal paid leave policy, one in five respondents to the 2018 survey reported that fears of discrimination could prevent them from requesting a leave if it would require disclosing their LGBTQ identity. And without explicit federal laws protecting us from being fired simply because of who they are, LGBTQ workers also remain at risk of being fired if they are forced to come out when requesting leave.

This means that if a person suspects that they have contracted COVID-19, they may be unable to take time off to care for themselves or other family members and minimize spreading the illness. According to HRC Foundation's 2018 [LGBTQ Paid Leave Survey](#), 50% of respondents have taken time off for

⁸ Transgender, non-binary, and bi+ parents and families may not be fully captured in these estimates as measures of same-sex couples do not necessarily capture these identities or their contexts completely.



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a medical reason. Yet only 29% of respondents said their employer offers paid leave specifically for medical reasons and that they were eligible to use it. Only 20% of respondents reported having access to paid leave to care for a loved one, forcing many to use sick days, vacation days, or unpaid leave in order to be there for a loved one who is seriously ill. These same people may also be unable to take the time off they need to care for loved ones suffering from COVID-19 due to restrictive leave policies.

OLDER LGBTQ PEOPLE FACE UNIQUE CHALLENGES

Systemic discrimination in housing, employment, and healthcare results in an increased risk for poverty, and exacerbates health disparities and social isolation among aging LGBTQ people. Harassment by peers and healthcare providers also silences many LGBTQ older adults and their families. Governmental social service programs provide critical support for families facing these crises across the lifespan.

The Department of Health and Human Services commissioned a report from the National Academy of Sciences (formerly the Institute of Medicine, or IOM) to assess the health status of LGBTQ people. The report's findings were clear and telling. It specifically addressed the health disparities and unique needs facing older LGBTQ adults including barriers to healthcare services – like those provided under the Older Americans Act. The report highlighted several areas of concern regarding transgender older adults including high rates of sexual assault and violence, a general absence of data and invisibility in research and surveys, and rates of family rejection and isolation higher than any other population within the LGBTQ community. The report also found that “the combined stigma of being elderly and transgender can serve as a strong traumatizing force, potentially exacerbating both forms of discrimination and stigma.”

The HHS report specifically addressed transportation, isolation, and the failure of government programs to meet the needs of LGBTQ older adults as factors that undermine the health status of this population. Older LGBTQ adults living in rural areas faced even more extreme barriers to obtaining culturally competent care and social supports.

According to [SAGE](#), LGBTQ older people are twice as likely to be living alone and four times less likely to have children, which means that older LGBTQ people are especially at risk to lack care or support from family. According to the [Movement Advancement Project](#), there are more than 2.7 million older LGBTQ adults in the United States. However, a survey of older (aged 50+) LGBTQ adults by [AARP](#) found that three in four respondents were concerned about having enough support from family and friends as they age. This may compound with the effects of family rejection that pull crucial safety nets out from under LGBTQ people. Ultimately, this can lead to more difficult access to treatment and support if and when a COVID-19 infection occurs.

LGBTQ YOUTH FACE UNIQUE CHALLENGES

LGBTQ youth are more likely than cisgender and heterosexual youth to experience homelessness, unstable housing, or live in foster care -- often times due to family rejection. In fact, HRC Foundation's 2018 [LGBTQ Youth Report](#) has documented how often LGBTQ youth face family rejection, as 67% of youth reported that their family makes negative comments about LGBTQ people. Moreover, True Colors United reports that LGBTQ youth are 120% [more likely](#) to experience homelessness than non-LGBTQ youth. It is also [estimated](#) that 30% of youth in foster care are LGBTQ and an [estimated](#) 40% of homeless youth identify as LGBTQ. This means that many LGBTQ youth may heavily rely on food and resources provided by public schools and child welfare agencies. Due to widespread school closures as a result of COVID-19, LGBTQ youth are at risk of accessing basic needs provided by schools. They may also be required to spend more time in unsupportive environments - including home environments where they face family rejection.



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HEALTH RISK FACTORS FOR EXPOSURE AND COMPLICATIONS DUE TO COVID-19

Many LGBTQ people face a higher risk of having various illnesses that either increase the risk of contracting COVID-19 or amplify complications after contraction.

RESPIRATORY RISKS

COVID-19 is a zoonotic virus with some of its most common symptoms being respiratory. The virus primarily spreads through the transfer of respiratory droplets from person-to-person by coughing or sneezing. According to the LGBT Cancer Network, smoking is believed to increase risk to more severe cases of COVID-19. Unfortunately, LGBTQ people in the US are much more likely than the general population to smoke. HRC Foundation's analysis of 2018 BRFSS data found that 37% of LGBTQ adults smoke every day compared to 27% of non-LGBTQ people. The Asthma and Allergy Foundation of America has stated that those with asthma are considered at high risk of severe symptoms as a result of the coronavirus. HRC Foundation's analysis of the 2018 BRFSS found that 21% of LGBTQ adults have asthma, compared to 14% of non-LGBTQ people.

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OTHER CHRONIC ILLNESS RISKS

Those with chronic illnesses, especially ones that are immunocompromising, are more at risk of complications if infected with COVID-19. While people with diabetes are not more likely to get COVID-19 than the general population, the American Diabetes Association warns that people with diabetes face a higher chance of experiencing serious complications from COVID-19 if their diabetes is not well managed. According to HRC Foundation's analysis of the 2018 BRFSS, 1.4 million LGBTQ adults have diabetes. The risk of complications as a result of COVID-19 is further compounded by age for older LGBTQ adults. According to HRC Foundation's analysis of the 2018 BRFSS, one in five LGBTQ adults aged 50 and above have diabetes.

According to the California Office of AIDS, the impact of COVID-19 on people living with HIV is currently unknown. However, research suggests that those with certain chronic medical conditions are at increased risk of serious illness associated with COVID-19. People with HIV are more likely to possess these conditions which include older age, cardiovascular and chronic lung disease, and immune suppression. This will have a greater impact on Black and Latinx communities according to the Centers for Disease Control. One in two Black cisgender men who have sex with men (MSM) and one in four Latinx cisgender MSM will be diagnosed with HIV in their lifetimes. Today, one in two Black transgender women and one in four Latinx transgender women have HIV.

CONCLUSION

This brief has summarized the ways in which COVID-19 could adversely affect the lives and livelihood of the LGBTQ community at disproportionate rates. In many cases, LGBTQ people are at greater exposure and risk of both economic and health complications than non-LGBTQ people because of the types of jobs they are more likely to have, because of their experiences with poverty and lack of paid leave, and because of the health disparities they have compared to non-LGBTQ people. This means that the responses to COVID-19 taken by the government, policymakers, and the private sector must

actively consider the unique situations of LGBTQ people in their plans for addressing this crisis. This especially includes those within the LGBTQ community who are most marginalized. For example, responses to COVID-19 must consider older LGBTQ adults struggling to access care and satisfying basic needs in social isolation, or homeless LGBTQ youth struggling to find meal stability during changes in school operations. These responses must also consider the unique needs of LGBTQ people of color and transgender people who are more likely to live in poverty or forego care due to costs. Lastly, policymakers must prioritize making paid leave more accessible to all workers. Without access to paid leave, too many Americans who take unpaid leave are thrown into financial chaos and struggle to cover everyday expenses like groceries and rent without a steady income - especially during a public health crisis. As more Americans gain access to paid leave, we must ensure that the paid leave needs of LGBTQ working people and their loved ones are fully considered and equally protected.

Methodology Appendix

DATA AND ESTIMATION PRIORITIES

Analyses of primary data in this brief use two sources: the 2018 Centers for Disease Control and Prevention's Behavior Risk Factor Surveillance System (BRFSS) and the 2018 National Opinion Research Center's General Social Survey (GSS). Estimates prioritize maximization of statistical power and precision. For example, certain answers for sexual orientation and gender identity (SOGI) questions, such as GSS' "a gender not listed here" or BRFSS' "something else", may not always include individuals who fall under the LGBTQ umbrella. In the case of GSS data, <1% of gender identity responses fell into this category and were included under the transgender and LGBTQ umbrella for precision maximization.

BRFSS is a national probability survey through the Center for Disease Control (administered by states) that collects data on health risk behaviors, chronic diseases and conditions, access to health care, and the use of preventive health services related to the leading causes of disabilities, mortality and morbidity ([Center for Disease Control, 2019a](#)). Since 2014, BRFSS has collected measures on sexual orientation and gender identity. Its questionnaire has been reported as a best practice for collecting these metrics ([Human Rights Campaign, 2019](#)). HRC analyzes data from 29 states that provided a recommended but optional module that included measures on sexual orientation and gender identity ([Center for Disease Control, 2019b](#)). Results are generally limited to these 29 states, rather than the entire United States. Nevertheless, they are a representative set of states in their comparison to those that did not provide the module.

GSS is a national probability survey administered by the National Opinion Research Center at the University of Chicago. It collects data on a range of public opinion and social trends in the United States, and since 2018, is one of a handful of sources that collects SOGI metrics.

THE NEED FOR LGBTQ DATA COLLECTION

State and federal officials have failed the LGBTQ community when it comes to ensuring equal treatment in government data collection efforts. While some federal and state data collection efforts include metrics on gender identity, most state and federal data collection efforts fail to obtain this data. Measures are also omitted from the country's largest demographic data collection endeavors such as the decennial U.S. Census. Municipalities, states and the federal government can and should promulgate policies that require their respective data collection undertakings to be fully inclusive of the transgender and non-binary community.



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Sexual Orientation, Gender Identity And Industry Variables

BRFSS

SEXUAL ORIENTATION. Data from BRFSS provide two variables for sexual orientation by the self-reported “sex” (“male” and “female”) of respondents. Measures of self-representation include “gay,” “straight (that is, not gay),” “bisexual,” “something else” and “I don’t know the answer.” Respondents had the opportunity to not self-report. Data for these were aggregated for both “males” and “females” and a single recorded variable for sexual orientation was created using the same measures.

GENDER IDENTITY. Data from BRFSS provide one variable for gender identity. Respondents could select they were transgender: “male-to-female,” “female-to-male” or “gender non-conforming.” If a respondents did not identify as transgender, they selected “no.” Options for “don’t know/Not sure” were available as well as the option to refuse or skip the question. This variable was collapsed into one variable for all transgender people to include transgender women, men, and gender non-conforming people. In some cases, the original variable was used to understand unique results within identity.

ALL LGBTQ. A variable for LGBTQ people was created by first creating a baseline for cisgender and straight people. That includes people who did not identify as transgender but identified as straight. LGBTQ people were coded as anyone who did not identify as cisgender and straight, net of those who selected “don’t know/not sure” or refused/skipped the question.

GSS

SEXUAL ORIENTATION. Data from GSS provide one variable for sexual orientation. Respondents could select to identify as “gay, lesbian or homosexual,” “bisexual,” “heterosexual or straight,” or “don’t know.” Respondents could also refuse.

GENDER IDENTITY. Data from GSS provide both sex assigned at birth (“male,” “female” or “intersex”) and a current gender which includes “man,” “woman,” “transgender” and “a gender not listed.” Respondents could also refuse. HRC Foundation used a two-step process to create a variable for transgender respondents. Transgender respondents were identified as those whose sex assigned at birth differed from their current gender.

ALL LGBTQ. A variable for LGBTQ people was created by first creating a baseline for cisgender and straight people. That includes people who did not identify as transgender and also identified as straight. LGBTQ people were coded as anyone who did not identify as cisgender and straight, net of those who selected “don’t know” or skipped the question.

INDUSTRY. Industries were determined using the 2007 [North American Industry Classification System](#) and were already provided as a recoded variable in the GSS data. For the additive industry estimate, we provide a confidence interval to account for variation across sectors.

WEIGHTING

HRC Foundation weighted data based on documentation provided by the Center for Disease Control and the National Opinion Research Center. For BRFSS, this weighting scheme accounts for selection and noncoverage error (see [Center for Disease Control, 2019c](#)). Specifically, the core module weight is used to analyze BRFSS data since the SOGI data analyzed are only recorded by the 29 states (including Puerto Rico) in the core module. GSS weighting corrects for the subsampling strategy and nonresponse error (see [National Opinion Research Center, 2020](#)). For variance estimation within strata that contain a single unit, the strata are centered at the population mean instead of the stratum mean.