Outing Age

PUBLIC POLICY ISSUES AFFECTING GAY, LESBIAN, BISEXUAL AND TRANSGENDER ELDERS

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Preface

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Age is dirty word to many people in America. People lie about it. Others avoid or ignore those who are old. Youth is a virtue, but old age is just plain sad, so we are told. Politicians pander to the senior vote each election cycle, but fail to authorize urgently needed funds for social service programs, as the re-authorization of the still-not-yet-fully-funded Older Americans Act would do. And with the notable exception of some extraordinary individuals and organizations, the gay, lesbian, bisexual and transgender (GLBT) movement has followed this overall cultural pattern.

Today we stand at the edge of two tidal waves: a growing wave of GLBT people aging and entering the social service and community institutions which care for and advocate for the elderly; and a tidal wave of reaction against government, and against government funding for social service needs. How will GLBT people fare as these waves wash over our communities? To date, aging service providers are not ready for the new wave of GLBT elders, policy makers are running away from it, and until very recently, frankly, the GLBT community has not faced this wave either. This report aims to change these responses by increasing the awareness of policy makers, advocates and service providers about the realities facing GLBT elders.

Federal and state governments offer a wide variety of social programs and services that aim to support the lives of elderly people. Yet none of these programs recognize or support, in even the most rudimentary ways, the families GLBT people build. Social Security survivor benefits are an essential part of a widow or widower's income, yet same-sex partners do not receive this benefit, even after decades of building a family together. Nursing homes and assisted living facilities have ignored the special needs of GLBT elderly, and the dearth of data on old GLBT people makes identifying problems and advocating for solutions very difficult. Little thought has been given to the special caregiving needs and realities of GLBT seniors. Plans are made, surveys conducted, research on the elderly done—all with no awareness of the existence of GLBT seniors and of their sometimes unique situations.

This country's aging policies assume heterosexuality and close relationships with children and extended families to provide basic needs as we age. Yet what of those people without such family ties or those who are not parents? Should the ability to access good care in old age be dependent on one's parental status or one's relationship to one's family of origin? As a matter of public policy, what kind of support do the elderly need? How does that need for support change based on sexuality, or income status, or race or ethnicity? What is the responsibility of government, if any, to provide such support?

Even as GLBT old people face oblivious or alienating social service agencies, they also face devastating race, class and age bias within GLBT communities. Part of this is due to simple ignorance: because the "out" GLBT community is still an emerging community, many GLBT people just do not think of old people and the issues they face when they conceptualize community and prioritize issues. But some of our denial is certainly due to the persistent youth bias in the broader culture and in the GLBT subculture. Ageism operates to deprecate old people, and to ignore the serious problems presented by aging in a political culture that pays lip service to concern for the elderly but will not deliver the support needed to fulfill the promises made. Ageism operates when the involvement and participation of old GLBT people is not evident or even sought as desirable by our national and local organizations. And like heterosexism, ageism has consequences for the health, security, and lives of GLBT seniors.

In order to address ageism in our society and to spark advocacy for GLBT seniors, the Aging Initiative was launched in 1999 by the National Gay and Lesbian Task Force (NGLTF) Policy Institute. Through research, relationship building with GLBT and non-GLBT aging policy organizations, training, and advocacy, NGLTF works to ensure that the needs of GLBT seniors become a visible and conscious part of public policy frameworks and service programs.

The NGLTF Aging Initiative includes four main strategies:

- To collect and disseminate factual, empirically-based information and analysis on the lives, realities, and policy needs of GLBT seniors;
- To raise consciousness within the GLBT community to confront ageism that keeps older people invisible and robs the community of their unique contributions;
- To challenge aging service providers and policy makers to fully include the needs of GLBT older Americans in their policies, programs, and advocacy, without prejudice or homophobia; and
- To form partnerships with national aging advocacy groups to fight for the full inclusion of older GLBT Americans in federal and state policy.

Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual, and Transgender Elders is a pathbreaking report on an acutely understudied yet critical situation within aging services and the GLBT community—the emergence of a growing GLBT elder community. *Outing Age* marks the NGLTF Policy Institute's first effort in what is an ongoing commitment to producing research and analysis on the needs of GLBT elders. Additional research is underway and much more data are needed. For more information on NGLTF Policy Institute's Aging Initiative, visit www.ngltf.org or call the NGLTF offices.

The history of gay, lesbian, bisexual and transgendered (GLBT) people is the story of transformation. It is the story of a people whose experiences, families, communities, histories and even moral worthiness have been stigmatized, but who have emerged with courage and creativity to secure respect and create cultural and institutional change. With this publication, we seek nothing less than the transformation of consciousness needed to secure meaningful change in the lives of GLBT elders.

Outing Age

PUBLIC POLICY ISSUES AFFECTING GAY, LESBIAN, BISEXUAL AND TRANSGENDER ELDERS

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Executive Summary and Recommendations

Who are gay, lesbian, bisexual, and transgender elders? What particular issues do they face? Which public policy frameworks affect gay, lesbian, bisexual, and transgender (GLBT) elders, and how should these policies be changed to better serve GLBT elders and treat same-sex couples equally? This report provides answers to these questions, and articulates a public policy agenda for GLBT and elder activists.

We estimate that one to three million Americans over 65 are gay, lesbian, bisexual, or transgender, based on a range of 3-8% of the population.[1] The number and proportion of GLBT elders will increase significantly over the next few decades, along with the overall elder population. By 2030, one in five Americans will be 65 or older.[2] Roughly four million of these will be gay, lesbian, bisexual or transgender.[3]

GLBT elders face a number of particular concerns as they age. GLBT elders often do not access adequate health care, affordable housing, and other social services that they need, due to institutionalized heterosexism.[4] Existing regulations and proposed policy changes in programs like Social Security or Medicare, which impact millions of GLBT elders, are discussed without a GLBT perspective engaging the debate. By releasing *Outing Age: Public Policy Issues Facing Gay, Lesbian, Bisexual, and Transgender Elders*, the Policy Institute of the National Gay and Lesbian Task Force (NGLTF) seeks to change this dynamic, and intervene in these critical policy discussions.

Federal programs designed to assist elderly Americans can be ineffective or even irrelevant for GLBT elders. Several studies—of nursing home administrators, of Area Agency on Aging directors, of health care providers—document widespread homophobia among those entrusted with the care of America's seniors. Most GLBT elders do not avail themselves of services on which other seniors thrive. Many retreat back into the closet, reinforcing isolation.

Several federal programs and laws blatantly treat same-sex couples differently from married heterosexual couples.[5] For example:

- Social Security pays survivor benefits to widows and widowers, but not to the sur-

viving same-sex life partner of someone who dies. This may cost GLBT elders $124 million a year in unaccessed benefits.

- Married spouses are eligible for Social Security spousal benefits, which can allow them to earn half their spouse's Social Security benefit if it is larger than their own Social Security benefit. Unmarried partners in life-long relationships are not eligible for spousal benefits.
- Medicaid regulations protect the assets and homes of married spouses when the other spouse enters a nursing home or long-term care facility; no such protections are offered to same-sex partners.
- Tax laws and other regulations of 401(k)s and pensions discriminate against same-sex partners, costing the surviving partner in a same-sex relationship tens of thousands of dollars a year, and possibly over $1 million during the course of a lifetime.
- And even the most basic rights such as hospital visitation or the right to die in the same nursing home as one's partner are regularly denied same-sex partners.

Many GLBT elders experience social isolation and ageism within the GLBT community itself. These issues, often compounded by racism and other kinds of discrimination, demand the attention of policy makers, service providers and activists working on behalf of, and with, the elderly. As GLBT people grow older, they enter a world of services that may not be familiar with GLBT people. Some activists have created GLBT-specific service organizations for the aged, such as Senior Action in a Gay Environment (SAGE), Gay & Lesbian Outreach to Elders (GLOE), Pride Senior Network, and a few others. These types of programs are not available in all parts of the country and cannot provide all the services needed. This is particularly true in rural areas.

A number of the problems faced by GLBT elders also stem from the fact that they often do not have the same family support systems as heterosexual people. This is compounded by the failure of the state to recognize their same-sex families. Many gay men and lesbians already have experience providing care. Despite the attempts of the right wing to construct "family" and "gay" as mutually exclusive categories, one in three gay men and lesbians provide some kind of caregiving assistance—either to children or to adults with an illness or disability.[6] Since a disproportionate number of GLBT elders live alone, innovative support networks are critical.[7]

GLBT elders are among the most invisible of all Americans. Little is known about GLBT elders because of the widespread failure of governmental and academic researchers to include questions about sexual orientation or gender identity in studies of the aged. Legal and policy frameworks which have traditionally excluded GLBT people engender social and economic consequences that deny GLBT elders access to financial resources and community support networks.

The need to make broad assumptions about the size of the GLBT elderly population underscores one of the major problems in understanding the needs of this population. GLBT elders are not only underserved, they are also understudied. There is an overall lack of empirical demographic data on gay, lesbian, bisexual or transgender persons of any age, but data on GLBT seniors are particularly limited. Very little literature examines the lives of GLBT old people, and that which exists has many limitations. Most samples heavily overrepresent white gay men from urban areas with middle or upper incomes, and underrepresent women, people of color, low-income people or residents

of suburban and rural regions. In addition to a policy agenda, a research agenda is urgently needed.

This report is an attempt to bring a new awareness to the pressing issues facing gay, lesbian, bisexual, and transgender old people. We hope that the concrete suggestions offered for public policy change and intracommunity change will challenge young and middle aged GLBT activists, as well as heterosexual aging activists, to join with GLBT elders and play a more active role in overcoming the barriers which exist.

- First, we review the social science literature and explain what we already know about GLBT elders, as well as the sizable gaps in our knowledge about the demographics of GLBT elders.
- Second, we describe the context of heterosexism and presumptive heterosexuality in which GLBT elders live.
- Third, we discuss the major public policy issues facing seniors, and examine how these policies affect GLBT elders in particular. These policies include: federal aging programs, such as the Administration on Aging, which funds many local senior services; Social Security; Medicare and Medicaid; long-term care; housing, including nursing homes; 401(k) and pension regulations; public health; disability; family policy; welfare reform; and other issues.
- Fourth, we propose recommendations for public policy advocacy to improve the lives of GLBT elders and move toward equal treatment of this population.
- Finally, we provide a resource listing of GLBT organizations working on aging issues for further exploration and action.

Major Recommendations

Detailed recommendations for policy change and advocacy are found at pages 70-79 of this report. Among the major recommendations are:

1. Government agencies charged with serving the needs of older Americans must fund and actively initiate research on GLBT seniors and should amend their mandates to encompass GLBT people.
2. Amend the Older Americans Act to explicitly include services, training, and research on issues of concern to GLBT seniors; to prohibit discrimination in services on the basis of sexual orientation and gender identity; and to incorporate the inclusive definition of family in Part E of the National Family Caregiver Support Program.
3. Legally recognize and support GLBT families to ensure equal access to Social Security benefits by partners and children and to minimize discrimination against GLBT seniors in nursing homes and senior housing.
4. Expand social services to the GLBT elder population.
5. Pass non-discrimination laws to ensure GLBT people, including seniors, are not vulnerable to discrimination because of sexual orientation or gender identity.
6. Mainstream aging organizations must expand programs and missions to incorporate an awareness and response to the needs of GLBT elders.

Through a combination of policy reform, education, increased research and training, advocates can address the pressing needs of GLBT seniors in a tangible and meaningful way.

GLBT Elders and Aging

While we know a lot about the basic demographics of people 65 years of age and older in the US, we know far less about gay, lesbian, bisexual and transgender elders. More basic research to document the size of the GLBT senior population, its income profile, its racial diversity, its geographic distribution, and the health and quality of life issues it faces is urgently needed. This chapter summarizes

- what we know about seniors in general;
- what we know about GLBT elders based on the existing social science research;
- the context of homophobia, heterosexism, and ageism in which GLBT elders live.

WHO ARE ELDERLY AMERICANS IN GENERAL?

Much is known about the demographics of the total population of older Americans, thanks to significant data gathering by the US Census Bureau, the Administration on Aging in the Department of Health and Human Services, and other governmental agencies, and thanks to research by aging advocacy organizations like the American Association of Retired Persons and academic gerontologists. It bears restating that the absence of sexual orientation or gender identity variables in almost all major research studies and in the US Census makes these data far less useful to advocates for GLBT seniors than they could be.

A Rapidly Growing Population

The senior population in the US has grown dramatically over the past century, largely due to increased life expectancy. While the US population overall has tripled in the past century, the elder population has increased elevenfold.[8] Today nearly 35 million Americans are 65 or older, representing 13% of the population, or one in eight Americans.[9] Most older Americans are women (more than 20 million, versus 14 mil-

lion men) as women live longer, on average, than men. Fifty-three percent of seniors are 65-74 years of age, 35% are 75-84, and 12% are 85 or older.[10] Between 2000 and 2030, as baby boomers age, the number of seniors in the US will double, from 34.7 million to 69.4 million. At that point, one in five Americans will be 65 or older.

An Increasingly Diverse Population

In 1998, 16% of older Americans were ethnic minorities, according to Census Bureau data, while 84% were white, non-Hispanic. Eight percent were African American, 5% Hispanic, 2% Asian and Pacific Islander, and less than 1% Native American.[11] By 2050, it is expected that only two in three seniors will be white non-Hispanic; 16% will be Hispanic, 10% black, 7% Asian and Pacific Islander, and 1% Native American.[12] About one in eight seniors speaks a language other than English at home; in 1990, 28% of those elders who spoke a language other than English at home spoke Spanish, while 72% spoke another language. Because the Latino/-a population is disproportionately young, the percentage of seniors speaking Spanish at home is expected to increase over the next half century.[13]

People on Limited Incomes

Poverty is a reality for millions of older Americans, and seniors are more likely to be poor if they are female, black or Latino. Concentrations of poverty vary widely across regions of the country and from state to state, and the official definitions of poverty are so low that they clearly underestimate the problem.

In 1998 the median annual income of American elders was $18,166 for males and $10,504 for females.[14] About 3.4 million elders (or 11%) live below the poverty level, defined as $8,050 for an individual, $10,850 for two people and $16,450 for a family of four. Another 2 million, or 6% of elders, are classified as near-poor (income between the poverty level and 125% of this level).[15] Without support from Social Security, the official poverty rate among seniors would rise to 54%.[16]

Seniors are more likely to be poor if they are female, black or Latino.

Perhaps a better measure of poverty among American seniors is provided by the American Association of Retired Persons: 40% of all older persons in the US earn less than 200% of the official poverty level, or less than $16,100 for one person and $21,700 for a couple.[17] Even among those seniors who work full-time year round, 2.1 million live below the official poverty level.[18]

Old women experience a higher poverty rate (13%) than old men (7%). Old persons living alone or with non-relatives were more likely to be poor (20%) than were old persons living with families (6%). One of every 11 elderly whites were poor (9%), compared to one in four elderly blacks (26%), and one in five Hispanic elders (21%). The highest rate of poverty, 49%, is experienced by African American women who live alone.[19] Older people living in rural areas, urban areas and in the South and Southwest are more likely to live in poverty. The District of Columbia has the highest senior poverty rate (21%). High rates are also found in Arkansas and Mississippi (17% each), and Louisiana, New Mexico and Texas (16% each).[20]

Part of the cause of disproportionate poverty among black and Latino seniors is their lower levels of educational attainment, a result of historical racism, segregated and

lower quality schools, and the disproportionate impact of poverty, which forced many to leave school and work. While 69% of white elders graduated from high school, only 43% of black and 30% of Hispanic elders did, according to data from the 1998 Current Population Reports.[21] And while 15% of white seniors graduated from college, only 7% of black seniors and 6% of Hispanic seniors did.[22] Lower levels of educational attainment, lower earnings, and fewer years in the work force—also due in large part to sex and race discrimination—mean that women and ethnic minorities earn less income in retirement, as pensions and Social Security pay more to those with higher earnings histories and more years of paid work.[23]

More than half of seniors (53%) reported at least one disability.

Living Arrangements

In 1990 about 5% of seniors lived in nursing homes. Most of those living in nursing homes are older women: three in four nursing home residents were 75 or older and 70% were women, according to 1990 Census data.[24] Two-thirds of older noninstitutionalized people live with a family member. Only 20% of older men live alone, versus 42% of older women; this is in large part due to the longer life expectancy of women, who are more likely to become widows than men are to become widowers.[25] About 5% of elder women, and 4% of elder men, have never married.[26]

Geographical Distribution

Seniors are concentrated in a number of states, although it is unclear if there is any discernable pattern to the distribution of population. Florida—traditionally a popular retirement destination—has the highest percentage of seniors, with 18% of its population 65 or over. Other states with significant senior populations are Pennsylvania and Rhode Island at 16% each, and Iowa and West Virginia at 15% each.[27] The need for more funds to be funneled to sunbelt states like Florida—which have experienced dramatic growth in the elder population in recent years—under state funding formulae is acute.

Health and Disabilities

Elders are three times as likely to report fair or poor health. While 9% of all Americans reported fair or poor health in 1996, 27% of seniors rated their health fair or poor. Racial disparities obtained here as well: 42% of older African Americans, and 35% of older Hispanics reported fair to poor health, versus only 26% of older whites.[28] More than half of seniors (53%) reported at least one disability, as did 72% of those 80 or older. One third of all seniors 65 or older reported a chronic condition, such as hypertension or heart disease, and one third had at least one severe disability.[29] Elders with disabilities such as a self-care or mobility limitation were twice as likely to be poor as elders without such limitations, according to 1990 data.[30]

In 1997 seniors averaged $2,855 in annual out-of-pocket expenditures on health care; those under 65 spent about half this annually on health care.[31] Premium payments are the single largest out-of-pocket health expenditure for US elders, followed by spending on prescription drugs, which accounts for about 17% of out-of-pocket expenditures.[32] Older women spend more each year out-of-pocket on health care needs than men; also, because on average women have lower incomes than men, their health care costs con-

sume a larger share of their annual income.[33] Younger people are more likely to have insurance offering some coverage for prescriptions.

WHAT DO WE KNOW ABOUT GLBT ELDERS?

What we know about GLBT seniors in the United States comes from the pioneering social science research conducted by a small number of scholars since the 1960s. Most of these studies are of gay men; a smaller number are of lesbians. There are very few studies that include transgender or bisexual individuals, or that examine the findings to discern issues of particular concern to bisexual and transgender seniors.[34] Most studies involve small sample sizes that do not reflect the racial and economic diversity of the community.[35] Gilbert Herdt *et al.* report that "in the case of older bisexuals, lesbians and gays, the combination of poor research literature, clinical samples, and dated historical narratives from prior generations has had the effect of making this population appear more homogeneous than it is, undercutting diversity in life-course experience."[36] Future research must do better at gathering information on *all* GLBT seniors, including people of color, low-income, and immigrant populations. The following sections synthesize what existing research on GLBT people tells us about GLBT seniors.

How Many GLBT Elders Are There?

We are unable to give an exact number of GLBT seniors for the same reasons that we cannot give an exact number of the total gay, lesbian, bisexual and transgender population of all ages in the US: few national surveys ask about sexual orientation and fewer still ask about gender identity, making it difficult to accurately estimate the total GLBT population. The few surveys that do capture data usually ask about sexual behavior, not orientation or identity.[37] Whether or not surveys ask about sexual behavior or orientation, they likely undercount GLBT populations because respondents are wary about "coming out" to a researcher and because responses vary based on the methodologies used.

Estimates of the gay, lesbian, and bisexual senior population in the United States range from 1 to 2.8 million.

Estimates of the GLBT senior population in the US depend on estimates of the overall GLBT population. In the early 1980s, two researchers estimated that the GLBT elderly population ranged from from 1.75 million lesbians and gay men age 65 and older to 3.5 million 60 and older.[38] These estimates were based on Alfred Kinsey *et al.*'s estimates of the predominantly homosexual population at roughly 8 to 10% of the overall population.[39] Kinsey *et al.* found that 37% of men and 20% of women had at least one sexual experience with someone of the same sex since puberty, while 13% of men and 7% of women had more homosexual than heterosexual sexual experiences.[40] Today, using Peter Fisher's reinterpretation of Kinsey that estimates 8% of the adult population to be gay or lesbian, there would be 2.8 million gay men and lesbians age 65 and older in the US.[41]

Aside from Kinsey, estimates of the homosexual population have ranged from as low as 1%[42] to as high as 7%,[43] while several studies have documented the percentage of those reporting some homosexual behavior as well as heterosexual behavior in the double digits.

Although the number of GLBT seniors has not been empirically documented, the various estimates described above and in Appendix A place the gay, lesbian and bisexual population of the United States somewhere between 3% and 8%. It is likely that many of these studies underestimate the gay, lesbian and bisexual population due to the inevitable reluctance of some to come out to an interviewer or on a survey. Given the potentially high incidence of bisexuality, which still remains taboo not only among heterosexuals but also among homosexuals, this range may be quite conservative. If 3-8% of the total population is gay, lesbian or bisexual (GLB), and if seniors exhibit the same range of sexuality as other age cohorts, then the GLB senior population today would range from 1 million to 2.8 million individuals. And by 2030, there would be from 2 million to 6 million GLB seniors.[44] Until sexual orientation becomes a standard demographic variable on national random surveys, this range is the best estimate we can make of the GLB senior population.

There are no national data available on transgender people in the US, so our estimates undercount the full GLBT population.[45] It is important to note that transgender people exhibit the full range of sexual orientations, from homosexual to bisexual and heterosexual.[46]

Racial and Class Diversity

Because few national surveys document the size of the GLBT community in the US, we know little about the racial and class diversity of the GLBT community. However, there is evidence that random samples of gay, lesbian and bisexual (GLB) people are as racially diverse as heterosexual samples. For example, the Voter News Service's GLB sample is racially representative of the larger population.[47] Unfortunately, this diversity is not always reflected in GLBT media images of our community, representations of gay people in the larger culture, or the leadership of mainstream GLBT organizations. Yet there is no reason to believe that the GLBT community is any less racially diverse than the overall population of the United States.

Little research on GLBT people of color exists. According to Clarence Adams and Douglas Kimmel, as of 1997 there were no empirical studies specifically of older African American gay men.[48] The work of Vickie Mays *et al.* on disclosure of sexual orientation to family members among black lesbians and gay men provides some useful information on income, family structure, and other demographic variables. However, although their sample was large (n = 506 women, 673 men), less than 10% were age 45 or older.[49] Still, given the dearth of data on black gay and lesbian people, their data may predict future trends among African American GLBT seniors.

Mays *et al.* note the integral role adult children play in providing caregiving support to aging parents in African American families. Aging parents are more likely to reside in the home of immediate family and less likely to enter a nursing home than elders of other ethnic backgrounds.[50]

One in four black lesbians in the study lived with a child for whom she had childrearing responsibilities, suggesting strongly that "[a]s lesbian mothers and/or grandmothers, [black lesbians] are connected to family-based social networks and supportive relationships in which they provide assistance to younger generations of the family (i.e. children and grandchildren, nieces, nephews)."[51]

There is little empirical social science research on Latino/Latina, Asian Pacific Islander, and Native American GLBT elders. In recent years more and more scholars have studied the demographics and needs of GLBT people from these ethnic communities, particularly in the area of health. Few of these studies have focused primarily on GLBT seniors of color. Much of the scholarship has not been in the social sciences but in the humanities. For more information on this research see Appendix E, pp. 93-94.

In 1992 one in four elders living alone or not living with relatives was poor, compared with only one in 20 elders in a married couple family.[52] This is also an indicator of the correlation between marriage and minimal economic security. Since many studies, described in the following section, indicate GLBT seniors may be more likely to live alone and lack family support networks, GLBT seniors may experience poverty and economic insecurity at higher rates than heterosexual seniors.

A widespread myth holds that gay and lesbian people are economically privileged relative to the majority population. In fact, GLBT people are distributed along the income scale in the same proportions as heterosexuals. Anti-gay activists and governmental officials have portrayed gays as wealthy to justify opposing non-discrimination laws.[53]Such claims are derived from reader surveys aimed at potential advertisers conducted by gay and lesbian newspapers and magazines, which reflect the affluence of those able to subscribe to such publications.

Non-market research-generated data sets demonstrate that gay men and lesbians earn no more than heterosexual men and women. In fact, some studies indicate gay men earn less on average than heterosexual men.[54] M.V. Lee Badgett's analysis of the General Social Survey found gay men working full time earned as much as 27% less than comparable heterosexual men. Marieka Klawitter and Victor Flatt's analysis of the 1990 Census data on same-sex and married couples living in areas without sexual orientation non-discrimination laws found that men with male partners earned 26% less than married men of similar educational background, geographic location, racial background, age, number of children, and disability status. Klawitter and Flatt also found that gay male couples earned the same total household income as male-female married couples, despite the fact that men on average earn more than women.[55] Women with female partners showed no statistically significant differences from heterosexual women when the other factors were taken into account.

Political Scientist Robert Bailey's study of 40 metropolitan areas with gay and lesbian residential concentration shows a "slightly negative" relation between homosexuality and household income. In metropolitan areas such as Chicago, Washington, Boston, St. Louis and Denver, "[t]he household incomes of zip code areas in which gay male and lesbian residents are concentrated correlate positively with the lower- to lower-to-moderate-income brackets or negatively with the upper-income categories." Bailey notes that, except in Los Angeles, Manhattan and Atlanta, "the notion that gay neighborhoods are relatively well off is not true."[56]

Anecdotal evidence indicates that poverty and wage discrimination are widespread experiences of transgender people. Few specific data exist on poor GLBT people and how poverty may be experienced differently by GLBT people because most studies which measure poverty fail to ask questions about sexual orientation and gender identity. Neither gay activists nor anti-poverty activists have developed an analysis of how public policy frameworks constructed to alleviate poverty reach GLBT people.[57] We do

know that Medicaid, the insurance program for the nation's poorest residents, pays for the health care of half of all persons living with AIDS, including many gay and bisexual men.[58]

Living Arrangements

Are GLBT seniors more or less likely to live alone? Are they more or less likely to live in isolation, and experience loneliness? What potential caregiving networks are in place, and what needs will not be met by family and friends as GLBT seniors age and develop greater caregiving needs? These are critical questions for those concerned with aging and aging policy.

There is some evidence from the limited research that exists that GLBT seniors are more likely to live alone. A 1999 study conducted for Senior Action in a Gay Environment found that 65% of 253 gay and lesbian seniors surveyed in New York City reported living alone. This was nearly twice the rate of all people 65 years or older in New York City, of whom only 36% lived alone.[59] In general, women are more likely than men to live alone, in part because widows are more common than widowers. In New York among all elders, 42% of women 65+ lived alone, versus 21% of men 65+.[60]

The New York study also found that "less than one in five gay/lesbian seniors are currently living with a life partner in contrast to the nearly half of the general elderly population who are currently married," and that 90% of gay seniors have no children, versus only 20% of all seniors.[61] Another more representative study found that 75% of gay and lesbian seniors in Los Angeles lived alone.[62]

It should be noted that while the lonely old gay man or lesbian is a long-standing stereotype, many studies have refuted the view that loneliness is any more prevalent among older gay men and lesbians than it is among older heterosexuals or among younger homosexuals.[63] In fact, "the literature suggests that a positive experience and healthy adjustment to old age are both possible and frequent for gay men," Jim Wahler and Sarah Gabbay write. The same is true for older lesbians.[64]

Partnership and Singlehood

Much of the existing social science research examines differences between those who are partnered and those who are single. In general the research documents a greater sense of well-being among those in partnered relationships than among single gay and lesbian seniors.[65] These include fewer sexual problems, lower levels of regret regarding their sexual orientation, and less depressive symptomatology. One study comparing partnered heterosexual women, partnered lesbian women, and single straight and gay women found that those in partnered relationships had higher senses of well-being than single straight women or single lesbians.[66] However, this could be due to a sense of self-satisfaction at meeting a societal norm of being partnered, and not a result of being partnered in and of itself.[67]

In terms of the percentage of gay and lesbian people in partnered relationships, a number of surveys from the late 1970s to the late 1990s document a range of 40-60% of gay men and 45-80% of lesbians in a committed relationship at any given time.[68]

Geography

Exit polling data indicate that there are more openly gay, lesbian and bisexual (GLB) voters in urban areas than in rural and suburban areas. Such data suggest that large and mid-sized cities may have a higher concentration of GLBT senior populations. Voter News Service data from 1996 and 1998 reveal that 8.8% of voters in big cities (500,000+ population) self-identify as gay, lesbian or bisexual, versus 7.2% for medium size cities (50,000-500,000), 3.7% in suburbs, 3.9% in small towns (10,000-50,000), and 2.3% in rural areas.[69] It is unclear whether there are actually more GLB voters in large cities, whether GLB people are less likely to self-identify in an exit poll in suburban and rural areas, or both. It could also be that GLB people in urban areas are more politicized and therefore more likely to vote than GLB people in suburbs or small towns. Other data show concentrations of gay men and lesbians in more than 40 metropolitan areas around the US.[70]

PROFILE: ALLEN JONES, 63

Business to Business Magazine

A Georgia native and long-time resident of Atlanta, Allen Jones is known as a talented entrepreneur, political organizer, networking guru and the founding president of the Atlanta Executive Network (AEN), a gay and lesbian business and professional association.

Because of Jones's considerable organizing skills, AEN has emerged as one of the most successful organizations of its kind in the country, providing an opportunity for gay and lesbian professionals to comfortably congregate, share business ideas and have an impact on the corporate world. During Jones's five-year tenure as President, AEN's membership grew to more than 1,200 people.

During the early days of the HIV/AIDS epidemic in Atlanta Jones created another very effective organization known as Helping Hands of Atlanta. This unique association brought together community leaders for a monthly fundraising dinner (at $280 per person) to support local AIDS organizations. Helping Hands not only raised tens of thousands of dollars. Its members also provided free management consulting assistance to Atlanta's growing number of struggling HIV/AIDS organizations.

Ever since his graduation from Georgia Tech in 1960, Jones has been a considerable force in the business community. He began his career in the insurance business from 1961 to 1964. His experiences as an investment banker from 1975 to 1984 provided him with the perfect background to engage the challenge of creating elderly retirement housing projects. From 1984 to 1988 he developed a luxury elderly housing retirement community in Richmond, Virginia that included independent housing, assisted living and a nursing home.

At the present time Jones's company,

ARI Consultants, provides emerging companies and those in need of capital for expansion with a range of services, including strategic planning, business plan development, and capital acquisition planning. He also provides merger and acquisition advice. In addition, his firm prepares market feasibility studies and management financial forecasts.

And, with all this activity in his life, Jones is also no stranger to the realm of politics and political organizing. In years past he was employed by the Republican National Committee, and in 1963 was elected president of the Georgia Young Republicans and beat out Newt Gingrich for the post. As Chairman of the Platform Committee of the National Convention of Young Republicans in 1965, he led the passage of a civil rights plank despite considerable protest. Over the years Jones has also served on the campaign committees of several political office seekers.

Since Jones's message to the community is always about maximizing personal potential, learning to network better for results, and living your vision, it is clear that his life is just beginning.

Health Issues

We know very little about the health care needs of older GLBT people. A key reason for this ignorance is the failure of many national population based health surveys to assess sexual orientation. Federal funding for research on sexual orientation and GLBT people has also been denied by Congress.[71] Other obstacles include methodological challenges, such as the difficulty of recruiting subjects; respondents' fear of self-disclosure; difficulties defining homosexual, bisexual, and transgender identity; and differentials in response rates based on type of survey conducted.[72]

GLBT elders are less likely to receive supplemental coverage through their partners' health plans.

The Gay and Lesbian Medical Association and the Center for LGBT Health at Columbia University have identified a number of major structural concerns related to GLBT health overall, including: 1) the lack of a coordinated public health infrastructure to support and direct funded initiatives on GLBT health; 2) institutional barriers to quality health services, such as the denial of benefits to same-sex spouses by insurers and employers; and 3) barriers to communication between health care providers and GLBT consumers.[73]

Bias

Despite the dearth of public health research, anti-GLBT discrimination and barriers to care are well-known and documented.[74] Numerous studies document discrimination and bias against GLBT people in health care settings. Stereotyping and inadequate education can cause health care providers to ignore known preventive care procedures or treatment needs of GLBT patients, and may lead GLBT people to remain silent about health issues and concerns they have for fear of stigmatization.[75] This latter problem may be particularly pronounced among older GLBT people, many of whom have concealed their sexual orientation throughout their lives.[76]

Mental Health

Mental health care delivery may be hampered by a reluctance on the part of health professionals to address issues of sexuality. Treatment approaches that are dependent on group therapy or support groups may also be problematic for GLBT people who are concerned that disclosure of their sexual orientation or gender may result in peer disapproval. Discrimination following disclosure of sexual orientation in nursing homes, senior centers, domestic violence centers and other auxiliary care settings has been reported.[77] A recent study found that one in four lesbian and gay people who sought mental health counseling reported receiving inappropriate treatment.[78]

Lack of Health Insurance

Lack of health insurance is a major concern for GLBT people. Although possession of health insurance correlates positively with age, GLBT elders are less likely to receive supplemental coverage through their partners' plans. This is of particular importance for prescription drug coverage, which is not available under traditional fee-for-service Medicare. A large number of those without health insurance are poor, African American or people of color.[79] In a study of 40- to 60-year-old lesbians in the National Lesbian Health Care Survey, Judith Bradford and Charlotte Ryan found that 80% reported excellent health, but 27% had no health insurance.[80] The 1990 Michigan Lesbian Health Survey found that 12.3% of lesbians lacked health insurance, compared with 9.7% of Michigan women in general.[81] The National Lesbian Health Care Survey found that 16% of lesbian respondents could not afford health care.[82]

Twenty-seven percent of lesbians 40 to 60 years old lack health insurance.

Social and economic marginalization resulting from the pathologization of transgenderism means that access to health care and health insurance is even less prevalent among transgender individuals.[83] Transgender youth and transgender people of color may be particularly at risk of economic and social marginalization, including poverty and homelessness.[84]

Health Risks

Lesbian Health Concerns

There may be some health risks which are particularly pronounced among GLBT populations, including GLBT elders. A number of studies indicate that certain risk factors associated with breast cancer occur at higher levels among lesbians than among heterosexual women. These risk factors include nulliparity (never having given birth), differential rates of exposure to hormones due to less use of oral contraceptives, obesity, alcohol consumption, smoking, poor diet, and lower rates of breast cancer screening.[85] Yet the Institute of Medicine's 1999 *Lesbian Health* study cautioned that, to date, there are "no epidemiological studies supporting a conclusion that lesbians are at increased risk for breast or other cancers."[86]

The *Lesbian Health* study also reported possible higher risk factors for cervical cancer for lesbians: lesbians were less likely than women in general to get a Pap test done at least once a year, and at one community health center, lesbians went 21 months between Pap smears versus an average of 8 months for heterosexual women of the same age.[87]

Cancer diagnosis rates vary with race. The most commonly diagnosed cancer for black and white women in the US is breast cancer. Yet the second most commonly diagnosed cancer for black women is cancer of the colon and rectum; for white women, it is lung cancer.[88] Lesbians on average have a higher body mass index; if this is accompanied by a high fat diet, this may place lesbians at higher risk for colorectal, ovarian, and endometrial cancers.[89] Never having given birth and the nonuse of oral contraceptives may place lesbians at increased risk of endometrial and ovarian cancer. However, as of yet there is no epidemiological research which definitively proves higher risk for any form of cancer among lesbians. Other health concerns of older lesbians include Alzheimers, fibromyalgia, arthritis, heart disease, and hypertension. Lesbians and women who have sex with women with HIV clearly face some risk of transmission of HIV and other sexually transmitted diseases. Consequently, safer sex guidelines tailored to this population are limited.[90] More research is needed to determine risk factors and effective prevention strategies.

Gay Men's Health Concerns

Prior to the approval of antiretroviral drug regimens, gay men were at higher risk for Kaposi's sarcoma and non-Hodgkin's lymphoma, both as a byproduct of HIV's weakening of the immune system.[91] In the US, gay and bisexual men who do not practice safe sex remain at elevated risk for the transmission of HIV and other sexually transmitted diseases like hepatitis.[92] Hepatitis can be severely debilitating and even fatal; while vaccines are available for hepatitis A and B, vaccination remains rare. A 1996 CDC analysis of a San Francisco study of 385 young men who have sex with men found that only 3% were vaccinated against hepatitis B. Yet 20% showed evidence of current or previous hepatitis B infection.[93] Sell and Bradford also report that "[c]ommunity-based clinics reported epidemic rates of HAV (hepatitis A virus) in 1998 and 1999 among gay men in New York, Boston, Atlanta, and various cities outside the US.[94] There is increasing evidence that gay men who engage in unprotected anal sex are at higher risk for anal cancer.[95]

Alcohol and Drug Use

While there is no conclusive evidence that alcohol abuse is more prevalent among gay men and lesbians, numerous studies document much higher smoking rates among both gay men and lesbians than among heterosexual men and women. Stall *et al.*, using a household-based sample, found that 41.5% of gay male adults smoked, versus 28.6% of men in general.[96] Other studies have documented higher rates of smoking among lesbians than among heterosexual women.[97] The Institute of Medicine's Lesbian Health study reported twice as many lesbians as heterosexual women are heavy smokers as (6.8% to 7.4% of lesbians compared to 3.5% of heterosexual women.)[98] One study of gay and lesbian youth in the southern United States found higher rates of smoking among young lesbians than among young gay men.[99]

Old Gay and Bisexual Men and HIV/AIDS

There are two issues which make HIV/AIDS a particular concern for GLBT elders: the continued transmission of HIV among older populations, especially of men who have sex with men, and the increased lifespan of people with HIV and AIDS due to the new medications which offer the promise, as yet unrealized, of transforming HIV/AIDS into a chronic condition rather than a terminal disease.

A number of studies indicate that prevention messages are not working with older men who have sex with men (who may not identify, however, as gay or bisexual) and that older men may be at higher risk for HIV transmission. A 1994 study of 432 self-identified gay men in Chicago compared men 60 and older and younger men in the study. It found that 44% of the older men reported multiple partners, and fewer of the older men were in a primary relationship with another man.[100] Kooperman's 1993 study of 191 American and Canadian gay and bisexual men over 50 found that 9% of those reporting sexual activity within the past month (13 of 139) had engaged in anal intercourse without a condom. When asked why they hadn't used a condom, 59% said, "My partner and I are not at risk," and 32% said, "Sex is less enjoyable with condoms."[101]

Nathan Linsk reports that

> [o]lder gay men appear to have more difficulty negotiating the change to safer sex practices. During their adolescence and early and middle adulthood, this generation of men had little to fear from unprotected sex other than hepatitis and relatively easily treatable sexually transmitted disease. Many are finding it difficult to incorporate safer sexual practices into their sexual repertoire. Although older gay men may be quite knowledgeable about HIV transmission, many express the sentiments of a 67-year-old client who said, "Our people don't use condoms."[102]

Of more than 700,000 Americans diagnosed with AIDS through 1999, 10-11% of them were age 50 or older at the time of their diagnosis.[103] Women accounted for about 11% of AIDS diagnoses for people over 50.[104] Fifty-four percent of the 700,000 people with AIDS in the US were men who have sex with men.[105] About 38% of newly reported cases of HIV are men who have sex with men; a disproportionate number of these are African American and Latino men.[106] The Centers for Disease Control and Prevention reported that from 1991 to 1996, people age 50 and older experienced a sharp increase in the incidence of HIV-related illnesses (up 22%), while the 13-49 year old age group experienced a 9% increase. The success of new drug regimens will also contribute to an increase in the number of old people living with HIV in the future. Based on CDC data, Nathan Linsk predicted in 1997 that by the year 2000, there would be about a quarter of a million HIV-positive people 50 and older in the US, and 100,000 to 120,000 people with HIV 60 years or older.[107]

The Life Course of Growing Old

As Bertram Cohler notes, more research needs to be done on the normative living process of aging GLBT people. Nonetheless, a range of existing studies dispel many of the widespread stereotypes promulgated about GLBT elders.[108] While many young and middle-aged gay men and lesbians seem to hold to a stereotype that they will live out their mature years in loneliness and isolation, research has proven otherwise. As with other populations, GLBT people tend to live out the last decades of their life very much as they lived the middle decades. Life experience and the influence of a cohort of their peers seem to have much more influence on how people adjust to old age than either age alone or sexual orientation.

Studies also show a difference between the choices many elderly people make to be alone versus being lonely. New forms of relationship in old age can include living independently but continuing close, intimate relationships with one partner or several. Nurturing friendships, not just a long-term relationship with a partner, seem to provide a major source of life satisfaction.

These studies show, as might be expected, that gay men age in very different ways from lesbians.[109] There is some indication that gay men experience "accelerated aging," i.e. experience themselves as old at an earlier age than their chronological age.[110] Such feelings can occur as early as age 30.[111] These attitudes are especially profound among those men who find much of their social acceptance and life meaning in physical attractiveness and desirability. This phenomenon is perhaps the most striking example of internalized ageism.

Many lesbians, on the other hand, have been found to approach midlife and old age with a greater sense of freedom and fulfillment. Women tend to find themselves in a wider, intergenerational circle of friends and family than gay men.[112] Much of the literature "suggests that a positive experience and healthy adjustment to old age are both possible and frequent for gay men" as well as for lesbians.[113]

Gay men experience "accelerated aging," i.e. experience themselves as old at an earlier age than their chronological age.

It should be reemphasized here that, as in many other aspects of American life, men and women can experience the world very differently. While both sexes are exposed to the same realities of all the forces of the culture during any particular decade, social change can be experienced differently by both groups. Many old lesbians report, for instance, that feminism is a much more powerful force in their lives than the political dynamics of gay liberation. However, for gay men, Stonewall and its aftermath may be the most salient influence in their political development.

Some GLBT people age with a sense of crisis competence. Many have experienced so much pain and crisis in their lives as a result of homophobia and discrimination, including the ravages of the AIDS epidemic, that they have been, in a sense, in training, learning life skills for the challenges they may face in old age.[114] Douglas Kimmel argues that gay men are more prepared for aging because they have had to take more responsibility for their own needs earlier in life than many straight, married men. He also suggests that gay male lives may be less disrupted by life-cycle changes than heterosexual men's lives, such as role changes that ensue after the death of a spouse or when children leave home.[115]

Another important variable may be whether or not a person has been married to someone of the opposite sex before coming to terms with their sexual orientation. Among older age cohorts, such experiences are common. For example, in Clarence Adams and Douglas Kimmel's study of older black gay men in New York, six out of 20 had been married to a woman. At least four and as many as six of the 20 reported having fathered children, and 16 of 20 reported at least one heterosexual experience.[116]

Gilbert Herdt *et al.'s* study of 160 older gay men, lesbians, and bisexuals in Chicago found that 40% of the sample had been married to a person of the opposite sex, for an average of 14 years. Some 40% of the women had children, as did 24% of the men. While Herdt *et al.* found no difference in marriage rates among younger (45-50) and slightly older (51+) cohorts of lesbians, they did find a significant difference among the same two age cohorts in the gay male population. Only 29% of the men 45-50 had been married to a woman, whereas 40% of the men 51+ had been married.[117]

Little research has been done to analyze any effects of being in prior heterosexual relationships, if any, on GLBT elders' later experiences in the GLBT community. It is also

unclear how GLBT people with children from a prior heterosexual relationship experience aging differently from GLBT people without children.

Some gerontologists characterize people by age cohort. Bertram Cohler proposes that GLBT persons be seen as growing up in four generations, in essence, the pre-Stonewall generation, the Stonewall generation, the post-Stonewall generation, and the turn of the century generation.[118]

THE CONTEXT: HETEROSEXISM

GLBT elders live in a social environment of heterosexism. Psychologist Gregory Herek defines heterosexism as "an ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity, relationship or community."[119] While many significant advances have been made by GLBT liberation movements in the US, especially in the last 30 years, heterosexism is still a fundamental part of the life experiences of most GLBT people. Many municipalities have adopted sexual orientation nondiscrimination laws, but these gains are not universal, and are continually under attack by anti-gay groups and individuals. Although 11 states and the District of Columbia now outlaw bias based on sexual orientation in employment, only one state, Minnesota, outlaws anti-transgender discrimination.[120] GLBT people still face discrimination in all aspects of life, including health care, housing, employment, education, social services, credit, law enforcement, union practices, and public accommodations. Numerous studies document discrimination against GLBT people in employment, housing and public accommodation.[121]

Anti-gay attitudes are widespread among elderly people in the United States. In a study of 99 elderly Americans, Ginny Kish Garrett found that 52% of respondents age 65-72 and 41% of respondents 73 years of age or older were homophobic, according to the Index of Homophobia developed by Hudson and Ricketts in 1980.[122]

For GLBT elders, struggles with heterosexism can pose serious threats to health, well-being and happiness in old age. As GLBT people grow older and rely more and more on public programs and social services for care and assistance, they may have less independence from heterosexist institutions. The fear of experiencing discrimination can reinforce social isolation, placing people at higher risk for self-neglect, decreased long-term quality of life, and increased mortality risk. Of particular concern is what happens when a transgender person with a non-congruent body (meaning that an uninformed observer would think that the genitals or other physical features of a person do not "match" the gender and/or legal identity) has to be intimately assisted by health care providers and caregivers, such as with bathing. These elders are unlikely to use such services, perhaps to the extent of refusing lifesaving emergency medical treatment or succumbing to self-neglect, rather than deal with the providers' insensitivity and ridicule.[123] Programs that work to eliminate bias among those providing services to old people are vital to the development of a safe, comfortable aging process for GLBT people.

AGEISM WITHIN THE GLBT COMMUNITY

Heterosexism, homophobia, transphobia, and exclusion in traditional aging service environments are not the only barriers that GLBT old people face.[124] Gay seniors must also confront ageism within GLBT communities. Groups like Old Lesbians Organizing for Change (OLOC), Senior Action in a Gay Environment (SAGE), and Pride Senior Network have been addressing the issue of ageism in the GLBT community for several years, even decades. Ageism is the devaluing of, exclusion of, or discrimination against people because of their age. Like racism, sexism, classism, ableism, homophobia, and transphobia, it is systemic; operating across GLBT culture to enforce the value that what is "old" is less attractive, less important, less useful, less worthy of attention and resources. Shevy Healey, one of OLOC's founders, points out that "the very word old has become such a term of insult and denigration, that it is almost out of a sense of decency and politeness that all sorts of euphemisms are substituted. We are the golden agers, elders, older (than who?), anything to avoid the word old."[125] Healey considers "senior" and other terms ageist. Because there is no community consensus on this point, and because many gay aging organizations use the term "senior," we are using the terms "old," "older," "senior," and "elder" interchangeably in this study.

Ageism is the devaluing of, exclusion of, or discrimination against people because of their age.

Manifestations of ageism within the GLBT community include beauty standards that privilege youth, the exclusion of old people from community discussions, and the absence of senior issues from the mainstream GLBT political agenda. However, the problem of ageism in GLBT communities is more than just a problem of attitude; it is also structural. Why are organizations and social institutions within the GLBT community age segregated? There is a general lack of outreach to elders; few programs honor their contributions; and very few articles in the GLBT press feature GLBT old people, except for those done with a historical perspective.[126] Discounts for elders are rarely given for admission to GLBT events. There are very few intentional intergenerational organizations, with the GLBT religious community as probably the most visible exception.

In a recent article, Patricia Nell Warren summed up the issue when she said: "Community means all of us, numerically including the old. I won't use the term again till we've earned it...and I will do my part to help bring those changes about. Till then, we need to stop kidding ourselves. Age bias is destroying the very gay world that we're trying so hard to build."[127]

Organizers against ageism have called on GLBT people to examine their own ageism and take action to remedy the ageism of GLBT communities. This includes eliminating ageist stereotypes and language, listening to and considering old people seriously, involving old people in decision making and policy bodies, creating opportunities for intergenerational personal and social interaction, and taking on the political issues that concern elders, particularly health care and economic security issues.

ELDERLY GLBT VETERANS

Although the recent media coverage of the decades-old ban on openly gay, lesbian and bisexual servicemembers leads some people to believe that "gays in the military" are a new phenomenon, thousands of GLBT people are veterans of military service. A May 2000 analysis of recent national survey data indicates that gay men are about half as likely as straight men to serve in the military, while lesbians are several times more likely than straight women to serve in the military.[128] Black *et al.* examined the 1990 US Census data on same-sex households, as well as a several year sample from the General Social Survey (GSS) and the National Health and Social Life Survey (NHSLS) from 1989 to 1996. Some 17.3% of partnered gay men on the 1990 Census were veterans, in the reserves, or on active duty in the military, compared to 36.8% of other men; a similar pattern was seen in the GSS-NHSLS data, with 16.9% of gay men and 32.3% of heterosexual men identifying as veterans. Among women, the Census data showed 6.6% of the lesbian partners to be veterans, on active duty, or in the reserves, versus only 1.4% of other women. The GSS-NHSLS data revealed military service rates of 8.1% for lesbians and 1.4% for heterosexual women.[129]

GLBT Americans who have served their country in the armed forces are acutely aware of the injustice homophobic prejudice can foster. Even before the failed "Don't Ask, Don't Tell" policy was implemented, GLBT people who were discovered in the military were forced to leave with a less than honorable discharge. This meant they were barred from all the services of the Department of Veterans Affairs, including health care, for the rest of their lives. Those who were eligible for a pension also lost their source of income.

Those who managed to fulfill their service obligation without detection face continuing problems as they look to Veterans Affairs ("the VA") to provide the services for which they are entitled. GLBT vets report that the record of the VA in serving them is mixed. Staff in some VA hospitals has been very knowledgeable and supportive of GLBT veterans, and have even provided help with surgery and psychiatric support for transsexual vets. However, GLBT veterans also report the attitude of staff in most health care environments is callous, if not dismissive, of GLBT veterans' needs.

While there are thousands of veteran's organizations across the country serving 9.3 million elderly veterans, few at this point welcome GLBT vets.[130] If GLBT vets want to avail themselves of the services these organizations provide, they must continue, however reluctantly, to live under an unofficial "Don't Ask, Don't Tell" policy to get by. Advocacy and assistance for GLBT veterans is provided by the Gay, Lesbian, and Bisexual Veterans Association (GLBVA), a national volunteer group with several local chapters and by Servicemembers Legal Defense Network. In addition, the Alexander Hamilton American Legion Post 448 in San Francisco is the first post in the country to have a predominantly GLBT membership.

GLBT AGING ORGANIZATIONS

Several organizations have long been working on the issues detailed in this report. For instance, Senior Action in a Gay Environment (SAGE) in New York City is a model program which provides advocacy, policy leadership and direct services in an intergenerational context. SAGE sponsors the only national conference on GLBT aging. For over 20 years SAGE has worked to train other communities to develop similar organizations. For example, there are now SAGE programs in Rochester, NY; Fort Lauderdale, FL; and Ottawa, Ontario. Griot Circle organizes African American GLBT elders in the New York City area.

A number of other strong advocacy groups exist. Prime Timers and Chiron Rising bring intergenerational gay men together. Old Lesbians Organizing for Change (OLOC) has made efforts to bridge the gap between academics and activists who conduct advocacy based on the actual experience of aging and the consequences of public policy. Red Dot Girls in Seattle, WA, is a model community-building project for old lesbians. Pride Senior Network advocates for the needs of GLBT elders in New York City and state. Gay & Lesbian Outreach to Elders (GLOE) provides similar services in San Francisco. The International Longitudinal Transsexual and Transgender Aging Institute in Richmond, VA researches, publishes and supports the needs of transgender elders.

These groups are on the front lines, working with GLBT seniors to provide creative advocacy and programming. However, they are only able to provide services to a tiny fraction of the population in just a few locations. The GLBT community must awaken to the unmet needs of GLBT elders in most parts of the country and advocate for private and public services to aging GLBT people.

Three national GLBT organizations have recently created specific programs aimed at an aging GLBT population. The Policy Institute of the National Gay and Lesbian Task Force launched its Aging Initiative in 1999. The NGLTF Aging Initiative seeks to change institutions and policies in the United States to support the needs of GLBT elders through research and policy analysis, training, networking and public policy advocacy. Through this initiative, NGLTF will engender more meaningful advocacy on GLBT senior issues on the part of both the mainstream, predominantly younger GLBT movement as well as the mainstream, predominantly heterosexual aging organizations.

The National Center for Lesbian Rights (NCLR) launched an aging initiative with the naming of Del Martin and Phyllis Lyon as co-chairs of the effort. NCLR provides free legal advice and workshops on issues of special concern to old people, including Social Security, domestic partner benefits and health care.[131] The Lambda Legal Defense and Education Fund has initiated a program to identify discrimination towards lesbian and gay elders, especially in long term care institutions. Much additional work remains to be done and indeed every organization with a policy focus should incorporate issues affecting seniors into its agenda. In such initiatives, old GLBT activists should be engaged as partners and consultants to provide the valuable connection between experience, strategy and activism.

PROFILE: VERA MARTIN, 77


David Brewer

Vera Martin has been national coordinator for Old Lesbians Organizing for Change (OLOC) since its founding and a co-coordinator since 1997. She is currently the director of media and information. "I remember," Martin commented, "how many years we, the old lesbians, tried so hard to be heard and recognized at conferences produced by younger generations…[A]t their conferences, when they did what they called 'intergenerational sex discussions,' not one person was asked to participate that was ready and able to admit they were 50 years old or one day over."

Martin continues her life of activism and advocacy in the fight for the dignity and respect of GLBT old people. "Now many graduate students are ready to study us," she reminds people, "our recreational activities, our sexual behavior, etc. We have [borrowed] a phrase from the Disabled Rights Coalition: 'nothing about us without us'. We intend to see that you get it right by discussing it with us and listening carefully to what we say.

"Most of the gay and lesbian organizations go about their plans, totally insensitive, and without thinking [they] exclude us. We are usually invited at the last minute without any thought to how we can/will finance getting there. We are retired and living on fixed incomes for the most part while they are employed and their respective agencies are picking up the tab for them. Those of you who care about these issues need to hear from us, learn about us, and include us. We have a lot to share. Our life experiences can be a map for those coming behind us. We love the younger generation, wish you well and are willing to share our skill and experiences."

Born in Mississippi and growing up in Louisiana, Martin lived most of her adult life in the Los Angles area. In 1995 she moved to Arizona to a community where she could find support and friendship with other old lesbians. She is the mother of two children and delights in her family of six grandchildren and six great grandchildren.

"I remember when some guru, in his infinite wisdom, decided that after the age of 55 we needed a special location for housing," Martin said. "This location would absolutely not be planned for intergenerational living. I think we all know and understand that if you put people of any particular group in some special place it is a given they will be denied many services and privileges."

Martin is proud to be an African American lesbian now retired from her career as a middle management civil service employee. Recalling her experience with ageism on the job, she said, "I remember when we were bombarded with letters and applications from insurance companies. We could get the premiums without physicals, they said. When you applied you were told you are too old. Institutional ageism!"

A lifelong civil rights worker, Martin

belongs to such organizations as the NAACP, Urban League, Committee On Racial Equality, CONNEXXUS, and Local 660 of the AFL/CIO. She is also a member of the American Society on Aging and its Lesbian and Gay Aging Issues Network, the National Gay and Lesbian Task Force, and is a supporter of the Black Gay and Lesbian Leadership Forum, Southern Poverty Law Center, Mazer Archives and Sister Spirit.

Policy Issues Affecting Seniors

This section outlines some of the major policy frameworks that impact seniors in the United States today, and introduces some policy debates underway. The next section examines the particular ways that these broad policy frameworks affect the lives of GLBT seniors. This brief and basic primer is aimed to orient advocates less familiar with aging policy and not to present the complex debates underway among experts. Readers with greater familiarity with aging policy frameworks are urged to proceed to the next sextion, which starts on page 36.

SERVICES

The Older Americans Act

The federal Older Americans Act (OAA) has provided funds for the majority of home and community-based services to seniors since its enactment in 1965.[132] This Act enables the provision of a wide range of services to elders over 60, including: 1) the ability to access social services, which can include among others case management, information and outreach, and transportation programs; 2) in-home services, including home delivered meals, home repair and modifications, homemaker help, home health aides, and home modifications; 3) community services, including senior centers, congregate meal programs, adult day care, employment and pension counseling, nursing home ombudsman services, and elder abuse prevention and treatment; and 4) caregiver services, including respite care, adult day care, counseling and education.

In Fiscal Year 2000 Congress appropriated $933 million to support the Older Americans Act, which is administered by the federal Administration on Aging.[133] Funds are awarded each year through a National Aging Network composed of 57 state units on aging, 661 Area Agencies on Aging (AAAs), and 222 tribal organizations, all of which coordinate these programs through 27,000 community based service providers.[134] In order to access

the funds through the OAA, Area Agencies on Aging are required to submit an area plan to the federal Administration on Aging. This plan, which includes community input and comment, is an assessment of the service needs for elderly in a particular jurisdiction and justifies the allocation of funds for the proposed services.

Annual appropriations by Congress for Older Americans Act programs have not kept pace with costs, resulting in an actual decline of more than 40% in real dollars since 1980. Also over the past two decades the senior population has steadily increased. Congress has not reauthorized the legislation since it expired in 1995, and has approved only minimal funding increases that still do not meet the need for services.

Caregiving Needs

Caregivers play a critical role, particularly for those elders with a chronic illness.[135] Caregivers meet the social, economic, emotional and medical needs of those they support. They provide practical support such as shopping, housekeeping, and transportation to medical care and other services, as well as more basic assistance such as help with bathing, going to the bathroom, and feeding. As symptoms worsen, caregivers are also likely to take on more clinical roles such as keeping track of medications, giving injections, inserting catheters, and cleaning wounds. Caregivers often provide front-line medical and psychological assessment, as they are the first to note changes in health status and must decide when to seek additional help. Unfortunately, many lack basic medical training.

More than 25 million Americans provide such care for elderly relatives or friends. About four in five caregivers are family members. Caregivers face enormous burdens that jeopardize their own well-being and threaten their ability to fulfill the duties they willingly undertake. Health care cost containment, along with medical advances, have trimmed hospital stays and moved daunting and complex care into the home. These advances are saving lives, but as a result, many more people must manage long-term, chronic illnesses at home. In addition, women, the traditional caregivers, have continued to move into the workplace and are therefore less able to provide full-time care just as this aging population requires more care than ever.[136]

Women are both the majority of caregivers and the majority of care recipients. According to the AARP Public Policy Institute, three in four nursing home residents are women, as are two in three home care consumers. More than 70% of unpaid caregivers are women.[137] Recent studies estimate that about 10% of the U.S. adult population provides care to family members. These studies do not take into account caregiving to non-biological families or families of choice. As many as one in three gay men and lesbians provide some kind of caregiving assistance–either to children or to adults with an illness or disability.[138] Family members provide two-thirds of the home care services in the country, a market value of about $190 billion a year. Unfortunately, most family caregivers act alone: 65% of these caregivers do not receive help from other family members or friends; 69% say frustration is the most frequently felt emotion; and half of all family caregivers say they have experienced prolonged bouts of depression. Family caregivers strive to keep their aging relative at home as long as possible, hoping to avoid institutional placement.[139]

Long Term Care

Long term care refers to the medical, social, personal care, nutritional, and supportive services needed by people who have lost some capacity for self-care because of a chronic illness or condition. The total number of persons over 65 needing some amount of long term care will increase from the current number of 8.8 million to over 12.3 million by 2030. By then the number of people over 85, the fastest growing segment of the total population and that needing the most care, will have tripled.[140] Surveys show that the majority of long-term care is provided informally by family members and friends, usually female spouses, daughters, and daughters-in-law.[141] People without children may be less likely to have caregivers who are willing and able to provide long-term care for an extended period.

Four out of five elder Americans lack adequate public or private insurance for long term care.

Four out of five elder Americans lack adequate public or private insurance for long term care.[142] Only 5% of total long term care costs each year are paid for by private insurance. The total number of people purchasing private long-term care insurance is growing, from 800,000 policies sold in 1987 to over 4.3 million in 1995. But the costs of this type of insurance remain out of reach for most Americans: an average policy to cover a 65-year-old can cost over $3,500 a year.[143] Approximately 12% of seniors are enrolled in Medicaid, which does cover some long term care nursing home services and some limited alternative services which differ from state to state. This lack of long-term care coverage means that people receive less care than they need, and that they face the real prospect of a major financial crisis because of the extraordinary expenses of this type of care.

Two other important issues in long-term care are independent living and personal choice. The disability community has been an advocate for both. The primary long term care option for seniors with significant disabilities has traditionally been institutional care, with the exception of some cases where home health care and community-based services are included in private long term care insurance or through state supported public programs. Federal programs will only pay for licensed personnel such as nurses or medical attendants because federal law requires Medicare and Medicaid to only contract with licensed home care agencies. Many feel that this emphasis on institutionalization and licensed home help is misplaced, and that help with daily living is really the most important need in long term care situations. These services—known as "personal care"— include help with shopping, dressing, bathing, food preparation and similar daily activities. For much of this work, a licensed professional is not necessary, yet very few insurance plans provide payment to non-professional helpers. As a result, people who need personal care are pressured into being institutionalized or using more expensive licensed home care providers instead of being able to choose at-home alternatives which may be less expensive, including services provided by community based, non-profit service organizations.

SOCIAL SECURITY

Social Security is the main source of income for most elder Americans: 62% of elders use Social Security for half or more of their annual income, while 26% use it for up to

90% of their income. A full 15% rely on Social Security as their only source of income.[144] More than one in seven Americans currently receives benefits from the program and more than 90% of all working people are subject to the tax that funds the program.[145] Social Security keeps some 15 million Americans above the poverty line. As of 1995, monthly average benefits for retired workers were $621 for women and $810 for men.[146]

Social Security helps both old people in retirement and young families who encounter economic problems due to death and disability. Established in 1935, the program provides a base of income should the breadwinner(s) of a family retire, become disabled or die. While Social Security provides benefits to all qualified workers regardless of income, benefits are weighted so that lower income workers have a higher portion of their income replaced by Social Security than higher income workers. Social Security is a stable base of income to which pension and personal savings can be added to ensure an economically secure retirement. However, it was never designed to be the sole source of retirement income.

The financial stability of the Social Security program is not in immediate crisis. However, sometime within the next 30 years when the majority of baby boomers (those born in the decade and a half after World War II) retire, payroll taxes will no longer be sufficient to pay all the benefits owed to them. Social Security is a pay-as-you-go program. That is, payroll taxes cover immediate annual expenses. For instance, in 1997, money paid into the Social Security trust fund was $397 billion, while that same year benefits to retirees were $316 billion with the balance of some $80 billion going to the fund.[147] Because of this system, the ratio of workers to retirees is crucial. In 1950, for instance, there were 16 workers paying Social Security taxes for every eligible retiree. By 2030, that ratio will dramatically decline to only two to one.

Reform proposals

Most people agree that Social Security must be reformed.[148] Yet there is little agreement among members of Congress, Social Security experts or policy analysts about the ways to do so or the financial realities of the emerging crisis. There are very clear differences in how the major parties propose to reform Social Security.

In general there are three "camps" in the reform debate. The first group is those who prefer reforms to fix the current program as it is; a tax-supported, government administered, pay-as-you-go, income maintenance program which has worked well for the last 65 years. A second group argues that times have changed dramatically since the days of the Depression, and that only a completely private, mandatory pension system will ensure financial security for retirees. They point out ample examples of such successful programs in other industrial nations. They argue that recent examples of the growth of other types of private pension plans like 401(k)s show the public's attraction to systems in which they control their own resources. A third camp proposes some combination, with partial privatization of the system within the current framework.

It is important to note that certain reform proposals disproportionately disadvantage certain groups. In particular, poor people, women, and people with disabilities will be adversely impacted by certain proposed reforms, including a reduction in the COLA (Cost of Living Adjustment), the raising of the age of retirement, and the prospect of privatization.[149]

A number of proposed "fixes" to the system were recently introduced by the Clinton Administration and members of Congress. Congressional debate is ongoing and will continue well into the next administration. In a poll conducted by Public Opinion Strategies, more than two thirds of Americans believe that Social Security will require "major" or "radical" change within the next 20 years. However, they also reject most reforms such as raising the retirement age, raising payroll taxes, or reducing benefits.[150]

Nonetheless, the eligibility age will increase from 65 to 67 in 2022.[151] A bipartisan Congressional group recently recommended an increase in eligibility to 70.[152] Such increases in eligibility would hit women, and especially lesbians, particularly hard. Over 90% of women 65 and older collect Social Security. Social Security accounts for 38% of the income of married couples, but over 50% of the income of unmarried women, and over 40% of the income of unmarried men.[153] Because unmarried women, and to a lesser extent, unmarried men, are disproportionately dependent upon Social Security to cover their basic living expenses, a delay of two to five years would mean serious economic hardship.

Social Security accounts for 38% of the income of married couples, but over 50% of the income of unmarried women, and over 40% of the income of unmarried men.

Because life expectancy for African Americans and some other ethnic minorities is significantly less than for European Americans, delaying the age of eligibility for Social Security can literally mean cheating people out of their retirement income. As of 1991, life expectancy at birth was 80 years for white women, versus only 74 years for black women. For white men it was 73 years, versus only 65 years for black men. Life expectancy for those born significantly before 1991 is lower, but the racial disparities are similar.[154] Thus proposals to delay the eligibility age are a matter of gender and racial equity.

Perhaps the most controversial reform proposed is the investing of Social Security funds in the stock market. The 1994-1996 Social Security Advisory Council considered various options for solving the impending solvency crisis but could not agree on a single solvency proposal. Instead it offered three substantially different plans. However, all three plans proposed some form of "privatization" or investment of Social Security funds into corporate equities to enhance individual returns on Social Security investments.[155] Proponents of investing Social Security funds into the stock market argue that, over the course of one's working life, such an investment will result in a larger nest egg for retirement. They point to the average return on equities to predict that the average person—whether they invested through the Maintenance of Benefits plan, Individual Accounts, of Personal Security Accounts—would earn more through this system than through the current system. Opponents point out that the Social Security program was created to provide a guaranteed retirement income, and that "few or none will receive the average return on stocks. Some people will do better than average, and some will do worse."[156] The Social Security Advisory Committee argued that the long-term real return for investment in stocks from 1900 to 1995 was 7% per year, while investment in safer intermediate government bonds promised a real return of only 2.3%.[157] But opponents stress that bear markets can be deep and long-lasting, and argue that the bull market of the late 80s and 90s is atypical of stock market history in the past half century.[158] They also argue that women, low-income people, and people of color are traditionally more conservative investors and therefore may not do as well under a privatized Social Security system, further exacerbating income and wealth

inequalities along racial and gender lines.[159] Finally, because many women and people of color earn less, on average, and have earned less over the course of their lifetimes, they have less money to invest than whites and men.

Given the unprecedented economic boom which started in the early 1990s, the date at which Social Security is projected to become insolvent continues to be pushed back, as unemployment hits a 25-year low and Social Security receipts swell. In 1996 trustees predicted the system would go broke in 2029. An April 1999 report predicted it would not go broke until 2034. If the boom continues, it is expected that the insolvency date will be pushed off further. President Clinton's proposal to use the current government surplus to retire the publicly held share of the national debt and credit that amount to the Social Security trust fund would push insolvency even further off, to 2050. Some experts predict no major changes in the Social Security system, perhaps for at least five more years.[160] But with a possible new administration in Washington in 2001 and the securities industry eagerly pushing some form of privatization, Social Security reform may take a more prominent role on the nation's political agenda.

PROFILE: ELDON MURRAY, 70

Jay Blumenberg

Eldon Murray has been active in Milwaukee's gay, lesbian, bisexual and transgender community since 1969. He was a founder of the Gay People's Union (GPU), one of the first gay liberation groups in the country, and edited the GPU News from 1970-80. He also helped establish the GPU Venereal Disease Clinic in the 1970s. That clinic evolved into what is known today as the Brady East Sexually Transmitted Disease Clinic.

Murray was inducted into the Milwaukee County Commission on Aging, Senior Citizen Hall of Fame. This tribute recognized his tireless efforts as an advocate for seniors within the GLBT community and the community at large. Murray was the founder of the Milwaukee chapter of SAGE (Senior Action in a Gay Environment) in 1994. Last year alone, SAGE sponsored 59 educational and social events for older GLBT people.

Murray was also the first openly gay person to be appointed to the advisory board of the Milwaukee Commission on Aging. In 1999 he arranged to bring the "Village Elders' exhibit from New York to Milwaukee for Older Americans Month. It was displayed at the LGBT Community Center, the Department on Aging and the Washington Park Senior Center, where it raised consciousness about older GLBT people.

Asked if he thought things have improved for GLBT seniors, Murray told a local publication, "We still have a long way to go. We badly need an outreach program, because the older a per-

son is, the more likely they are to be in the closet, and we know we are not reaching a lot people who might need our assistance. Even though we've been in existence for six or seven years," he said, "there are sill a lot of older people out there who don't know about us."

"One priority should be trying to make the District Attorney understand that he must prosecute gay bashings under the hate crimes laws. I think it's a disgrace that he refuses to. And, of course, SAGE could really use a strong outreach program to help more of our gay and lesbian seniors. You know, a community is judged by the way it treats its elderly people."

For the future, Murray sees the greatest challenge to the GLBT community to be in meeting the needs of its older members. "Older gays and lesbians not only have to swim against the current of ageism found by all older people, but they must also swim against a second current of prejudice and ignorance because of their sexual orientation!"

HEALTH POLICY

Medicare

Medicare is the federal health insurance program which provides insurance to Americans 65 and older and persons with disabilities of any age. When Medicare was created in 1965, roughly half of American elders did not have health insurance.[161] Most people could not get coverage from private health insurance because of their age or because they could simply not afford it. Today, because of Medicare, only 1% of elderly Americans lack health insurance. Medicare is one of the largest federal programs, with an annual budget in 1997 of $194 billion, or roughly 12% of the entire federal budget. This program provides health care to 40 million American elders and people with disabilities.[162]

Today, because of Medicare, only 1% of elderly Americans lack health insurance.

Medicare covers two types of health care needs. Medicare (Part A) covers the costs of hospital care. Medicare's supplementary medical insurance (Part B) covers the following services: physician and outpatient care; home health care; short stays in skilled nursing facilities; medical equipment, such as wheelchairs; and some preventive services. However, Medicare does not cover long-term care.[163] Medicare pays 80% of the costs for the outpatient services it covers. Beneficiaries pay the remaining 20% as deductibles and co-payments.[164]

The Medicare Program encompasses both a fee-for-service payment system and membership in health maintenance organizations. Older people have the option to choose between the two methods of payment.

At present, health maintenance organization (HMO) program covers roughly 6 million beneficiaries, with the remaining 34 million opting for the fee for service payment plan. However, recently HMOs have dropped Medicare patients because reimbursement rates fail to cover the cost of services. Nearly three-quarters of a million seniors are going to be dropped in 2001 by major health plans complaining of inadequate reim-

bursement, including such giants as Aetna and Cigna Corp.[165] A survey by the American Association of Health Plans found that 18 of 37 health plans surveyed intend to cease offering the coverage—known as Medicare Plus Choice—in at least one of the counties they serve in 2001. Consumer advocates counter that health plans are at fault for not containing costs.[166] Even HMOs can provide choice relative to traditional Medicare. When major health plans stop accepting Medicare Plus Choice, those living in communities without other options may be forced back into the traditional Medicare program, under which out-of-pocket expenses are higher and prescription drugs are not reimbursed.[167]

Medicaid

Medicaid is a joint federal and state health care insurance program for low-income, categorically determined medically needy populations and people with disabilities. It is administered by state and local governments within federally mandated guidelines. Medicaid, often confused with Medicare, is a separate program. While Medicare is a health insurance program that helps people over age 65 and people with disabilities regardless of their income, Medicaid is a health insurance program to help people of low income regardless of age. Medicaid is the largest government-financed health care assistance program for the poor. Over 36 million Americans received Medicaid benefits at a cost of $160 billion in 1996.[168] And while Medicare is administered uniformly throughout the United States, Medicaid activities are financed jointly by federal, state, and local taxes, and its provisions vary from state to state.

Although the scope of optional Medicaid services is determined by individual states and varies from state to state, a basic level of services must be provided to qualify for federal matching funds. Those services affecting elders include: laboratory tests and x-rays, prescription drugs, physical therapy, nursing home care, adult day care, personal care, and home health care.

States have broad discretion in determining eligibility criteria. However, there are federally designated categorically needy groups of persons that states are required to cover in order to receive federal funds. They include Supplemental Security Income (SSI) recipients, children under six from poor families, and low-income pregnant women. Most states expand their coverage to include certain seniors, people with disabilities, or medically needy persons whose incomes exceed the designated federal poverty level.

Medicaid and the Elderly

Very poor elders are eligible for both Medicare and Medicaid. Medicaid often covers services not provided by Medicare, such as prescription medicine, eye exams and glasses, and ambulatory services. But most importantly, Medicaid provides coverage for nursing home long term care and home health care. Medicaid currently pays for nearly 45% of all nursing and home health care costs in the US, amounting to $40 billion annually for over 3.6 million recipients. Unfortunately, because of low income eligibility requirements, many older people requiring nursing home care are forced to spend down any income and savings to become eligible for Medicare nursing home care and home health care.

Medicaid, HIV & AIDS

Medicaid is the largest single payer of direct medical services covering 50% of all persons living with AIDS and 90% of all children with AIDS.[169] The estimated federal and state total HIV/AIDS-related Medicaid expenditure was $4.1 billion in 2000. Most people living with AIDS qualify for Medicaid because they have a low income, limited assets, and are disabled by definition of their HIV status. Still others, who may have too much income or resources to qualify, become eligible through the state-sponsored medically needy programs.

Medicaid and People with Disabilities

Medicaid supported the medical care of 6 million people with disabilities at a cost of $49 billion in 1995. Limited Medicaid benefits are also available to certain qualified disabled working individuals whose earnings are less than 200% of the poverty level. Recently, Congress passed the Work Incentives Improvement Act, to extend Medicare and Medicaid benefits to more people with disabilities who work.[170]

Medicaid and Immigrants

As a result of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, non-citizen immigrants who arrived in the US after August 22, 1996 and PRUCOL (persons resident under color of law) immigrants are barred from full Medicaid coverage for five years and are eligible for emergency Medicaid and nursing home care only. For most immigrants, this means that primary and preventive health care are not available. This is not only unethical, but bad public health policy. It is a particular threat to elders, who can require a greater degree of health care than younger people.

Managed Care

Managed care plans combine the delivery of health care services with the financing of those services. When people enroll in managed care plans such as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), they agree to receive health care from a pre-selected group of doctors, hospitals and other service providers for a set monthly fee for the services they receive.

Managed care has been increasingly popular since the passage of the federal HMO Act in 1973. One of the distinct advantages of membership in managed care plans for elders is that they include free or very low cost co-payments for medications. This is not a feature of most fee-for-service health plans. As health costs have gone up, employers and the public health insurance programs (Medicare and Medicaid) have increasingly looked to expanding managed care coverage as a means of containing health costs. About half of the total US population is now enrolled in some kind of managed care plan. Some 85% of these people are insured through their employers. Forty-eight percent of all Medicaid beneficiaries are enrolled in managed care plans. However, only 16% of Medicare beneficiaries are enrolled in HMOs.[171]

About two-thirds of non-institutionalized elders live in a family setting, while most of the rest live alone. About 3% of elderly men and 2% of elderly women live with non-relatives.[172] For a number of reasons, including finances, challenges in physical conditions and the need for community, many will choose special housing options. Developers of elderly housing promote the idea of a continuum of care in housing, i.e. the creation of choices for elders which reflect their changing needs as they age. At the beginning of the continuum is independent, subsidized housing to respond to the financial realities of a lower income at retirement.

Subsidized Housing

There are two federal elder housing programs administered by the Department of Housing and Urban Development (HUD). The Section 8 voucher program pays landlords the market price of an apartment less the tenant's payment of a small percentage of their total income. In this program, the tenant is able to choose from apartments throughout a community and live in typical multi-generational apartment complexes. The Section 8/202 program, generally administered by not-for-profit organizations and/or municipalities, is what is commonly known as elderly housing. This program funds three million senior housing units, generally reserved for low-income people 62 and older.[173] Tenants pay only a small fixed percentage of their income for their rent that is far below the market rent for that community. All the residents in these facilities are elderly citizens or adults with disabilities. These programs are very popular, waiting lists are long, and they answer an ever-growing need for elderly housing. The eligibility criteria is also fairly strict. Potential residents must be 62 years of age at application, with an annual income under $15,000 (which varies somewhat according to the community).

Assisted and Congregate Living and Elder Housing

If a person finds that he or she can no longer live alone in such an apartment complex because of his/her need for assistance with daily living, an assisted living facility or a congregate living facility may be appropriate. These facilities provide limited medical and home care services and social services, including assistance with daily living and food service. In some states, a state license is required for these facilities to operate. In the nine states which outlaw sexual orientation discrimination in public accommodations and housing, this provides some level of non-discrimination protection and an assurance of a basic level of care.[174]

Accessibility for People with Disabilities

Other housing concerns addressed primarily by the disability community are questions of accessibility and "visit-ability," that is, the removal of physical barriers to make it easier to visit in a specific facility. Housing which is accessible to all, whether the resident is disabled or not, is beneficial to everyone. Enabling people with disabilities to visit friends and neighbors easily is a fundamental part of equal access.[175]

Employment

The United States Congress passed the Age Discrimination in Employment Act (ADEA) in 1967 to stem the tide of discrimination based on age in the workplace.[176] In spite of the enactment of the ADEA, elders still face employment discrimination based on age. The Bureau of Labor statistics reported an unemployment rate of 2.9 % for persons age 55-64, but 3.3 % for persons age 65-69, and 3.2 % for persons age 70 and over in 1996. Although these numbers seem low, many old workers have left the job market because they could not find employment and are therefore not counted among the unemployed.[177]

An unhealthy paradox exists for elderly workers. While the overall age of the US work-force is increasing, the workplace in America is changing in ways that is detrimental to elderly workers. Ageist management attitudes that elderly workers cost the company more money because of failing health, are inflexible in learning new tasks on the job, or are unable to learn about new technologies, have been found to be false. As Susan Imel points out in her paper "Myths and Realities: Older Workers" "older workers don't fear change, they fear discrimination." There is a gray ceiling in American business that can only be broken with a change in attitude and the dispelling of stereotypes about older workers.[178]

Because of unchallenged stereotypes, employers tend to ignore the skills of old workers. Corporate downsizing and a lack of training in new technologies often leaves older workers vulnerable to layoffs. Blue-collar workers, especially, are often displaced or experience work-related injuries at early ages. Many lack pension coverage or rely on inadequate pensions until they become eligible for Social Security. Old people, no less than anyone else, deserve the opportunity to contribute their labor in productive and satisfying ways.

Older workers are also affected by race and gender pay differentials. Because racism and sexism are still endemic to American society, women and people of color still make far less, on average, than men in general and white men in particular. This situation, not surprisingly, continues into old age, as people who have been paid less throughout life will encounter smaller pensions and a higher prevalence of poverty. Activists must work to eliminate gender and race disparities in pay scales.

Education and training are key to solving the problem of unemployment for old Americans. The educational level of the elderly population is increasing. Between 1970 and 1995, the percentage who had completed high school rose from 28% to 64%. About 13% in 1995 had a bachelor's degree or more.[179] However, educational level varies considerably by race and ethnic origin among elderly persons. In 1995 67% of whites, 37% of blacks, and 30% of Latino elders had completed high school.

Activists should remain vigilant to ensure that the Justice Department and the Equal Employment Opportunity Commission vigorously enforce the Age Discrimination in Employment Act of 1967.[180] Federal agencies should also prosecute discrimination based on race, color, religion, sex, or national origin under Title VII of the Civil Rights Act of 1964, and the Equal Pay Act of 1963; and enforce the Americans with Disabilities Act of 1990.[181]

Supplemental Security Income (SSI)

The Supplemental Security Income (SSI) program was established by Congress in 1972 as part of the Social Security system to provide income support and medical care for disabled persons of any age, elders, and the blind with limited incomes (under $500 per month).[182] In 1998, five million SSI recipients were categorized as disabled while 1.2 million were over 65.[183] SSI recipients are automatically entitled to Medicaid and food stamps in most states. Cash benefits provided are very modest. In 1997, the standard amount of support for disabled persons living in the state of New York was $570 per month and $640 in California.[184] A recipient's income from other sources is deducted from the standard amount provided by SSI. For example, if a New Yorker had some other source of income providing them $100 per month, their payment from SSI would only be $470, (a total of $6,840 per year) which is below the official poverty level.

Disability Policy

Many elders encounter various levels of disability as they grow older. According to the Administration on Aging's 1999 *Profile of Older Americans* more than half of the population 65 and older (53%) reports at least one disability. One-third reports a severe disability or multiple disabilities. However, it is important to note that most elders with disabilities remain active and adapt in order to carry on their lives. Still, over 4 million (14%) have difficulty carrying out activities of daily living including bathing, dressing, eating and getting around the house, while 6 million (21%) experience difficulty with instrumental activities of daily living, including preparing meals, shopping, managing money, using the telephone, doing housework, and taking medication. The percentages increase sharply with age. Policy issues such as: long term care; decision-making authority regarding institutionalization choices; accessibility in housing, transportation and social services; and the rights extended through the Americans with Disabilities Act are arenas where the disability community and old people can form and strengthen existing political coalitions.

The Americans with Disabilities Act (ADA), passed into law in 1990, is a federal civil rights law designed to eliminate discrimination against people with disabilities. The law's definition of disability includes HIV and AIDS. Not all elderly people have disabilities. However, many older people have significant medical conditions that would qualify as disabilities, including mobility impairment. Any physical or mental impairment that substantially limits the ability of an individual to engage in ordinary life activities is considered a disability under the ADA.

Protections under the Americans with Disabilities Act

The ADA's public accommodation section requires the removal of architectural barriers that block access for people with disabilities. In existing buildings, businesses have a limited obligation to remove such barriers. Such removal must be easily accomplishable, without much difficulty or expense. But businesses that undertake new construction or renovations have significant obligations to ensure access for all people with disabilities. In addition, all businesses and service providers—from the video store to the doctor's office—must ensure that aids for communication or reading are available for people with vision or hearing impairments. Finally, no business or service can refuse to provide goods or services to qualified individuals solely because of their disabilities.

The ADA's employment section prohibits private employers with 15 or more employees, employment agencies, and labor unions from discriminating against qualified individuals with disabilities seeking employment. The ADA prohibits discrimination in all aspects of state and local governmental programs.

The ADA marks a huge victory for people with disabilities by making accessibility and non-discrimination enforceable rights. However, any civil rights legislation is only as good as its enforcement. The Department of Justice and the Equal Employment Opportunity Commission have oversight, and some enforcement, authority under the ADA. Both agencies have highly qualified and committed staff people and lawyers in their disability sections, but both agencies could use increases in their enforcement and technical assistance budgets. Technical assistance is a particularly acute need, as businesses, employers, and many courts continue to misunderstand and misapply the law.

How Aging Policy Frameworks Can Benefit GLBT Elders

Government policy can dramatically affect the lives of seniors in general and GLBT seniors in particular. This chapter examines over a dozen key policy areas to see how they could better serve the needs of GLBT elders. These issues are complex. In many cases, all of the implications for GLBT people are yet to be discovered. Little policy analysis or research into the particular policy needs of GLBT elders has been conducted. To determine specific policy options in each issue area, activists need to first learn about the needs of GLBT elders in their own communities. Thus research is a key area of concern.

RESEARCH AND NEEDS ASSESSMENT

We have little empirical information about GLBT people in general, but even less about the realities, unmet needs, and policy priorities of GLBT elders, people of color, immigrants, people in rural areas, and low-income people.[185] Significant political and methodological obstacles continue to exist for researchers interested in studying GLBT populations: funding is difficult to find; the constituencies in question are very diverse, hidden, fearful of disclosure and hard to survey; and the techniques and best practices to doing research on GLBT people are only now being developed. Despite the broad cultural visibility of GLBT people, nearly all national studies, surveys and data sets still do not gather information on sexual orientation or gender identity variables.

This lack of data can be addressed in two ways: by direct research in local communities; and through advocacy to add sexual orientation and gender identity to all surveys conducted or funded by the federal government.

Local Research

The best vehicle for assessing the needs of GLBT seniors may be through the Area Agencies on Aging—the local agencies which coordinate the delivery of elder services

with community based service providers under the rubric of the Older Americans Act.[186] Area Agencies on Aging submit area plans to the Administration on Aging in order to access funds under the Older Americans Act. This plan, which includes community input and comment, assesses the service needs for elderly in their jurisdiction and justifies the allocation of funds for the proposed services.

GLBT advocates should work with their Area Agencies on Aging (AAAs) to assess the needs of GLBT elders, evaluate whether those needs are being met by community-based services, and influence their area plans to see that GLBT elders have the services they need and deserve. Because AAAs are local, their recommendations can both document unmet needs and provide political cover should programs targeting GLBT seniors come under attack in Congress.

Activists should also push for funding for 1) research on the needs and concerns of GLBT seniors; 2) evaluation of existing services and their use by GLBT seniors; and 3) the development of gerontology and social work curricula at colleges and universities to train aging specialists and service providers in the particular needs of GLBT seniors.[187]

Advocacy for such funding need not take place only in Congress, where anti-gay sentiment is still strong. Decisions to fund research, evaluation, and curricula development on GLBT elder issues could be made at the level of the executive branch through the Administration on Aging. In addition, state legislative and executive agencies and municipal entities also set significant policy on issues affecting seniors. Key to any activism are local needs and community assessments that help make GLBT seniors visible.

Advocacy for Inclusion in Research

The fundamental structural cause of the lack of basic information on GLBT people is that the research apparatus, both governmental and academic, rarely asks about sexual orientation or gender identity. Only a few health surveys, many having to do with sexually transmitted diseases, ask about sexual behavior along with age, race, income, education, etc. The key finding of the National Institute of Health's recent Lesbian Health Study was that we know next to nothing about lesbian health issues and that research is critically needed.[188]

The Department of Health and Human Services, the Bureau of Labor Statistics, and the US Census conduct regular surveys which, if they asked about sexual orientation and gender identity, could provide much-needed data. For example, the Elder Abuse and Neglect Survey asks about a lot of demographic variables but not sexual orientation. Is accessing care or neglect a bigger problem for gay and lesbian seniors, especially gay men who are less likely to have children to provide care to them? Without questions that could enable GLBT respondents to share their experiences of abuse or neglect, we cannot know. The survey's failure to ask about sexual orientation and gender identity means that a potential longitudinal (multi-year) data set on abuse and neglect of GLBT seniors simply does not exist.

What is the degree of workplace discrimination, and what is the climate like for GLBT employees? The Bureau of Labor Statistics could help us find out by asking about sexual orientation and gender identity in its research. How many GLBT people have children, and how many children do they have on average? The US Census could provide

these data if it asked about sexual orientation. And private research that is federally funded could also gather these data if the government recommended that this be done.

Although there are serious methodological challenges to defining, identifying, and surveying GLBT people, these problems can be solved.[189] Indeed, groundbreaking work is being done by leading social scientists to develop better research methods on sexual orientation. Advocates for GLBT elders and other GLBT communities should prioritize the research required for informed public policy advocacy and development, and demand that the various levels of government, including state and federal health agencies in particular, incorporate issues of sexual orientation and gender identity as standard demographic variables in social science research.

PROFILE: TINA DONOVAN, 61

Tina Donovan has recently become a spokesperson and activist at SAGE (Senior Action in a Gay Environment) on behalf of the transgender community. As a "transgendered, pre-op" man who has lived as a woman for the past 27 years, she is mostly "out" since appearing on a cable TV show produced by QGLU (Queens Gays and Lesbians United) and participating in the opening panel for SAGE's national conference in May 2000. Donovan passes very convincingly as a middle-aged woman, with a woman's voice—she does not stand out as different as she walks down the street—but still fights for social acceptance. She does not consider herself gay. She likes men and moves in mostly heterosexual circles, identifying with straight women's lives. But still, the gay community offers a sanctuary which doesn't exist elsewhere.

Yet, despite this, Donovan says that some lesbians and some gay men have not been accepting of her. Lesbians are sometimes confused by her disinterest in socializing with them, and neither group can understand her. "There is no social outlet for people like myself," she says. Straight women, on the other hand, pretty much accept her as one of the girls. She may not have children or grandchildren, but she has had three important long-term relationships with men. Sadly, tragedy struck 21 years ago when the love of her life was stabbed to death on Central Park West. As for sex, she wishes that people would get their minds out of the bedroom and realize that everyday life is similar for all of us.

As a child, Donovan always felt different, played mostly with girls, and secretly tried on her mother's clothes. As she got older, her friends were pretty much gay men because no other "categories" existed. "I grew up in the gay world," she said, "it's all I knew and it was all there was. Those gay men like my type."

Back in the 70's Donovan was doing drag shows at a bar on the Upper West Side of Manhattan. One night she just decided to keep the dress and makeup on for good and made the switch then and there. One of her biggest supporters was her aunt, to whom she is still close.

Donovan recalls, "When she first saw 'Tommy' dressed in women's clothing, she gave me the once over from head to toe and said, 'Okay, you look good. Now what are you going to call yourself?'" Eventually her mother became supportive, though not her father. "I only wish my mother had had more years with me as Tina," she says.

She continues, "Legally, Tina is still 'Thomas' Donovan. I could change my name, but without surgery, I would still be considered male in the eyes of the law." Years ago, she was on the verge of having the operation, but backed out for mostly financial reasons. Today, she feels that it would be "like putting a new engine in a 12-year-old car." Going to a doctor can also subject a transgender person to considerable hostility and Donovan has had her share of that. She now takes a proactive/defensive attitude with any new doctor she sees, putting her cards on the table immediately. It usually works.

Recently, Donovan was asked to join a panel of advisers to assess the needs of the older GLBT population. She would like to see social activities just for transgender people, where no one would have to fear ostracism or ridicule. Asked how people should relate to transgender people in our communities, she says, "Relate to the individual, not the movement. You love some, you hate some—just like people in general."

Donovan is a friendly visitor with SAGE. Her friend-at-home is a 65-year-old man suffering from congestive heart failure. She also volunteered for six years with AIDS patients at St. Luke's Hospital where she came to be known as the "Bingo Lady."

Until 12 years ago, Donovan worked in bars. She had no place of her own until she was 37. Ten years ago she went on SSI and moved from the Upper West Side to senior housing in Long Island City, a neighborhood in Queens. Finally she had her own bedroom! She is a member of SAGE/Queens and a regular at their socials. And three years ago—the day Princess Diana died—she gave up drinking once and for all, thus conquering a life-long problem. Soon she is to become a published author. In the audience at this summer's SAGE conference was a McGraw-Hill editor who later called with an invitation for Donovan to write her autobiography. So life is looking pretty good. "I like to be happy and I like to make other people happy," says Donovan, facing the next chapter of her life.

Used with permission from News & Events SAGE, the newsletter of Senior Action in a Gay Environment, September 2000, p. 8.

The Need for Access for GLBT Elders

Few agencies exist to specifically meet the social service needs of GLBT seniors. Those that exist, like Senior Action in a Gay Environment, do heroic work with few resources. In addition, mainstream aging service providers do not adequately serve GLBT clients. A 1994 study of 24 Area Agencies on Aging and 121 lesbian and gay elders (60+) who lived in those 24 regions found that AAAs have a long way to go in terms of providing services to gay and lesbian seniors. The survey found that 96% of the AAAs did not offer any services specifically designed for gay and lesbian elders, and did not target outreach efforts to lesbian and gay seniors. Only 17% reported staff training in the area of sexual orientation, but half said they thought there was a need for such training and 88% said they would be willing to provide an in-service training to staff were it available.[190]

Expansion of Services Under the Older Americans Act

Congressional refusal to reauthorize the Older Americans Act (OAA) since 1995 and the chronic underfunding of services provided under this act limit the ability of advocates to push for expansions of services to GLBT seniors. GLBT activists must strongly pursue renewal and full funding of this act. The reauthorization bill before the 106th Congress as this publication went to press also contains two elements of special interest to GLBT activists.

First, eligibility for support for caregivers to older persons under the act is not limited to immediate relatives. Part E, the National Family Caregiver Support Program, recognizes that family caregivers can include "an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual."[191] This broader definition of family can begin to support the many friends and partners who provide care to GLBT seniors.

Second, part F of the OAA provides for State and Local Innovation and Programs of National Significance demonstration funds. GLBT organizations seeking to train professionals in aging services about the unique needs of GLBT elders could apply for these funds.[192] Funding to train aging service providers in the concerns and needs of GLBT seniors can help decrease homophobia and transphobia and help create a safe environment in which GLBT people can fully partake of services offered to other seniors. GLBT elders should be included as both trainers and advisors to this process.

Activists should also work toward amending the Older Americans Act's services under Title III, which authorizes and funds the core programs of the OAA. Targeting language should be added that specifically authorizes outreach to GLBT seniors, along with other underrepresented and underserved populations.[193]

The Need for Training

A 1994 study of New York State Area Agencies on Aging (AAAs) also documented the need for training and outreach efforts. Some 46% of the AAAs interviewed reported that gay men and lesbians would not be welcome at the senior centers in their areas if their sexual orientation were known. Of 63 lesbians and 58 gay men surveyed, 84%

were open about their sexuality, and three-quarters knew about AAAs and the services they provide. Yet 72% of the gay and lesbian elders were "tentative" about using their services because of a lack of trust and perceived lack of understanding on the part of AAA personnel. Only 19% reported any involvement with a senior center. While 62% of the gay and lesbian seniors said that there should be separate service organizations for gay men and lesbians, 64% of the AAAs surveyed disagreed.[194]

Area Agencies on Aging could do a better job of serving gay, lesbian, bisexual and transgender seniors by:

- asking about sexual orientation and gender identity in the initial confidential client assessment, along with other demographic questions;
- offering in-service training conducted by GLBT elders to the staff of AAAs;
- developing effective outreach strategies in collaboration with local GLBT senior activists, including marketing strategies inclusive of GLBT elders;
- developing collaborations with GLBT social service organizations, including elder organizations.[195]

Forty-six percent of New York Area Agencies on Aging reported that open gay men and lesbians would not be welcome at senior centers in their areas.

Caregiving Needs

Long Term Care

Barriers to Caregiving for GLBT Elders

There is a critical need for more research and policy analysis into how caregiving issues affect older GLBT people, both in terms of the caregiving needs of GLBT elders and the caregiving practices of middle aged and senior GLBT people.[196]

Anecdotal evidence indicates that gay and lesbian children often serve as the primary caregivers for their elderly parents, as their heterosexual siblings are busy raising families of their own and gay siblings—sometimes closeted—are viewed as "single." So aging GLBT people may actually have heavier caregiving burdens than aging people in general.[197]

Most seniors turn to their families of origin for support in their old age. Surveys have shown that family members and close friends—usually spouses, daughters, and daughters-in-law—provide the majority of caregiving to old people in this country.[198] In fact, the Administration on Aging has reported that 67% of American seniors live with a spouse or other relative, and only 31% live alone.[199] According to the limited data existing on gay and lesbian seniors, gay elders are more likely to live alone. In Dana Rosenfeld's recent study, some 75% of lesbian or gay seniors lived alone.[200] Another study of New York gay seniors found that 65% live alone.[201] People without children may be less likely to have caregivers that are willing and able to provide long-term care for an extended period. This could be particularly problematic for gay men—and, to a lesser extent, lesbians—as they age, since they are less likely than heterosexual men to have children. Formal sources of care are often prohibitively costly. Moreover, public programs generally offer inadequate coverage or require participants to deplete their financial resources in order to gain eligibility. An urgent question presents itself: who will care for aging GLBT seniors?

GLBT seniors face a number of barriers to caregiving services:

- Lack of access to health care coverage to pay for caregiving needs results from lack of coverage in family plans or loss of health care benefits with loss of employment due to discrimination.
- GLBT elders, especially gay men, may have fewer adult children who can provide caregiving. Of course, many gay men have children. Black *et al*. found that 5.2% of partnered cohabitating gay men in the 1990 Census had children in the household (and more had adult children living outside the home); 14% of gay men in another national sample had children living with them.[202]
- GLBT old people are often denied the financial support and incentives provided by government support strategies for caregiving, such as inclusion in the Family and Medical Leave Act of 1993.
- The massive number of gay men who died from AIDS markedly reduced the number of caregivers that might otherwise be available to provide caregiving to others.
- Pervasive ageism within the gay male population in particular may be an impediment to the provision of caregiving on an intergenerational basis. The fear of being viewed as old and ugly can reinforce isolation and loneliness.
- Barriers to effective long-term care can arise when the health care professional's cultural and racial background and sensitivity differs from those of his/her clients.
- Some caregivers who are not immediate family members, or who do not fit into the heterosexual definition of "family," frequently encounter difficulties obtaining information from, or being acknowledged by, hospital and nursing home staff.

Sixty-eight percent of New York City GLBT seniors don't know who would provide care to them if they needed it.

GLBT elders' sense that they will not have access to caregiving was demonstrated in a 1999 survey (n=98) conducted at a gay and lesbian health fair in New York City by Pride Senior Network. Sixty-four percent of respondents under 50 years of age indicated that if they needed a caregiver immediately they would have someone to rely upon. By contrast, 68% of those over the age of 50 could not identify such a person.[203] This significant shift in caregiver confidence is the result of both realities and misperceptions. For example, the AARP predicts that today's younger generation will have fewer and fewer caregivers available to them due to decreased population density in their aging cohort. There is a need for conversations within the GLBT community about coming together to support the caregiving needs of GLBT elders, as well as for concerted public policy advocacy to open up mainstream caregiving institutions to GLBT seniors.

RECOGNITION OF GLBT FAMILIES

The lack of legal recognition for family bonds is a major difficulty that all GLBT people must face. Because people of the same sex cannot legally marry, and domestic partnerships are not available widely and are usually not as comprehensive as the rights and responsibilities of marriage, GLBT families are often deprived of the rights and privileges that heterosexual families automatically receive. These include inheritance, hos-

pital visitation, employee health benefits, housing, Social Security benefits for survivors, and countless others. GLBT people encounter these issues specifically as they age because they may rely more and more on families to provide care or make critical decisions. This frequently places GLBT people in a position where their blood relatives have more power to make important decisions for them than their partners who are not related by blood or law.

There are a number of policy options that could help increase the recognition of GLBT families. Achieving civil marriage rights for same-sex couples is a critical goal of the GLBT movement. This would give GLBT people legal equality in terms of state recognition of their relationships. Some, however, argue that this limits new options for defining marriage since it is confined to the traditional heterosexist model. What most GLBT people do agree on, however, is the damage caused by laws banning same-sex marriage. Such laws have been passed in 32 states since 1996.[204]

Social Security

Survivor Benefits for Same-Sex Partners

GLBT activists need to engage several key Social Security policy issues: the unequal treatment of same-sex partners in regard to survivor benefits and spousal benefits, and the sweeping Social Security reform proposals currently being debated. Social Security's treatment of same-sex couples is perhaps the most blatant and costly example of institutionalized heterosexism in federal policy. Currently married spouses and children are eligible for survivor benefits. In the current system an unmarried life partner of a deceased person is not eligible for survivor benefits or the spousal benefit. While widows or widowers or even divorced spouses can count on a portion of the deceased's Social Security income, this does not apply to non-married partners no matter how many years they may have lived with and supported their partners. Minor children of GLBT parents are also negatively affected by Social Security's failure to recognize GLBT families. In states that do not recognize second-parent adoptions, in the event of the death of the second parent, children are deprived of minors' survivor benefits, which the children of married heterosexual parents would receive.

The failure to pay survivor benefits costs GLBT seniors about $124 million per year.

In 1998, 781,000 widows and widowers received an average of $442.00 a month in survivor benefits, for a total of $4.1 billion a year.[205] If only 3% of the total population of seniors who have survived their life partner are gay or lesbian individuals whose same-sex partner is deceased, the failure to pay survivor benefits costs GLBT seniors about $124 million a year. Unequal treatment of same-sex couples by the Social Security system costs GLBT seniors money they deserve which could help ensure their economic security in their old age. Equal treatment of same-sex couples in Social Security survivor benefits must be at the top of the agenda for GLBT and aging activists advocating for the needs of GLBT elders. Some reform proposals being put forth today are aimed at addressing the economic hardship faced by widows and widowers. If same-sex couples do not receive legal recognition and these reforms are passed, then the disparity between surviving spouses of same sex couples and surviving spouses of legally married couples will increase significantly.

Spousal Benefits for Same-Sex Partners

The spousal benefit allows a married spouse to earn more than he or she is entitled to in Social Security benefits based on his or her own personal work history. Spouse A can choose to receive 1) the benefit that Spouse A would receive based on his or her own work history, or 2) one half of the monthly amount of Social Security benefits to which the other spouse (Spouse B) is entitled based on his or her own work history.[206]

The spousal benefit is really the difference between what Spouse A is entitled to under his/her work history and half the benefit Spouse B is entitled to based on his/her work history. In other words, if Spouse A worked part-time or sporadically, or simply didn't earn much over the course of his/her lifetime, but Spouse B earned a lot and is therefore entitled to higher Social Security payments in retirement, then it is in Spouse A's interests to opt for the spousal benefit equivalent to 50% of Spouse B's Social Security benefit.

Unequal treatment can cost an average same-sex partner hundreds of thousands of dollars in retirement wealth.

For example, Frank and Stella are a legally married couple who have been together for 40 years. At age 65 Stella, who was the main breadwinner for the couple, is entitled to a monthly Social Security benefit of $1400. Frank is entitled to a monthly benefit of $500 based on his own work history. Under the spousal benefit option, Frank can choose to receive $700 a month, or half of Stella's monthly benefit, instead of the $500 he would receive based on his own work history. Thus due to the spousal benefit, Frank is entitled to an additional $200 a month, or $2400 a year.

Now assume Stanley and Juan are a gay male couple who have supported each other for 40 years. Juan receives $1400 a month, while Stanley receives only $500. Stanley is ineligible for the spousal benefit, which would be $700 a month if Juan were Stanley's wife instead of his male partner; thus Stanley loses out on $200 a month, or $2400 a year.

To provide a concrete example of the unequal treatment of same-sex couples under the survivor benefit, if Stella dies before her husband Frank, Frank is entitled to $1400 a month. However, if Stanley dies before Juan, Juan is still only eligible for $500 a month, almost two-thirds less than if Stanley and Juan were allowed to marry.

Disability Benefits for Same-Sex Partners

Same-sex couples are also discriminated against in terms of disability benefits for partners. Assume that a 55-year old worker earning $45,000 a year becomes disabled and can no longer work. That worker's monthly Social Security disability benefit would total $1,332 a month, while his or her married spouse would receive half that, or $666. Thus the total monthly family benefit would be $1,998. But because Social Security does not recognize same-sex spouses, a same-sex spouse in a similar situation would not receive the spousal disability benefit of $666.[207] Instead, for the same-sex couple in an otherwise equivalent relationship, the total family benefit would only be $1,332, or one-third less.

401(k) Plans

The inability of same-sex couples to marry means that same-sex surviving partners are treated differently than surviving partners of married couples who enjoy the legal protections of marriage. As a result, same-sex partners lose tens of thousands, or even hundreds of thousands, of dollars in retirement wealth.

An example will best illustrate this point. If a person with a 401(k) plan dies, the tax implications for the beneficiary depend on whether or not the beneficiary is a legal spouse. If the beneficiary is a legally married spouse, then he or she may roll over the total amount of the distribution into an individual retirement account (IRA) with no tax implications except applicable estate taxes. The spouse can maintain the funds in an IRA until he or she turns 70 1/2, the age at which withdrawals from retirement accounts become mandatory. However, if the beneficiary is a same-sex spouse, who is unable to legally marry, then he or she is subject to a 20% federal withholding tax. Depending on the beneficiary's tax bracket, he or she may also be responsible for paying additional income tax on the amount received. The beneficiary is subject to applicable estate taxes.[208]

The effect of this unequal treatment is striking. Assume Deborah dies at age 50 with $100,000 in her 401(k) account, which she leaves to her life partner, Pat, also age 50. Pat will receive the sum less taxes (at least $20,000), for a total of $80,000 or less. Pat is not able to roll the sum over into a tax-free IRA. If Pat were a man and Deborah's widower, Pat would receive the full $100,000 and be able to shield it from taxes until age 70 1/2. The survivor of the legally married couple has a nest egg to invest which is roughly 20% larger than that of the surviving spouse in the same-sex couple. The nest egg can grow in a tax deferred account until the maximum age of disbursement for the surviving spouse in a legally married couple. The surviving spouse of the same-sex couple, however, will not be able to roll the initial disbursement into an IRA.

There are many types of retirement savings plans, depending on, for example, whether one is a government worker, self-employed, or working in the private sector. The above example merely scratches the surface as to the problems faced by same-sex couples. The very absence of relevant information provided to employees in same-sex relationships by employers, the government, retirement plans and advocacy groups is itself a major obstacle to intelligent retirement planning by same-sex couples.

Because many people are unfamiliar with distribution options concerning 401(k) plans and other retirement instruments, same-sex couples may underestimate the amount they need to save in order to provide for an adequate retirement. GLBT people need to consider how to allocate money between partners to ensure adequate retirement income for the surviving partner.

401(k) plans may also allow an individual to make hardship withdrawals from their account while still working for their employer. Hardship withdrawals are allowed for unreimbursed medical expenses, college tuition, home purchase or the prevention of eviction from or foreclosure of one's principle residence. While hardship withdrawals made before age 59.5 are subject to a withholding tax of 20% and a 10% penalty tax, they are only available to the person contributing to the 401(k) and his or her family.[209]

It is unclear but unlikely that same sex spouses and their children would qualify; second-parent adoption may address the issue of non-biological children, but since 401(k) regulations are federal law, it is unlikely that state civil union legislation such as that passed in Vermont would address this inequality for same-sex partners.

Pensions

Same-sex spouses do not receive the legal protections provided married spouses under the Retirement Equity Act (REA) of 1984. This inequality based on sexual orientation can literally mean the difference between poverty and a comfortable retirement. Retirement income lost due to unequal treatment can amount to tens of thousands of dollars per year, and can even exceed a million dollars over the course of a lifetime.

Most pension plans have a joint and survivor annuity option (J&S). This allows the pension to be payable over both lifetimes of a married couple so that the surviving spouse receives the pension even if he or she was not the employee participating in the pension plan. Under the REA, the inclusion of the spouse in the pension plan through J&S is automatic. Both spouses must file forms if only the spouse who was employed is to receive the pension. Upon retirement, under a J&S the retired worker earns less so that, upon his or her death, the surviving spouse continues to receive half of the worker's pension. The point of the J&S option is that the surviving spouse continues to get the pension benefit regardless of when the other spouse dies.[210]

The problem faced by same-sex spouses is simple. Pension plans are not required to pay benefits to anyone but a legal spouse following the death of a participant (i.e. the person who worked under employment covered by a pension fund). Additionally, if a person dies after becoming vested in a pension plan, but before reaching the age of retirement, then a legal spouse is entitled to a pension beginning in the year that the deceased would have started receiving the pension. The surviving spouse receives this benefit until death.

Here again a hypothetical may help illustrate the problem facing a same-sex couple which is unable to gain the protections afforded by legal civil marriage. Assume two couples, first a legally married heterosexual couple and then a same-sex couple. Everything is the same about these two couples except that the heterosexual couple has the legal protections of marriage. In each couple one spouse works for an employer which offers a pension plan. This employee is fully vested in the pension plan, and is entitled at retirement to a sum equal to $35,000 a year when taking the J&S option. At his retirement party the employee dies of a heart attack. What does the surviving spouse receive in pension benefits? The surviving spouse in the heterosexual couple would receive $35,000 a year for life. The surviving spouse in the same-sex couple would receive nothing.[211] If both surviving spouses (heterosexual and homosexual) were to die at 75, ten years after retirement, this means that the surviving spouse in the heterosexual couple protected by the legal rights of marriage would receive $350,000 more in retirement income than the surviving spouse of the same-sex couple. If this hypothetical death occurs at 85, the difference in income would be $700,000, and if death occurs at 95, the difference would total $1,050,000.

Because GLBT people can still be discriminated against in employment and credit in most of the country, it is vitally important that GLBT activists understand the policy issues surrounding retirement and pensions. GLBT people must plan carefully in order

to ensure financial stability for themselves and their loved ones in old age. Discrimination based on race, sexual orientation, disability and gender, attacks on affirmative action programs, inequality in education and multiple other circumstances cause many GLBT people to find themselves in old age without adequate financial security from their employers. Legal recognition of GLBT families, non-discrimination laws, and the maintenance of social insurance programs are important steps in securing healthy and comfortable aging processes for GLBT people.

The Medicaid Spend-Down's Unequal Treatment of Same-Sex Couples

According to US Health Care Financing Administration, nursing home stays averaged about $126/day, or $46,000/year, in 1995.[212] Medicare covers some short stays, which may occur after an acute medical experience like surgery, for the first 100 days, but most long-term stays are not covered at all. Individuals insured by Medicaid can still encounter financial difficulties resulting from nursing home stays, due to the high co-payment requirement. Medicaid covers only people who meet strict income and asset rules. Even those who do qualify to enter nursing homes generally may retain only $30/month for personal needs.

The lack of coverage for long term care for most elders constitutes a crisis in their care as well as personal finances. Often seniors who enter nursing homes spend all of their assets on their care, and then apply for Medicaid when they have next to nothing left. This phenomenon is known as "Medicaid spend-down." Medicaid spend-down has special significance for GLBT elders, because unmarried life partners of people who enter Medicaid-supported nursing homes are not eligible for the important income and asset protections available to legally married spouses of heterosexual nursing home residents. These protections were put in place to protect against impoverishment of spouses. Additionally, life partners of GLBT Medicaid nursing home residents do not have the same home protection that married spouses have. Legally married spouses of nursing home residents using Medicaid may remain in the couple's home until death, before the state may attempt to recover the cost of the care provided through an estate recovery process. Federal recognition of GLBT families is therefore essential to according same-sex partners these vital financial protections in their old age.

Grandparenting Relationships

Coming out, at any age, sometimes results in strained relationships with families of origin. Young people fear that their parents' disappointment or hostility will result in the loss of parental love and support. Parents who come out as lesbian, gay, bisexual or transgender often face draining and costly court battles with former spouses or partners to retain a relationship with their children either through visitation or custody.

While great gains have been made, many courts across the country still refuse to allow GLBT parents custody or visitation with their children on the grounds that their sexual orientation or gender variance is harmful to the children's interests.

The terrain of grandparents' ability to maintain a relationship with their grandchildren is still uncertain. Not only could coming out strain their relationship with their adult children, but it may result in their children denying any visitation or relationship of any kind with grandchildren, claiming that the grandparent's sexual orientation is harmful to the grandchildren.[213]

In cases where the parent claims that the grandparent's sexual orientation is harmful to the child, then state law governing gay, lesbian, bisexual or transgender custody cases will likely guide the courts' decisions. In states where a parent's sexual orientation is not grounds for denying visitation, GLBT grandparents are more likely to maintain relationships with grandchildren.

Domestic Partnership and Civil Unions

Advocates for equal treatment of same-sex couples achieved a victory in December 1999, when Vermont's Supreme Court ordered the Vermont legislature to provide to same-sex couples every benefit and protection it currently provides to married heterosexual couples. Yet although the "civil unions" for same-sex couples granted since July 1, 2000 by the state of Vermont guarantee hundreds of state and local benefits to same-sex couples, the federal denial of marriage rights to same-sex couples means that 1,049 protections, benefits and responsibilities under federal law are denied to same-sex couples.[214] These include such critical benefits as immigration rights for binational couples, and the right of a surviving spouse to receive Social Security benefits should one partner die before he or she can receive his or her retirement benefits.

Achieving civil marriage rights for same-sex couples is a critical goal of the GLBT movement.

Domestic partnership, which provides recognition and/or benefits to residents of a particular jurisdiction, partners of government workers, or the employees of private corporations, offers another avenue for gaining recognition of GLBT families. Domestic partnerships are ongoing relationships between two adults of the same or opposite sex who share a residence, are emotionally interdependent, and intend to reside together indefinitely. Beyond this basic framework, however, employers have defined domestic partnership in a number of ways to determine which members of an employee's family will qualify to receive benefits.[215]

While local and private domestic partnership policies are fundamentally improving the lives of many GLBT people of all ages, a federal policy recognizing unmarried domestic partners would extend this option to many more people. The federal government is far behind local and state governments in terms of recognizing same-sex families. Within the executive branch, only the Fish and Wildlife Department offers any tangible benefit to domestic partners of employees: relocation assistance to the domestic partner of an employee being transferred for work-related reasons. Such benefits are also offered to married spouses. Although partner-oriented benefits for employees of the federal government are usually allowed only for spouses as defined by a husband or wife under the Defense of Marriage Act (DOMA), a broader definition of "family member" in federal sick leave regulations accommodates other family structures. In the Federal Employees Family Friendly Leave Act, 5 USC § 6307(e) (West 2000), Congress allows sick leave to be used by an employee to care for a family member with such illness as the employee would usually take sick leave for or to take care of issues surrounding the death of a family member. The term "family member" is left to be defined by the Office of Personnel Management as it sees appropriate, and under 5 CFR 630.201(b) (2000), a family member is defined to include "any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship." This was

defined broadly in order to account for different family structures and to account for the fact that there are now different types of "traditional and nontraditional families." See 59 Fed. Reg. 62,266 (1994).

Immigration and Same-Sex Couples

Binational same-sex couples are often torn apart because the immigrant partner is not allowed to stay in the country by the Immigration and Naturalization Service. Heterosexual couples can get married and the immigrant partner is automatically allowed to stay. The Attorney General should exercise discretion to the fullest extent allowable by law to permit committed same-sex couples to stay together legally in the United States under immigration provisions for family reunification, as more and more democracies around the world are doing.

Family and Medical Leave Act of 1993

The spousal provision of the Family and Medical Leave Act of 1993 requires employers to grant unpaid leave of up to 12 weeks to care for the employee's spouse if that person develops a serious health condition. Domestic partners are not included in this definition. NGLTF supports an amendment to the Family and Medical Leave Act (H.R. 2104) defining spouse as an unmarried partner of the same or opposite sex.

PROFILE: DAN TRAVIS, 75

Rev. Dan Travis, retired United States Air Force Chaplain, started a whole new life two years ago when he came out to his family, and the community, as a gay man.

After struggling within himself over the course of several years, Travis tentatively started discussing the issue of homosexuality with his trusted doctor. He said, "I started testing the waters in discussions with my urologist in January of 1996. I was pretty confused and just didn't quite know what was going on."

Like most of his peers from the WWII generation, he found that the feelings associated with his deepest private thoughts and emotions concerning same sex attractions were overshadowed by the severe pressures of surviving the depression, accepting the prevailing expectations of marriage and the raising of a family, not to mention the calamity of going to war. Like most Americans brought up on a farm in Iowa, Travis's expectations of himself and his role in society were rather clear. After serving in England and France during World War II as a chaplain's assistant, he returned to Tulsa to marry his sweetheart Lfton on August 28, 1949. They proceeded to raise a family of one daughter, now 49 years old, and a son, currently 46. Both his children now have children of their own making Dan and Lfton grandparents 3 times over.

The GI bill meant that Travis could attend Phillips University, where he earned a degree in music. Years later he returned to school to earn a masters degree in public administration. There was also time for a master of divinity degree and ordination in the Disciples of Christ and returning to the military as a

career Chaplain in the Air Force. After 26 years he retired at the rank of Major.

The year 1998 was very significant for Travis, because that year at the age of 75, at a Burger King in New York City, he first spoke the words "I am gay" to another person, in this case his gay nephew. Since then Travis is proud to announce that he has personally come out to over 860 people! However, it was also in 1998 that Travis was diagnosed with prostate cancer, a battle he continues today.

Olan Mills

The reaction to his coming out to his family on the part of his wife of 52 years and his daughter has been warm and supportive. His son, on the other hand, a devoted evangelical Christian, has behaved just the opposite, causing Travis serious emotional pain and adding to the suffering he endures in the process of fighting his prostate cancer. In spite of this he has found an entire new world of support, trust and love in the GLBT community of Tulsa.

The highlight of Travis's current life is his participation in the Council Oak Men's Chorale (COMC), a gay men's singing group. Through singing in the COMC he has made many new friendships. He has found two of his closest friends to be much younger men, but men who are dealing with the realities of HIV/AIDS and can easily relate to his struggles with his treatments for his cancer. When asked about how this felt, he said, "I would not expect to find this kind of acceptance in any other community than in the gay community."

Last year he sang with the chorus at Gala 2000 held in San Jose, California where over 142 gay men's groups performed. This past Gay Pride Day found Travis marching in the COMC drill team with his wife and daughter cheering him on from the sidelines. Lfton, by the way, is the only female wife with membership in the chorus! When Travis talks about the chorus he frequently chokes up with emotion when he says, "The COMC now gives me a reason to live." When asked how such a group of young gay men accepts him as an elder, he responds, "The purpose of the chorale is freedom, not political, but to be and say who we are. They accept me entirely because they know what it feels like to not be accepted."

In all his other activities in the gay community in Tulsa, Travis takes pride that he is usually the oldest person in the group. He joined PFLAG a number of years ago so he could be supportive of his gay nephew in New York and then found that his nephew became supportive of him. He is active in the gay supportive Community of Hope United Methodist Church, which, because of its stand on GLBT issues, left the denomination and is now uniting with Fellowship United Church of Christ. He also sings in the choir at All Souls Unitarian Church. The Gay and Lesbian Community Center provided Travis's first opportunity to work on some of his issues by his participation in a coming out support group.

So, at 75 years of age, Travis has found a new life of activism, friendships and relationships. He says, "my new life is my way of helping others who can now follow in my footsteps."

HOUSING AND NURSING HOMES

Key Housing Policy Issues for GLBT Seniors

There are a number of critical housing policy issues that activists must engage in order to advocate for the needs of GLBT seniors. These involve Housing and Urban Development nondiscrimination policy, the treatment of GLBT elders in nursing homes, and services to support independent living as long as possible. First, current Department of Housing and Urban Development practice is to make decisions about renting the country's 3 million subsidized senior apartments without regard to the sexual orientation of applicants. This is as it should be, but an administrative practice has less legal force than a statement of nondiscrimination in federal law. The Employment Non-Discrimination Act, which has been stalled in the Congress since the early 1990s, does not mandate nondiscrimination in housing and public accommodations. A more comprehensive federal nondiscrimination bill that explicitly bans housing and public accommodation discrimination on the basis of sexual orientation or gender identity could address this shortcoming. Another means of effective nondiscrimination practices in housing would be the inclusion of sexual orientation in the targeting provisions of the Fair Housing Act, along with outreach to the directors of subsidized senior housing developments and other congregate housing facilities. This was a key policy recommendation of the Lesbian and Gay Aging Issues Network of the American Society on Aging submitted to the White House Conference on Aging in 1994.[216]

Second, nursing homes, assisted living centers, congregate housing and home health care services need to take proactive steps to minimize the incidence of discrimination, abuse and neglect of GLBT elders, which are documented in surveys and research described in this section. All providers of caregiving services and housing to elders and their staff should be trained to be competent in issues of sexuality and gender. Nursing homes in particular should include detailed sexuality policies within residents' rights policies. Such policies validate the natural and healthy sexual needs of all seniors and also remove moral judgements regarding sexuality from individual staffers and place them at the level of institutional policy where they belong.[217]

Finally, GLBT people should have a range of options to either stay in their own homes and receive appropriate, respectful services to help them live there, or, if they choose, to help them find specifically designed housing to accommodate their needs. Housing should provide opportunities for elders to live openly in an environment where they would not face homophobia or transphobia. GLBT elder housing should consider affordability for all low- and moderate-income old people and be sensitive to racial and cultural diversity. In addition, Congress should expand the funding of elder housing programs because, at present, there are significantly more applicants than vacancies. Maximum income requirements for eligibility for low-income elder housing should be expanded so that more elders will be able to live in affordable, decent housing. Such housing should be accessible to people with disabilities as well as the old.

A Generation with Smaller Savings and Bigger Mortgage Payments

Like their counterparts in the majority aging population, most GLBT elderly will choose to age in place and, upon retirement, remain in their own homes for the rest of their lives. But unlike their parents, most baby boomers will not find themselves with

a mortgage-free home at retirement, as this generation has had a tendency to "trade-up" as people purchased homes. Chances are very good that many baby boomer elders will still have sizable mortgage payments at age 65.

Compared to previous generations, members of the Stonewall generation—who will retire over the course of the next decade—are less financially prepared for their own retirement. Their savings rates are far below that of their parent's generation, and they have not been aggressive in using private retirement plans like 401(k)s or IRAs. And as is described in the next section, inequalities in pension and retirement plan regulation make it harder for people in same-sex relationships to save money.

A recent survey documented a lower savings rate when it found that the average working male in the United States was earning just over $30,000 per year and was only saving about $3,000 each year for all purposes. Even with Social Security, at this type of savings rate, this average person will, at retirement, have to live on less than 50% of his current income.[218]

Subsidized Housing and Sexual Orientation Discrimination

Although there are no federal laws banning sexual orientation discrimination in housing, HUD rules ban discrimination based upon sexual orientation. Two unrelated individuals may apply for an apartment together, and HUD rules prevent housing personnel from asking about the nature of the relationship between the pair applying for the apartment. Housing cannot be denied on the basis of sexual orientation, according to HUD rules.[219] However, because such rules are not enshrined in law, a more anti-gay administration could change these practices. There are no rules or laws protecting against gender identity discrimination in HUD housing. Because household income eligibility requirements are so low, few couples could qualify for a shared apartment; instead, they would most likely have to apply separately for two individual apartments in a complex. This is true of both opposite-sex and same-sex couples.

GLBT Senior Housing Developments

In recent years, there has been a growing discussion within the GLBT community about developing housing communities specifically for GLBT seniors. This would answer some people's desire to avoid homophobic elderly living environments.[220] There seems to be a growing demand for these types of housing projects.[221] They are a wonderful resource for GLBT seniors who desire housing designed with their special needs in mind and who do not want to face the invisibility or homophobia often found in traditional elderly housing. A few retirement communities in the planning stages became front-page news in major newspapers around the country in 1999. The projects described in these articles are being created and will be marketed, to a very small, but affluent, section of the GLBT community. While stories about these projects have been helpful in raising the visibility of GLBT elders for the general public, they will clearly only be accessible to a small and very affluent segment of the total GLBT elder population.

The housing needs of rural and poor GLBT elders, including the incorporation of federally subsidized elder housing, must not be overlooked in providing housing options for all GLBT elders. Recent surveys of American elders have found that there is a remarkably equal distribution of elderly among urban areas (31%), rural areas (37%), and in suburbia (32%). It is unknown whether these distribution patterns are the same for GLBT seniors.[222]

Nursing Homes and Homophobia

Should individuals become too incapacitated to live in an assisted living facility, they may then find the services of a nursing home necessary where they can get around-the-clock medical care. As GLBT old people enter assisted living situations, nursing homes, independent elderly housing or retirement communities, they are often presumed heterosexual and may feel the need to go back into the closet; often their long-term relationships are devalued and not recognized. Even if they have lived openly in the past, they may suddenly find themselves in situations where disclosing their sexual orientation or gender variance makes them vulnerable to discrimination or even abuse. The lack of sensitivity to sexual orientation in housing and supportive care programs for elders often places GLBT elders in vulnerable and uncomfortable circumstances.

More than half of the nursing home social workers surveyed said their staff were intolerant or condemning of homosexual activity between residents; 38% declined to answer the question.

There is no law prohibiting discrimination against people based on sexual orientation in housing or public accommodations in 41 states. Transgender people lack legal protections in 49 states and most municipalities.[223] This means that GLBT old people must not only face the limitations of their decreased incomes and possible changes in their mobility and health status, but may also encounter prejudice on the basis of sexual orientation and/or gender, and even neglect or abuse. As noted above, homophobia is pronounced, not only among nursing home staff but also among the predominantly heterosexual elder population. One researcher reported an older woman resident of a nursing home whom staff refused to bathe because they did not want to touch "the lesbian."[224] One home care assistant threatened to "out" an elder gay male client if he reported her negligent care.[225] Since self-neglect makes up a majority of elder abuse and neglect cases, the possibility that GLBT elders may be more likely to live alone and lack caregiving support could make self-neglect a greater problem for GLBT seniors than for the general senior population.[226]

This homophobia is often constitutive of a larger sexphobia within assisted and congregate living situations, particularly in nursing homes. A number of researchers have documented a high degree of anxiety and discomfort on the part of nursing home staff regarding the continued sexual expression of residents. Due to limitations on privacy and space, most nursing homes "inherently inhibit sexual expression," and are simply not designed to handle the sexual needs and desires of their residents.[227] Most nursing homes do not have an express policy regarding sexual relations between residents, whether homosexual or heterosexual.[228] This in itself adds to the desexualization of elders, implying that sex is not a normal and expected aspect of senior's lives. By contrast, most nursing home residents consider sexual behavior appropriate, and many report continued sexual activity.[229] Most older GLBT people continue active sex lives after age 65.[230] Other aspects of nursing home life, such as the lack of locks on doors or the dearth of single rooms, also inhibit sexual expression, even though they may be motivated by safety and economic concerns.

Same-sex sexual behavior may elicit a homophobic response. One researcher documents a harsh response by nursing home staff to homosexual activity between two male residents:

> A nursing assistant who enters a room without knocking, sees two elderly male residents engaging in oral sex. Both of the men have mild dementia, and their sexual

history is unknown. The two are separated immediately after the assistant notifies her supervisor. Within a day, one man is transferred to a psychiatric ward and placed in four-point restraints. The case is referred for evaluation by a community health board, which holds that the transfer was a warranted response to "deviant behavior."[231]

A random survey of 29 social workers at 29 different nursing homes in New York state revealed some disturbing attitudes toward gay and lesbian residents on the part of nursing home staff. When asked about their staff's attitudes toward sexual behavior by nursing home residents, 10 (34%) said their staff's attitudes were "mixed," while 13 (45%) said staff attitudes toward resident sexuality were largely negative. [232]

Fairchild *et al.* found that "[w]hen social workers were asked about their residents' sexual behaviors, no mention was ever made of homosexuality/lesbianism. Rather, the social workers seemed to assume that sexuality referred to heterosexual sexuality." When explicitly asked about staffers' attitudes toward homosexuality, 15 social workers, or 52%, said staff attitudes were either intolerant or condemning. Interestingly, while only 2 social workers (7%) avoided answering the question regarding residents' sexuality, 11 (38%) avoided answering the question about attitudes toward homosexuality.[233]

Those social workers willing to discuss their staff's attitudes toward homosexuality made the following comments: "[H]omosexuals are very much in the closet…Staff would be horrified…This is a rural area…;" "I've heard staff members joking, 'You're OK just as long as you're not gay.'…[Gay and lesbian residents] either go into the closet or face problems from the staff." One social worker said staffers didn't accept homosexuality because they "think it's gross" and consequently "react with anger" when confronted with homosexuality among residents. One respondent's nursing home avoids the issue by banning same-sex partners: "We don't allow partners of the same sex into the home…[It's] part of the admission requirements."[234]

Only one of the 29 nursing homes had a formal program to train staff about sex-related issues and the rights of residents to express themselves sexually. About half (15) said sexuality was addressed in some manner in staff training; 12 reported it was not, and 2 were not sure. In general, this training did not include discussions of homosexuality.[235] The study did not inquire about attitudes toward gender variance.

Transgender individuals face particular concerns of sensitivity and safety in such living environments. Transgender people with gender-congruent bodies may be closeted, while transgender people with non-congruent bodies are at risk for psychological and physical abuse at the hands of caregivers.

Changing Practices and Regulations

Each state Department of Health is responsible for issuing administrative regulations that govern the operation of nursing homes in that state. This responsibility includes a federal mandate that nursing homes ensure that each resident is able to maintain as much as possible of the quality of their life they enjoyed before entering the facility. For GLBT residents and advocates, there are at least two ways to start the process of change that could lead to GLBT-sensitive regulations. First, each state Department of Health has a hotline for reporting patient abuse and neglect. Some states, like New York, require that the department investigate the complaint within 24 hours. It is up to the department to decide whether the complaint rises to the level of patient abuse which

must stop. For obvious reasons, of course, most residents are not going to have the means or confidence to file a complaint of abuse. For GLBT residents, filing a complaint has many possible ramifications. Activists and friends of GLBT people in nursing homes should attempt to resolve a problem with nursing home staff before filing a report, since the senior resident of the nursing home must live with any repercussions and may have limited options for relocation. But complaints filed and addressed by a DPH may lead to systemic changes that benefit all residents.

Second, advocates should seek changes to the state regulations that would: mandate that nursing homes allow partners to visit; establish sex-positive policies for dating and relationships among residents as well as non-resident partners; require sensitivity training of all staff; set forth policies banning discrimination within nursing home facilities against GLBT residents and staff; and other changes that meet the quality of life needs of GLBT nursing home residents.

While the administrative regulation process is not a quick fix, advocates are advised to start by calling the Department of Health and asking to set up a meeting with individuals in the department in charge of nursing home regulations. Research the rules in your state for changing health department regulations, so that you have a sense of the process and the time line. Bring to the meeting not only specific examples of problems to be addressed, but also specific proposals for change. Be prepared to follow up and see the process through over the long haul.

Options for Independent Living

Disability activists have been working for many years to create viable possibilities to encourage and increase independent living. Two of the most important policy issues surrounding independent living are the enforcement of the Americans with Disabilities Act (ADA) and the passage of the Medicaid Community Attendant Services and Supports Act (MCASSA). MCASSA calls for an assessment of the individual's needs and coverage of the care needed to make the transition from institutional care to a home setting. People who are currently entitled to nursing facility services or intermediate care services would be given the option of choosing qualified community-based services. People would have more choice in terms of receiving their care through institutions or through accessing home care services in their area.

MCASSA has special significance for GLBT people with disabilities and GLBT elders. This new legislation would provide the option of living at home and prevent separation from a long-term partner or exposure to a homophobic institutional care situation. Because of the problems with homophobia and heterosexism in the health care system and because of the mainstream culture's continued insensitivity to GLBT family structures, more choice in long term care living options could mean better care for GLBT elders. As long as homophobia and transphobia persist in health and aging services, providing more choices for clients will be one of the best preventive steps for keeping GLBT people out of discriminatory care situations. Of course, home care workers must also be culturally sensitive and respectful of GLBT old people. Abuse and neglect motivated by homophobia and transphobia are concerns that must be addressed when shifting to a greater reliance on home healthcare aides.

PROFILE: LILLI VINCENZ, 62

Lilli is a gay elder, 62 years old, who is enjoying her life more every year. Being gay has meant that she is free to be herself. "Growing up," she said, "once I recognized my attractions to women, I felt different, even 'abnormal.' My best friend in high school, whom I was in love with, said matter of factly, 'You are not abnormal; you are just unique.' What a relief!" Vincenz loved her all the more, even though she was straight.

Her life now is richer than she could ever have imagined. She met her wonderful spouse on May 9, 1984. In May 1986 they moved into the house they bought together, and, after an engagement of almost one and a half years were married December 27, 1986, by a Metropolitan Community Church minister. Vincenz says their wedding was the most important day of her life and the fulfillment of her dreams. The second most significant date for her was April 17, 1965 when she proudly participated in the first White House picket, sponsored by the Mattachine Society of Washington to protest Castro's incarceration of Cuban homosexuals in work camps and also drawing a parallel with the plight of gay Americans. In addition to Vincenz there were ten other picketers, seven men and three women.

The site of another landmark moment in Vincenz's life took place at the Ace of Spades bar in Provincetown, MA, in 1961 when she first met other lesbians and experienced the exhilaration of finally realizing that she was no longer alone. That event lead to the first time, in 1963, when a woman loved her back. She foreswore suicide forever.

That same year she was discharged from the Army because of her homosexuality with a General Discharge under Honorable Conditions. This event was an unexpected boon. She immediately joined the Mattachine Society of Washington and became a homophile activist. Now liberated from obligations imposed by prior expectations and academic achievements, she felt free to pursue her ideals of disseminating the truth about gay people and dispelling the lies told about us. The joy of participating in the struggle for gay rights prior to Stonewall is a cherished memory.

After discontinuing her active involvement in the homophile movement in 1971 in order to earn a master's degree in psychology, she started a psychotherapy practice for gay people, later earning a doctorate in human development. From 1985 to 1989, at the Whitman-Walker Clinic in Washington, DC, Vincenz and her life partner developed and led the first positively oriented empowerment and counseling group for people living with AIDS.

In 1991 Vincenz and her life mate founded the Program for Creative Self-Development to empower gay women and men and gay-friendly people psychologically and spiritually. Later PCSD became the Community for Creative Self-Development (CCSD), a gay-posi-

tive holistic learning community dedicated to the psychological, spiritual, and creative fulfillment of all gay-friendly people. CCSD has been a wonderful way for Vincenz to continue her own development and make new friends.

"In my older years," says Vincenz, "I am becoming increasingly gay, in the broadest sense of the word. My 25-year-old psychotherapy practice continues to benefit from my personal growth. Thanks to the spiritual work I and my love mate (who is a metaphysical counselor and channel) have done together, all the pieces of my life have come together in a most beautiful mosaic. I am full of gratitude, joy, and youthful spirit!"

HEALTH CARE

GLBT elderly share many common health care challenges with all other elderly. Among these are the need for high quality, accessible and comprehensive health care; the need for prescription drug coverage; and the need to be able to access long-term care as needed. Some issues unique to GLBT elders are: physician bias; unequal treatment of same-sex couples under Medicaid regulations; disproportionate risk for certain sexually transmitted diseases, such as hepatitis; stress arising from homophobia/transphobia and the fear of being exposed as GLBT; and transphobic and homophobic hate violence.

Medicare

Pharmaceutical Coverage

One of the shortcomings of Medicare is that, in general, it does not pay for prescription medications.[236] Prescription drugs costs skyrocketed 17.4% in 1999, and hit elders on fixed incomes hardest.[237] Elders with HIV/AIDS using expensive antiretroviral medications are particularly hard hit. Transgender elders may have to pay for medicines to treat aging-related issues, as well as hormones and other transgender-related medications. Even those with some form of prescription drug coverage may have inadequate coverage because Medigap policies and HMOs may have maximum benefits and/or may only cover certain drugs. Fortunately, prescription drug coverage under Medicare emerged as a key issue in the 2000 presidential campaign; it is up to activists to hold politicians accountable in order to translate their promises into real policy changes.

As Americans live longer and retire earlier, and as the baby boom generation reaches the years when its members will need aging services, Medicare may face solvency problems similar to those faced by the Social Security program. Medicare is one of the fastest growing segments of the federal budget, increasing on average 7.7% annually between 1984 and 1993 while the entire federal budget only increased 2.5% per annum during that same period.[238] Unless Congress curtails benefits, raises revenues, or cuts its payments to providers, the program will become insolvent. This increase continues

because health care costs in general are rising faster than inflation. At the same time, there is a net increase in beneficiaries each year as millions more Americans become eligible for the program while life expectancy of the elderly also increases.[239]

One issue of particular concern to elderly GLBT communities is how reforms will affect one's choice of a physician. In ongoing efforts to contain costs, Medicare recipients are increasingly being encouraged to enroll in an HMO (Health Maintenance Organization). Under these managed care plans, patients may only choose from a pre-selected group of physicians approved by the HMO. For many GLBT people, finding a friendly, accepting and knowledgeable physician can be difficult; to not find one can be injurious to the patient's health.

Medicaid regulations allow one member of a married heterosexual couple to retain a jointly owned house without jeopardizing his or her spouse's right to Medicaid coverage. However, Medicaid regulations do not make the same provisions for same-sex couples.

As data reveal, bias in health care and other social service settings is real and more widespread than commonly assumed. A 1994 study by the Gay & Lesbian Medical Association indicated rampant bias: two-thirds of doctors and medical students reported knowing of biased caregiving by medical professionals; half reported witnessing it; and nearly 90% reporting hearing disparaging remarks about gay, lesbian, or bisexual patients.[240] Nearly half the Area Agencies on Aging (AAAs) report that gay men and lesbians would not be welcome at the senior centers in their areas if their sexual orientation were known. And nearly three-quarters of gay and lesbian elders surveyed were "tentative" about using AAA services.[241]

Public policy analysts argue that programs like Medicare, Medicaid and Social Security are now such an integral part of the life of this country that their demise is not even conceivable. These programs were created by Congress, involve major segments of the society from consumers to providers, and most importantly, all service voters.[242] Solvency scares are serious and require policy solutions to reform the program. Reforms must not compromise the entitlement to basic health coverage for all old Americans and people with disabilities. Concerns over rising Medicare costs must not overshadow the much larger societal benefits of providing for America's health care needs.

Medicaid

There are a number of ways in which Medicaid fails to meet the needs of GLBT people. Most importantly, regulations allow one member of a married heterosexual couple to retain a jointly owned house without jeopardizing his or her spouse's right to Medicaid coverage. However, Medicaid regulations do not make the same provisions for same-sex couples in long-term, committed relationships. This unequal treatment can force same-sex couples into a Hobson's choice between getting the medical coverage to meet a partner's health care needs versus giving up a couple's home and life savings.[243]

The federal poverty line is unrealistically low. As of 2000, the federal poverty level was $8,350 for an individual, $11,250 for a family of two, and $17,050 for a family of four.[244] Many working poor people, who earn just over the poverty line, do not qualify for Medicaid benefits but often work in jobs that don't provide health insurance. Many families forced off welfare due to welfare reforms, but who remain eligible for Medicaid, are not being informed by their caseworkers of their continued eligibility and the need in some jurisdictions to reapply to continue receiving the benefit.[245] With no federal sanc-

tions for state non-compliance with Medicaid regulations, abuses such as these continue, resulting in many low-income people not getting health care when they need it most.[246] Also, about 42% of impoverished Americans do not qualify for Medicaid because they do not have dependent children, or are not pregnant, or do not have a disability.

Many doctors refuse to treat Medicaid patients. Surveys show that because of low reimbursement rates, about a third of the nation's physicians limit the number of Medicaid patients they see, and about a quarter will not see Medicaid patients at all.[247] Neither Medicaid nor Medicare cover hormone therapy or sex reassignment surgery for transsexuals.

Congressional Medicaid reform proposals currently under consideration would further curtail the number of Americans in the program. The welfare reforms passed by the 104th Congress in 1996 cuts hundreds of thousands of poor people from eligibility through 1) decoupling welfare and Medicaid eligibility, 2) narrowing eligibility for disabled children in the SSI program, 3) terminating access to Medicaid for some legal immigrants, and 4) barring most future legal immigrants from the program for five years.[248] The welfare reform act of 1996, which is up for renewal in 2001, should be amended to restore eligibility for all legal immigrants for full Medicaid coverage.

Public Health Targeting

Public health efforts should target GLBT people, particularly with prevention messages in areas we know GLBT people may face a higher risk. For example, breast cancer screening and education may be even more critical for lesbians than other women, if, as research indicates, lesbians are more likely to have certain risk factors for breast cancer. HIV/AIDS prevention messages must do a better job at reaching older gay and bisexual men, as well as transgender people, particularly male-to-female transsexuals. If current strategies are failing, new ones should be developed in collaboration with older gay men and older HIV/AIDS activists. A large-scale campaign of vaccination for hepatitis A & B could also prevent this disease from unnecessarily spreading. Drug trials for new HIV/AIDS medications should include older men and women, whether homosexual, bisexual, or heterosexual. Smoking cessation and prevention campaigns should target GLBT people, who appear at higher risk for tobacco use. And health care access campaigns should challenge homophobia and transphobia within the health care profession and encourage GLBT people to seek regular health care and be out to their health care providers. The Massachusetts Department of Public Health has an excellent public education campaign challenging homophobia and transphobia in health care, including subway and bus advertising. A recent increase in grassroots organizing among lesbians and gay men is an encouraging sign that a broader, more systemic and holistic GLBT health movement could emerge in the near future.[249] It is important that this grassroots movement, as well as the professional GLBT health organizations, incorporate aging health concerns into their overall approach to GLBT health care.

Managed Care

Quality of Care for Older People

Seniors have reason to be especially concerned about the quality of care they receive within managed care programs. Well-documented studies have found that elderly patients receive substandard care, especially patients with long-term chronic health

conditions. In fact, elderly patients have been "voting with their feet" by withdrawing from managed care programs, according to a General Accounting Office study of senior manage care patients.[250]

In essence, seniors are in a Catch 22: seniors are withdrawing from HMOs, more and more HMOs are dropping Medicare Plus Choice, but traditional fee-for-service medical care usually means excessive out-of-pocket expenses. Those seeking to advocate for the needs of GLBT elders must grapple with this conundrum.

Limited Choice of Doctors

For most Americans, a trusted, long-term relationship with a health care provider has been considered an important value. Many elderly citizens have gone to the same trusted physician for many years. Limiting patient choice of doctors also hinders those who desire a doctor from their racial or cultural grouping or community.

Limited physician choice may be a disincentive to GLBT old people to get health care.

GLBT elders face particular concerns resulting from the limitations on physician choice that participants in managed care plans experience. Because participants must choose from a pre-selected group of health care providers, often they cannot follow referrals from friends to gay or gay-friendly doctors. This is an important restriction considering the problem of discrimination against GLBT people in health care. GLBT people may be faced with a homophobic health care provider if they have enrolled in an HMO offering a limited pool of physicians that does not include a GLBT-sensitive and competent physician. This may be a disincentive to GLBT old people to get health care that can be vital to their quality and length of life.[251]

For transgender people, managed care is often especially problematic. It is critical for transgender people to have a physician who has at least some knowledge of transgender health care needs. Unfortunately, transgender-sensitive physicians are even harder to find than GLB-sensitive ones. As a result, transgender individuals chronically underuse public health services and social services, and don't get the medical and psychological support services they may require.[252] Often health professionals so lack education and information on the particular health care needs of transgender people that transgender individuals are required to educate health professionals about their own health care needs.[253]

Referral Limitations

One of the ways HMOs keep down costs is by limiting the number and type of referrals to specialists outside the particular HMO circle of providers. This is a particular concern to elders who may have multiple needs for various specialists because of multiple chronic conditions. It is especially difficult for patients with conditions like HIV/AIDS, which requires physicians with special expertise and training in the HIV/AIDS field.

In 1996, 11% of adolescents and adults living with AIDS were age 50 or older. Males accounted for 84% of cases and African Americans accounted for the highest proportion (43%) by race/ethnicity.

—*AIDS Among Persons Aged >50 Years*,
Centers for Disease Control and Prevention[254]

Misperceptions and ignorance about HIV and AIDS can lead people to higher risk for infection. Because some older GLBT people perceive AIDS as only a young person's disease, they do not see themselves at risk and may ignore life saving prevention messages. One study, conducted in 1994, found that sexually active older people engaging in high-risk behaviors were less likely to use a condom or to be tested for HIV than were younger people.[255] Older men are rarely the targets of HIV education, prevention, and services. Advertising campaigns frequently present images of attractive younger men and rarely include images of middle-aged men, let alone older men. Some older gay men report that health care workers assume erroneously that they are not at risk for HIV/AIDS, and one man reported "he had great difficulty convincing health care providers that he needed an HIV test."[256]

Older people with HIV and AIDS may have particular health care needs. There is little research on how HIV affects the immune system of older people, but we do know that the immune system generally declines gradually with age. There is some evidence that older people with HIV progress to end stage AIDS and die faster than younger people, but it is unclear if this is due to normal age-related immunological decline, due to a delay in diagnosis, or due to problems stemming from the interaction of HIV/AIDS medications and other medications often prescribed to elders. Because many HIV/AIDS drug treatment protocols and drug trials exclude people 45 and older, physicians prescribing medication to older people with HIV or AIDS often do so without a basis of research upon which to inform their decisions.[257]

Many HIV/AIDS drug treatment protocols and drug trials exclude people 45 and over.

Becoming HIV positive or developing the symptoms of AIDS may be particularly traumatic to older gay men who have never fully come out to family members, employers and coworkers, and some friends. These factors may limit access to medical and social services and reinforce a sense of isolation and low self-esteem.[258]

Transgender people are represented in all economic classes. However, some depend upon work in the sex industry, due to loss of employment during gender transition, or an inability to get more mainstream employment because of anti-transgender bias. This situation places them at higher risk for HIV infection.

Hormone therapy becomes even more problematic for some transgender people with HIV. Transgender health advocates recommend taking hormones orally, although insurance companies won't cover hormone therapy, claiming it is an elective therapy. Often the only forms of hormones transgender people can afford are those which must be injected intramuscularly. Low-income transgender people often rely on non-prescription hormones or silicone bought on the street because of the prohibitive cost of prescription hormones. HIV infection risk increases substantially with the use and sharing of non-sterile injection equipment.

HIV positive transgender people have particular issues. It is often more difficult for them to find a surgeon willing to conduct sex reassignment surgery. Some medical professionals say this kind of surgery is too intensive a blow to the immune system to perform on HIV positive people. Safer sex information also rarely addresses trans-specific issues, like the relative risk of sexual activity following sex reassignment surgery.[259]

GLBT elders with HIV/AIDS often experience an extreme sense of isolation. Often services are not designed specifically for them. Shame and fear of discrimination also keeps many GLBT elders with HIV/AIDS from being open about their health status to people in their elder communities or service organizations. Age-related differences may also make it difficult for GLBT old people to make contact with younger people living with HIV/AIDS. Some gay seniors describe difficulty in communicating with young gay men in their HIV/AIDS support groups because of different experiences with gay identity and different understandings of sexuality.[260]

In order to prevent further HIV infection of people over 50, and the isolation of old people who are struggling with HIV/AIDS already, education and training about prevention and treatment of HIV/AIDS needs to be targeted at GLBT elders and their caregivers. People who work on HIV/AIDS issues need to be educated about the specific needs of older populations, and people who work on aging issues need to be trained to deal with HIV/AIDS and GLBT elders. Clinical trials and HIV/AIDS drug protocols must also be made inclusive of middle aged and elder people living with HIV and AIDS.

Mental Health

The impact of prejudice and stigma on the mental health of GLBT people of all ages has been studied by psychologists. Most Americans continue to view homosexuality as morally wrong.[261] In many instances, older gay men are viewed as disengaged from society, oversexed individuals with an unfilled sexual appetite for younger men. Older lesbians are often seen as totally nonexistent, bitter, and lonely.[262] Findings from a study of 241 gay men between the ages of 16 and 79 have refuted this popular stereotype. Kelly found that older gay men found their lives quite satisfactory and desired contact with men their own age.[263] In another study, older gay men scored as high as or slightly higher than the other men their age in terms of life satisfaction; a great majority of the respondents had an active sexual and social life; and few respondents indicated serious depression, anxiety, or lack of self-acceptance.[264] Similarly it was reported that 80% of lesbian respondents reported being "satisfied" or "highly satisfied" with their lives.[265]

In testing the assumption that elderly lesbian and gay men were more depressed and alone, Dorfman *et al.* found no significant differences between older heterosexuals and homosexuals with regards to social support and depression.[266] It was concluded that elderly lesbians and gay men had a decrease in family support and an increase in support from friends. In contrast to Dorfman *et al.*, whose sample participants were predominately white, Mays *et al.* concluded that African American gay men and lesbians maintain close ties to their biological families even after coming out.[267]

One possible explanation for high levels of life satisfaction and low levels of depression and isolation is that a certain level of crisis competency is gained as a result of the coming out process. Older gays and lesbians are better able to deal with certain circumstances around stigmatization and isolation as a result of difficult experiences earlier in life.[268] In

support of this, Adelman's study of 52 white homosexual men and women demonstrated a significant relationship between coming out earlier in life and life satisfaction.[269]

Caution, however, should be taken before attempting to extrapolate these findings to the entire population of GLBT seniors. Working class people, ethnic minorities, those not fully out of the closet, and transgender people are usually underrepresented in most research available on GLBT elders while white, educated, and middle and upper class respondents are usually overrepresented.[270]

Stigmatization and isolation are issues faced by the transgender community as well. Mental health problems for transgender people are more likely to include "adjustment disorders, anxiety disorders, post-traumatic stress disorders, and depression" as well as specific issues related to gender.[271] Studies indicate that some transgender people do not receive the necessary services to deal with depression or other psychosomatic symptoms because they feel that their gender identity will be judged negatively.[272] Mental health caregivers must be trained about homophobia, transphobia, and ageism in order to foster the creation of safe spaces for transgender people to be able to discuss the stresses they experience without risking further stigmatization. More detailed research about transgender people and transgender seniors in particular is needed to determine an appropriate mental health care agenda.

For many years, homosexuality was viewed as a mental illness. As GLBT people began to demand equality, from pickets in Washington and Philadelphia to the Stonewall Revolution, activists pushed the American Psychiatric Association to remove homosexuality from its classification of mental illnesses in 1973.[273] The case is different for transgender people. Unlike gay, lesbian and bisexual people, the mental health profession classifies transgender people as suffering from a diagnosable mental disorder—gender identity disorder (GID). The *Diagnostic and Statistical Manual of Mental Disorders* offers three categories in this area: gender identity disorder, tranvestic fetishism, and gender identity confusion, which occurs during a schizophrenic episode.[274]

"Gender Identity Disorder"

The National Gay and Lesbian Task Force, the National Center for Lesbian Rights, GenderPac, the Gender Identity Center of Colorado, and a number of other GLBT organizations have urged the American Psychiatric Association to reform the Gender Identity Disorder classification to help lessen social stigma and discrimination against those who may be gender dysphoric (averse toward the physical characteristics and social roles of their own biological sex) or gender variant (not exhibiting stereotypically male or female physical or behavioral characteristics). The current classification fails to distinguish gender identity from gender dysphoria. Transgender rights activists argue that, in doing so, the APA inappropriately promotes false and harmful stereotypes that equate difference with mental disease. Ironically, however, at the same time the medical and psychiatric establishment denies the medical legitimacy of gender dysphoria as a serious and treatable medical condition through sex reassignment surgery.[275] So gender variance is at once considered pathological enough to be classified as a psychiatric disorder (rather than a naturally occurring variation on the spectrum of gender) and not pathological enough to warrant the medical treatment desired by many transsexual people.

The Need for More Research on the Mental Health Needs of GLBT Old People

The lack of extensive research and representative samples in studies on GLBT seniors make it difficult to determine the mental health needs of GLBT old people. Both logic and the limited existing research suggests that GLBT elders do not have mental health concerns significantly different from other elders. It is estimated that 20% of all Americans have a diagnosable mental disorder, including 19% of adults 55 and older.[276] While mental health care is urgently needed for those in all economic classes, it is least available for the poor, who encounter greater trauma and stress in their lives.[277] We need more conclusive research with more representative samples in order to develop an empirically-based mental health agenda for GLBT elders. In the meantime, practitioners must continue to make themselves aware of the interactive effects of ageism, heterosexism, homophobia, racism, and classism, because fear of stigmatization and perceived cultural insensitivity remain barriers to mental health treatment.[278]

Hate Violence as a Public Health Concern

Healthy People 2010, a paper written by the Department of Health and Human Services which sets goals for improving the health care of the American people over the next decade, defines a number of goals which encompass the concerns of GLBT people:[279]

> Goal 1: Quality of Life
>
> "Quality of life reflects *a general sense of happiness* and satisfaction with our lives and environment…encompasses…*rights, values, beliefs, aspirations*, and the conditions that support a life containing these elements…*a personal sense of mental and physical health*…" (italics added)
>
> Goal 2: Eliminate Health Disparities
>
> "…to eliminate health disparities among different segments of the population. These include differences that occur by gender, race…or *sexual orientation*… America's gay and lesbian population comprises a diverse community with disparate health concerns…*Gay male adolescents are two to three times more likely than their peers to attempt suicide*. Some evidence suggests lesbians have higher rates of…stress than heterosexual women. The issues surround personal, family, and social acceptance of sexual orientation can place a *significant burden on mental health and physical safety*."
>
> Goal 15: Injury and Violence Prevention
>
> "Violence in the United States is pervasive and can change quality of life. [It]…*threatens the health and well-being of many persons of all ages in the United States*."

Anti-GLBT violence is one extreme on a continuum of devaluation of GLBT people. It has significant deleterious physical and mental health effects. As researchers D'Augelli *et al.* have noted, anti-gay violence, harassment and discrimination correlate with psychological distress, low self-esteem, and suicidality.[280]

Anti-GLBT violence is a public health issue. The fear of anti-GLBT violence is well founded, and a significant source of social stress for many GLBT people. Even as overall violent crime has declined, reported anti-GLBT attacks increased in the 1990s. In 1998 2,552 anti-GLBT incidents were reported to the FBI in the US; because most municipalities don't report anti-GLBT hate crimes, this is just the tip of the iceberg.[281]

Prevention and punishment of anti-GLBT hate violence must be a priority of those advocating for the health and well-being of GLBT seniors, as well as GLBT people in general.

NONDISCRIMINATION AND ANTI-POVERTY POLICY

Employment

"The best anti-poverty program is a job," runs the old adage. Despite its simplicity and its use to disparage the social safety net, there is some truth to this claim. Jobs provide income, and one's level of income defines whether or not one is poor. But for many women, people of color, and GLBT people, job discrimination based on gender, race, or sexual orientation means that this basic "anti-poverty program" is not always accessible to many people. In most political jurisdictions in the US, GLBT elders are at risk of employment discrimination based on sexual orientation or gender identity and have no legal recourse. The United States Congress passed the Age Discrimination in Employment Act (ADEA) in 1967 as an attempt to stem the tide of discrimination based on age in the workplace.[282] While GLBT elders can look to this law to protect them against age bias, any employer can still fire or refuse to hire them because of their sexual orientation in 39 states, and because of their gender identity in 49 states.[283] Wages may also suffer because of sexual orientation discrimination. As described earlier, at least two studies document significantly lower wages on the part of gay men compared with heterosexual men; lesbians appear to earn the same as heterosexual women, but since women earn less than men, on average, lesbian couples earn less than heterosexual married couples.[284]

Thanks to the hard work of grassroots activists, hundreds of towns, cities and counties have passed nondiscrimination laws, such that today nearly 38% of the US population is covered by a sexual orientation nondiscrimination law, and nearly 4% is covered by transgender-inclusive nondiscrimination language.[285] Still, in most places GLBT people can be fired or not hired because of sexual orientation or gender identity.[286]

Supplemental Security Income

Congress is considering reforms to combat fraud and abuse in the SSI program that could negatively impact GLBT people with disabilities. The SSI Fraud Prevention Act of 1999 (HR 545) was introduced in February of 1999 and is currently still under committee review.[287] This reform, if adopted, would seriously restrict benefit levels for elderly adults with disabilities. One of the most drastic of these reforms is what is called the "family cap restriction," which would limit cash assistance for beneficiaries in shared living arrangements. The idea behind the bill is to stop the fraud that sometimes occurs when people who are related by marriage get divorced in order to receive greater benefits as two single people than they would get as a married couple. The family cap would reduce benefits based on how many unrelated people who are SSI beneficiaries are living in a shared living arrangement, i.e. a 25% cut for homes with two residents who are beneficiaries, a 30% cut for homes with three residents, a 35% cut for homes with four residents and a 40% cut for homes with four or more residents.[288]

GLBT elders with disabilities who live in group living situations would be seriously hurt by reforms such as the "family cap." Group homes, which greatly benefit people with disabilities by linking housing with other services, would be threatened by these reforms. Policies that aim to make cuts in essential programs in the name of preventing fraud should be examined carefully by advocates for GLBT elders to ensure that budget cuts do not ride on the backs of people with disabilities.

Welfare Reform and Charitable Choice

Many gay, lesbian, bisexual, and transgender people, some of whom have HIV, AIDS, or another disability, are dependent on Medicaid, food stamps, housing subsidies, and other welfare programs. Medicaid remains one of the most important medical and health care assistance providers for the elderly, people with disabilities, HIV-positive individuals, and people living with AIDS. About 68% of all Medicaid expenditures are for services for disabled, blind, and nursing home-confined elderly. As the nation's population ages, the cost and need for long-term, nursing home care are expected to rise even more dramatically.

GLBT aging activists should subject charitable choice provisions to the highest degree of scrutiny.

Welfare reform, set into motion with the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, aims not only to restrict benefits but also to decentralize government aid programs by shifting more and more of the responsibilities to the states and the cities. This legislation eliminated the former AFDC program (Aid to Families with Dependant Children) and changed it to the TANF (Temporary Assistance to Needy Families) program. Block grants give state governments responsibility over the maintenance of aid programs for the poor, people with disabilities, and the elderly. Counties and cities with the least financial resources for health care for the indigent, and those most dependent on Medicaid and other federal subsidies to begin with, are particularly hard hit. Block grants also remove an important level of federal oversight of state and local policy making. States can determine eligibility with no federal guarantees that the poor will receive assistance. Time limits, work requirements and sanctions have also depleted the number of people receiving cash assistance and other supports.

There is already an alarming "race to the bottom" trend as states ostensibly compete to deter migrations of poor people from neighboring states by increased cuts in their welfare programs.[289] There is no evidence that poor people move from one state to another based upon on the level of welfare benefits offered. More control of welfare programs at the state level also risks the possibility of further discriminatory policies against GLBT people in states dominated by conservatives and the far right. These are just a few problematic impacts of these policy reforms.

Charitable Choice: Increasing the Role of Organized Religion in Social Service Provision

One aspect of welfare reform—which is up for renewal by Congress in early 2001—is of particular concern to GLBT activists. The welfare reform act of 1996 contained a provision which expanded the ability of religious institutions to provide social services, generally referred to as "charitable choice." More expansive charitable choice provisions are now before Congress.

Of course religious institutions have long been involved in the provision of certain types of social services in this country. Many have been at the forefront of providing care to the poor and immigrants and have long played a central role in African American communities. But in the past the government has required that services be provided in environments that are not "overtly religious," "pervasively sectarian," or evangelical. It has also required that federal civil rights laws covering hiring not be violated. Charitable choice provisions eliminate both of these safeguards. We know of at least two state-run programs currently in which gay, lesbian, bisexual and transgender employees and clients may be at risk for discriminatory treatment.[290]

There are a number of charitable choice bills currently before Congress. They would change current law, allowing 1) the provision of services in a house of worship and by "pervasively sectarian" institutions; 2) the display of religious "art, icons, scriptures" and "other symbols" in abundance in areas where federally funded services are provided; and 3) allow religious contractors to discriminate in all aspects of employment, including a requirement that employees subscribe to the tenets of the religious faith. This raises serious church-state separation issues as well as practical issues of access and discrimination.

Services to elders could also be handed over to churches, synagogues, mosques, and other religious institutions via this provision. Although we are not yet aware of a social service provided to elders which denies access to GLBT seniors, we are concerned about the potential for such an abuse. During the 2000 presidential election, both the Bush-Cheney and Gore-Lieberman tickets expressed support for an expanded role of faith-based institutions in social service provision. But charitable choice is opposed by a number of religious and civil rights organizations.[291] Given the concerns about constitutionality and discriminatory treatment of people in need of services, GLBT aging activists should subject charitable choice provisions to the highest degree of scrutiny, and consider the potential constitutional and practical concerns they raise.

Non-Discrimination Legislation

The National Gay and Lesbian Task Force supports non-discrimination legislation at the local, state and national level that prohibits discrimination based upon sexual orientation and gender identity. Gay, lesbian, bisexual and transgender (GLBT) individuals suffer pervasive discrimination in employment, housing, education, medical care, and everyday life because of continuing societal ignorance and fear of difference. GLBT Americans often find they must leave their homes and move if they wish to live honest, open lives. Indeed, the lack of civil rights legislation helps perpetuate an environment in which hate and harassment can flourish.

Sexual orientation non-discrimination enjoys widespread majority support in the US. 83 percent of Americans support equal rights in employment, and 75 percent support equal rights in housing for gays and lesbians.[292] Half of Republican voters support laws banning discrimination on the basis of sexual orientation, as do 65 percent of Independents and 74 percent of Democrats. More Republicans support such laws (49%) than oppose them (42%).[293]

PROFILE: RUTH ELLIS, 101

Ruth Ellis passed away in October 2000. We are reprinting this profile in memory of her.

by Yvonne Welbon

The first time I laid eyes on Ruth C. Ellis she was dancing. I was at the 1997 National Women's Music Festival women of color dance. When my girlfriend and I had to pause for water and rest, Ruth did not. I wondered how old she was. I later learned that Ruth C. Ellis was 97 years old. Born July 23, 1899, in Springfield, Illinois, Ruth C. Ellis was the oldest "out" African American lesbian I knew. When I met her, I was indeed intrigued. I wanted to know everything about her. I could not begin to imagine the almost one-hundred years of history that was living in the 4'8" tall woman that everyone calls Ruth.

Clint Steib/Washington Blade

Ruth C. Ellis was always out. Her first crush was her high school gym teacher in 1915, in Springfield, IL. She didn't meet her life companion of 34 years, Ceciline "Babe" Franklin, until 1936. In 1937, they moved Detroit. There Ruth C. Ellis became the first woman to own her own printing business in northwestern Detroit: Ellis and Franklin Printing. She also taught herself photography and hand-colored painting. From 1946 to 1971, Ellis and Franklin's home became known as the "Gay Spot." For generations of African American gays and lesbians in the Midwest, Ellis and Franklin's home provided an alternative to the bar scene that discriminated against blacks. Her home was a refuge of sorts to African Americans who came "out" before the civil rights movement and Stonewall. Ellis and Franklin offered lodging to black gay men newly arrived from the South. They also helped many of the young people through college.

Throughout her life Ellis was always an advocate for the rights of gays and lesbians. Recently when she heard a woman in her senior citizens building speaking in derogatory terms about "queers" she seized the moment to come out and say, "When you are talking about them, you are talking about me."

It wasn't until Ellis was well into her senior years that she began a new life as a cherished senior in the gay and lesbian community. Ellis recalled how she met her new friends in 1979. "I didn't know anyone in this senior citizens building that was gay. Then this girl, she taught karate, she came and taught us adults how to take care of ourselves. I looked at her and I said, 'Oh! I bet she's gay.' I wrote her a card and asked her if I could be better acquainted with her. She invited me over to another class, and I meet a lot of the girls there. They were gay. They took me to one of these bars and I met more people there. The ball just kept rollin'. I kept meetin' the women, and the women, the women, until, Oh, I just know a gang of them now. I am the oldest lesbian that they know."

Ruth C. Ellis outlived her entire family.

While this situation is not one that is particular only to lesbians, it may occur more frequently due to a number of circumstances. Many lesbians never had children. Others have been cut off from their immediate families because of [hostility toward] their sexual orientation. Ellis's life is testimony to the importance of "community as family" for both seniors and lesbians. Most recently, Ellis advocated for an organization for gay and lesbian seniors that is sort of a Big Brother/Big Sister program in reverse. The way this program would work is that younger gays and lesbians would be partnered with seniors according to interests.

Like one-quarter of the centenarian population, Ruth continued to live on her own. Witnessing Ruth's life as a senior offered a rare opportunity to experience a century-long history of African American gays and lesbians through the life lived by one inspiring woman. By example, she showed us what is possible and what can be realized, if one not only lives long but ages well.

Used with permission, and minor changes, from Sisters in the Life website (www.sistersinthelife.com).

Recommendations for Policy Advocacy and Activism

POLICY RECOMMENDATIONS

Research

- Governmental and academic research could dramatically increase knowledge about the basic demographics of GLBT people by routinely incorporating questions about sexual orientation, sexual behavior, and gender identity into survey research. The federal government should take the lead on this by setting a standard of inclusion and requiring the inclusion of these variables, when appropriate, through guidelines for federal research grants.

The Department of Health and Human Services should gather information on sexual behavior, sexual orientation, and gender identity in its Elder Abuse and Neglect Survey.

- Researchers should ensure that old people are included at every stage of the research process. Research is particularly needed on the experiences and issues facing the following populations within the GLBT elder population: African American, Asian American, Latino/-a, and Native American elders; transgender and bisexual elders; working class and poor elders; rural, suburban and urban elders; immigrants; people whose first language is not English; people who are homosexually active but do not identify as GLBT.
- To increase knowledge about the prevalence of abuse and neglect of GLBT elders, the Department of Health and Human Services should gather information on sexual behavior, sexual orientation, and gender identity in its Elder Abuse and Neglect Survey. Such routine research would provide a national, longitudinal data set on abuse and neglect of GLBT seniors.
- Increase funding for research and policy analysis into how caregiving issues affect older GLBT people, both in terms of the caregiving needs of GLBT elders and the caregiving practices of middle aged and senior GLBT people.[294]
- Funding should be made available under the Older Americans Act for 1) research on the needs and concerns of GLBT seniors; 2) evaluation of existing services and their use by GLBT seniors;

and 3) the development of gerontology and social work curricula at colleges and universities that train aging specialists and service providers in the particular needs of GLBT seniors.[295]

Services, Training, and Caregiving

Older Americans Act

- Congress should reauthorize the Older Americans Act.
- Since funding for OAA programs has not kept pace with costs, resulting in an actual decline of more than 40% in real dollars since 1980, even as the senior population has increased, Congress should appropriate new funding for the OAA to pay for additional services and to expand existing ones.
- Congress should maintain the inclusive language in Part E of the National Family Caregiver Support Program that defines family caregiver as "an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual."[296]

The Older Americans Act should be amended to explicitly include services, outreach, training, and research on issues of concern to GLBT seniors; and to prohibit discrimination in services on the basis of sexual orientation and gender identity.

- The Older Americans Act should be amended to explicitly include services, outreach, training, and research on issues of concern to GLBT seniors; and to prohibit discrimination in services on the basis of sexual orientation and gender identity.
- GLBT activists should apply for funding under Part F, which provides for State and Local Innovation and Programs of National Significance demonstration funds, to train those who provide aging services in the concerns and needs of GLBT elders.[297] Programs and services must be sensitive to this population and responsive to its needs. Training and education can decrease homophobia and transphobia and help create a safe environment in which GLBT elders can partake in full in services offered to other elders. GLBT elders should be included as both trainers and advisors to this process.
- Activists should also work toward amending the Older Americans Act's services under Title III, which authorizes and funds the core programs of the OAA. Targeting language should be added that specifically authorizes outreach to GLBT seniors, along with other underrepresented and underserved populations.[298] But any new targeting language should be accompanied by new funding to pay for the services, so that funds are not taken away from one needy community and redirected to another.
- Activists should work with their Area Agencies on Aging to assess the needs of GLBT elders, evaluate whether those needs are being met by community-based services, and influence their area plans to see that GLBT elders have the services they need and deserve.

Senior centers must work to increase their staff's competency to deal with the particular needs of GLBT seniors, not just in metropolitan areas but in rural and suburban regions as well.

- Area Agencies on Aging (AAAs) could do a better job of serving gay, lesbian, bisexual and transgender seniors by: 1) asking about sexual orientation and gender identity in the initial client assessment, along with other demographic questions, such as significant relationships for GLBT seniors; 2) offering in-service training conducted by GLBT elders to the staff of AAAs; 3)

developing effective outreach strategies in collaboration with local GLBT senior activists, including marketing strategies inclusive of GLBT elders; 4) developing collaborations with GLBT social service organizations, including elder organizations.[299]

- Senior centers must work to increase their staff's competency to deal with the particular needs of GLBT seniors, not just in metropolitan areas but in rural and suburban regions as well. Staff should provide a safe and sensitive environment that is inclusive of sexual minorities. In areas with sizable GLBT populations, programs targeting GLBT elders and even gay-operated senior centers should be developed.

Activists should work with their Area Agencies on Aging to assess the needs of GLBT elders, evaluate whether those needs are being met by community-based services, and influence their area plans to see that GLBT elders have the services they need and deserve.

Long Term Care and Caregiving

- Maintain the inclusive definition of caregiver contained in the Older Americans Act reauthorization legislation.
- Expand Medicare to cover long-term care.
- Expand the definition of spouse in the Family and Medical Leave Act of 1993 to include domestic partners, as H.R. 2104 would do. This would require employers to provide up to 12 weeks unpaid leave to an employee in the event of a serious medical condition of one's partner.
- Hospitals and nursing homes should adopt policies treating the families of GLBT people the same as they treat family members of heterosexual patients and residents. Such policies should be integrated into staff training.
- Congress should pass the Medicaid Community Attendant Services and Supports Act (MCASSA). MCASSA calls for an assessment of the individual's needs and coverage of the care needed to make the transition from institutional care to a home setting. People who are currently entitled to nursing facility services or intermediate care services would be given the option of choosing qualified community-based services. People would have more choice in terms of receiving their care through institutions or through accessing home care services in their area. This new legislation would provide the option of living at home and prevent separation from a long-term partner or exposure to a homophobic institutional care situation.
- Home care agencies should be trained to be culturally sensitive and respectful of GLBT old people, and they should not tolerate abuse and neglect motivated by homophobia, transphobia, or any other form of prejudice.
- Appropriate social service agencies should provide GLBT-sensitive support for informal family caregivers, including same-sex partners and close friends.

Home care agencies should be trained to be culturally sensitive and respectful of GLBT old people, and they should not tolerate abuse and neglect motivated by homophobia, transphobia, or any other form of prejudice.

Recognition of GLBT Families

Social Security

- Social Security regulations should be amended to allow the surviving partner of a same-sex couple to receive benefits just as heterosexual married widows and widowers do.
- Regulations should also be amended to allow for equal treatment of same-sex spouses under the spousal benefits provision.

Social Security regulations should be amended to allow the surviving partner of a same-sex couple to receive benefits just as heterosexual married widows and widowers do.

Medicaid's treatment of same-sex couples

- Medicaid regulations should be changed to treat same-sex couples equally. Specifically, same-sex couples in long-term relationships should have the same rights as married couples, allowing one of the partners to retain a jointly owned home without jeopardizing his or her partner's right to Medicaid coverage.[300]
- Medicaid spend-down protections, which provide income and asset protections to the husband or wife of a nursing home resident, should be expanded to cover the partners of GLBT people who enter nursing homes. Additionally, life partners of GLBT Medicaid nursing home residents should have the same home protection that married spouses have, and be allowed to remain in the couple's home until death, before the state may attempt to recover the cost of the care provided through an estate recovery process. The ultimate solution to these inequities would involve federal recognition of same-sex couples, but in the meantime Medicaid should adopt such regulations in order to treat same-sex elder couples equally under the law.

401(k)s and Pensions

- Tax laws should be reformed to treat unmarried partners in long-term, committed relationships equally under 401(k) plans and other pension plans. Specifically taxation rates, tax exemptions, penalties, and other policies should be changed to treat same-sex and opposite sex domestic partnerships equally with heterosexual couples recognized as married by the state under current marriage laws.

Same-sex couples in long-term relationships should have the same rights as married couples, allowing one of the partners to retain a jointly owned house without jeopardizing his or her partner's right to Medicaid coverage.

Access to Civil Marriage and Partnership Rights

- State and federal policies should be changed to allow equal access to civil marriage for same-sex couples.
- Congress should repeal the "Defense of Marriage Act," passed in 1996.
- States should repeal the 32 anti-same-sex marriage laws passed since 1996.
- The federal government should provide the full range of spousal benefits to the domestic partners of federal employees—by statute, regulation, and executive order. City and state governments should do the same for the domestic partners of city and state employees.

- The US tax code should be amended to make the cost of health insurance benefits for an employee's domestic partner tax-free, just as it would be if the benefits were for a heterosexual employee's spouse.
- The Attorney General should exercise discretion to the fullest extent allowable by law to permit committed same-sex couples to stay together legally in the United States under immigration provisions for family reunification, as more and more democracies around the world are doing.

Tax laws should be reformed to treat unmarried partners in long-term, committed relationships equally under 401(k) plans and other pension plans.

Housing

Non-Discrimination and Public Housing

- The Fair Housing Act should be amended to ban discrimination in housing on the basis of sexual orientation or gender identity.
- Department of Housing and Urban Development (HUD) senior housing nondiscrimination provisions should be expanded to explicitly ban discrimination on the basis of sexual orientation and gender identity, and such senior housing administrators and staff should be trained to understand and enforce these regulations.[301]

Nursing Homes

- Nursing homes, assisted living centers, congregate housing and home health care services need to take proactive steps to minimize the incidence of discrimination, abuse and neglect of GLBT elders. All providers of caregiving services and housing to elders should be trained to be competent in issues of sexuality and gender.
- Nursing home staff must be fully trained to understand and better serve the needs of GLBT clients. Diversity training is critical given documented examples of bias among health care providers.
- Nursing homes should include detailed sexuality policies within residents' rights policies, and accommodate the appropriate, private expression of the sexual needs of residents, be they homosexual, bisexual or heterosexual. The right to privacy is already included in most nursing home regulations, but is not always protected for GLBT seniors.

Health Care

Medicare

- Medicare reform must not excessively restrict physician choice. Medicare policies encouraging enrollment in HMOs must take into account the particular health care needs of GLBT seniors and other populations with particular needs and concerns, and HMOs should be required to train all physicians to provide competent and sensitive medical care to GLBT seniors and other communities.
- Medicare should attempt to limit the number of health plans that are ceasing to accept Medicare Plus Choice, which results in a limiting of physician choice, higher out-of-pocket expenses, and

HUD senior housing nondiscrimination provisions should be expanded to explicitly ban discrimination on the basis of sexual orientation and gender identity.

failure to reimburse prescription drugs.[302] This means that health plans and medical service providers need to limit cost increases.

- Congress should pass legislation allowing Medicare to cover prescription drugs and long-term care, and calling for expanded coverage options in supplemental Medicare insurance policies.
- Low-income protections for Medicare should be expanded up to 150 percent of the federal poverty level, and efforts should be made to increase program participation rates.
- Substantial increases in copayments, deductibles, Part B premiums, and any increase in the Medicare eligibility age should be opposed.
- Any funds resulting from cost savings, reductions of fraud and abuse, inefficiencies, and cost-sharing should be used to support the current program and expand coverage, and not for tax cuts.[303]
- Access to health care should be understood not only in terms of coverage, but also in terms of the effective delivery of services. Medicare covers preventive services such as mammograms, Pap smears, and prostate cancer screenings, yet many eligible patients do not avail themselves of these services. Reform efforts should include policies to increase the delivery of such services through targeted prevention and health promotion education.[304]

Nursing homes should include detailed sexuality policies within residents' rights policies, and accommodate the appropriate, private expression of the sexual needs of residents, be they homosexual, bisexual or heterosexual.

Medicaid

- Medicaid eligibility should be expanded to at least 150% of the federal poverty level and preferably higher. (As of 2000, the federal poverty level was $8,350 for an individual, $11,250 for a family of two, and $17,050 for a family of four.[305])
- The Personal Responsibility and Work Opportunities Reconciliation Act (welfare reform) of 1996, which is up for renewal in 2001, should be amended to restore eligibility for all legal immigrants, including PRUCOL immigrants, for full Medicaid coverage.
- Efforts should be taken to encourage or require doctors to treat Medicaid patients. Currently, about a third of the nation's physicians limit the number of Medicaid patients they see, and about a quarter will not see Medicaid patients at all.[306]

Congress should pass legislation allowing Medicare to cover prescription drugs and long-term care.

Elder Abuse and Neglect

- Public education campaigns should be undertaken by appropriate local, state and federal governmental agencies to identify, prevent, stop, and punish abuse and neglect of GLBT elders.
- More research on abuse and neglect of GLBT seniors should be done by agencies responsible for monitoring such abuse.

Efforts should be taken to encourage or require doctors to treat Medicaid patients.

Public Health

- Target prevention messages to GLBT people, particularly on issues that may disproportionately affect GLBT people, such as breast and cervical cancer, HIV/AIDS, other sexually transmitted diseases, tobacco and substance abuse, hate violence, and domestic violence.
- Include older men and women, and especially older GLBT people, in trials for new HIV/AIDS medications.
- Conduct public education outreach campaigns to end homophobia, transphobia, and the presumption of heterosexuality in health care, including mental health care services, and encourage GLBT people to be out to health care professionals.
- Increase funding for public health and mental health research into the particular needs and experiences of GLBT people.
- Pass the Hate Crimes Prevention Act, S.622 / H.R. 1082, and fully enforce the act upon passage. Fully fund and implement programs authorized by the Hate Crimes Prevention Act designed to reduce violence.

Include older men and women, and especially older GLBT people, in trials for new HIV/AIDS medications.

- Increase law enforcement and criminal justice funding to states passing hate crimes laws inclusive of GLBT people and increase federal funds for community-based anti-violence projects.
- Fund age-appropriate programs at all educational levels that teach tolerance, understanding and respect, regardless of race, religion, ethnicity, age, national origin, sexual orientation, disability, gender, or gender identity.

Managed Care

- Protections regarding physician choice and the right to culturally competent health care for GLBT patients should be incorporated into the Patients' Bill of Rights.

Discrimination and Income Support

Anti-Poverty and Income Support Programs

Social Security

- GLBT policy advocates should examine the pros and cons of investing the Social Security Trust Fund into equities and bonds, and initiate a national discussion of the potential risks and benefits assumed by such a reform for our communities. It must be clearly explained to workers that in the event that investments perform poorly, an increase in the Social Security tax on future wages may be necessary to make up the shortfall.[307] Any market investments should be of minimal risk, and social and ethical concerns should factor into investment decisions. If any funds are invested in stocks and/or bonds, they should be a small percentage of the total Social Security Trust Fund, and not constitute the partial or total "privatization" proposed in the more extreme reform proposals of the 1994-1996 Advisory Council on Social Security.[308]

- Attempts to raise the age of retirement for purposes of Social Security beyond 67, or to move up the date of that change, should be rejected.

Welfare Reform and Charitable Choice

- Charitable choice provisions in the Personal Responsibility and Work Reconciliation Act of 1996, up for renewal in 2001, should be amended to protect against sectarianism, evangelism, and discrimination against clients by religious organizations providing social services with government funding. The rights of atheists, agnostics, and religious people of all faiths to equal access to services in a non-sectarian, non-evangelical, and non-discriminatory environment must be explicitly guaranteed. Service consumers must be protected against discrimination based on sexual orientation and gender identity, as well as those characteristics currently protected under federal civil rights law.

Employment and Non-Discrimination Legislation

Sexual Orientation and Gender Identity Non-Discrimination

- The Employment Nondiscrimination Act should be expanded to 1) ban discrimination on the basis of gender identity, and 2) outlaw discrimination in employment, housing, education, public accommodations, credit and other areas on the basis of sexual orientation and gender identity. Such a comprehensive civil rights bill should be passed into law.
- Until a federal law banning employment discrimination against GLBT people is passed, the U.S. Equal Employment Opportunity Commission should accept and record complaints of discrimination based on sexual orientation or gender identity. An executive order could direct the EEOC to record anti-GLBT discrimination.
- Executive Order No. 13087, banning discrimination based on sexual orientation in Executive Branch agencies, must be maintained and enforced.
- Executive Order No. 13087, which bans discrimination based on sexual orientation in federal agencies, should be amended to include employment protection for transgender people, and require reasonable accommodations for people employed by the federal government who are undergoing gender reassignment.
- Existing nondiscrimination laws should be used to secure transgender civil rights; in particular, the Department of Justice should use Title VII and Title IX in litigation to secure equal rights for transgender individuals.

Discrimination based on age, race, religion, sex, or national origin

- The Justice Department and the Equal Employment Opportunity Commission should strictly enforce the Age Discrimination in Employment Act of 1967; and prosecute discrimination based on race, color, religion, sex, or national origin under Title VII of the Civil Rights Act of 1964, and the Equal Pay Act of 1963.[309]

Americans with Disabilities Act

- Activists should work with the Department of Justice and the Equal Employment Opportunity Commission to enforce the accessibility and nondiscrimination mandated by the Americans with Disabilities Act.

- Congress should increase funding for enforcement and technical assistance efforts to assist employers in understanding and abiding by the law.

RECOMMENDATIONS FOR ACTIVISM FOR GLBT AND SOCIAL JUSTICE ACTIVISTS

- **Fight Ageism**. GLBT communities need to address the ageism that exists within their own networks and organizations. The exclusion of old people from the community's social, economic and political agendas must end. Organizations such as Old Lesbians Organizing for Change, Senior Action in a Gay Environment, and Pride Senior Network are excellent resources for information and policy recommendations. GLBT elder organizations are listed in the resource section, which immediately follows this section.
- **Survey own memberships to determine needs.** GLBT community centers and other social service providers should determine the unmet needs and policy priorities of their elder constituents and develop strategies to meet those needs and advocate for those priorities.
- **Support the concept of "nothing about us without us."** The GLBT community has learned from the HIV/AIDS epidemic that true reform and political action is not just, or successful, if those affected are not included at every level of decision-making. GLBT elders must be included at every level of strategy development, policymaking, and programmatic activity.
- **Create Alliances with Aging Organizations.** GLBT activists need to work with predominantly heterosexual organizations that focus on aging issues. These groups must be encouraged to take up GLBT concerns through collaborations with GLBT and GLBT aging organizations.
- **Form Coalitions with the Disability Community.** GLBT activists need to develop an analysis of disability issues and form coalitions with disability activists to work toward policy solutions that will help old people, some of whom are also people with disabilities.
- **Fight Racial and Gender Inequality.** If the mainstream GLBT movement is to do meaningful work on issues of concern to GLBT elders, then it must confront the ways that racism and poverty shape the parameters of the aging process. As is evident in the data presented above, poverty is a problem for old people and is particularly pronounced for women and people of color. Organizing against racism, poverty and sexism is vitally important to any public policy or service program that seeks to improve the lives of GLBT seniors. The struggle to improve the lives of GLBT old people must come from an understanding that the educational, employment, and economic opportunities of people throughout life seriously affect their aging experiences. There must be an understanding that engaging in any struggle for social justice for any disenfranchised group also improves the lives of GLBT people. Restricting the GLBT struggle to one against homophobia and transphobia is short-sighted and counterproductive, when so many people also battle sexism and racism throughout their lives and into old age.

- **Support Retirement Planning.** GLBT organizations and employers should help their members and employees plan for the future. GLBT organizations should examine their own employee benefit plans to ensure they include some sort of retirement income program. It is especially important that employees and consumers understand the growing need for pension plans to supplement Social Security income in retirement, and the need for long term care insurance.
- **Influence the Next White House Conference on Aging.** GLBT aging activists need to decide early on how they will participate in the next White House Conference on Aging, particularly given that it will occur in the context of a new presidential administration. It is essential that delegates to the event include activists with a solid understanding of the particular policy issues facing GLBT seniors.

Conclusion

This report has been written in the interest of providing a basic introduction to some of the issues policy makers, GLBT and aging activists, and researchers must consider in order to advocate on behalf of, and with, GLBT elders. It also marks an initial step toward articulating a GLBT policy agenda on current and emerging aging issues in a field in which much more needs to be done.

To better ascertain and meet the needs of GLBT seniors, several major changes must take place. Governmental and academic researchers must include sexual orientation and gender identity as standard demographic variables in their research. Social service needs of GLBT seniors, including the need for caregiving, must be assessed and appropriate, culturally sensitive services provided through the Older Americans Act and other programs. Social Security, Medicaid, and pension policies must change to treat same-sex relationships equally to heterosexual relationships. Public health efforts must target GLBT seniors with prevention messages targeting their particular health concerns. Nursing homes must treat GLBT elders with respect and dignity in their final days. Senior housing regulations must safeguard the right of GLBT seniors to rent an apartment or purchase a home.

As GLBT people age, they will continue to face the intersections of heterosexism and ageism both in the social service arena and within the GLBT community itself. The GLBT movement must take up the struggle of acknowledging, supporting, and respecting old people in all contexts, so that aging can become a process of discovery, enjoyment, and fulfillment rather than one filled with uncertainty, fear, and discrimination. Likewise, elders and those providing services and advocacy to elders must provide a welcoming and nurturing environment to their GLBT sisters and brothers.

In recent years, federal programs designed to alleviate poverty and provide health care to elders and people with disabilities have been seriously dismantled under the banner of reform. At the same time, the elderly portion of the US population is growing at a dramatic rate. Welfare, Social Security, Medicaid and Medicare are programs that have, with varying degrees of success, provided basic security to America's poorest popula-

tions. Contrary to right-wing rhetoric, they have alleviated poverty significantly, especially since Lyndon Johnson's War on Poverty in the mid- 1960s and especially among old people. Anti-poverty programs provide assistance to elders, people with disabilities, the unemployed, and parents with dependent children. Now, as these programs undergo major reassessment, it is vital that GLBT movement activists be more involved and vocal than ever about the changes being proposed. The quality of life of GLBT elders today and the millions to come depends on a steadfast and unwavering commitment to justice.

Appendix A

ESTIMATES OF THE GLBT POPULATION IN THE UNITED STATES

Sell *et al.* (1995) found that 8.7% of American men and 11.1% of American women in a national random survey reported same-sex attraction but no homosexual behavior since age 15. Nearly 21% of US men and 18% of US women reported either homosexual attraction or behavior since age 15. But only 6.2% of men and 3.6% of women in the US reported having had sex with a person of the same sex within the past five years. Sell *et al.* argue that their findings "highlight the importance of using more than just homosexual behavior to examine the prevelance of homosexuality."[310]

A 1970 reader survey conducted by *Psychology Today* found 37% of males and 12% of females reported "some homosexual contact to orgasm," while a similar 1983 survey of *Playboy* readers found 35% of men and 22% of women reported "some homosexual contact to orgasm during adolescence," while 10% of men and 12% of women reported homosexual sex since adolescence. These latter two surveys are of questionable validity in that they are self-selecting, and their readerships are not representative of the US population as a whole.[311] A 1991 analysis of the National Opinion Research Center's (NORC) General Social Survey documented 5-6% reporting some homosexual contact since age 18,[312] while an analysis of NORC data from 1989-93 found 2.8% of men and 2.5% of women identified themselves as homosexual.

Laumann *et al.* estimate that between 1.4% and 4.3% of women, and between 2.8% and 9.1% of men in the United States are lesbian, gay, or bisexual.[313] In the country's 12 largest cities, Laumann *et al.* estimate that 2.6% of women and 9.2% of men identify as lesbian or gay, while 4.6% and 15.8% of women and men, respectively, have had sex with a person of the same sex since puberty.[314]

One of the largest figures comes from the 1994 Yankelovich Monitor research, in which 6% of a national sample identified as gay or lesbian. Yankelovich surveyed a nationally representative sample of 2,500 consumers age 16 and older across the continental US weighted to mirror 1990 US Census demographics and found that 148 of 2,500, or nearly 6%, identified as gay or lesbian in a door-to-door interview.[315]

Another source of data is voter exit polls. Since 1990, the Voter News Service, a consortium of television networks and major newspapers, has asked about sexual orientation in voter exit polls during national elections.[316] Since 1990 the percentage of voters polled across the country who self identify as gay, lesbian or bisexual has increased from 1.3% to 5.0% in 1996, dropping slightly to 4.2% in 1998.[317] We do not know if gay, lesbian and bisexual voters are more or less likely to vote than heterosexual voters, since we don't have strong national random sample data to which to compare these figures. It is likely that many gay, lesbian, and bisexual voters do not self identify on the exit poll survey form, as polling places are in one's neighborhood of residence and some people do not feel safe coming out to a stranger in their home neighborhood.

Exit poll data demonstrate striking age differences, with voters under 40 more likely to self identify as gay than voters over 40. In 1996, 4.3% of voters over 40 said they were gay, lesbian, or bisexual, versus 6.0% of voters under 40. In 1998 these figures further diverged: 3.3% of older voters self-identified as gay, lesbian, or bisexual, while 6.4% of younger voters did.[318] It is unclear whether this means that older voters are less likely to consider themselves gay, or if it means that older gay voters are less willing to "come out" to a stranger outside a polling place. It's probably a combination of both factors. Given changing social norms and an increased acceptance of homosexuality, it is likely that more young people are choosing to live as homosexuals or bisexuals than those born a generation or two ago. But social science research among elder gays and lesbians has found that for many older gays, "passing" as straight by remaining discrete about one's homosexuality was seen as an appropriate and competent "management" of one's homosexuality, while "coming out" was viewed as evidence of incompetence or mismanagement.[319] This view, albeit rooted in once dominant homophobic discourses, could be responsible for part of the age differential in the voter exit poll data.

Appendix B

LESBIAN AND GAY ACTIVISM AT THE WHITE HOUSE CONFERENCE ON AGING

The first White House Conference on Aging (WHCoA) was designed by President Harry Truman in 1950 to assess the challenges emerging from the growing population of old Americans in the mid-twentieth century. Since then conferences have provided an opportunity for delegates from around the country to come together to encourage a nationwide focus on aging issues and to strategize about aging policy. The conferences had taken place every 10 years until President George Bush broke the pattern. The 1990 conference was therefore delayed until President Bill Clinton convened it in 1995. The goal of these conferences is to evaluate current needs and make recommendations to the President and Congress regarding amendments to the Older Americans Act for the next decade. The Older Americans Act expired in 1995 and has not been re-authorized despite attempts by many in the Congress to do so. What this means is that the Older Americans Act remains funded, but at about 40% below need, given the dramatic growth in the elder population and its changing demographics.[320]

For more than a decade grassroots activists have led a national movement to increase visibility and equality for GLBT elders. A turning point in the movement came in 1995 at the WHCoA when three "out" lesbian delegates—Del Martin and Phyllis Lyon, co-founders of the Daughters of Bilitis, the first national lesbian organization, and Nancy Moldenhauer, vice-president of the Older Women's League—challenged some 2217 other delegates to include gay and lesbian issues in the conference agenda and report. With help from Lisa Hamburger, then vice-president of the National Association of Lesbian and Gay Gerontology, Carlos Martinez, diversity coordinator for the American Society on Aging, and others, they succeeded in getting the words "sexual orientation" added to the non-discrimination resolution. This resolution was ultimately defeated in a vote, but served as a consciousness-raising tool and became part of the official conference record.

Having learned that delegates could make post-conference recommendations for implementation of resolutions that had been adopted, Lyon, Martin and Hamburger

launched a national letter-writing campaign from their home base in San Francisco. They also arranged two post-conference conferences, one sponsored by San Francisco's Commission on the Aging, the other by the National Association of Lesbian and Gay Gerontology. They gathered enough letters and testimony to support their contention that to implement sexual orientation nondiscrimination it was necessary to name the population it referred to.

In the end, these pioneers of gay and lesbian inclusion were rewarded with success in the final White House Conference on Aging report, which listed gay men and lesbians as a "special population" in its report, and added sexual orientation to the non-discrimination statements of the conference.

Appendix C

LEGAL ISSUES FACING SAME-SEX COUPLES

The information presented here is given for descriptive purposes only.

To create valid legal documents, readers are advised to consult with an attorney. Much of the social work literature on GLBT aging focuses on the legal problems older gay and lesbian couples often encounter when one of them becomes incapacited or in the event of the death of a partner. In the famous case of Sharon Kowalski, Kowalski's lover Karen Thompson was not allowed to see or care for her partner after Kowalski was nearly killed by a drunk driver, due to the homophobia of Kowalski's family of origin. Only after a several-year legal battle in the Minnesota courts was Karen allowed to see Sharon, help in health care decision-making, and bring her home to care for her.[321]

In another case, when two elder lesbians who have been together for 42 years take ill, distant family members take over decisionmaking responsibilities and disregard the women's desire to be together. Family members ignore their lifelong relationship, separating them into two different nursing homes, selling their home (which legally belonged to only one of them), and selling off their belongings. Family members refuse to let them visit each other, saying to do so would be "upsetting."[322]

When GLBT people—and particularly people in same-sex relationships—age, heterosexism and homophobia can cause a process of infantilization. As family law expert Paula Ettelbrick notes, "it is usually assumed that unmarried adults, regardless of age, are always children under the law."[323] Hospital personnel may limit visits to "immediate family," which would include a married sister-in-law but not one's own same-sex partner with whom one has shared one's life. Treating physicians may follow the instructions of a patient's parent or sibling rather than that person's life partner. GLBT seniors are encouraged to make the following legal provisions:

Durable Medical Power of Attorney, or Durable Power of Attorney for Health Care

Through this document, person A authorizes person B to make all medical decisions should person A become incapacitated and unable to make such decisions. Medical

decisions can include choices about medications or surgery, changing physicians, moving to another health facility, and dietary requirements.[324]

Durable Power of Attorney

Durable powers of attorney take two forms. First, a general durable power of attorney grants to another person the ability to make any and all financial and legal decisions on the grantor's behalf. This may include anything from selling a home to writing checks from the grantor's account. It lasts until the grantor revokes it or executes a new power of attorney. The second is a limited durable power of attorney, which may limit the range of decisions another person can make (i.e., to simply sell the house or write a check each month from the grantor's account for the rent) or the timeframe during which any decision can be made (i.e., only during hospitalization). The term "durable" means that the document remains in effect even if the person goes into a coma or is otherwise incapacitated from acting on his or her own behalf.[325]

Priority for Hospital Visitation

Although these documents are still of questionable legal validity, they specify that a particular person is to be given priority over other family members; usually hospital administrators will defer to the person given priority in the document over other family members. Such documents can also be written to specify priority for visitation in nursing homes, substance abuse treatment facilities, and other institutions. Some of these institutions also allow for the patient to name those who should be given priority visitation.[326]

Living Will

A living will or advanced directive is a statement written prior to incapacitation in which a person spells out what he or she wants a doctor to do in case of terminal illness when life support or resuscitation is required. Individuals can tell a physician that in the event that they must go on life support or be resuscitated through extraordinary means, they prefer not to undergo such treatments. A living will cannot be overridden without formal legal proceedings, and is an important safeguard for effecting a patient's wish to die with dignity.[327]

Last Will and Testament

A will is a legal declaration by an individual that spells out how his or her property should be distributed and any estate administered upon his or her death. Wills become effective only upon the death of the person making the will. Wills are the best insurance against a homophobic family member challenging a life partner's desire to stay in a house that was never jointly owned by the two partners, or challenging a life partner's access to other items left by the deceased. Wills should be written well in advance of the point at which one is on one's deathbed. Deathbed wills are often challenged by disgruntled birth family members on the grounds of mental incompetence.[328]

Appendix D

RESOURCES

GLBT ORGANIZATIONS WORKING ON AGING ISSUES

Alexander Hamilton American Legion Post 448
P.O. Box 411077
San Francisco, CA 94141-1077
(415) 431-1413
f (415) 824-3944
www.post448.org

American Educational Gender Information Service, Inc.
PO Box 33724
Decatur, GA 30033-0724
(770) 939-2128
www.ren.org/rafil/aegis.html

Fine Wine (an on-line organization for Lesbian/Bi Women over 40)
www.GLBT.com/finewine/index.html

Gay, Lesbian & Bisexual Veterans of America
P.O. Box 29317
Chicago, IL 60629
www.glbva.org

Gay & Lesbian Association of Retired Persons
PO Box 30808
Los Angeles, CA 90024
www.gaylesbianretiring.org

Gay and Lesbian Outreach to Elders (GLOE), a program of New Leaf: Services for Our Community
1853 Market Street
San Francisco, CA 94103
(415) 626-7000
http://bayarea.citysearch.com/E/G/SFOCA/1000/08/86

Golden Threads: A national network created for ageful lesbians
PO Box 65
Richford, VT 05476-0065
http://members.aol.com/goldentred/index.htm

International Longitudinal Transgender and Transsexual Aging Research Institute
PO Box 28089
Richmond, VA 23228
(804) 421-2428
www.int-trans.org
tmwitten@earthlink.net

Lambda Legal Defense and Education Fund
120 Wall Street, Suite 1500
New York, NY 10005
(212) 809-8585
www.lambdalegal.org

Lesbian Aging Issues Task Force
PO Box 843
Madison, WI 53701

Lesbian and Gay Aging Issues Network (LGAIN)
American Society on Aging
833 Market Street, Suite 511
San Francisco, CA 94103-1824
(415) 974-9600
www.asaging.org/lgain.html.

Mature Friends
P.O. Box 84772
Seattle, WA 98124
(206) 781-7724

National Center for Lesbian Rights (NCLR)
870 Market Street, Suite 570
San Francisco, CA 94102
(800) 528-6257
www.nclrights.org

National Gay and Lesbian Task Force Policy Institute, Aging Initiative
Rev. Kenneth South, Fellow
1700 Kalorama Rd. NW
Washington, DC 20009
(202) 332-6483
f (202) 332-0207
www.ngltf.org

Old Lesbians Organizing For Change (OLOC)
PO Box 908422
Houston, TX 77098
www.oloc.org

Online Information for GLBT Elders
www.seniorpages.com

Pride Senior Network
356 West 18th St.
New York, NY 10011
(212) 271-7288
www.pridesenior.org.

Red Dot Girls; Elders Initiative
1122 Pike St #745
Seattle, WA 98122
(206) 559-3992
RedDot@aol.com

Senior Action in a Gay Environment (SAGE)
305 Seventh Avenue, 16th fl.
New York, NY 10001
(212) 741-2247
www.geocities.com/~carl7942

The Renaissance Transgendered Association Inc.
987 Old Eagle School Road, Ste. 719
Wayne, PA 19087
(610) 975-9119
info@ren.org www.ren.org

Transgender Aging Network of the American Boyz
c/o Loree Cook-Daniels,
49 Canterbury Circle
Vallejo, CA 94591
LoreeCD@aol.com

Worldwide Prime Timers
90971 Highway 101 #2
Warrenton, OR 97146
www.primetimers.org

GLBT ELDER HOUSING PROGRAMS

A Place for US Foundation
Westlake, OH
(440) 899-1475
FGVlinda@aol.com

Arbours at City Center
Fort Lauderdale, FL

Care Consortium
Huntington Valley, PA
(215) 657-9990 ext. 218
bkeane@whitmangroup.com

Cluster Housing Project
East Lansing, MI
(517) 336-0231
nancy.nystrom@ssc.msu.edu

GLARP Housing Project
Palm Springs, CA
(310) 966-1500
www.gaylesbianretiring.org

Our Town
San Francisco, CA
www.ourtownvillages.com

Palms of Manasota, Inc.
Palmetto, FL
(941) 722-5858
www.prideworks.com/palms.htm

Queen City Development Corporation
Seattle, WA
www.seattlegayculture.org

Rainbow Adult Community Housing
3890 24th Street
San Francisco, CA 94114
(415) 285-4307
SFRACH@aol.com

Stonewall Communities
PO Box 990035, Prudential Center
Boston, MA 02199
(617) 369-9090
stonewalco@aol.com

RACH Project
San Francisco, CA
(415) 281-0800
sfrach@aol.com

Rainbow Vision Properties
Sante Fe, NM
(212) 989-3573
jsilver@msm.com

The Resort on Carefree Boulevard
Fort Myers, FL
(800) 326-0364
www.resortoncb.com

SOURCES OF INFORMATION ON AGING

Administration on Aging
www.aoa.dhhs.gov

AFL-CIO Department of Employee Benefits
www.his.com/~afhha/usa.html

AFSCME Retiree Program
www.ncscinc.org

Alliance for Aging Research
www.agingresearch.org

Alzheimer's Disease Centers Directory
www.alzheimers.org/adcdir.html

American Association for International Aging
www.ncscinc.org/lcao/members/aaia.html

American Association of Health Care Plans
www.aahp.org

American Association of Homes and Services for the Aging
www.aahsa.org

American Association of Retired Persons
(AARP) www.aarp.org

American Federation for Aging Research
www.afar.org/welcome.html

American Federation of the Blind
www.afb.org

American Geriatrics Society
www.americangeriatrics.org

American Society on Aging
www.asaging.org

Asociacion Nacional Por Personas Mayores
3325 Wilshire Boulevard, Suite 800
Los Angeles, CA 90010-1724
(213) 487-1922
F (213) 385-2014

Association for Gerontology and Human Development in Historically Black Colleges and Universities
c/o Institute of Gerontology
University of the District of Columbia
4200 Connecticut Avenue, N.W. MB #5103
Washington, D.C. 20008
(202) 274-6687
F (202) 274-6605

Association for Gerontology in Higher Education
www.aghe.org

Association of Jewish Aging Services
www.ajas.org

B'Nai B'rith Center for Senior Housing and Services
www.bnaibrith.org

Center for Aging Persons with Developmental Disabilities
www.isdd.indiana.edu/capdd.htm

Center for Health Care Strategies
www.chcs.org/CHCS/welcome.html

Clearinghouse on Aging and Developmental Disabilities
www.uic.edu/orgs/rrtcamr/clearindex/html

Commission on Legal Problems of the Elderly (American Bar Association)
www.abanet.org:80/elderly/home.html

Fight Managed Care
www.his.com/~pico/usa.html

Gray Panthers
www.graypanthers.org

The Gerontological Society of America
www.geron.org

Green Thumb, Inc.
www.greenthumb.org

Health Care Finance Administration
www.hcfa.gov

Health Care Liability Alliance
www.wp.com/HCLA

Institute for Alzheimer's Disease and Related Disorders
http://rwja.umdnj.edu~coyne/copsa.html

Institute for Public Accuracy
www.accuracy.org.

Medicare and Managed Care
www.hcfa.gov/medicare/mgdcar1.htm.

National Academy on an Aging Society
1275 K Street, NW, Suite 350
Washington, D.C. 20005-4006
(202) 408-3375

National Asian Pacific Center on Aging (NAPCA)
Melbourne Tower, Suite 914
1511 Third Avenue
Seattle, WA 98101-1626
(206) 624-1221
F (206) 624-1023

National Association for Home Care
www.nahc.org

National Association of Area Agencies on Aging
www.n4a.org

National Association of Foster Grandparent Program Directors, Inc.
Union/Snyder Foster Grandparent Program
Laurelton Center, Box 300
Laurelton, PA 17835
(717) 922-1130 F (717) 922-4799

National Association of Meal Programs
www.projectmeal.org

National Association of Nutrition and Aging Services Programs
www.nanasp.org

National Association of Retired Federal Employees
www.narfe.org

National Association of Retired Senior Volunteer Program Directors
Audubon Area RSVP 1650
West Second Street,
Owensboro, KY 42310
(502) 683-1589
F (502) 683-1580

National Association of Senior Companion Project Directors
2414 Park Avenue
Minneapolis, MN 55404
(612) 872-1719
F (612) 879-5220

National Association of State Units on Aging
staff@nasua.org

National Caucus and Center on Black Aged
1424 K Street, N.W., Ste. 500
Washington, DC 20005
(202) 637-8400 F(202) 347-0895

National Center on Elder Abuse
www.gwjapan.com/NCEA

National Committee to Preserve Social Security and Medicare
www.ncpssm.org/menu.html

National Council of Senior Citizens
www.ncscinc.org

National Council on the Aging
www.ncoa.org

National Family Caregivers Association
www.nfcacares.org

National Hispanic Council on Aging (NHCOA)
2713 Ontario Road, N.W., Ste. 200
Washington, D.C. 20009
(202) 745-2521 F (202) 745-2522

National Osteoporosis Foundation
www.nof.org

National Senior Citizens Law Center (NSCLC)
www.nsclc.org

National Senior Service Corps Directors Association
4958 Butterworth Place, N.W.
Washington, DC 20016
(202) 244-2244 F (202) 244-2322

Older Women's League
666 Eleventh Street, NW, Ste. 700
Washington, DC 20001
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Appendix E

GENERAL RESEARCH ON LATINO/-A, ASIAN PACIFIC ISLANDER, AND NATIVE AMERICAN GLBT AND TWO-SPIRIT PEOPLE

For issues affecting GLBT people of color in general, see Greene, Beverly, ed., *Ethnic and Cultural Diversity Among Lesbians and Gay Men*, Thousand Oaks, CA: SAGE Publications, 1997; and Fukayama, Mary A., and Angela D. Ferguson, "Lesbian, Gay, and Bisexual People of Color: Understanding Cultural Complexity and Managing Multiple Oppressions," in Perez, Ruperto M., Kurt A. DeBord, and Kathleen J. Bieschke, *Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients*, Washington, DC: American Psychological Association, 2000, pp. 81-106. Unfortunately the only piece in Greene dealing with primarily with elder people of color is the piece by Adams and Kimmel on elder African American gay men, cited on page 7. In Perez *et al.* there are two separate pieces on elder lesbian, gay, and bisexual (LGB) clients and on LGB people of color clients, but neither piece devotes significant attention to the concerns of old LGB people of color.

For issues affecting GLBT Latino and Latina people in general, see Marsiglia, Flavio Francisco, "Homosexuality and Latinos/as: Towards an Integration of Identities," in *Journal of Gay and Lesbian Social Services*, 8(3), 1998, pp. 113-125; Rosabal, Gina Scuteri, "Multicultural Existence in the Workplace: Including How I Thrive as a Latina Lesbian Feminist," in Ellis, Alan L., and Ellen D.B. Riggle, eds., *Sexual Identity on the Job: Issues and Services*, Binghampton, NY: Haworth Press, 1996, pp. 17-28; Zamora-Hernandez, Carlos E., and Davis G. Patterson, "Homosexually Active Latino Men: Issues for Social Work Practice," in Longres, John F., ed., *Men of Color: A Context for Service to Homosexually Active Men*, Binghampton, NY: Haworth Press, 1996, pp. 69-91; and Alquijay, Marta A., "The Relationship Among Self-Esteem, Acculturation, and Lesbian Identity Formation in Latina Lesbians," pp. 249-265, in Greene, Beverly, ed., *Ethnic and Cultural Diversity Among Lesbians and Gay Men*, Thousand Oaks, CA: SAGE Publications, 1997.

For issues affecting GLBT Asian Pacific Islander people, see Rodriguez, Felix I.,

"Understanding Filipino Male Homosexuality: Implications for Social Services," *Journal of Gay and Lesbian Social Services*, 5(2/3), 1996, pp. 93-113; Eng, David L., and Alice Y. Hom, eds., *Q&A: Queer in Asian America*, Philadelphia: Temple University Press, 1998; Leong, Russell, ed., *Asian American Sexualities: Dimensions of the Gay and Lesbian Experience*, New York: Routledge, 1996; Chan, Connie S., "Don't Ask, Don't Tell, Don't Know: The Formation of a Homosexual Identity and Sexual Expression Among Asian American Lesbians," in Greene, Beverly, ed., *Ethnic and Cultural Diversity Among Lesbians and Gay Men*, Thousand Oaks, CA: SAGE Publications, 1997; and Kanuha, V.K., "Local and Gay: Addressing the Health Needs of Asian and Pacific Islander American (A/PIA) Lesbians and Gay Men in Hawaii," *Hawaii Medical Journal*, 58(9), 1999.

For a review of scholarship on Native American GLBT and Two-Spirit people, see Tafoya, Terry and Douglas A. Wirth, "Native American Two-Spirit Men," *Journal of Gay and Lesbian Social Services*, 5(2/3), 1996, pp. 51-67; Jacobs, Sue-Ellen, Wesley Thomas, and Sabine Lang, *Two-Spirit People: Native American Gender Identity, Sexuality, and Spirituality*, Chicago: University of Illinois Press, 1997; and Weber, Janis C., "Two-Spirit People: Native American Gender Identity, Sexuality, and Spirituality," *Contemporary Sociology*, 27(5), September 1998.

Notes

Executive Summary and Recommendations

1. For a review of research into the size of the gay, lesbian, bisexual and transgender population, see discussion later in this chapter, and see Appendix A, Estimates of the GLBT Population in the United States.

2. Projected population of 69.4 million seniors in 2030, Administration on Aging, *Profile of Older Americans 1999*, www.aoa.dhhs.gov/aoa/stats/profile/.

3. This estimate is derived by assuming 6% of the senior population will be GLBT, based on the higher self-identification rates among younger people documented in the Voter News Service exit polling data. VNS has documented steadily increasing rates of self-identification as gay, lesbian or bisexual among voters over the past decade, along with a higher likelihood among younger voters to self-identify as gay, lesbian, or bisexual (GLB). In 1998 6.4% of voters under 40 years of age self-identified as GLB, whereas only 3.3% of voters 40+ self-identified as GLB. Assuming self-identification rates remain constant among this age cohort, by 2030 roughly 5 to 6% of seniors would self-identify as gay, lesbian or bisexual. Bailey, Robert W., *Out and Voting II: The Gay, Lesbian, and Bisexual Vote in Congressional Elections: 1990-1998*, New York: Policy Institute of the National Gay and Lesbian Task Force, 2000, p. 14. Of course, voter exit polls may overrepresent the size of the GLB population. But as Grant Lukenbill notes, a 1994 Yankelovich random national marketing survey also found that 6% of the US population self-identified as gay or lesbian. Lukenbill, Grant, *Untold Millions: Positioning Your Business for the Gay and Lesbian Consumer Revolution*, New York: Harper Business, 1995, p. 70.

4. Psychologist Gregory Herek defines heterosexism as "an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community." Herek, Gregory M., "The Social Context of Hate Crimes: Notes on Cultural Heterosexism," in Herek and Kevin T. Berrill, eds., *Hate Crimes: Confronting Violence Against Lesbians and Gay Men*, Newbury Park, CA: SAGE Publications, 1992, p. 89.

5. Specific documentation of each of these inequalities is included in the more elaborate discussions of each topic starting on page 36.

6. Fredriksen, Karen, I., "Family Caregiving Responsibilities Among Lesbians and Gay Men." *Social Work*. Volume 44, Number 2, pp. 142-155, 1999.

7. *Assistive Housing for Elderly Gays and Lesbians in New York City*. A report from the Brookdale Center on Aging of Hunter College, April 1999. Commissioned by SAGE, N.Y. Several other studies have found that anywhere from 41% to 75% of older gays and lesbians live alone (Hamburger (1997) 50%, Quam and Whitford (1992) 52%,Whitford (1997) 63%, Rosenfeld (1999) 75%, Porter (1991) 41%).

GLBT Elders and Aging

8. Hobbs, Frank B., with Bonnie L. Damon, *65+ in the United States*, P23-190 Current Population Reports: Special Studies, Washington: US Census Bureau, April 1996, "Highlights" section, p. 1, www.census.gov/prod/1/pop/p23-190/p23-190.html.

9. While some elder activists disagree about who is elder/senior/old, for the most part we use the definition of 65 and older, which is what the United States Administration on Aging uses. Some of the social science research we summarize in this study defines older as 50+ or 60+. The American Association of Retired Persons considers people 50+ as older. The Older Americans Act defines "older" as 60+. The most important thing is to be clear about what age bracket one is referring to.

10. Administration on Aging, *Profile of Older Americans: 1999*, Washington: Administration on Aging, US Department of Health and Human Services, p. 2, www.aoa.gov/aoa/stats/profile/.

11. *Ibid*, p. 5.

12. Hobbs and Damon, "Highlights," p. 1.

13. Hobbs and Damon, pp. 6-22.

14. Administration on Aging, *Profile of Older Americans: 1999*, p. 9.

15. *Federal Register*, Vol. 63, No. 36, February 24, 1998, pp. 9235-9238.

16. American Association of Retired Persons, *Poverty and Older People Fact Sheet*, Washington, DC: AARP Reach, 1998. The fact that elder poverty roughly mirrors that of the overall US population is a relative victory. Prior to the War on Poverty of the 1960s, more than a third of elders lived in poverty, compared with about a fifth of all Americans (35% vs. 22%). By 1983, only 14% of elders lived in poverty, compared to 15% of all Americans. Burtless, Gary, "Public Spending for the Poor: Trends, Prospects, and Economic Limits," in Sheldon Danziger and Daniel Weinberg, editors, *Fighting Poverty: What Works and What Doesn't*, Cambridge: Harvard University Press, 1986, cited in Theda Skocpol, "Targeting Within Universalism," in Christopher Jencks and Paul Peterson, editors, *The Urban Underclass*, Washington: Brookings Institution, 1991, p. 427.

17. American Association of Retired Persons, *Poverty and Older People Fact Sheet*, Washington, DC: AARP Reach, 1998.

18. *Ibid*.

19. Administration on Aging, *Profile of Older Americans: 1999*, p. 10.

20. *Ibid*, pp. 7-9.

21. Administration on Aging, *Profile of Older Americans: 1999*, p. 11.

22. Current Population Reports, *Educational Attainment in the United States: March 1998*, P20-513, Washington: US Census Bureau, March 1998, Table 1, "Educational Attainment of Persons 15 Years Old and Over, by Age, Sex, Race, and Hispanic Origin," pp. 1-3.

23. Mitchell, Olivia S., Phillip B. Levine, and John W. Phillips, *The Impact of Pay Inequality, Occupational Segregation, and Lifetime Work Experience on the Retirement Income of Women and Minorities*, Washington: American Association of Retired Persons Public Policy Institute, #9910, September 1999, p. ix. Another limitation of the official poverty statistics is that the federal government's definition of poverty is usually based upon income. Income differences are often less striking than differences in wealth—i.e. in assets accumulated over the course of a lifetime, such as a house or savings account. Data from the first wave of the Health and Retirement Study, a 1992 national representative sample of US households about to enter into retirement, indicate significantly lower projected retirement wealth among black and Hispanic households when compared to white households. There are less striking differences between women and men. Marriage is a strong predictor of higher projected retirement wealth, while nonmarried older people—particularly single women, blacks and Hispanics—have assets well below the median for married couples. (*Ibid.*, p. 17.)

24. Hobbs and Damon, pp. 6-9.

25. *Ibid*, p. 4.

26. *Ibid.*

27. Administration on Aging, *Profile of Older Americans: 1999*, p. 5.

28. *Ibid*, p. 11.

29. *Ibid*, pp. 11-12.

30. Hobbs and Damon, p. 2.

31. Administration on Aging, *Profile of Older Americans: 1999*, p. 13.

32. Gibson, Mary Jo, and Lisa A. Foley, "FYI: Out-of-Pocket Spending on Prescription Drugs by Women and Men Age 65 and Older: 1999 Projections," Washington: AARP Public Policy Institute, April 2000.

33. *Ibid.*

34. One study coming out soon is Witten, Tarynn M., A.E. Eyler, and Cathy Weigel, "Quality of Life Issues for Older Transsexuals, Transgenders, and Cross-Dressers: Information for the Health Service Professions," *Journal of the National Association of Social Workers*, 2000, in press.

35. "Almost without exception," as one social science literature review notes, studies of older gay men have disproportionately focused on "white, middle class, well educated, urban-dwelling men who participate in the gay community through friendship networks, gay bars, support organizations, etc." (Wahler, Jim, and Sarah G. Gabbay, "Gay Male Aging: A Review of the Literature," *Journal of Gay and Lesbian Social Services*, 6(3), 1997, p. 5.) Another reviewer notes the pressing need for research which examines "the significance of ethnicity, poverty, and heterosexism among aging gay men, lesbians, and bisexuals." (Boxer, Andrew, "Gay, Lesbian and Bisexual Aging into the Twenty-First Century: An Overview and Introduction," *Journal of Gay, Lesbian and Bisexual Identity*, 2(3/4), 1997, p. 191.)

36. Herdt, Gilbert, Jeff Beeler, and Todd W. Rawls, "Life Course Diversity among Older Lesbians and Gay Men: A Study in Chicago," *Journal of Gay, Lesbian, and Bisexual Identity*, 2(3/4), July 1997, p. 234.

37. This raises interesting epistemological and ontological questions: What does it mean to be gay, or lesbian, or bisexual or transgender? If one identifies as homosexual, but has not engaged in sex for a long time (because of a vow of celibacy or the military's ban on homosexual sex, for example), is one a homosexual? What if one engages in homosexual sex, but doesn't consider oneself gay or bi? What if one is attracted to members of the same sex, but

never acts upon it or identifies as a homosexual? Transgender people include: pre-, post- and nonoperative transsexuals; cross-dressers; intersexed people (hermaphrodites); and "men and women whose appearance or characteristics are perceived to be gender atypical." (Jamison Green, "Introduction to Transgender Issues," in *Transgender Equality: A Handbook for Activists and Policymakers*, New York: Policy Institute of the National Gay and Lesbian Task Force and the National Center for Lesbian Rights, 2000, p. 3.) If transgender people include those perceived by others to be gender variant, clearly some who are perceived as transgender may not consider themselves so. If we are estimating the transgender population, should we count these individuals? These are interesting questions for social scientists and activists seeking to document basic demographic information about the GLBT community.

38. Berger, Raymond M., "The Unseen Minority: Older Gays and Lesbians," *Social Work*, Vol. 27, May 1982, pp. 236-242; Dawson, Ken, "Serving the Older Gay Community," *SIECUS Report*, New York: Sexuality Information and Education Council of the United States, November 1982, p. 5. Berger bases his estimate on the assumption (from reworked Kinsey data) that 8% of the adult population is homosexual; Dawson's estimate is based on an assumption that 10% of adults are homosexual.

39. Kinsey, Alfred C., Wardell B. Pomeroy, and Clyde E. Martin, *Sexual Behavior in the Human Male*, Philadelphia: W. B. Saunders Co., 1948, p. 650; and Kinsey *et al.*, *Sexual Behavior in the Human Female*, Philadelphia: W. B. Saunders Co., 1953, p. 473; both cited in Berger, 1982, p. 241. Kinsey et al. estimated that 13% of white males in the US were predominantly homosexual for at least three years of adult life, while between 3 and 8% of unmarried women, and 1% of married women, were predominantly homosexual from age 20-35. Berger also cites "a more recent interpretation of the Kinsey data suggest[ing] that 8 percent of the total adult male and female population at any one time are homosexual": Peter Fischer, *The Gay Mystique: The Myth and Reality of Male Homosexuality*, New York: Stein and Day Publishers, 1972, p. 254.

40. Sell, Randall L., James A. Wells, and David Wypij, "The Prevalence of Homosexual Behavior and Attraction in the United States, the United Kingdom, and France: Results of National Population-Based Samples," *Archives of Sexual Behavior*, 24(3), 1995, p. 236. Kinsey *et al.*'s methods were flawed in that they interviewed only white college-aged respondents.

41. Fischer, Peter, *The Gay Mystique: The Myth and Reality of Male Homosexuality*, New York: Stein and Day Publishers, 1972, p. 254.

42. Batelle Human Affairs Research Center study of HIV risk in the sexual behavior of men ages 20-39, 1993, cited in Singer, Bennett L., and David Deschamps, *Gay and Lesbian Stats: A Pocket Guide of Facts and Figures*, New York: The New Press, 1994, p.12. This study has been criticized for its lack of extensive interviews and its lack of professional sex researchers.

43. Janus and Janus (1993), cited in Singer and Deschamps, 1994, p. 12. This study reports that 9% of men and 5% of women report "ongoing" or "frequent" homosexual experiences, but only 4% of males and 2% of females self-identify as homosexual. Dan Black *et al.*'s study of the General Social Survey and the National Health and Social Life Survey 1989-1996 data found that 4.7% of men and 3.5% of women reported at least one same-sex experience since age 18, but only 2.5% of men and 1.4% of women had exclusively same-sex sex within the year preceding the survey. (Black, Dan, *et al.*, "Demographics of the Gay and Lesbian Population in the United States: Evidence from Available Systematic Data Sources," *Demography*, 37(2), May 2000, p. 141.)

44. This is based on the Administration on Aging's projection of an elder population of 69.4 million on 2030, as cited in footnote 2.

45. 25,000 Americans have undergone sex reassignment surgery, 60,000 consider themselves candidates for such surgery, and the doctors who perform it have long waiting lists. (Carey Goldberg, "Shunning 'He' and 'She,' They Fight for Respect," *New York Times*, Sept. 8, 1996, p. A10; John Cloud, "Trans Across America; Watch Out, Pat Buchanan. Ridiculed for Years, 'Transgenders' are Emerging as the Newest Group to Demand Equality," *Time Magazine*, July 20, 1998, p. 48.) The earliest estimates of transgender prevalence for adults were 1 in 37,000 males and 1 in 107,000 females. More recent estimates from Holland are 1 in 11,900 males and 1 in 30,400 females. Four observations, not yet firmly supported by systematic study, increase the likelihood of a higher prevalence: 1) unrecognized gender issues are occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions; 2) some nonpatient male transvestites, female impersonators, and male and female homosexuals may have a form of "gender identity disorder" (for more on this concept and the controversy surrounding it see mental health section in Chapter III); 3) the intensity of some persons' gender identity fluctuates below and above a clinical threshold; 4) gender variance among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists. (Harry Benjamin International Gender Dysphoria Association Standards of Care, Part III, Section I, available at http://www.hbigda.org/soc5.html.) *The Diagnostic and Statistical Manual of the American Psychiatric Association* (Washington, DC: American Psychiatric Association, 4th ed., 1997) cites older statistics showing roughly 1 in 30,000 adult males and 1 in 100,000 adult females undergo sex reassignment surgery. There are no worldwide statistics available. Time Magazine reported that "gender identity disorder" occurs in at least 2% of children. (Cloud, *Time Magazine*, July 2, 1998, p. 48.)

46. Jamison Green, "Introduction to Transgender Issues," in *Transgender Equality: A Handbook for Activists and Policymakers*, New York: Policy Institute of the National Gay and Lesbian Task Force and the National Center for Lesbian Rights, 2000, p. 7.

47. Bailey, 2000, p. 16.

48. Adams, Clarence Lancelot, Jr., and Douglas C. Kimmel, "Exploring the Lives of Older African American Gay Men," in Greene, B., editor, *Ethnic and Cultural Diversity Among Lesbians and Gay Men*, Sage: Thousand Oaks, CA, 1997, pp. 132-148. Adams and Kimmel surveyed and interviewed 20 New York City African American gay men between the ages of 39 and 73, with an average age of 56. They found that nearly all maintained ties with their biological families, and that many had never discussed their sexuality with their families; instead, "the fact was simply understood." Many reported that when they first started experimenting sexually, they limited themselves to white partners so that no one in the African American community would learn of their sexual orientation. Six had been married, and four had children; two others thought they might have children but were not sure. Twelve of the 20 were living alone at the time of the interview. Nearly all of the respondents (84%) had experienced racial discrimination, while only 21% had experienced age discrimination and 16% anti-gay discrimination. Many reported both racial and age discrimination within the gay community.

49. Mays, Vickie M., Linda M. Chatters, Susan D. Cochran, and Joanna Mackness, "African American Families in Diversity: Gay Men and Lesbians as Participants in Family Networks," *Journal of Comparative Family Studies*, 29(1), Spring 1998, pp. 73-87. Large percentages of their sample were low-income: 61% of the women and 41% of the men surveyed reported annual incomes of less than $20,000. But because more than 80% of the sample was less than 40 years of age, income figures may be lower on average than for a more age-diverse black GLBT population. One in three women reported one or more children, and 26% reported a child living in their household; nearly 12% of men reported one or more children, but only 2% reported a child living in the household with them. (p. 78)

50. *Ibid*, p. 83.

51. *Ibid*., p. 84.

52. Hobbs and Damon, 1996, p. 1.

53. Supreme Court Justice Antonin Scalia expressed this view in his dissent to *Romer v. Evans*, the 1996 decision striking down Amendment 2, which was passed by Colorado voters in 1992 outlawing non-discrimination laws based on sexual orientation: "[B]ecause those who engage in homosexual conduct tend to reside in disproportionate numbers in certain communities [and]…have high disposable income," Scalia wrote, "they possess political power much greater than their numbers, both locally and statewide." Scalia wrote that gays were "a group which enjoys enormous influence in American media and politics," in part due to their allegedly high income. S. Ct. 1996 WL 262293 (US) *Roy Romer, Governor of Colorado, et al., Petitioners v. Richard G. Evans et al.*, No. 94-1039, Supreme Court of the United States, argued October 10, 1995; decided May 20, 1996; on write of certiorari to the Supreme Court of Colorado, pp. 7-13. Colorado for Family Values (CFV), the group behind Amendment 2, used this theme to evoke resentment against gays on the part of those struggling to make ends meet. "[D]espite their claim to be 'oppressed,'" wrote CFV, "…[gays] are among Colorado's most affluent citizens," with "an average household income of more than $55,400…Gays are three times more likely to be college graduates. Three times more likely to hold professional or managerial jobs. Four times more likely to be overseas travelers. Almost four times more likely to earn over $100,000 annually." Fundraising letter from former US Senator Bill Armstrong for Colorado for Family Values, reprinted in Political Research Associates, *Constructing Homophobia: How the Right Wing Defines Lesbians, Gay Men and Bisexuals as a Threat to Civilization*, Cambridge: Political Research Associates, 1993, Part III of a three part resource packet, p. 4.; Colorado for Family Values, "What's Wrong with 'Gay Rights'? YOU Be the Judge!", in Political Research Associates, *Constructing Homophobia*, Part III. Anti-gay activists have also portrayed gays as wealthy to justify opposing non-discrimination laws.

54. A multiple regression analysis of the General Social Survey (GSS) data from 1988-1990 and of 1990 US Census data on same-sex households indicates that when adjusted for education, occupation, race, geographic location, and experience, gay men earn as much as one-quarter less than heterosexual men, while lesbians earn about the same as heterosexual women. Source: Badgett, M.V. Lee, "The Wage Effects of Sexual Orientation Discrimination," *Industrial and Labor Relations Review*, 48(4), July 1995, p. 737; Klawitter, Marieka M., and Victor Flatt, "The Effects of State and Local Antidiscrimination Policies for Sexual Orientation," *Journal of Policy Analysis and Management*, 17(4), Fall 1998,pp. 674-675.

55. Klawitter and Flatt, 1998, pp. 674-675; Badgett, M.V. Lee, *Income Inflation: The Myth of Affluence among Gay, Lesbian, and Bisexual Americans*, New York: Policy Institute of the National Gay and Lesbian Task Force and the Institute for Gay and Lesbian Strategic Studies, 1998, p. 13.

56. Bailey, Robert W., *Gay Politics, Urban Politics: Identity and Economics in the Urban Setting*, New York: Columbia University Press, 1999, p. 78.

57. For example, how have the changes in welfare policy adopted under the reforms of 1996 affected GLBT people receiving Transitional Aid to Needy Families? How has the increased role of faith-based organizations under the "charitable choice" provision of welfare reform affected lesbian and bisexual women-led families? These are pressing questions in need of research. The Racial and Economic Justice Initiative of the National Gay and Lesbian Task

Force Policy Institute is committed to increasing research and advocacy on issues of concern to GLBT people of color and low-income people. For more information, see www.ngltf.org/pi/justice.htm. One model study of poverty among lesbians and gay men comes from Ireland: Gay and Lesbian Equality Network and NEXUS Research Cooperative, *Poverty, Lesbians and Gay Men: The Economic and Social Effects of Discrimination*, Dublin: Combat Poverty Agency, 1995.

58. Bozzette, Samuel A., *et al.*, "The Care of HIV-Infected Adults in the United States." *New England Journal of Medicine*, 339 (26), 24 December 1998, pp. 1897-1904.

59. Brookdale Center on Aging of Hunter College and Senior Action in a Gay Environment, *Assistive Housing for Elderly Gays and Lesbians in New York City: Extent of Need and the Preferences of Elderly Gays and Lesbians*, New York: Hunter College and SAGE, April 1999, p. 16.

60. Brown, Patricia Leigh, "Raising more than consciousness now," *New York Times*, August 24, 2000, www.nytimes.com/library/home/082400thea-group.html.

61. Brookdale Center on Aging of Hunter College and SAGE, 1999, p. 2. However, it is unclear how valid these data are. The SAGE study was mailed to SAGE's 2900 members, and 253 questionnaires from members over age 65 were returned. This sample was 80% male, only 2% black and 2% Hispanic (in a city where the senior population is 19% black and 16% Hispanic), and the median yearly income was $39,900 (versus a citywide median of $11,100 for all seniors). In terms of race, gender and income, this sample was not representative and therefore it is problematic to draw conclusions from it. This is true of many of the samples that are the basis for studies on gay and lesbian seniors. Often good faith efforts are made to ensure a representative sample. The methodological challenge of getting a racially diverse sample must be among the first to be addressed and achieved.

62. Rosenfeld, Dana, "Identity Work among the Homosexual Elderly," *Journal of Aging Studies*, 1999, 13(12) p.121 ff. Of Rosenfeld's sample of 37, 54% were women, 8% black, and 8% Latino/-a. Income ranged from below $10,000 to over $100,000 per year, although a median income is not given.

63. Berger, Raymond, "The Unseen Minority: Older Gays and Lesbians," *Social Work*, May 1982, pp. 237-238; Wahler, Jim, and Sarah G. Gabbay, "Gay Male Aging: A Review of the Literature," *Journal of Gay and Lesbian Social Services*, 6(3), 1997, pp. 8-12.

64. Dawson, Ken, "Serving the Older Gay Community," *SIECUS Report*, November 1982, p. 6. One study found that older gay men had significantly more close friends than did older heterosexual men, while another found that gay and lesbian seniors derived their social support more from friends, while heterosexual elders derived it more from blood relatives or family members. Friend, R.A., "Gay Aging: Adjustment and the Older Gay Male," *Alternative Lifestyles*, 3(2), 1980, pp. 231-248, cited in Wahler and Gabbay, 1997, p. 10; Dorfman, R., Walters, K., Burke, P., Hardin, L., Karanik, T., Raphael, J. and E. Silverstein, "Support in the Aging Process for Gays and Lesbians," *Journal of Gerontological Social Work*, 24(1/2), 1995, pp. 29-44, cited in Baron, Augustine, and David W. Cramer, "Potential Counseling Concerns of Aging Lesbian, Gay and Bisexual clients," in Perez, Ruperto M., DeBord, Kurt A., and Kathleen J. Bieschke, editors, *Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients*, Washington: American Psychological Association, 2000, p. 214.

65. Hostetler, Andrew J. and Bertram J. Cohler, "Partnership, Singlehood, and the Lesbian and Gay Life Course: A Research Agenda," *Journal of Gay, Lesbian, and Bisexual Identity*, 2(3/4), July 1997, p. 201.

66. Bell, A., and M. Weinberg, *Homosexualities: A Study of Diversity Among Men and Women*, New York: Simon and Schuster, 1978; O'Brien, K., "Primary Relationships Affect the Psychological Health of Men at Risk for AIDS," *Psychological Reports*, 71, 1992, pp. 147-153; Wayment, H., and L. A. Peplau, "Social Support and Well-Being Among Lesbian and Heterosexual Women: A Structural Modeling Approach," *Personality and Social Psychology Bulletin*, 21, pp. 1189-1199; all cited in Hostetler and Cohler, p. 201.

67. Hostetler and Cohler, p. 201.

68. Bell and Weinberg, 1978; Jay, K., and A. Young, *The Gay Report: Lesbians and Gay Men Speak Out About Sexual Experiences and Lifestyles*, New York: Summit Books, 1979; Harry, J., *Gay Couples*, New York: Praeger, 1984; Kurdek, L., "Lesbian and gay couples," in Anthony R. D'Augelli and Charlotte Patterson, eds., *Lesbian, Gay and Bisexual Identities Over the Lifespan: Psychological Perspectives*, New York: Oxford University Press, 1995, pp. 243-261; all cited in Hostetler and Cohler, p. 202. A 1996 study of 160 gay men and lesbians in Chicago found that 79% of the lesbians were partnered, as were 46% of gay men. (Herdt, Gilbert, Jeff Beeler, and Todd W. Rawls, "Life Course Diversity among Older Lesbians and Gay Men: A Study in Chicago," *Journal of Gay, Lesbian, and Bisexual Identity*, 2(3/4), July 1997, p. 237.) Unfortunately, this study's sample is also too white (94%) and male (70%) to be truly representative of Chicago's elder GLBT population. Mays et al.'s analysis of a sample of 506 black lesbians and 673 black gay men found that 33% of the women and 54% of the men were single; the rest were in a relationship. More than a third of the women (36%) lived with their partner, whereas only 18% of the men lived with their partner. (Mays, Vickie M., *et al.*, Spring 1998, p. 78.) It is important to note that many of the studies mentioned in this section are not elder focused, although some (like the work of Herdt *et al.*) are.

69. Bailey, Robert W., *Out and Voting II: The Gay, Lesbian and Bisexual Vote in Congressional Elections, 1990-1998*, New York: Policy Institute of the National Gay and Lesbian Task Force, 2000, p. 17.

70. Bailey, Robert W., *Gay Politics, Urban Politics: Identity and Economics in the Urban Setting*, New York: Columbia University Press, 1999, pp. 49-95. In this analysis, Bailey overlays a master list of 525,000 households which have donated money to a gay political organization or political candidate, or subscribed to a gay magazine, with 1990 US Census data and determines relative densities. There are limits to the list's validity, as it is disproportionately male (60%) and white. However, in many cities lesbian concentrations are documented, as well as gay and lesbian concentrations in predominantly people of color neighborhoods like Jackson Heights, Queens, New York.

71. Laumann, O., and J.H. Gagnon, R.T. Michael, S. Michael, 1994. *The Social Organization of Sexuality: Sexual Practices in the United States*, Chicago: University of Chicago Press, cited in Dean, Laura, *et al.*, *Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns*. New York: Gay and Lesbian Medical Association and the Center for LGBT Health, Columbia University School of Public Health, 2000, p. 9. Some national surveys do ask about sexual orientation or behavior, including the General Social Survey, National Health and Nutrition Examination Survey, and the National Health and Social Life Survey. However, most do not.

72. Solarz, Andrea L., editor, *Lesbian Health: Current Assessment and Directions for the Future*, Washington: National Academy Press, Institute of Medicine, 1999, pp. 70-105.

73. Dean *et al.*, 2000, pp. 12-17.

74. Bradford, Judith, and Caitlin Ryan, *National Lesbian Health Care Survey: Final Report*, Washington: National Lesbian and Gay Health Foundation, 1988; Bockting, W.O., B.E.

Robinson, and B.R.S. Rosser, "Transgender HIV Prevention: A Qualitative Needs Assessment," *AIDS Care*, 10(4), 1998, pp. 505-526, cited in Dean *et al.*, 2000, p. 9. In 1994, the American Association of Physicians for Human Rights (AAPHR), now known as the Gay & Lesbian Medical Association, surveyed 711 physicians and medical students who were members of AAPHR to assess the prevalence of anti-gay discrimination in medicine. The results of this survey indicated rampant bias: "67% of respondents reported knowing of lesbian, gay or bisexual patients who have received substandard care or been denied care because of their sexual orientation. 52% reported actually observing colleagues providing reduced care or denying care to patients because of their sexual orientation. 88% reported hearing colleagues make disparaging remarks about lesbian, gay and bisexual patients." (Schatz, Benjamin, and Katherine O'Hanlan. *Anti-Gay Discrimination in Medicine: Results of a National Survey of Lesbian, Gay and Bisexual Physicians*, San Francisco, CA: American Association of Physicians for Human Rights, May 1994.)

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79. Bradford, Judith, and J. White, "Lesbian Health Research," in Goldman, M., and M. Hetch, editors, *Women and Health*, San Diego: Academic Press, 2000, cited in Dean et al., 2000, p. 13.

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82. Sell and Bradford, April 3, 2000, p. 8.

83. Dean *et al.*, 2000, p. 45.

84. *Ibid*, p. 47.

85. Solarz, 1999, p. 64; Haynes, S., "Breast Cancer Risk: Comparisons of Lesbians and Heterosexual Women," in Bowen, D.J., Cancer and Cancer Risks Among Lesbians, Seattle: Fred Hutchinson Cancer Research Center Community Liaison Program, 1995; Dibble, S.L., Vanoni, J.M., and C. Miaskowski, "Women's Attitudes Toward Breast Cancer Screening Procedures: Differences by Ethnicity," *Women's Health Issues*, 7(1), 1997, pp. 47-54; Haynes and Dibble *et al.* cited in Dean *et al.*, p. 21.

86. Solarz, 1999, p. 64.

87. Bowen *et al.*, 1997; Marrazzo, J.M., Stine, K., Handsfield, H.H., Kiviat, N.B., and L.A. Koutsky, "Epidemiology of Sexually Transmitted Diseases and Cervical Neoplasia in

Lesbian and Bisexual Women," paper presented at 18th Conference of the National Lesbian and Gay Health Association, Seattle, WA, July 13-16, 1996, cited in Solarz, Andrea, editor, *Lesbian Health: Current Assessment and Directions for the Future*, Institute of Medicine, Washington: National Academy Press, 1999, p. 67.

88. Solarz, 1999, p. 64.

89. *Ibid*, p. 67.

90. Solarz, 1999, p. 71. The prevalence of HIV transmission among women who have sex with women is unknown in part because research studies have not targeted these populations and because of methodological barriers to getting representative samples of these women. Of the 85,500 women with AIDS in the US in 1996, the CDC attributed 45% of their transmissions of HIV to injection drug use, 38% to heterosexual sex, and 17% to "infection by contaminated blood products or an undetermined route of infection. (*Ibid*, p. 75.) Most studies indicate, however, that women who have sex with women are more likely to contract HIV than women who are exclusively heterosexual. (*Ibid*. The Institute of Medicine's *Lesbian Health* study cites 11 studies from the early and mid-1990s. The study also notes that women who have sex with women "may possibly be more highly represented among injection drug users.") It is important to note that this is a correlation only; causality between lesbian experiences and HIV transmission has not been established, and is unlikely, given the low HIV transmission rates among exclusively homosexual women.

91. Dean *et a*l., p. 21.

92. Sell and Bradford, April 3, 2000, pp. 9-10.

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102. Linsk, Nathan L., "Experience of Old Gay and Bisexual Men Living with HIV/AIDS." *Journal Of Gay, Lesbian, and Bisexual Identity*. 2: 285-308.1997, pp. 289-290.

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105. Sell and Bradford, April 3, 2000, p. 9.

106. CDC data from 1999 and 2000, cited in Sell and Bradford, April 3, 2000, p. 9.

107. Linsk, 1997, p. 287.

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113. Wahler, Jim, and Sarah G. Gabbay, "Gay Male Aging: A Review of the Literature," *Journal of Gay and Lesbian Social Services*, 6(3), 1997, p. 12.

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116. Adams, Clarence Lancelot, Jr., and Douglas C. Kimmel, "Exploring the Lives of Older African American Gay Men," in Greene, B., editor, *Ethnic and Cultural Diversity Among Lesbians and Gay Men*, Thousand Oaks, CA: Sage Press, 1997, p. 141.

117. Herdt, Gilbert, Jeff Beeler and Todd W. Rawls, "Life Course Diversity among Older Lesbians and Gay Men: A Study in Chicago," *Journal of Gay, Lesbian, and Bisexual Identity*, 2(3/4), 1997, p. 235.

118. Bertram Cohler, "Aging, Generation, and the Course of Gay and Lesbian Lives," paper presented at conference on "New Approaches to Research on Sexual Orientation, Mental Health, and Substance Abuse," National Institute of Mental Health, September 1999, pp. 17-19. The terms suggested are not Cohler's. Stonewall refers to the riots following a police raid at the Stonewall bar in Greenwich Village, New York in June 1969, widely viewed as the birth of the modern gay liberation movement. Cohler includes in the pre-Stonewall generation those persons now in their 80s who were born in the 1920s. This generation lived through times of significant persecution and discrimination. It is no wonder that many in this generation continue to choose to live very quiet, discreet lives and are largely invisible, even now, to the rest of the GLBT community. For many in this generation, coming out to themselves or others was not experienced until much later in life. The Stonewall generation encompasses those born in the wake of World War II. This group, now in their 50s, are the first class of baby boomers that will start to retire in 2010. Some people in this generation have lived out the greater part of their adult lives as openly GLBT people. They have come to expect that the social support systems they may need in the future will be much more accommodating to them than has historically been the case. The HIV/AIDS epidemic has had a profound impact on this generation. Not only have tens of thousands of persons died prematurely, but those who remain are left facing a future without members of their families of choice they thought would be with them in old age. Many GLBT elders state that the Stonewall riots were not a defining experience; instead, they cite factors like "the compulsory heterosexuality of the 1950s." Yet they too would be categorized into this rough age cohort. Those born after Stonewall, now in their 20s, can be thought of as the post-Stonewall Generation. These people have lived much of their lives in a world that has seen tremendous progress in liberation and civil liberties for sexual minorities and an explosion of organizations and services to support them as openly GLBT people. Today's GLBT teenagers, whom Cohler calls the "Millennium Generation" are those people born around 1985 who will reach age 65 in the middle of the 21st century. People in the last two generations came out within the context of AIDS, but also in a context of more visible expressions of homosexuality.

119. Herek, Gregory M., "The Social Context of Hate Crimes: Notes on Cultural Heterosexism," in Herek and Kevin T. Berrill, eds., *Hate Crimes: Confronting Violence Against Lesbians and Gay Men*, Newbury Park, CA: SAGE Publications, 1992, p. 89.

120. van der Meide, Wayne, *Legislating Equality: A Review of Laws Affecting Gay, Lesbian, Bisexual, and Transgendered People in the United States*, New York: Policy Institute of the National Gay and Lesbian Task Force, 2000, pp. 4-5; Currah, Paisley, and Shannon Minter, *Transgender Equality: A Handbook for Activists and Policymakers*, New York: Policy Institute of the National Gay and Lesbian Task Force and the National Center for Lesbian Rights, 2000, p. 17.

121. One-third of a national sample of 534 members of the National Gay and Lesbian Task Force, LLEGO (Latino/-a GLBT Organization), and National Black Lesbian and Gay Leadership Forum reported employment discrimination. (Ragins, Belle Rose, *National Workplace Climate Project*, 1997 study conducted for NGLTF, LLEGO, and NBLGLF, unpublished.) One-third of lesbians and gay men in Pennsylvania reported having experienced discrimination. (Philadelphia Lesbian and Gay Task Force, 1996.) 32% of gay and lesbian political scientists reported discrimination within their profession. (American Political Science Association, 1995.) 50% of lesbian historians, and 37% of gay male historians also reported such discrimination. (Committee on Women Historians, 1993.) 27% of a sample of GLBT residents of Gainesville and Alachua County, FL reported experiencing discrimination. (Human Rights Council of North Central Florida, 1997.) 61% of over 1,000 Washington, DC lawyers surveyed reported having witnessed or heard reports of anti-

gay discrimination within their firms. (*Report of the District of Columbia Bar*, 1999.)

122. Garrett, Ginny Kish, "Homophobia Among the Elderly," Masters in Social Work thesis, California State University, Long Beach, August 1994, pp. 31-36; Hudson, W.W. and W.A. Ricketts, "A Strategy for the Measurement of Homophobia," *Journal of Homosexuality*, 1980, 5(4), pp. 357-372, cited in Garrett, 1994, p. 31.

123. Cook-Daniels, Loree, "Lesbian, Gay Male, Bisexual and Transgendered Elders: Elder Abuse and Neglect Issues," unpublished manuscript, 1998, p. 5.

124. Homophobia is the fear or hatred of, or aversion to, gay men and lesbians, sometimes related to homoerotic feelings and desires within oneself. (*Facilitator's Handbook: Confronting Ageism—Consciousness Raising for Lesbians 60 and Over*, Houston: Old Lesbians Organizing for Change, 1992, p. 19.) Transphobia is the devaluing of, exclusion of, or discrimination against people on the basis of the perception of them as gender variant, i.e. "people who are inclined to cross the gender line, including transsexuals, cross-dressers, and gender benders." (Transgender Nation, San Francisco, "A Glossary of Gender," reprinted in Green, Jamison, *Investigation into Discrimination Against Transgendered People: A Report by the Human Rights Commission*, City of San Francisco, 1994, p. 66.)

125. Healey, Shevy, "Diversity with a Difference: On Being Old and Lesbian," *Journal of Gay and Lesbian Social Services*, 1(1), 1994, p.113.

126. Pride Senior Network's *Networker* newspaper is the first in the country to cover GLBT elders. For more information, visit www.pridesenior.org/Networker.

127. Warren, Patricia Nell, "Elephant Graveyards, Gay Aging and Gay Ageism in the Year 2000," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, San Francisco, CA, Fall 1999.

128. Black, Dan, Gary Gates, Seth Sanders, and Lowell Taylor, "Demographics of the Gay and Lesbian Population in the United States: Evidence from Available Systematic Data Sources," *Demography*, 37(2), May 2000, pp. 141-150.

129. For the first time, the 1990 Census allowed people to identify an adult member of their household as an "unmarried partner," and also to specify that person's gender, thus allowing the gathering of data on same-sex cohabitating partners. GSS and NHSLS ask about patterns of recent sexual behavior. It's important to note that the gay and lesbian samples from the GSS-NHSLS samples in Black *et al.* are quite small, n=77 and n= 37, respectively. However, the samples drawn from the 1990 Census data are significantly larger: 7,287 partnered gay men, and 5,762 partnered lesbians. Black *et al.*, 2000, pp. 141-150.

130. Hobbs, Frank, and Bonnie L. Damon, *65+ in the United States*, Current Population Reports: Special Studies, Washington: US Bureau of the Census, April 1996, p. 6-23, www.census.gov/prod/1/pop/p23-190/p23-190.html.

131. Del Martin and Phyllis Lyon also played a key role in focusing the attention of the 1995 White House Conference on Aging onto gay and lesbian aging issues. For more information, see Appendix B, Lesbian and Gay Activism at the White House Conference on Aging.

Policy Issues Affecting Seniors

132. *The Older Americans Act of 1965*, 103rd Congress, Washington: US Government Printing Office, #103-E, ISBN 0-16-041061-4, 1993.

133. For FY2001 President Clinton has asked for $1.08 billion, while the House and Senate have proposed only $926 million and $955 million, respectively. Administration on Aging,

Older Americans Act Appropriation Information, www.aoa.gov/oaa/oaaapp.html.

134. Administration on Aging, *The Administration on Aging and the Older Americans Act*, www.aoa.gov/may97/aoa-oaa.html.

135. Kiemman, A., *The Illness Narratives: Suffering, Healing and the Human Condition*, New York: Basic Books, 1988, p.183, 1988.

136. Cantor, M., and M. Brennan, *Social Care of the Urban Elderly: The Effects of Ethnicity, Class and Culture*, New York: Springer, 1999.

137. Adams, Stephanie, Heather Nawrocki, and Barbara Coleman, "Women and Long-Term Care," AARP Public Policy Institute Fact Sheet, Washington, DC: AARP, November 1999.

138. Fredriksen, Karen, I., "Family Caregiving Responsibilities Among Lesbians and Gay Men," *Social Work*, Volume 44, Number 2, pp. 142-155, 1999.

139. *Caregiving Across the Life Cycle: Family Caregiving Demands Recognition: A Final Report*, Kensington, MD: The National Caregivers Association, 1998.

140. Estimates from the Congressional Budget Office cited at the Administration on Aging website, www.aoa.dhhs.gov/NAIC/Notes/longtermstdates.html.

141. *Caregiving Across The Life Cycle: Family Caregiving Demands Recognition: A Final Report*, Kensington, MD: The National Family Caregivers Association, 1998, p. 2.

142. Szczygiel, Anthony, "Long Term Care Coverage: The Role of Advocacy," *University of Kansas Law Review*, 44, 1996, p. 748.

143. Butler, Robert N., Grossman, Lawrence, and Mia R. Oberlink, editors, *Life In An Older America*, New York: Century Foundation Press, 1999, p. 60.

144. Liu, Goodwin, "Social Security and the Treatment of Marriage; Espousal Benefits, Earnings Sharing and the Challenge of Reform," *Wisconsin Law Review*, 1999, (1) p. 6. Meyers, Robert, J., "Dispelling the Myths about Social Security," in Butler, Robert N., Grossman, Lawrence, and Mia R. Oberlink, editors, *Life In An Older America*, New York: Century Foundation Press, 1999, p. 9.

145. Hylton, Maria O'Brian, "Evaluating the Case for Social Security Reform: Elderly Poverty, Paternalism and Private pensions," *Brooklyn Law Review*, 62(3), 1998, p. 753.

146. Rix, Sara E., and John B. Williamson, "Social Security Reform: How Might Women Fare?" Issue Brief Number 31, Washington: AARP Public Policy Institute, 1998, p. 7.

147. Nickles, Don, "Retiring in America: Why the United States Needs a New Kind of Social Security for the New Millennium," *Harvard Journal on Legislation*, 36, 1999, p. 82.

148. Some prominent critics do not share this consensus, however. 2000 Green Party presidential candidate and consumer activist Ralph Nader argues that there is nothing wrong with Social Security, and that the claim that the system is in crisis is nothing but "a hoax." Dao, James, "Fading in Polls, Nader Still Gets Star Treatment from Adoring Crowds," *New York Times*, September 24, 2000, p. 32.

149.Women tend to be more reliant upon Social Security than men. Consequently, any reduction in benefits will affect women (as poor people) more severely.

150. Nickles, Don, 1999, p. 108.

151. National Council on Aging, *NCOA's 1999-2000 Public Policy Agenda*, www.ncoa.org/advocacy/1999pubpolicy.htm≠healthcare.

152. Walker, John F., and Harold G. Vatter, "Do We Want to Raise the Age of Eligibility for Social Security Retirees?" *Journal of Economic Issues*, 33(3), September 1999, p. 729.

153. Rix, Sara E., and John B. Williamson, "Social Security Reform: How Might Women Fare?" Issue Brief Number 31, Washington: AARP Public Policy Institute, 1998, p. 3.

154. Hobbs and Damon, 1996, p. 2.

155. Munnell, Alicia H., and Pierluigi Balduzzi, *Investing the Social Security Trust Funds in Equities*, Washington: AARP Public Policy Institute, March 1998, pp. 2-3.

156. Gist, John R., "Social Security Reform: How Do Minorities Fare Under Social Security? A Response to Two Heritage Foundation Reports," Issue Brief Number 34, Washington: AARP Public Policy Institute, 1998, p. 6.

157. Munnell and Balduzzi, 1998, p. 5.

158. Rix and Williamson, 1998, p. 15.

159. Gist, 1998, p. 7.

160. Goozner, Merrill, "Social Security Changes Put on Hold for Another Year," *Chicago Tribune*, Knight-Ridder/Tribune Business News, November 9, 1999.

161. "Medicare 35th Anniversary Event; Medicare's Milestones," Official U.S. Government Site for Medicare Information, Department of Health and Human Services, Medicare program, www.medicare.gov/35/milestones.asp.

162. Jost, Timothy, "Governing Medicare," *Administrative Law Review*, 51(1), 1999, p.40; statement by Medicare administrator Nancy-Ann DeParle, in Morgan, Dan, "More Health Plans Quit Medicare: 711,000 Elderly, Disabled to Lose Broad HMO coverage," *Washington Post*, June 30, 2000, p. A8.

163. National Council on Aging, *NCOA Public Policy Agenda 1999-2000*, www.ncoa.org/advocacy/1999pubpolicy.htm#healthcare.

164. Sabatino, Charles P., *Legal Guide for Older Americans*, American Bar Association, New York: Random House, 1998, p. 55.

165. Morgan, Dan, "More Health Plans Quit Medicare: 711,000 Elderly, Disabled to Lose Broad HMO Coverage," *Washington Post*, June 30, 2000, p. A8.

166. *Ibid.*

167. Morgan, Dan, June 30, 2000, p. A8.

168. Department of Health and Human Services Medicaid Fact Sheet, April 2000, www.hcfa.gov/medicaid/obs11.htm.

169. *Ibid.*

170. Pear, Robert, "Senate Approves Health Care for the Disabled," *The New York Times*, June 17,1999, p. A28.

171. *Managed Care in Medicare and Medicaid*, Health Care Finance Agency fact sheet, February 20, 1998, www.hcfa.gov/facts/f980220.htm.

172. Administration on Aging, Profile of Older Americans, 1999, www.aoa.dhhs.gov/aoa/stats/profile/default.htm#figure3.

173. Juli, Sharon B., "A Hidden Resource for LGBT Elders: HUD Low-Income Senior Housing," Outword, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, 6(1), summer 1999, p. 2.

174. van der Meide, Wayne, *Legislating Equality: A Review of Laws Affecting Gay, Lesbian, Bisexual, and Transgendered People in the United States*, New York: Policy Institute of the National Gay and Lesbian Task Force, 2000, p. 4.

175. The Fair Housing Amendments Act of 1988 contains requirements that all new multi-unit housing (buildings with four or more units) built after 1991 must have certain accessibility features, including an accessible route entrance; accessible common areas; elevators, doors and hallways wide enough for wheelchairs; and sufficient space in kitchens and bathrooms for wheelchairs to maneuver. (*Disability Watch: The Status of People with Disabilities in the United States*, a report by Disability Rights Advocates, Inc., Volcano, CA: Volcano Press, Inc., 1997, p. 57.) Accommodations like safety bars in bathrooms and ramps on the first floor of housing structures are helpful to old people and people with disabilities as well as children. Making housing accessible to all residents and visitors lessens segregation in communities along lines of physical ability and age, and should be a goal of equal housing proponents.

176. Sabatino, Charles P., *Legal Guide for Older Americans*, American Bar Association, New York: Random House, 1998 p.3.

177. National Council on Aging, *NCOA's 1999-2000 Public Policy Agenda*, www.ncoa.org/advocacy/1999pubpolicy.html.

178. Imel, Susan, "Myths and Realities: Older Workers," Columbus: Ohio State University, Center on Education and Training for Employment On-Line, 1996, www.cete.org/capacity.html.

179. AARP, *A Profile of Older Americans: 1997*, December 1996, http://research.aarp.org/general/profile97.html.

180. In a setback to the struggle against ageism, the US Supreme Court ruled on January 11, 2000 that age discrimination is not protected by the constitution. Employees of the State of Florida filed an age discrimination case (*Kimel v. Florida Board of Regents*) against their employer citing the provisions of the ADEA. (Nicholson, Trish, "Age Bias Setback: State Employees Lose Ground in Age Bias Cases," *AARP Bulletin*, Washington: American Association of Retired Persons, 41(3), March 2000, p. 16; for a summary of the opinion see www.findlaw.com/images/michigan.gif&navby'year&year'1998.) Justice Sandra Day O'Connor, writing for the 5 to 4 majority, argued that age hasn't been granted the same constitutional protections as sex and race. Therefore, Congress lacks the authority to override the states' usual immunity from federal lawsuits. Activists were very disappointed to read from her opinion that "older persons, unlike those who suffer discrimination on the basis of race or gender, have not been subjected to a history of purposeful unequal treatment." Citing three previous opinions of the Supreme Court, O'Connor also wrote: "Old age also does not define a discrete and insular minority because all persons, if they live out their normal life spans, will experience it." While this specific ruling only relates to protections for state employees, it nevertheless sends a very harmful message to the rest of the nation that age discrimination is somehow not as reprehensible as all other forms of discrimination.

181. US Equal Employment Opportunity Commission, *Equal Employment Opportunity is the Law*, Washington: EEOC, 1998.

182. Landay, David, *Be Prepared*, New York: St. Martin Press, 1998, p. 99. Additional information about SSI can be found at the National Association for the Mentally Ill website at www.nami.org.

183. Ross, Barnhart, Hansen, Keys and Schieber, *Annual Report*, Social Security Advisory

Board, May 30, 1998, p. 2.

184. Landay, David, p. 100.

How Aging Policy Frameworks can Benefit GLBT Elders

185. See, for example, Diaz, Rafael M., *Latino Gay Men and HIV: Culture, Sexuality, and Risk Behavior*, New York: Routledge, 1998.

186. Administration on Aging, *The Administration on Aging and the Older Americans Act*, www.aoa.gov/may97/aoa-oaa.html.

187. Such funding is consistent with the purposes of Part F, Sections 381 and 382 of the Older Americans Act (formerly Title IV), which call for: 1) "expand[ing] the Nation's knowledge and understanding of the older population and the aging process…;" 2) "education and training to develop an adequately trained workforce to work with and on behalf of older individuals;" 3) "applied social research and analysis to improve access and delivery of services to older individuals;" 4) "evaluation of the performance of the programs, activities, and services provided under this part; [and] the development of methods and practices to improve the quality and effectiveness of the programs, services, and activities provided under this part;" and 5) "the training of graduate level professionals specializing in the mental health needs of older individuals." Section 382 also authorizes "any other activities that the Assistant Secretary determines will achieve the purposes of this part." (OlderAmericans Act Amendments of 1999, S. 1536, Part F—State and Local Innovations and Programs of National Significance, Section 381. Purposes; Section 382. Program Authorized, http://thomas.loc.gov/cgi-bin/query/D?c106:1:./temp/~c106gJ7EPs:e62982:. Similar recommendations were made by the Lesbian and Gay Aging Issues Network of the American Society on Aging to the White House Conference on Aging in 1994. "Recommendations to the White House Conference on Aging, presented by the Lesbian and Gay Aging Issues Network of the American Society on Aging," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, Winter 1994, pp. 4-5.

188. Solarz, 1999.

189. For interesting discussions of methodological and definitional issues, see Jacobson, Sharon, "Methodological Issues in Research on Older Lesbians," *Journal of Lesbian and Gay Social Services*, 3(1), 1995, pp. 43-56; and Sell, Randall L., Wells, James A., and David Wypij, "The Prevalence of Homosexual Behavior and Attraction in the United States, the United Kingdom and France: Results of National Population-Based Samples, *Archives of Sexual Behavior*, 24(3), 1995, pp. 235-248.

190. Behney, Robert, "The Aging Network's Response to Gay and Lesbian Issues," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, Winter 1994, p. 2.

191. Older Americans Act Amendments of 1999, S.1536, http://thomas.loc.gov/cgi-bin/query/D?c106:1:./temp/~c1067Igvet:e56488:.

192. Older Americans Act Amendments of 1999, S.1536, http://thomas.loc.gov/cgi-bin/query/D?c106:1:./temp/~c1067Igvet:e56488:.

193. A similar recommendation was made by the Lesbian and Gay Aging Issues Network of the American Society on Aging to the White House Conference on Aging in 1994. "Recommendations to the White House Conference on Aging, presented by the Lesbian and Gay Aging Issues Network of the American Society on Aging," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, Winter 1994, pp. 4-5.

194. *Ibid.*

195. These recommendations are based on those made by Robert Behney, public information specialist with the Bucks County Area Agency on Aging in Doylestown, PA, in Behney, 1994, p. 2. One successful example of such a collaboration is Cleveland's GrIT (GrAY Pride Interagency Task Force on Gay and Lesbian Aging) created in 1995 as a collaboration dedicated to advocacy, community education and programming for GLBT seniors. GrIT is comprised of the Western Reserve Area Agency on Aging (WRAAA), Fairhill Center for Aging, Lakewood Office on Aging, Lesbian/Gay Community Service Center of Greater Cleveland, Case Western Reserve University and its hospital, and other partners. Partly as a response to community awareness and training provided by GrIT, in 1996 WRAAA, which serves seniors in greater Cleveland, declared gy and lesbian seniors a "targeted," at-risk, and underserved segement of the population in the Agency's service area due to the many barriers to traditional service access (WRAAA Operational Plan 1996). In 1997 GrIT received a $10,000 Title III-F Older Americans Act Health Promotion grant from the WRAAA to create a program of health education, community services, estate planning and related topics of interest to gay and lesbian seniors for the calendar year 1997 (WRAAA Area Plan 1995-99). With this grant, the task force produced 60 hours of health education, information and referrals to gay and lesbian people over 60 years old in the Cleveland area. Nine educational meetings were sponsored for professionals and other interested community members. The task force collaborated with several agencies and offices on aging to produce this programming, among them the City of Cleveland Health Department and Cuyahoga County Department of Senior and Adult Services. A presentation at the National Association of Area Agencies on Aging annual conference raised awareness about the special challenges lesbians and gay men face as they age, including unique barriers to housing, health care, long-term care and other social services.

196. Connolly, Laura, "Long-Term Care and Hospice: The Special Needs of Older Gay Men and Lesbians," in Peterson, K. Jean, editor, *Health Care for Lesbians and Gay Men: Confronting Homophobia and Heterosexism*, Binghampton, NY: Haworth Press, 1996, p. 80.

197. In focus groups that the NGLTF Policy Institute and Pride Senior Network conducted with GLBT seniors across New York City in 2000, many GLBT people reported frustration and resentment at heterosexual siblings who look to them to provide primary care for ailing elderly parents because they are—often falsely—seen as "single" while heterosexual siblings are presumed busy with a married partner and/or children. These experiences can shape GLBT seniors' expectations, fears, and anxieties about their futures as caregivers.

198. *Caregiving Across the Life Cycle: Family Caregiving Demands Recognition: A Final Report*, Kensington, MD: National Caregivers Association, 1998, p. 2.

199. See the Administration on Aging (AOA) website, Long-term Care related agencies, at http://www.aoa.dhhs.gov/NAIC/Notes/longtermstdates.html.

200. Rosenfeld, Dana, "Identity Work Among the Homosexual Elderly," *Journal of Aging Studies*, 13(12), p. 121, 1999.

201. *Assistive Housing for Elderly Gays and Lesbians in New York City*, a report from the Brookdale Center on Aging of Hunter College, commissioned by Senior Action in a Gay Environment (SAGE), New York, April 1999.

202. The other sample was pooled data from the General Social Survey and the National Health and Social Life Survey from 1989-1996. Black, Dan, Gary Gates, Seth Sanders, and Lowell Taylor, "Demographics of the Gay and Lesbian Population in the United States: Evidence from Available Systemic Data Sources," *Demography*, 37(2), May 2000, p. 150.

203. Pride Senior Network, "LGBT Seniors May Be Unable to Access Needed Caregivers," *Networker*, New York: Pride Senior Network, summer/fall 1999, p. 1.

204. As this publication went to press, two anti-same-sex marriage ballot initiatives were pending in Nebraska and Nevada.

205. Social Security Administration, "Fast Facts and Figures about Social Security," Social Security website, www.ssa.gov/statistics/fast_facts/index.html.

206. The formula is that the spouse receives one-half of the beneficiary's monthly payment if taken starting at age 65, but only 37.5% of the beneficiary's monthly payment if taken starting at age 62. Treanor, J. Robert, Dale R. Detlefs, and Robert J. Myers, *1999 Guide to Social Security and Medicare*, Louisville: William Mercer, Inc., 1998, p. 17.

207. *Ibid.*, p. 23.

208. *Your 401(k) Plan: Building Toward Your Retirement Security*, Washington: American Association of Retired Persons, undated, pp. 17-22.

209. *Ibid.*, p. 16.

210. *Your Pension Plan: A Guide to Getting Through the Maze*, Washington: American Associate of Retired Persons, undated, p. 11.

211. *A Woman's Guide to Pension Rights*, Washington: American Association of Retired Persons, undated, p. 11.

212. AARP, "Medicaid and Long-Term Care for Older People," p. 3, http://research.aarp.org/health/fs18r_medicaid.html.

213. A recent Supreme Court case upheld the right of parents to determine with whom their children interact over the right of grandparents to visit their grandchildren. In a 6-3 decision, the Supreme Court ruled this year in Troxel v. Granville that a state law allowing "[a]ny person" to petition for child visitation rights "at any time" violated a parent's rights to her children when the children's paternal grandparents sought court-ordered visitation over her objection. The case was closely watched by GLBT advocates interested in 1) securing the rights of GLBT biological parents from claims of outsiders, and 2) advocating that GLBT co-parents should be entitled to legal recognition of children they raise with their partners. Justice Sandra Day O'Connor's plurality decision seemed to leave the window open for the future of GLBT co-parents when she recognized that the biological, nuclear family is not the sole model for defining parent-child relationships. Yet six of the nine Justices wrote independent decisions outlining their views on how to decide thorny parenting cases in the future, leaving the country with no clear direction and a very splintered Supreme Court. Any changes to the Court could significantly define the direction of family law cases in the future.

214. General Accounting Office, *Abstracts of GAO Reports and Testimony*, FY97, OGC-97-16, January 31, 1997, www.gao.gov/AindexFY97/abstracts/og97016.

215. Kohn, Sally, *Domestic Partnership Organizing Manual*, New York: Policy Institute of the National Gay and Lesbian Task Force, 1999, p. 2. Domestic partnership involves the extension of rights and privileges usually reserved for married couples to unmarried couples who seek recognition of their relationships. States and municipalities, as well as private employers, have instituted domestic partner status to provide a range of benefits to the partners of their unmarried employees. These policies provide both soft benefits like access to employer recreational facilities or inclusion in employee discount programs, or more substantive benefits like medical care and life insurance. Domestic partner registries for residents of particular political jurisdictions can guarantee visitation rights in a public hospital, family

memberships in municipal recreational facilities, and access to the school records of a spouse's children. Currently seven states, 87 municipalities and more than 500 companies offer domestic partnership registries and/or benefits. Some, like New York City and Washington State, offer domestic partner benefits only to the spouses of government workers. Others, like California and Boston, provide registries open to any unmarried residents of the jurisdiction.

216. Freedman, Marcia, and Carlos Martinez, "LGAIN Breaks New Ground; Policy Recommendations Submitted to the White House Conference on Aging," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, 1(2), Winter 1994, p. 1.

217. Fairchild, Susan K., Carrino, Gerard E., and Mildred Ramirez, "Social Workers' Perceptions of Staff Attitudes Toward Resident Sexuality in a Random Sample of New York State Nursing Homes: A Pilot Study," *Journal of Gerontological Social Work*, 26(1/2), 1996, p. 167.

218. *Men's Health* magazine survey, cited in Hoeflich, Michael H., "Reflections on Elderly Housing in the Baby Boom Era," *The University of Kansas Law Review*, 1996, 44, p. 714.

219. Juli, 1999, p. 8; Sabatino, Charles P., *Legal Guide for Older Americans*, American Bar Association, New York: Random House, 1998, p. 3.

220. There are now several projects across the country in various stages of development, from planning to fully operational. Projects are underway under the auspices of Senior Action in a Gay Environment in New York and the Gay and Lesbian Association of Retiring Persons (GLARP) in Palm Springs, California. The Queen City Community Development corporation is well along with the building of a multi-generational, multi-purpose facility that will house the Seattle Gay Cultural Center and a Senior Housing Project in Seattle, Washington. Our Town, sponsored by the Lundberg Group, is planning a facility near San Francisco, as is Metropolitan Community Homes, a project of the predominately GLBT Metropolitan Community Church. A project called Stonewall Communities is at the initial stages of planning in the Boston area. Already up and running, the Palms in Manasota, in Palmetto, Florida opened several years ago and has sold out the first phase of the development, and the Resort on Carefree Boulevard in Fort Meyers, Florida is almost full.

221. A SAGE housing survey found that half of New York City GLBT elders said that the desire to lower their costs of living was a major reason for moving into special needs housing. An overwhelming majority said they wanted to stay in New York City, and most cited failing health and the need for some sort of assistance as the reason for wanting to move to such a residence. Half the respondents also said they would move to avoid having to live alone, as 65% of the people surveyed were already living by themselves. (*Assistive Housing for Elderly Gays and Lesbians in New York City*, A Report from the Brookdale Center on Aging of Hunter College, April 1999, commissioned by Senior Action in a Gay Environment (SAGE), Inc.) A survey of GLBT senior service and housing advocates in San Francisco found that "the vast majority" wanted to live in a GLBT housing development so that they could "live in a community where one's sexual preference is irrelevant." (Hamburger, Lisa J., "The Wisdom of Non-Heterosexually Based Senior Housing and Related Services," *Journal of Gay and Lesbian Social Services*, 6(1), 1997, p. 15.)

222. Lutz, William, "The House Rich but Cash Poor Elderly; A Housing Solution for First Time Home Buyers," *Saint Louis University Law Review*, 10, 1991, p. 531.

223. van der Meide, 2000, pp. 4-5.

224. Raphael, S., "Lesbian and Gay Elders," paper presented at conference of National Center

on Elder Abuse, Long Beach, CA, June 1997, cited in Cook-Daniels, Loree, "Lesbian, Gay Male, Bisexual and Transgendered Elders: Elder Abuse and Neglect Issues," *Journal of Elder Abuse and Neglect*, 9(2), 1997, p. 38.

225. Cook-Daniels, 1997, pp. 38-39.

226. *Ibid*, pp. 39-40.

227. Fairchild *et al.*, pp. 154-156.

228. *Ibid*, p. 158.

229. Wasow, M., and M. Loeb, "Sexuality in Nursing Homes," *Journal of the American Geriatric Society*, 27, 1979, pp. 73-79; Mulligan, T., and R.F. Palguta, "Sexual Interests, Activity, and Satisfaction among Male Nursing Home Residents," *Archives of Sexual Behavior*, 20, pp. 199-204; both cited in Fairchild *et al.*, 1996, p. 155.

230. Kelly (1977) found that 83% of 30 gay men 65 and older surveyed reported satisfactory sex lives, as did 50% of men 50-65. Kelly, J., "The Aging Male Homosexual," *The Gerontologist*, 17, pp. 328-332, cited in Fairchild *et al.*, 1996, p. 157.

231. Parsons, Y., "Private Acts, Public Places," *Contemporary Long Term Care*, March 1995, p. 51.

232. Fairchild *et al.*, 1996, pp. 161-165.

233. *Ibid*, p. 161.

234. *Ibid*, p. 166.

235. Fairchild *et al.*, 1996, pp. 162-167.

236. There are a few limited exceptions, but generally anyone who is not in a Medicare health maintenance organization (HMO), or who cannot afford Medigap policies (private insurance plans that are supposed to cover the costs that Medicare does not), is not covered for prescription medications. Even those who have Medigap policies may lack prescription coverage because only about 15% of those with Medigap coverage have purchased the kinds of Medigap policies that provide drug coverage.

237. Study by Express Scripts, which manages drug benefits for 38.5 million Americans, cited in Pear, Robert, "17 Percent Increase in Prescription Drug Costs Hit Elderly Hardest, Study Finds," *New York Times*, June 27, 2000, p. A16.

238. Jost, Timothy, "Governing Medicare," *Administrative Law Review*, 51(1), 1999, p. 68.

239. When considering this problem, the immense social value Medicare provides to the society cannot be ignored. As described above, this program provides vital life saving and poverty-alleviating services to over 38 million Americans. Reforms which would cut coverage, or restrict participation by raising the age of eligibility or privatization, might adversely affect the GLBT community. One proposal would make recipients pay higher premiums and/or co-payments for services in Part B of the program. Since many elderly GLBT recipients have low incomes, this might seriously limit their access to adequate health care. Another reform plan proposes cuts in certain types of Medicare coverage, including home health care and other outpatient services. This would affect GLBT elders who live alone. Cuts in home hospice care services could force people to face their last days in the hospital as opposed to allowing them to die in a more humane home environment. In addition, proposals to make recipients pay much higher deductibles for hospital visits would add a serious additional burden to those with long-term chronic or terminal illness. Instead, Medicare should be expanded to cover long-term care needs, which are currently not covered by the program and prescription drug costs.

240. Schatz, Benjamin, and Katherine O' Hanlan. *Anti-Gay Discrimination in Medicine: Results of a National Survey of Lesbian, Gay and Bisexual Physicians*, San Francisco, CA: American Association of Physicians for Human Rights, May 1994.

241. Behney, Robert, "The Aging Network's Response to Gay and Lesbian Issues," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, Winter 1994, p. 2.

242. Jost, Timothy, "Governing Medicare," *Administrative Law Review*, 51(1), 1999, p. 101.

243. Dean *et al.*, 2000, p. 13.

244. From US Census Bureau Population Survey found on its website, www.census.gov.

245. Pear, Robert, "Study Links Medicaid Drop to Welfare Changes," *The New York Times*, May 14, 1999, p. A22; Cahill, Sean, *Tip of the Iceberg or Bump in the Road? The Initial Impact of Welfare Reform in Dorchester*, Boston: Massachusetts Human Services Coalition, March 1999.

246. An analysis by Families USA, a health care advocacy group, found that in the wake of the welfare reform law signed by President Clinton in August 1996, nearly 700,000 low-income parents and children lost Medicaid benefits even though they were still eligible for the federally subsidized health care program. Some 420,000 of these were children. The study estimates that 20% of the 3 million people who left welfare in the year after welfare reform was implemented lost health insurance. (Pear, Robert, "Study Links Medicaid Drop to Welfare Changes," *New York Times*, May 14, 1999, p. A22.) In 1997 and 1998 total Medicaid enrollment dropped by 3.6 million. Ron Pollack, executive director of Families USA, states that millions of families leaving welfare are not accessing Medicaid and food stamps—for which they continue to be eligible—because state welfare administrators are not processing applications. (Karen Houppert, "You're not entitled! Welfare 'Reform' is Leading to Government Lawlessness," *The Nation*, October 25, 1999, p. 12.)

247. Perloff, J.D., "Medicaid Participation among Urban Primary Care Physicians," paper presented at annual meeting of the Association for Health Services Research, Chicago, June 5-6, 1995, www.ahsr.org/AHSR2/1995/perloff.htm.

248. Ku, Leighton, and Teresa Coughlin, *How The New Welfare Reform Law Affects Medicaid*, Washington, D.C.: The Urban Institute, March 1997.

249. A great deal of grassroots activism led to the Institute of Medicine's Lesbian Health Study in 1999 and the Department of Health and Human Services' Scientific Workshop on Lesbian Health in March 2000, as well as the Boulder Gay Men's Health Summits of 1999 and 2000.

250. McClellan, Frank, "Is Managed Care Good for What Ails You? Ruminations of Race, Age, and Class," *Villanova Law Review*, 44(2), 1999, p. 232.

251. Morgan, Dan, "More Health Plans Quit Medicare: 711,000 Elderly, Disabled to Lose Broad HMO Coverage," *Washington Post*, June 30, 2000, p. A8.

252. Asian AIDS Project, *Needs Assessment among Asian Pacific Islander Transgenders*, San Francisco, 1995, cited in Dean et al., 2000, p. 44; Green, Jamison, *Investigation Into Discrimination Against Transgendered People*, A Report by the Human Rights Commission, City and County of San Francisco, September 1994, p. 43, www.ci.sf.ca.us/sfhuman-rights/lg_info.htm.

253. Bockting, W.O., Robinson, B.E., and B.R.S. Rosser, "Transgender HIV Prevention: A Qualitative Needs Assessment," *AIDS Care*, 10(4) 1998, pp. 505-526, cited in Dean *et al.*, 2000, p. 44.

254. Centers for Disease Control and Prevention, "AIDS Among Persons Aged >50 Years, United States, 1991-1996," *Morbidity and Mortality Weekly Report*, Atlanta: Centers for Disease Control and Prevention, January 23,1998.

255. Rice, Susan Dianne, "AIDS Risk Higher for Those Over 50," *Aging Today*, 19(2), March/April, 1998, p. 6.

256. Linsk, Nathan L., "Experience of Older Gay and Bisexual Men Living with HIV/AIDS," *Journal of Gay, Lesbian, and Bisexual Identity*, 2 (3/4), 1997, p. 305.

257. Anderson, Gregory, "AIDS and Older Adults," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, 1(1), Summer 1994, pp. 1-8.

258. *Ibid*, p. 8.; Linsk, 1997, pp. 291-302.

259. Witten, Tarynn M., and A.E. Eyler, "Conflicting Identities and Transgender Violence," *Peace Review*, 10(1), 2000.

260. Bennet, James, "The Old People Sit and Talk, about AIDS and Lives of Secrecy," *New York Times*, September 21, 1992.

261. Ungvarski, P. J. & A.H. Grossman, "Health Problems of Gay and Bisexual Men," *Nursing Clinicians of North America*, 34(2), 1999, pp. 313-331; Yang, Alan, *From Wrongs to Rights 1973-1999: Public Opinion on Gay and Lesbian Americans Moves Toward Equality*, New York: Policy Institute of the National Gay and Lesbian Task Force, 1999, p. 22. Yang cites National Opinion Research Center polling data, in which 56% and 58% of American respondents consider same-sex relations "always wrong" in 1996 and 1998 surveys, respectively.

262. Jacobson, S. & Grossman, A. H., "Older Lesbians and Gay Men: Old Myths, New Images, and Future Directions," in Savin-Williams R.C. & K.M. Cohen, editors, *The Lives of Lesbians, Gays and Bisexuals: Children to Adults*, Fort Worth, TX: Harcourt Brace College Publishers, 1996, pp. 345-373; Ehrenberg, M., "Aging and Mental Health: Issues in the Gay and Lesbian Community," in Alexander, C. J. editors, *Gay and Lesbian Mental Health: A Sourcebook for Practitioners*, Harrington Press: New York, 1996, pp. 189-209; Pope, M., & Schulz, R., "Sexual Attitudes and Behavior in Midlife and Aging Homosexual Males," *Journal of Homosexuality*, 20(3/4), 1990, pp. 169-177.

263. Kelly, J., "The Aging Male Homosexual: Myth and Reality," *The Gerontologist*, 17, 1977, p. 16-79, cited in Ehrenberg, 1996, p. 192.

264. Berger, R. M, "Psychological Adaptation of the Older Homosexual Male," *Journal of Homosexuality*, 5(3), 1980, p. 161-175; Berger, R. M., *Gay and Gray: The Older Homosexual Man*, Urbana, IL: University of Illinois Press, 1982, cited in Jacobson & Grossman, 1996, p. 354.

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266. Dorfman, R, Walters, K., Burke, P., Hardin, L., Karanik, T., Raphael, J., & E. Silverstein, "Old, Sad and Alone: The Myth of the Aging Homosexual," *Journal of Gerontological Social Work*, 24(1/2), 1995, pp. 29-44.

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268. Berger, R. M., "The Unseen Minority: Older Gays and Lesbians," *Social Work*, 29, p. 57-62, 1982, cited in Jacobson, S. A., and A.Grossman, "Older Lesbians and Gay Men: Old Myths, New Images, and Future Directions," in Savin-Williams, R.C., and K.M. Cohen, eds., *The Lives of Lesbians, Gays and Bisexuals: Children to Adults*, Ft Worth: Harcourt Brace, 1996, pp. 345-373.

269. Adelman, M., "Stigma, Gay Lifestyles, and Adjustment to Aging: A Study on Later-Life Gay Men and Lesbians," *Journal of Homosexuality*, 23(3/4), 1990, pp. 7-32.

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271. Dean, Laura, *et al.*, 2000, p. 51.

272. Israel, G. E. & Tarver, D. E, Transgender Care, Temple University Press: Philadelphia, 1997, cited in Dean *et al.*, 2000.

273. Kockman, Arlene, "Gay and Lesbian Elderly: Historical Overview and Implications for Social Work Practice," *Journal of Gay & Lesbian Social Services*, 6(1), 1997, pp. 1-10.

274. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), Washington, DC: American Psychiatric Association, Fourth Edition, 1994; Dean *et al.*, 2000.

275. Wilson, Katherine, *The Disparate Classification of Gender and Sexual Orientation in American Psychiatry*, a paper presented at the 1998 Annual Meeting of the American Psychiatric Association, Toronto, Canada.

276. US Department of Health and Human Services, *Mental Health: A Report of the Surgeon General—Executive Summary*, Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999, www.surgeongeneral.gov/Library/MentalHealth.

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279. US Department of Health and Human Services, *Healthy People 2010 Conference Edition*, January 2000, www.health.gov/healthypeople/Document/default.htm.

280. D'Augelli, Anthony R., Matthew S. Hesson-McInnis, and Craig C. Waldo, "Antecedents and Consequences of Victimization of Lesbian, Gay, and Bisexual Young People: A Structural Model Comparing Rural University and Urban Samples," *American Journal of Community Psychology*, (26:2) April 1998, 307-334.

281. National Coalition of Anti-Violence Programs (NCAVP), *Anti-Lesbian, Gay, Bisexual and Transgender Violence in 1998*, 1999. Since 1992, when the Federal Bureau of Investigations began to track anti-gay hate crimes, FBI statistics have consistently ranked anti-gay violence as the third most frequent form of bias crimes. (Federal Bureau of Investigation, *Annual Report on Hate Crimes*, released by the FBI in 1993, 1994, 1995, 1996, 1997, 1998.) In 1997, 335 reported victims of anti-GLBT violence were between the ages of 45 and 64, and 38 were 65 or older; in all, 15% of victims were 45 or older. In 1998 368 victims were 45-64, and 32 were 65 or older; altogether, 17% of victims that year were 45 or older. (NCAVP report, 1999, p. 20.) At least 33 people were murdered in 1998 because of their sexual orientation or gender identity. In the 12 months following Matthew Shepard's murder in October 1998, another 20 GLBT people were murdered because of their sexual orientation or gender identity. Anti-GLBT attacks are also among the most violent bias crimes. According to a 1994 study by the National Coalition of Anti-Violence Programs, GLBT murder victims are more likely than heterosexual victims to die brutal deaths characterized by dismemberments, multiple stabbings and severe bludgeoning, and their killers are less likely to be caught. Of 152 anti-GLBT murders between 1992 and 1994 documented by the study, almost 60% involved "extraordinary violence" and "overkill." (Auerbach, Jon, "Study: Killings of Gays More Brutal," *Boston Globe*, December 21, 1994.) In 1999, anti-GLBT murders in the US involved the beheading of a Virginia man, an Alabama man burned on a pyre of tires, and an African American transgender woman, Rita Hester, who was stabbed dozens of times in her Boston apartment.

282. Sabatino, Charles P. *Legal Guide for Older Americans*. American Bar Association, New York: Random House, 1998 p.3.

283. National Gay and Lesbian Task Force, "GLBT Civil Rights Laws in the US" (map), Washington: NGLTF, April 2000, at www.ngltf.org.

284. A multiple regression analysis of the General Social Survey (GSS) data from 1988-1990 and of 1990 US Census data on same-sex households indicates that when adjusted for education, occupation, race, geographic location, and experience, gay men earn as much as one-quarter less than heterosexual men, while lesbians earn about the same as heterosexual women. Source: Badgett, M.V. Lee, "The Wage Effects of Sexual Orientation Discrimination," *Industrial and Labor Relations Review*, 48(4), July 1995, p. 737; Klawitter, Marieka M., and Victor Flatt, "The Effects of State and Local Antidiscrimination Policies for Sexual Orientation," Journal of Policy Analysis and Management, 17(4), Fall 1998, pp. 674-675.

285. van der Meide, 2000; Currah, Paisley, and Shannon Minter, 2000, p. iv.

286. As mentioned above, in 39 states discrimination in employment based upon sexual orientation is still legal. The Employment Non-Discrimination Act (ENDA) is a bill pending in Congress that would make it illegal to discriminate against people on the basis of sexual orientation in employment anywhere in the US. (Further information about the Employment Non-Discrimination Act can be found in the NGLTF 1999 Federal Advocacy Summary at www.ngltf.org/federal/1999summ.html. As this bill is currently drafted, it would add sexual orientation but not gender identity to federal employment nondiscrimination statutes. NGLTF supports the inclusion of both sexual orientation and gender identity in nondiscrimination statutes The need for transgender nondiscrimination protection is critical. Late-transitioning transsexuals face particular employment problems. The fact that they

have little or no work history in their new name can be compounded by having to change careers if they have been in a very gender segregated profession. Depending on the types of work in which they have been trained, many transgender workers lose employment opportunities even before their Social Security benefits become available. We also support measures providing incentives to hire old people, and government-funded programs to train and educate old people to make them more qualified for new jobs. Further information about the Employment Non-Discrimination Act can be found in the NGLTF 1999 Federal Advocacy Summary at www.ngltf.org/federal/1999summ.html.

287. This information was gathered at the National Association for the Mentally Ill website, www.nami.org.

288. Serious criticism has been aimed at the family cap reform. Opponents believe that this reform does not adequately differentiate between alleged abusers who are former spouses and other unmarried or unrelated persons who are living together or living in group homes. Residents of group homes are typically unrelated strangers. Opponents argue there is no evidence that beneficiaries move into group homes to defraud the SSI program and receive more benefits. They claim that the effects of this reform would only be to reduce the benefits of deserving beneficiaries, while doing little in the way of reducing fraud.

289. Cashin, Sheryll. "Federalism, Welfare Reform, and the Minority Poor; Accounting for the Tyranny of State Majorities." *Columbia Law Review*, 1999 99 (3) p.556.

290. In Kentucky the largest provider of state-funded services to "at risk" youth (serving 3,000 youth annually) is managed and controlled by the Kentucky Baptist Home for Children, under the auspices of the Kentucky Baptist Convention. This institution has publicly announced that it will not hire gays and lesbians to work with the youth in its care and has publicly stated that it believes GLBT youth can and should be converted to heterosexuality through prayer and psychotherapy. One lesbian employee was fired after she appeared on TV at an AIDS fundraising walk. Preference is given in placement of foster children to homes of members of the Kentucky Baptist Convention. GLBT youth are overrepresented among runaway youth and youth fleeing abusive family situations. Activists are so concerned about the clear record of violation of rights and the potential for abuse of children within the foster care system that the American Civil Liberties Union's Gay and Lesbian Rights Project has filed a lawsuit against the Kentucky Baptist Convention. Another example is in Texas, where in order to access job training services people on welfare must agree to be mentored by members of a particular Christian faith. This raises concerns not only for lesbian and bisexual women on welfare, but also for non-Christians, Christians who are not of that particular faith, and those who are not religious.

291. These include the Anti-Defamation League and many other Jewish organizations, the Baptist Joint Committee on Public Affairs, Catholics for a Free Choice, the Quakers, Seventh Day Adventists, Unitarians, and Presbyterians, the National Organization of Women, the ACLU and others.

292. Gallup 1999 and Princeton Survey Research Associates 1998, in Alan Yang, *From Wrongs to Rights: Public Opinion Toward Gay and Lesbian Americans Moves Toward Equality 1973-1999* (New York: NGLTF Policy Institute, 1999).

293. National Election Study, 1996, in Yang.

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294. Connolly, Laura, "Long-Term Care and Hospice: The Special Needs of Older Gay Men and Lesbians," in Peterson, K. Jean, editor, *Health Care for Lesbians and Gay Men: Confronting Homophobia and Heterosexism*, Binghampton, NY: Haworth Press, 1996, p. 80.

295. Similar recommendations were made by the Lesbian and Gay Aging Issues Network of the American Society on Aging to the White House Conference on Aging in 1994. "Recommendations to the White House Conference on Aging, presented by the Lesbian and Gay Aging Issues Network of the American Society on Aging," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, Winter 1994, pp. 4-5. Both agency-level advocacy and legislative advocacy should be pursued to achieve such funding.

296. Older Americans Act Amendments of 1999, S.1536, http://thomas.loc.gov/cgi-bin/query/D?c106:1:./temp/~c1067Igvet:e56488:.

297. Older Americans Act Amendments of 1999, S.1536, http://thomas.loc.gov/cgi-bin/query/D?c106:1:./temp/~c1067Igvet:e56488:.

298. A similar recommendation was made by the Lesbian and Gay Aging Issues Network of the American Society on Aging to the White House Conference on Aging in 1994. "Recommendations to the White House Conference on Aging, presented by the Lesbian and Gay Aging Issues Network of the American Society on Aging," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, Winter 1994, pp. 4-5.

299. These recommendations are based on those made by Robert Behney, public information specialist with the Bucks County Area Agency on Aging in Doylestown, PA, in Behney, 1994, p. 2.

300. Dean *et al.*, 2000, p. 13.

301. Some of these recommendations were made by the Lesbian and Gay Aging Issues Network of the American Society of Aging. See Freedman, Marcia, and Carlos Martinez, "LGAIN Breaks New Ground; Policy Recommendations Submitted to the White House Conference on Aging," *Outword*, newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, 1(2), Winter 1994, p. 1.

302. Morgan, Dan, June 30, 2000, p. A8.

303. Some of these recommendations are taken from the National Council on Aging, NCOA's 1999-2000 Public Policy Agenda, www.ncoa.org/advocacy/1999pubpolicy.htm.

304. Foley, Lisa A., and Mary Jo Gibson, "In Brief: Older Women's Access to Health Care: Potential Impact of Medicare Reform," Washington: AARP Public Policy Institute, July 2000.

305. From US Census Bureau Population Survey found on its website, www.census.gov.

306. Perloff, J.D., "Medicaid Participation Among Urban Primary Care Physicians," paper presented at annual meeting of the Association for Health Services Research, Chicago, June 5-6, 1995, www.ahsr.org/AHSR2/1995/perloff.htm.

307. Munnell and Balduzzi, 1998, p. 24.

308. National Council on Aging, NCOA Public Policy Agenda 1999-2000, www.ncoa.org/advocacy/1999pubpolicy.htm≠healthcare.

309. US Equal Employment Opportunity Commission, *Equal Employment Opportunity is the Law*, Washington: EEOC, 1998.

Appendices

310. Sell, Randall L., James A. Wells, and David Wypij, "The Prevalence of Homosexual Behavior and Attraction in the United States, the United Kingdom, and France: Results of

National Population-Based Samples," *Archives of Sexual Behavior*, 24(3), 1995, p. 235.

311. Singer and Deschamps, pp. 10-11.

312. Smith (1991), cited in Singer and Deschamps, p. 12.

313. Laumann, O., and J.H. Gagnon, R.T. Michael, and S. Michael, *The Social Organization of Sexuality: Sexual Practices in the United States*, Chicago: University of Chicago Press, 1994, cited in Dean, Laura, and Ilan Meyer, Kevin Robinson, Randall Sell, Robert Sember, Vincent Silenzio, Daniel Wolfe, Deborah Bowen, Judith Bradford, Esther Rothblum, Scout, Jocelyn White, and Patricia Dunn, *Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns*, New York: Gay and Lesbian Medical Association and the Center for LGBT Health, Columbia University School of Public Health, January 2000, p. 7.

314. *Ibid.*

315. Lukenbill, Grant, *Untold Millions: Positioning your Business for the Gay and Lesbian Consumer Revolution*, New York: Harper Business, 1995, pp. 70-73.

316. Bailey, Robert W., *Out and Voting II: The Gay, Lesbian, and Bisexual Vote in Congressional Elections, 1990-1998*, New York: Policy Institute of the National Gay and Lesbian Task Force, 2000, pp. 12-21. In 1990 VNS started asking, in a long list of demographic questions, if respondents were gay or lesbian. Starting in 1992 VNS switched the wording of this question to "gay, lesbian, or bisexual." VNS, like nearly all the national surveys, does not inquire about gender identity.

317. *Ibid*, p. 12.

318. *Ibid*, p. 14.

319. Rosenfeld, Dana, "Identity work among lesbian and gay elderly," *Journal of Aging Studies*, 13(2), summer 1999, pp. 121 ff.

320. For more information about the history of the White House Conferences on Aging, consult the website of the Administration on Aging at www.aoa.dhhs.gov/aoa/pages/whcoa/history.html.

321. Ettelbrick, Paula, "Legal issues in health care for lesbians and gay men," *Journal of Gay and Lesbian Social Services*, 5(1), 1996, pp. 93-94.

322. Quam, Jean K., "The story of Carrie and Anne: Long-term care crisis," in *Journal of Gay and Lesbian Social Services*, 6(1), 1997, pp. 97-99.

323. Ettelbrick, 1996, p. 94.

324. *Ibid*, p. 97; Connolly, Lora, "Long-term care and hospice: The special needs of older gay men and lesbians," *Journal of Gay and Lesbian Social Services*, 5(1), 1996, p. 86.

325. Connolly, 1996, pp. 86-87; Ettelbrick, 1996, pp. 97-98.

326. Ettelbrick, 1996, p. 98.

327. Ettlebrick, 1996, p. 100.

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NGLTF works to change the American Psychiatric Association (APA) classification of homosexuality as a mental illness.

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1989
NGLTF establishes the only national Campus Organizing Project to improve the quality of life for GLBT people on campus; publishes comprehensive manual on campus issues in 1995.

1990
NGLTF secures passage of Federal Hate Crimes Statistics Act.

1980, 1984, 1988, 1992, 1996
NGLTF promotes gay, lesbian, bisexual and transgender civil rights, visibility and participation in national elections.

National Gay and Lesbian Task Force

Policy Institute *bestsellers*

A handbook providing activists and policymakers with the tools they need to pass transgender-inclusive non-discrimination and anti-violence legislation. Written by Paisley Currah and Shannon Minter, with an introduction by Jamison Green. This handbook is an invaluable resource guide providing model legislative language, talking points, responses to frequently asked questions, and a comprehensive resource listing. (June 2000; 96 pp; **$10.00**; www.ngltf.org /pub.html)

An in-depth profile of the gay, lesbian, and bisexual voting bloc and the first-ever analysis of the impact of this emerging constituency in national congressional elections. By Dr. Robert Bailey of the Rutgers University School of Public Policy and Administration. Among the report's findings: out GLB voters comprise roughly 5% of the national electorate, and 8.8% of voters in cities of 500,000 or more.
(January 2000; 54 pp; **$10.00**; www.ngltf.org /pub.html)

The major candidates' statements and votes on 6 key issues are presented along with data and research to contextualize these policy debates. Although in the past decade the US has become much more supportive of equality for GLBT people, many presidential candidates are acting as if the country hasn't changed a bit. Written by Policy Institute Research and Policy Director Sean Cahill.
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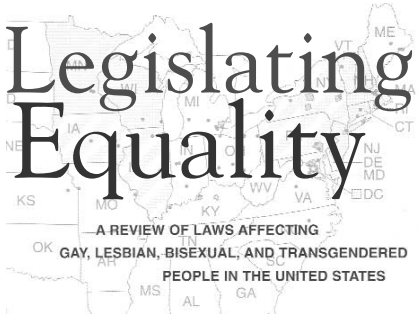

This comprehensive report, written by Policy Institute Research Fellow Wayne van der Meide, provides the most extensive description to date of local, county and state laws addressing GLBT equality. This report is an invaluable tool for activists, journalists and policymakers who require reliable facts on laws affecting GLBT people but lack the time, resources or desire to conduct primary research.
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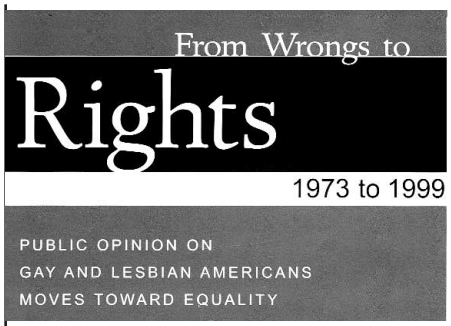

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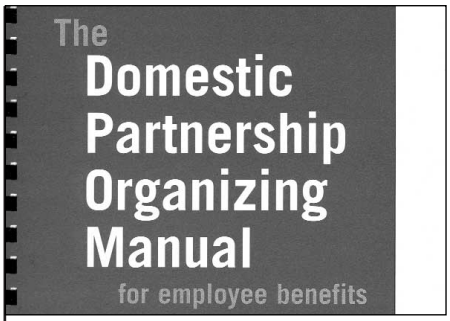

This manual, written by Policy Institute Research Fellow Sally Kohn, provides comprehensive information on what domestic partnership benefits are, why employers should adopt these benefits, and how employees and citizens organize effectively for policy change. Sample policies and lists of who offers domestic partnership benefits are included.
(May 1999; 140pp; **$10.00**; www.ngltf.org/pubs/dp_pubs.html)

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THE MYTH OF AFFLUENCE AMONG GAY, LESBIAN, AND BISEXUAL AMERICANS

This report, by Professor M.V. Lee Badgett, of the Department of Economics at the University of Massachusetts at Amherst, explores the pervasive and inaccurate notion that GLB people form an economic elite, insulated from discrimination by their wealth and disconnected from society at large by a special, privileged status. After examining data from seven different surveys, she finds that none support this stereotype. (November 1998; 23pp; **$10.00**; www.ngltf.org/downloads/income.pdf)

Calculated Compassion

HOW THE EX-GAY MOVEMENT SERVES THE RIGHT'S ATTACK ON DEMOCRACY

This report documents that the ex-gay movement serves as a camouflage for a retooled and reinvigorated assault by the religious right on legal anti-discrimination protections for gay, lesbian, bisexual, and transgender persons. Calculated Compassion is a joint publication of NGLTF, Political Research Associates, and Equal Partners in Faith. (October 1998; 30pp; **$6.00**; www.ngltf.org/downloads/calccomp.pdf)

Capital Gains and Losses 1999

A STATE BY STATE REVIEW OF GAY, LESBIAN, BISEXUAL, TRANSGENDER, AND HIV/AIDS-RELATED LEGISLATION

This report presents information about state legislative measures that sought to improve the quality of the lives of gay, lesbian, bisexual and transgendered (GLBT) people, as well as those that sought to denigrate and disenfranchise GLBT people.
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