

Bi+ People of Color: Counted, Seen, and Still Underserved

Bisexual and queer people of color exist at a convergence of compounding disadvantages — not by chance, but by structure. They are the **largest group within the LGBTQ+ community**, yet the least studied, the most economically precarious, and the most likely to fall through the gaps between systems of care. Medical care fails them through racial bias and provider ignorance of bisexual identity. Policy fails them through Medicaid underfunding and the absence of intersectional data. **When a population is not counted, it is not cared for.**

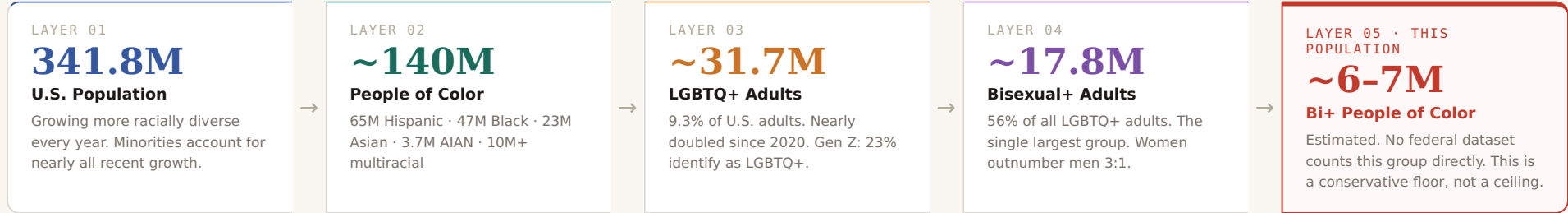
341.8M
Total U.S. population · 2025

~140M
People of color in the U.S.

~17.8M
Bisexual+ adults · 5.2% of U.S.

~6-7M
Bi+ people of color · est.
No federal dataset counts them directly

WHO WE'RE TALKING ABOUT — POPULATION FUNNEL



61%
lifetime IPV rate for bisexual women
Highest of any sexual orientation group. Hispanic bi women: 79%. Black bi women: 69%. vs. 44% lesbian · 35% straight.
CDC NISVS

29.4%
poverty rate for bisexual women
Highest of any orientation group — nearly double the rate of straight cisgender adults (16%). 48% of all bi respondents earn under \$30,000/year.
Badgett et al. / BRFSS 2014-17 · MAP Invisible Majority

≈ 0
federal datasets that count Bi+ POC directly
Most surveys collect race or sexual orientation — never both simultaneously. The ~6-7M bi+ people of color are invisible in the data that drives health policy and funding.
Science Policy Review 2024 · Williams Institute

RECOMMENDED ACTIONS — LOWEST HANGING FRUIT FIRST

POLICY **Structural changes**

- 01 Mandate SOGI data disaggregated by race**
Require federal and state health surveys (BRFSS, NHIS, NHANES) to collect and **report sexual orientation cross-tabulated with race/ethnicity separately** — not collapsed into "LGBTQ+." Most systems already collect both; the barrier is in how data is analyzed and published. **This is the unlock for every other policy.** No data means no funding, no research, no targeted programs. The ask is narrow, technical, and hard to argue against on principle. Contact your state health department or support the Williams Institute and Movement Advancement Project (lgbtmap.org).
Why it's achievable: Changes a reporting standard, not an infrastructure. Some states already do this.
- 02 Protect and expand Medicaid — oppose proposed cuts**
Medicaid is the **primary insurance for millions of bi+ adults of color** — 22% of Black LGBT adults, 21% of AIAN LGBT adults rely on it. Proposed \$880B in cuts would hit this community hardest. In Medicaid expansion states, LGBTQ+ uninsured rates drop from 18% to 7%. **Opposing cuts and supporting expansion in non-expansion states** is the highest-impact policy action available. Contact Congressional representatives via Protect Our Care or the National LGBTQ Task Force (thetaskforce.org).
Why it's achievable: Public pressure campaign already underway. Constituent contact is direct and documented.
- 03 Require behavioral-based clinical screening standards**
At the state level through Medicaid managed care contracts or health department guidance, **require that STI, HIV, reproductive, and cancer screenings be offered based on documented sexual behavior** — not identity, partner gender, or provider assumption. This is the policy version of the self-assessment tool. It doesn't mandate provider attitudes; it mandates the questions asked and screenings offered. Measurable, auditable, and directly addresses the delay-of-care problem shown in the clinical vignettes.
Why it's achievable: Attaches to existing Medicaid contract mechanisms. No new legislation required.

INDIVIDUAL **Actions anyone can take now**

- 01 Connect Bi+ POC to entitlements they already qualify for**
A significant portion of bi+ people of color are **already Medicaid-eligible but not enrolled**, or enrolled and dropping off due to re-verification friction. Ryan White HIV/AIDS Program services, Title X reproductive health, and federally qualified health centers (FQHCs) are already funded and available — but bi+ POC are underrepresented as users because intake systems don't signal those spaces are for them. **The resource exists. The bridge doesn't.** Use HRSA's Find a Health Center tool (findahealthcenter.hrsa.gov) and share it within community.
Why it's achievable: No policy change needed. Can start today with a link and a conversation.
- 02 Advocate for intake form reform at a single clinic**
Replacing identity-only checkboxes with **behavior-based questions** — "What are the genders of your current and recent partners?" alongside "How do you identify?" — doesn't require legislation or system-wide buy-in. It requires one clinical director making one decision. A community health center, FQHC, or Title X clinic could pilot it. **The Bridge Coalition self-assessment tool is the entry point** for this conversation. The barrier is awareness, not resources. This is the most direct intervention against delay of care.
Why it's achievable: One person, one meeting, one form revision. Replicable if it works.
- 03 Find a bi-affirming, culturally responsive provider**
Use the **GLMA Provider Directory** (glma.org) or **SAMHSA's Behavioral Health Treatment Locator** to filter for LGBTQ+-affirming and culturally responsive clinicians. You have the right to disclose your orientation on your own terms — you do not have to disclose to receive care. Telehealth has expanded access to affirming providers regardless of geography. For mental health support specifically: **988 Suicide & Crisis Lifeline** (call or text 988) has LGBTQ+-specific support. Bisexual Resource Center: biresource.net.
Why it's achievable: Free directories exist now. Telehealth removed the geography barrier.

Sources: Gallup LGBTQ+ Identification 2024-25 · CDC NISVS · Badgett et al. / BRFSS 2014-17 · MAP Invisible Majority (2016) · Williams Institute, Medicaid & LGBT Adults May 2025 · Center for American Progress, LGBTQ+ Community Survey 2024 · Science Policy Review: Decennial Review of Bi+ Health Disparities (2024) · KFF Survey on Racism, Discrimination & Health 2023 · U.S. Census Bureau Vintage 2025 · Brookings Institution 2025 · Bostwick et al. / PMC · HRC Bi Health Brief · NSVRC Disparities in Bi+ Health & Sexual Violence
Data note: No federal dataset cross-tabulates bisexual identity with race/ethnicity simultaneously. The ~6-7M Bi+ POC figure is a calculated estimate (MAP/BRFSS 35-36% POC share x Gallup 17.8M total), not a direct count. For educational purposes only — not a substitute for clinical care.