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Sexual Orientation, Health Insurance, and Domestic Partner Benefits: Evidence from Before and After California's AB205 Law

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Abstract

Sexual-orientation based health disparities are well-documented and may be due to unequal access to a partner's employer-sponsored insurance (ESI). We study a 2005 California law (AB205) requiring firms to treat same-sex partners equally to different-sex spouses with respect to ESI. Prior to reform, gay men and lesbians were significantly less likely to have ESI in someone else's name than heterosexuals. Pooling data from 2001 to 2007, we find that AB205 had no effects on gay/straight differences in health insurance for men but significantly increased partnership, reduced full-time employment, and increased health insurance coverage among lesbians relative to heterosexual women.

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I. Introduction

Disparities in access to health care as well as in health outcomes related to sexual orientation are well documented (see, for example, Institute of Medicine 1999, Cochran and Mays 2000, and others). While the disproportionate impact of the HIV/AIDS epidemic on the gay male community is well known, public health research has also shown that sexual minorities are at increased risk for cancer (e.g. Daling et al. 1987, Dibble et al. 1997), body weight problems (e.g. Carlat et al. 1997, Carpenter 2003), depression and other mental health disorders (e.g. Cochran and Mays 2000, Ferguson et al. 1999), substance use (e.g. Stall and Wiley 1988, Skinner and Otis 1996), and smoking (e.g. Stall et al. 1999, DuRant et al. 1998). Other work finds that lesbians are significantly less likely than other women to get routine preventive health care such as pap smears and breast cancer screenings (Robertson and Schachter 1981, Denenberg 1995) and that gay adults are significantly more likely than heterosexuals to report unmet medical needs and difficulty obtaining care (Diamant, Schuster and Lever 2000; Diamant, Wold, Spritzer, and Gelberg 2000).¹ However, the causes of these disparities are not well understood.

A low rate of insurance coverage among gay adults² is commonly cited as a primary reason for their reduced access, and indeed several recent studies document lower rates of insurance coverage for gay men and lesbians relative to heterosexual men and women (Diamant et al 2000, Cochran et al 2001, Harris Interactive/Witeck-Combs 2002, Ash and Badgett 2008, Heck et al. 2009, Buchmueller and Carpenter 2010). However, the data sources used in these existing studies have a number of limitations. Some use small, non-representative convenience samples. Other studies use nationally representative samples but are limited to adults in

¹ Elimination of these disparities has been identified as a major public health goal by Healthy People 2010 – the nation’s health promotion and disease prevention initiative (see, for example, the Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender Health, GLMA 2001).

² Throughout this paper we will sometimes use the terms “gay” or “gay couples” to refer to both gay men and lesbians. Because of data limitations, we can generally say very little about health insurance concerns unique to

partnered relationships and therefore provide no evidence on the insurance coverage of single individuals. All of the data sources used in existing studies have limited information on specific sources of coverage. This limits the policy relevance of the analyses, as the appropriate policy response, if any, to a gap in coverage will depend on the factors causing the gap.

One reason that sexual minorities might have lower rates of coverage is that employers have historically treated same-sex partners of employees differently than heterosexual spouses with respect to fringe benefits such as health insurance. Although same-sex domestic partner benefits have increased over time, many employers do not offer them, and in most states employers are not legally required to do so.

Government intervention with respect to health insurance benefits for same-sex partners has taken a variety of forms.³ Many state governments, for example, have extended a variety of fringe benefits – including health insurance – to the same-sex partners of government employees for several decades.⁴ More recently, the issue of same-sex partner benefits has been on the policy agenda in numerous states which have addressed this issue by legalizing gay marriage, civil unions, or some other domestic partner registration status within the state (e.g., New Jersey, Vermont, Massachusetts, California, and others). There has been no evidence, however, on whether and to what extent these laws have affected the disparity in health insurance between sexual minorities and heterosexual individuals.

bisexual or transgender persons, particularly in the context of domestic partner benefits; as such, we focus exclusively on gay men and lesbians.

³ Our study is also related to recent public policy activity at the state level to incrementally increase dependent coverage more generally, for example to adult children. Such a policy is one component of Massachusetts' landmark health reforms (Long, Yemane and Stockley 2010). Levine, McKnight, and Heep (2009) find that state laws increasing the age at which adult children can be covered under a worker's health insurance plan were associated with significant increases in health insurance coverage for the affected groups.

⁴ The practice varies across different branches of the US federal government but was made more complicated by the 1996 federal Defense of Marriage Act.

In this paper we fill this gap by examining differences in health insurance coverage related to sexual orientation in California using data from the California Health Interview Survey (CHIS) for the years 2001, 2003, 2005 and 2007. The CHIS has several advantages relative to other data sources that have been used by researchers in this area, including having large, representative samples and providing direct measures of sexual orientation as well as detailed information on sources of health insurance coverage. From a policy perspective, a key feature of our CHIS sample is that it provides data before and after the implementation of California's Domestic Partner Rights and Responsibilities Act—commonly known as AB205—which was passed in 2004 and took effect on January 1, 2005. AB205 gave same-sex domestic partners many of the same rights and responsibilities already afforded heterosexual married couples, including adoption rights, hospital visitation privileges, and equal state income tax treatment.⁵ One of the most important aspects of AB205 that we study here was a requirement that private organizations (including firms) within the state must treat same-sex couples in the same way as different sex couples. For employers, this means that any fringe benefits commonly extended to heterosexual spouses of employees must also be extended to same-sex partners of employees. In so doing, this policy had the potential to increase health insurance coverage among partnered gay men and lesbians.

Of course, this description raises several important considerations that may complicate empirical evaluations of AB205. First, since AB205 changed many other benefits besides just access to health insurance for partnered compared to non-partnered gay men and lesbians, it is

⁵ Federal benefits, of course, were unaffected. Note also that AB205 preceded California's short-lived period of gay marriage by three and a half years. On May 15, 2008, the California Supreme Court overturned the state's ban on same-sex marriage in the *In re Marriage Cases*, making gay marriage legal in California as of June 16, 2008. Gay marriage was ended by a state ballot initiative (Proposition 8) in the November 2008 election. The California Supreme Court upheld Proposition 8 in 2009, ruling that gays and lesbians who married between June and November would remain legally married, but any same-sex marriages after Proposition 8 were invalid. Our sample (2001-2007) entirely excludes this brief period when gay marriage was legal in the state.

plausible that partnership itself changed as a result of AB205. We can examine partnership directly in the CHIS, and a key feature of our analysis is that we test whether partnership rates changed appreciably for gays and lesbians relative to heterosexuals coincident with AB205 implementation. Second, AB205 may have changed the sources of health insurance coverage without changing overall rates of health insurance coverage by sexual orientation. For example, a partnered gay person who had previously purchased individual insurance may drop that coverage in favor of enrolling as a dependent on his or her partner's employer-sponsored plan. Or, some people may have been working simply to access health insurance benefits from an employer but may reduce employment in response to being able to access a partner's health insurance. In such cases we would not observe a change in the overall likelihood of having health insurance coverage, despite the fact that important behavioral changes occurred. We address these possibilities by examining the effects of AB205 on different labor market and health insurance outcomes, including the probability an individual works full-time and the probability an individual has health insurance in his or her own name versus someone else's name.

To preview, we find that the relationships among sexual orientation, partnership status and health insurance coverage differ in important ways between men and women and that these gender differences have important implications for the effect of AB205. In the years before AB205, partnered gay men were less likely than heterosexuals to receive ESI as a dependent than were partnered heterosexual men, though the difference was small. This result combined with relatively low rates of partnership for gay men suggest that the potential for laws like AB205 to increase health insurance coverage among gay men is limited. Indeed, a comparison of coverage

rates for the years just after AB205 went into effect and the years just prior to enactment suggest that the law had no discernable effect on the insurance coverage of gay men in California.

In contrast, pre-existing patterns of partnership and insurance coverage among women suggest a larger potential effect of AB205 on lesbians. In 2001 and 2003, lesbians were almost as likely to be in a partnered relationship as heterosexual women, but conditional on partnership they were much less likely to have ESI as a dependent. Lesbians were much more likely to have ESI in their own name, partly because they were more likely to work full-time than otherwise similar heterosexual women. We find evidence that after AB205 went into effect, the percentage of lesbians reporting being in a partnered relationship increased while the percent working full-time declined. The former result suggests that AB205 increased the perceived benefits of partnership, while the latter result is consistent with research showing that access to spousal health insurance coverage is negatively related to labor supply for married women (Olson 1998, Buchmueller and Valletta 1999, Wellington and Cobb-Clark 2000, Abraham and Royalty 2006, Kapinos 2009).

The remainder of this paper is organized as follows: Section II describes the relevant literature on sexual orientation and health insurance. Section III describes the CHIS data and the estimation framework. Section IV presents the results, and Section V concludes.

II. Literature Review and Institutional Details

Research on health insurance gaps by sexual orientation face formidable data challenges because most representative survey datasets do not include direct measures of sexual orientation at the individual level. Several researchers have attempted to overcome this data limitation by examining large datasets that allow identification of minority sexual orientation status indirectly

through information on household sex composition and intra-household relationships (since two men (women) living together in a married-like relationship are very likely to be gay (lesbian) (Carpenter 2005). Heck et. al. (2006) use data from the National Health Interview Surveys, Ash and Badgett (2003) use data from the Current Population Surveys, and Buchmueller and Carpenter (2010) use data from the Behavioral Risk Factor Surveillance System to document that individuals in same-sex relationships are significantly less likely to have health insurance than individuals in different-sex relationships.

A handful of studies have used individual level data on sexual orientation and health insurance. Diamant et. al. (2000), for example, use data from the 1997 Los Angeles Community Health Survey (LACHS) and find that sexual minority women are significantly less likely to be insured than heterosexual women. A 2002 report by Harris Interactive/Witeck-Combs reported that while only 70 percent of individuals who identified as gay, lesbian, bisexual or transgendered in an online survey reported that they had any health insurance, the associated figure for heterosexual adults was 86 percent. Both of these studies used pooled sample sizes of fewer than 200 sexual minorities, however, limiting their statistical precision. Finally, Cochran et. al. (2001) compare the insurance coverage rate for a convenience sample of lesbians with coverage rates from the National Health Interview Survey (NHIS), which does not ask direct questions about sexual orientation, with the idea that the vast majority of individuals in the NHIS are heterosexual. Based on this approach they conclude that lesbians are less likely to have health insurance than heterosexuals.

Despite these data limitations, several patterns from the literature emerge that are relevant for predicting the likely effects of a policy such as AB205. First, the evidence base for a disparity in insurance coverage is stronger for lesbians than it is for gay men. Multiple previous

studies have documented statistically significant differences in insurance coverage for lesbians compared to straight women (Diamant et. al. 2000, Cochran et. al. 2001), and studies that examine both men and women consistently find that the gap between lesbians and straight women is larger and statistically more precise than the associated gap between gay men and straight men (Heck et. al. 2006, Buchmueller and Carpenter 2010). Second, partnership rates among lesbians are closer to the associated partnership rates among heterosexual women than the similar comparison of partnership rates among gay men compared to straight men. Carpenter and Gates (2008), for example, use multiple representative sources of data from California and find that only about 30-40 percent of gay men are in partnerships, compared to almost 70 percent of straight men, while about 50-60 percent of lesbians are in partnership, compared to about 70 percent of straight women. Finally, previous research that has examined the effects of gay marriage or domestic partner registries in other contexts clearly indicate that lesbians are more likely to take advantage of these registration benefits than are gay men (Gates, Badgett, and Ho 2008, Badgett, Gates and Maisel 2008). These factors all suggest that AB205 has greater latitude for affecting sexual-orientation-based disparities in health insurance-related outcomes for females than males.

Partly due to data limitations, we know very little about the sources of health insurance coverage for gay men and lesbians, particularly when compared to the large body of research on sources of insurance for heterosexuals. The Harris Interactive (2002) report indicates that while only 3 percent of sexual minority individuals have health insurance through a partner, 14 percent of heterosexual adults report dependent ESI. Dependent coverage is an important source of health insurance for married women and to a lesser extent married men (Buchmueller 1996/1997, Farber and Levy 2000). Several studies suggest that access to ESI coverage through a spouse

has important effects on behavior. Married workers, especially women, are significantly more likely to decline coverage from their own employer when their spouse is offered ESI (Buchmueller 1996/1997, Zimmer 2009). There is also evidence that access to spousal insurance coverage is negatively related to labor supply among married women, as those who can be covered as a dependent do not need to work full-time to obtain health insurance (Olson 1998, Buchmueller and Valletta 1999, Wellington and Cobb-Clark, 2000, Abraham and Royalty 2006, Kapinos 2009).

The effect of a law like AB205 depends importantly on how common it is for employers to allow gay or lesbian employees to cover their partners as dependents on their health insurance in the absence of legislation. We know relatively little about the prevalence of such policies, though available evidence indicates that the practice of extending same-sex domestic partner health benefits is far from universal. Although a slight majority (57%) of Fortune 500 firms now offer health insurance benefits to same-sex partners of their sexual minority employees (HRC 2009), smaller firms are less likely to offer these benefits. A 2009 employer survey sponsored by the Kaiser Family Foundation, for example, indicated that among firms that offer any health insurance benefits, 36 percent of those with at least 200 employees and 20 percent of smaller firms also offer these benefits to same-sex domestic partners of their employees (KFF 2009).⁶ The study also revealed that same-sex domestic partner benefits were more prevalent in the West (40 percent of firms offering any health insurance also offered these benefits), followed by the Northeast (25 percent), the Midwest (15 percent), and the South (6 percent). By industry, the

⁶ Neither the HRC study nor the KFF study report availability of domestic partner benefits at the state level over time, so we are unable to directly assess whether AB205 changed employer benefits differentially in California relative to other states. Our approach (described below) therefore necessarily relies on reduced form comparisons of health insurance outcomes by source for gay men and lesbians compared to heterosexuals before and after AB205. It is important to note, however, that even if firms were offering domestic partner benefits prior to the reform, it is plausible that AB205 still had an effect if gays and lesbians viewed the benefits as uncertain or legally revocable prior to the reform (which they were).

employer survey found that state and local government employers were most likely to offer same-sex domestic partner benefits (58 percent), followed by: retail (45 percent) and service (24 percent) industries. The rate was less than ten percent in agriculture/mining/construction and wholesale industries.

In summary, there is a fair amount of evidence that gays and lesbians are less likely to have health insurance than heterosexuals, and some evidence suggesting that a source of this disparity is reduced access to a partner's ESI. Same-sex domestic partner health insurance benefits were far from universal in the period prior to the AB205 reform, suggesting a potential role for the law to increase access to a partner's ESI. In addition to changes in insurance, previous research on dependent ESI among heterosexuals suggests that labor supply effects are also possible. Finally, several considerations suggest that any effects are likely to be larger for lesbians than for gay men, including the much higher prevalence of partnership among lesbians.

III. Data and Empirical Approach

Our outcome data for this study are the 2001, 2003, 2005, and 2007 waves of the California Health Interview Surveys (CHIS). These surveys are administered by telephone to over 40,000 households using RDD methods in each year. The CHIS data provide detail on both the type (e.g., public, ESI, private non-group) and source (e.g., own name, as a dependent) of coverage for each respondent, as well as standard demographic characteristics (age, race, ethnicity, education, urban residence) and information on respondents' employment.⁷

⁷ The CHIS data also include some information on job characteristics, but this information is limited because the industry and occupation codes changed substantially from 2001 to 2003, such that they are not comparable across these periods. Also, industry and occupation information was not collected for the 2007 survey. We therefore are limited in what we can say about the importance of occupation in accounting for observed differences in insurance coverage by sexual orientation. Note also that because the CHIS is an individual level (not a household level) survey, we only observe information on the respondent. As such, we do not observe information on the employment

Importantly, these data also provide information on self-reported sexual orientation for all adults.⁸ Individuals in the 2001 CHIS, for example, were asked “Are you gay, (lesbian) or bisexual?”⁹ Since 2003, the CHIS has asked adults: “Do you think of yourself as straight-heterosexual, gay (lesbian), or bisexual?”¹⁰ Throughout this analysis, we drop individuals who report being bisexual.¹¹

We consider several outcomes related to health insurance coverage and its sources. Individuals in the CHIS are asked a series of detailed questions regarding whether they are covered by a variety of specific sources, such as Medicare, Medicaid (MediCal in California), employer plans, or other individually purchased plans. We use the CHIS recoded responses to create several indicator variables, including: Any Insurance (equal to one if the individual reports being covered by health insurance from any source and zero otherwise); Medicaid (equal to one if the individual reports being covered by Medicaid and zero otherwise); ESI (equal to one if the individual reports being covered by an employer-based insurance plan and zero otherwise); and

or insurance coverage of partners or other household members. In some years the CHIS included questions about spousal employment status, but these questions were not consistently asked for partnered gay men and lesbians.

⁸ We restrict attention to 25-64 year olds to focus on a period after most people have completed their education.

⁹ The 2001-2007 CHIS identified over 2,900 gay men and lesbians age 25-64. For privacy reasons, the question on sexual orientation is not available in the public use CHIS data file, though we have obtained access to these data through a confidential data agreement with the UCLA Data Access Center at the Center for Health Policy Research. Due to concerns about question wording (see, for example, Carpenter 2005) and the translation of the sexual orientation terms, we drop individuals who report that they speak English “not well” or “not at all”.

¹⁰ If the individual did not immediately volunteer an answer, the interviewer was directed to read the following statement: “Straight or heterosexual people are attracted to, or have sex with, people of the opposite sex; gays/lesbians are attracted to, or have sex with, people of the same sex; and bisexuals are attracted to, or have sex with, people of both sexes.” We drop a very small share of individuals who report they do not know their sexual orientation or who refused a response to the sexual orientation question

¹¹ Although these groups are independently interesting, bisexual is not a well-defined concept when studying policies related to same-sex partner benefits since we do not observe the sex of any respondent’s partner. This is because CHIS does not include a complete household sex roster. Note that this is also a potential problem for gay and lesbian adults, though we make the reasonable assumption that individuals who self-identify as gay or lesbian and who concurrently report their marital status as “living with partner” do, in fact, have a same-sex partner. Note that AB205 was almost exclusively about same-sex partner benefits and did not generally include provisions for different-sex partner benefits.

Individually Purchased Insurance (equal to one if the individual reports having a private non-group health insurance plan and zero otherwise).¹²

We begin by comparing regression-adjusted differences in insurance coverage (overall and by source), restricting attention to the period prior to AB205 (i.e. the 2001 and 2003 CHIS waves). This is an independently interesting and valuable descriptive exercise, since in many ways our large samples of population-based data with detailed information on source of insurance coverage improve on previous research that has used much smaller and geographically isolated samples, convenience samples, or couples-based samples and that has focused mainly on overall differences in insurance coverage. Specifically, we estimate the following model using OLS:

$$(1) Y_i = \alpha + \beta_1 X_i + \beta_2 (GAY/LESBIAN)_i + \varepsilon$$

where *GAY/LESBIAN* is an indicator variable equal to one for individuals reporting a gay or lesbian sexual orientation and *X* is a vector of demographic variables that includes: age and its square, 4 education dummies (less than high school, some college, bachelors degree, and masters/PhD degree, with high school degree as the excluded category), 4 race/ethnicity dummies (black, Hispanic, Asian/Pacific Islander, and other multiple race, with white as the excluded category), a dummy for being married or living with a partner¹³, and 5 dummies for urban location (second city, suburban, small town, rural, and urban status not ascertained, with

¹² We do not separately examine the very small share of individuals who report having CHIP (the public health insurance program targeted to children), Medicare, or “other public” insurance, though we do not exclude them from the analysis.

¹³ Specifically, the CHIS asks: “Are you now married, living with a partner in a marriage-like relationship, widowed, divorced, separated, or never married?”. A small number of gay men (34) and lesbians (25) reports being “married”, despite the fact that gay marriage was not legal in California until June 2008. Absent a household sex roster, we are unable to determine whether these are “closeted” heterosexuals, sexual minorities who were legally married in another jurisdiction (e.g., Canada), or sexual minorities who consider themselves to be effectively married. See Carpenter and Gates (2008) for a discussion of these issues. We do not exclude them from the current analysis, but we note they constitute a very small share of the gay and lesbian samples (2 and 2.5 percent, respectively).

urban location as the excluded category). The error term ε is assumed to iid, and we estimate models separately for males and females.

We then use the full pooled 2001-2007 CHIS sample to test whether AB205 differentially affected outcomes for gay men and lesbians relative to heterosexual individuals by examining how outcomes changed for this group relative to heterosexuals after the enactment of AB205 in 2005. This difference-in-differences (DD) model takes the form:

$$(2) Y_i = \alpha + \beta_1 X_i + \beta_2 (GAY/LESBIAN)_i + \beta_3 (POST\ AB205)_i + \beta_4 (GAY/LESBIAN * POST\ AB205)_i + \varepsilon$$

where *POST AB205* is an indicator variable equal to one for observations after the implementation date of the law (January 1, 2005), all other variables are as described above, and ε is again assumed to be a well-behaved error term. We again estimate models separately for males and females. The coefficient of interest is β_4 and represents the relative effect of AB205 on outcomes for gays and lesbians compared to heterosexuals. The key identifying assumption in this simple DD model is that there were no other shocks to relative outcomes over this period for gays and lesbians relative to heterosexuals.¹⁴

Finally, we note that the distribution of interview dates in the CHIS is far from uniform in a way that is fortuitous for our research design. Recall that AB205 was introduced and passed in 2003; Governor Gray Davis signed the law on September 19, 2003. The law was explicitly set to take effect January 1, 2005. Since insurance policies are generally revised in the fall to take effect the following calendar year, we expect that individuals would have seen the new benefits

¹⁴ Note that an alternative strategy for evaluating AB205 would be to use partnership status as an additional treatment status in a triple differences framework, since AB205 changed access to ESI for partnered gays and lesbians only. A limitation of this approach is that if partnership itself was affected by AB205, a triple difference model is inappropriate because of composition changes in the treatment and control groups coincident with the policy of interest. Indeed, we show below that there is evidence that partnership increased among lesbians relative

beginning in calendar year 2005. The 2005 CHIS interviews did not begin until July 2005 and actually continued into March and April of 2006. This means that there should have been ample time for individuals to have responded to the new benefits in the 2005 data (i.e., the 2005 CHIS wave is legitimately “after” AB205). All 2007 CHIS interviews were completed from June 2007 to March 2008, just before the California Supreme Court unexpectedly legalized same-sex marriage.

IV. Results

We begin by presenting descriptive evidence on the relationships among sexual orientation, health insurance, and sociodemographic characteristics from the pooled 2001-2007 CHIS in Table 1. These data reveal that over the full sample period, gay men are nearly as likely to have any health insurance as straight men, and the same is true for lesbians relative to straight women. There are, however, important differences in the sources of coverage. Table 1 also shows that gay men are somewhat more likely to have individually purchased (i.e. non-group) insurance and Medicaid compared to straight men. The higher rate of individually purchased insurance for gay men is interesting in light of common perception and past research suggesting discriminatory practices related to a minority sexual orientation in the individual insurance market.¹⁵ Finally, gay men and (especially) lesbians are far less likely to have ESI in someone else’s name compared to straight individuals, though the difference for lesbians is exactly offset by a much higher rate of own-name ESI compared to heterosexual women. This is likely related

to heterosexual women coincident with AB205, which is not surprising given that the policy increased many benefits to same-sex partnership. Given these changes in partnership, we do not report triple differences estimates..

¹⁵ Zellers, McLaughlin and Frick (1992) describe underwriting practices whereby insurers “redline” certain occupations disproportionately likely to have gay workers, such as male-owned beauty shops and hairdressers. Since 1993, such practices have been limited in California’s small group health insurance market. According to reforms enacted that year, coverage for small groups (3 to 50 employees) must be sold on a guaranteed

to the well-documented fact that lesbians have much higher labor force attachment compared to straight women (Antecol et. al. 2009).

The patterns for the sociodemographic characteristics are basically identical to those that have been reported previously using earlier waves of these data (Carpenter 2005, Carpenter and Gates 2008) and are also similar to patterns from other large, representative datasets (Black et. al. 2000, Black et. al. 2007), so we do not describe them in detail here. Briefly, the CHIS data reveal that the gay and lesbian samples are disproportionately white and highly educated compared to heterosexual individuals. Sexual minorities are also less likely to be partnered than straight individuals, and these patterns differ markedly for men and women: while the sexual orientation-related difference in the partnership probability among women is only about 11 percentage points, the associated difference among men is almost three times larger. The fact that only 40 percent of gay men are in a partnership in the 2001 and 2003 CHIS data highlights the potential limits of a domestic partner benefits policy to affect gay/straight differences in outcomes for men.

Table 2 also presents descriptive statistics from the CHIS but, in order to provide a sense of the potential impact of AB205, it differs from Table 1 in two key ways. First, we only use data from the 2001 and 2003 surveys to describe the situation facing gays and lesbians relative to heterosexuals prior to the domestic partner benefits reform (note that the raw means in Table 1 will include any true effects of AB205 on outcomes). Second, we break out the health insurance and employment information separately by partnership status and sexual orientation. Since the ESI provision of AB205 pertains only to partnered gays and lesbians, these comparisons may be

| issue/guaranteed renewal basis, and the amount by which premiums can vary according to risk is limited (Buchmueller and Jensen 1997). There are no such regulations in California's individual market, however.

instructive about the potential effects of AB205 on outcomes (keeping in mind that partnership is arguably endogenous).

The patterns in Table 2 largely confirm the patterns observed in Table 1, with some interesting nuances. First, we find that partnered gay men are slightly less likely to have any health insurance compared to partnered straight men, and this pattern is reversed for non-partnered gay men compared to non-partnered straight men. Regardless of partnership status, gay men are more likely to have non-group insurance. These differences are small in magnitude, but larger in percentage terms relative to the overall percentage purchasing non-group private insurance. Table 2 also indicates that non-partnered gay and heterosexual men are both more likely to have Medicaid compared to their partnered male counterparts. Lesbians have lower rates of health insurance coverage regardless of partnership status, though again the differences are small in magnitude. Non-partnered heterosexual women are much more likely to have Medicaid (fully 17.5% of these women have Medicaid) than either partnered heterosexual women or lesbians, regardless of partnership status.

With respect to own-name ESI, we find that non-partnered gay men are more likely than non-partnered straight men to have this type of coverage, while partnered gay men are slightly less likely than partnered straight men to have own-name ESI. Among non-partnered women, there is no strong difference in own-name ESI related to sexual orientation, but partnered lesbians are much more likely to have own-name ESI than partnered heterosexual women. As expected, partnered straight men are much more likely to have ESI in someone else's name than non-partnered straight men; there is a similar, though smaller difference between partnered and non-partnered gay men. This pattern is much more pronounced for women. Partnership is positively related to dependent ESI coverage for both lesbians and heterosexual women, though

the magnitude of the partnership difference in dependent ESI is much larger for heterosexual women.

Finally, Table 2 also shows full- and part-time labor force participation rates by sexual orientation and partnership. For men, partnered individuals are more likely to be full-time workers than non-partnered individuals regardless of sexual orientation. There is almost no difference in labor force participation between partnered and non-partnered lesbians, though partnered heterosexual women are far less likely to be full-time workers compared to non-partnered heterosexual women. Again, this difference is likely related to the fact that lesbians are more likely to have own-name ESI coverage and less likely to have dependent coverage compared to heterosexual women.

In Tables 3a and 3b we ask whether the patterns in Table 2 survive regression adjustment for observable demographic characteristics which have been shown in previous research to be independently associated with health insurance and its sources. As in Table 2, we restrict attention to data from the 2001 and 2003 CHIS to describe the relative situation of gays and lesbians before the AB205 reform. The format of Table 3 is as follows: each entry is from a separate estimation of equation (1) and includes controls for the gay/lesbian indicator (reported) as well as age, race, ethnicity, education, and urban location. Each panel (row) is for a different outcome, and each column is for a different sample. Columns 1-3 present results for all males, non-partnered males, and partnered males, respectively. Columns 4-6 present results for all females, non-partnered females, and partnered females, respectively.

In the top panel for the outcome indicating any health insurance, we see that the patterns observed in Tables 1 and 2 for males are confirmed when we control for observable characteristics: gay men are actually estimated to be 2 percentage points more likely to have any

health insurance in the full sample, though the estimate is not statistically significant. The full sample results masks significant differences by partnership status, which are offsetting. Among non-partnered males, gay men are significantly more likely to have insurance from any source, but among partnered males, the difference goes in the opposite direction. Moving down the rows for men, we see that after controlling for observable characteristics, gay men are significantly more likely than straight men to have non-group insurance and Medicaid but are less likely to have dependent ESI coverage. For partnered men, we find that gay men are significantly less likely to have both own-name and else-name ESI coverage compared to similarly situated straight men, and they are also significantly more likely to have Medicaid.

For women, the regression-adjustments have more meaningful effects on the comparisons between lesbians and straight women. For example, in the top panel of Table 3 for females we see that lesbians are 5 to 6 percentage points less likely to have health insurance from any source compared to straight women, and all of the estimates in columns 4-6 (for the full sample, non-partnered women, and partnered women, respectively) are statistically significant at conventional levels. Like the patterns for males these overall gaps are notably larger than the raw differentials observed in Tables 1 and 2 for females, which is not surprising given that lesbians are more likely than straight women to be white and highly educated—characteristics that are consistently positively associated with health insurance.

Turning to sources of coverage in the regression-adjusted models, we find a significant difference in Medicaid rates, which accounts for the majority of the lesbian/straight gap in any health insurance among non-partnered women. The bottom two panels of columns 4-6 confirm that the large differences in own-name and else-name insurance coverage for partnered women are borne out in the regression-adjusted models. Specifically, we find that among partnered

women, lesbians are 24.4 percentage points more likely than straight women to have ESI in their own name but are 29.5 percentage points less likely to have ESI in someone else's name. Differences in these sources among non-partnered women are much smaller and not significant, resulting in full-sample lesbian/straight differences in the sources of ESI that are also large and statistically significant (bottom two panels of column 4, Table 3).¹⁶

Overall, then, the data reveal a consistent picture of the situation facing gays and lesbians relative to heterosexual individuals prior to the AB205 reform. Among men, differences in any health insurance coverage were modest: although gay men were less likely to have dependent ESI, they were more likely to have individually purchased insurance and Medicaid. Moreover, partnership prevalence among gay men was low (about 40%), meaning that the potential role for AB205 to affect relative outcomes for men is limited. Among women, we find larger and statistically significant differences in insurance coverage associated with sexual orientation, largely due to a much lower likelihood for partnered lesbians to have dependent ESI compared to partnered straight women and a lower likelihood for non-partnered lesbians to have Medicaid compared to non-partnered straight women. While the Medicaid differential is unlikely to be affected by a domestic partner benefits policy (since it is concentrated among non-partnered women and because no Medicaid rules changed due to AB205), the large differences in the source of ESI are potentially a target of AB205 if partnered women were constrained due to lack of legal rights to access a same-sex partner's ESI. Moreover, the high rates of partnership among

¹⁶ In Appendix Table 1 we provide a detailed set of coefficient estimates for the outcome indicating the individual has any health insurance (coefficient estimates for other outcomes are available upon request). Results conform to predictions and previous literature, including: older individuals are more likely to have health insurance, though at a decreasing rate; highly educated individuals are more likely to have health insurance; racial and ethnic minorities are generally less likely to have health insurance; and partnered individuals are more likely to have health insurance than individuals without these characteristics.

lesbians (nearing 60 percent) also increase the latitude for a policy such as AB205 to have meaningful effects on outcomes.

We now turn to a direct evaluation of AB205. Specifically, we estimate difference-in-differences models (i.e., equation 2) that compare changes in outcomes for gay men and lesbians (the treatment groups) before and after AB205 to the associated changes in outcomes for heterosexual men and women (the control groups), respectively. Before turning to health insurance-related outcomes, however, we first examine in Table 4 a range of other outcomes that may speak to the appropriateness of our research design and to other behavioral changes that may have been due to AB205. The format of Table 4 is as follows: the top panel presents results for males, and the bottom panel presents results for females. Each column within each panel is from a separate regression that includes the standard demographic controls, and we report the relevant coefficients on the *GAY/LESBIAN*, *POST AB205*, and the interaction of these two indicators. The coefficient of primary interest in the DD models is the one on the interaction term.

We begin Table 4 in column 1 with an examination of partnership probabilities. Recall that AB205 changed several aspects of the benefits and costs of partnership for gays and lesbians, not just potential access to a partner's ESI. These other changes included: tax liability, parenting rights, and hospital visitation rights, among others. It is plausible, then, that partnership itself changed in response to AB205. Since one research design to test for differences in health outcomes surrounding AB205 would be to use partnership as a treatment/control group margin (i.e., to compare partnered gay men with non-partnered gay men versus partnered straight men with non-partnered straight men before versus after the law

change), it is necessary to examine changes in partnership itself.¹⁷ If we found that AB205 changed partnership substantially, this would raise concerns about composition biases in triple differences estimates of the effects of AB205 that used partnership as a treatment margin.

Indeed, we find evidence that AB205 increased partnership among lesbians. The bottom panel of column 1 indicates that in 2001-2003, lesbians were about 15 percentage points less likely to be in a partnership. The coefficient on the AB205 dummy indicates that for heterosexual women partnership remained stable between this early period and 2005-2007. The coefficient on the interaction term, however, suggests that lesbians were 7.6 percentage points more likely to be in a partnership following AB205 compared to the associated change for heterosexual women. This estimate is statistically significant at the ten percent level; relative to the pre-existing partnership figure for lesbians it represents an increase of about 14 percent.¹⁸ The interaction term coefficient for gay men is also positive but smaller in magnitude (suggesting a 1.6 point increase) and is statistically insignificant. However, because the relevant partnership figure for gay men was only around 40 percent, this point estimate does represent a nontrivial increase in partnership. These results suggest that it would be problematic to use

¹⁷ We also examined the probability an individual reports being gay or lesbian (in a simple pre/post model with no treatment/control setup). Although we have no reason to believe that people were more likely to self-identify as gay or lesbian following AB205, one would worry about composition bias to our treatment group if there were changes in these identities over the sample period. In results not reported but available upon request, we confirmed that there were no such changes. We estimate that males were .05% more likely to report being gay after AB205 was adopted while females were .01% more likely to report being lesbian. While we do not have a great deal of power with this test (since only about 1-2 percent of the full sample identifies as gay or lesbian), the fact that the point estimates are very small in magnitude reduces concerns that our treatment group suffers from composition bias over the AB205 period.

¹⁸ One possible concern with the partnership estimates is that legal recognition of gay and lesbian couples via AB205 could have changed the way some couples see their relationship and thus how they would respond to the marital status question, even in the absence of any true behavioral changes with respect to partnership. This concern would seem to be mitigated given the wording of the marital status question, which we use to define partnership. Specifically, the question refers to being “married” or “living with a partner in a marriage-like relationship”. Since the question in each wave has referred objectively to cohabitation, the main way a reporting bias would produce the observed results for lesbians is if couples previously did *not* see their relationships as ‘marriage-like’. Carpenter and Gates (2008) use data prior to AB205 to describe lesbian relationships and find that a large proportion of them are officially registered with state or local governments and that they are substantial in duration. These patterns suggest that the partnership estimates are likely to reflect true behavioral changes instead of spurious reporting effects.

partnership as a treatment margin in a triple differences framework to evaluate the effects of AB205 on outcomes, particularly for women.

In the next two columns of Table 4 we perform the related exercise for the probability an individual is employed at all (column 2) and the probability an individual is employed full-time (column 3). While we find small and statistically insignificant estimates for the coefficients of interest for men, we do find in the bottom panel of column 3 for women that lesbians were 7.1 percentage points less likely to be working full-time following AB205 compared to the associated change for heterosexual women. This reduction in full-time employment is marginally significant at the ten percent level and could represent the alleviation of suboptimal labor force decisions associated with the new ability to access a partner's ESI; we will return to this possibility later.

In Table 5 we turn to a direct examination of the effects of AB205 on insurance coverage using a difference in differences framework that compares changes in outcomes for gays and lesbians surrounding AB205 to the associated changes in outcomes for straight men and women, respectively. The format of Table 5 follows that of Table 4, except the outcomes differ in each column. In column 1 we show results for the probability an individual has any insurance; in column 2 for individually purchased insurance; in column 3 for Medicaid; in column 4 for own-name ESI; and in column 5 for else-name ESI. Again, the coefficients of interest are those on interaction terms of the *GAY/LESBIAN* indicator with the *POST AB205* indicator. All models include the same demographic controls.

The results in Table 5 suggest that AB205 had essentially no meaningful effect on health insurance outcomes overall or by source for gay men relative to straight men. All of the interaction terms are small and statistically insignificant; moreover, the most plausible channel

through which AB205 should have improved outcomes for gay men relative to straight men—increased access to a partner’s ESI—is contradicted by a negative interaction coefficient, suggesting that gay men were actually *less* likely to have ESI in someone else’s name following AB205 relative to the associated change for heterosexual men.¹⁹

For females, in contrast, we find evidence that AB205 helped to close the gap in health insurance coverage. We estimate that lesbians were 7.6 percentage points more likely to have insurance following AB205 compared to the associated change for heterosexual women. This estimate is statistically significant at the five percent level. While none of the interaction terms for the sources of coverage are individually statistically significant, the coefficient on the *LESBIAN* times *POST AB205* variable for ESI in someone else’s name is positive and sizable in magnitude (suggesting a three percentage point increase for lesbians relative to straight women over this period) with a p-value of about .16. The evidence therefore indicates that AB205 increased health insurance coverage for lesbians relative to straight women, with a suggestive indication that one of the mechanisms was an increase in access to a partner’s ESI.

In Table 6 we explore the behavioral links between health insurance and employment more directly by examining outcomes that jointly indicate insurance and work. The format of Table 6 again follows Tables 4 and 5, with results for males in the top panel and for females in the bottom panel. In column 1 we report results for an outcome equal to one if the individual is a full-time worker and has ESI in her own name; in column 2 we examine an indicator for part-time work and ESI in someone else’s name, and in column 3 we examine an indicator for not working and having ESI in someone else’s name. If AB205 induced some women to reduce

¹⁹ In results not reported but available upon request we also ran the triple difference models for outcomes for men, since the composition biases from partnership changes in response to AB205 appear to be smaller than for women (as indicated in Table 4). These models were similarly inconclusive and produced no consistent evidence that AB205 improved health insurance outcomes for partnered gay men.

work effort due to increased access to a partner's ESI, we should expect to see reductions in the probability a woman works full-time and has ESI in her own name and increases in the probability she is working either part-time or not at all and has ESI in someone else's name.²⁰ Indeed, we observe this pattern in the bottom panel of Table 6 for females. While none of the individual interactions is statistically significant, the coefficients of interest in columns 1 and 2 are both of the predicted sign and plausible in magnitude. For males in the top panel, we find smaller and wrong-signed interaction estimates, though recall there was no evidence from Table 5 that AB205 improved health insurance outcomes for gay men relative to heterosexual men.

V. Conclusion

Sexual orientation-based disparities in health outcomes are well-documented, and eliminating these disparities is an explicit goal of national health policy (Healthy People 2010). A difficulty in reducing such disparities, however, is that the causes of sexual orientation-based differences in health are not well understood. Disparities in health insurance coverage by sexual orientation have been documented using a variety of samples and methods and may contribute to differences in health outcomes. One plausible cause of these health insurance disparities is that sexual minorities face barriers to accessing a same-sex partner's health insurance benefits due to the historic employer practice of covering heterosexual spouses but not same-sex partners. This possibility has received some attention in the literature (Ash and Badgett 2006) and is consistent with previous descriptive research using couples-based samples (Heck et. al. 2006, Buchmueller and Carpenter 2010) but has not been directly evaluated using quasi-experimental methods.

²⁰ Note that in this scenario we would not expect to see overall increases in the probability of having any health insurance (which we do observe in Table 5), but instead would observe a shifting of sources. The increase in the probability of having any insurance could only therefore work through the channel of increased access to a partner's ESI if the partner was previously uninsured. Again, however, we do not observe the insurance status of the partner.

Recently, several states have adopted laws giving gay and lesbian couples increased rights, including (in some states) the right to access a partner's employer-sponsored insurance. Our study provides the first evaluation of such a law in California by using difference-in-differences methods to compare outcomes for gay men and lesbians before and after implementation of AB205 with the associated differences for heterosexual men and women, respectively.

To summarize, we find that in the years prior to California's reform gay men and lesbians were significantly less likely to have ESI in someone else's name (i.e., dependent coverage) than were heterosexual men and women, respectively. These differences, however, were largely offset by higher rates of insurance coverage for sexual minorities from other sources. Gay men were more likely than straight men to have Medicaid and non-group insurance, while lesbians were more likely than straight women to have own-name ESI. These descriptive differences prior to AB205 are independently interesting because they improve on limitations of previous work by: 1) using larger samples of sexual minorities; 2) examining individuals instead of couples; and 3) providing detailed information on differences by source of insurance.

We then provide the literature's first quasi-experimental evidence on a statewide domestic partner benefits law using data from 4 years before and 4 years after the implementation of AB205 (which took effect January 1, 2005). Our difference-in-differences results for men returned no evidence that AB205 had economically or statistically significant effects on gay/straight differences in insurance coverage overall or by source. We similarly find no evidence that AB205 affected partnership or work effort by gay men. These null findings are not particularly surprising given previous research showing low rates of partnership among gay men and low rates of official domestic partner registrations conditional on partnership among gay men (Carpenter and Gates 2008, Badgett, Gates, and Maisel 2008).

Among women, we do find evidence that AB205 affected outcomes differentially for lesbians compared to heterosexual women. First, we show that partnership rates increased and full-time employment decreased for lesbians compared to heterosexual women coincident with AB205. These effects are large in magnitude, which suggests that it is inappropriate to compare outcomes for partnered and non-partnered lesbians before and after the reform due to composition problems associated with partnership. The differences in the effects of AB205 on partnership for gay men versus lesbians are consistent with the limited evidence from administrative sources that indicates that two-thirds or more of sexual minorities who take advantage of domestic partner registries are lesbians. Turning to health insurance outcomes, we find in the DD framework that lesbians were significantly more likely to have any health insurance coverage after AB205 compared to straight women, with sizable but imprecisely estimated increases in dependent coverage. Overall, our results suggest a potential role for policies such as AB205 to increase health insurance coverage for lesbians.

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Table 1. Descriptive Characteristics, CHIS 2001-2007

	(1) Gay males	(2) Straight males	(3) Lesbians	(4) Straight females
Has any insurance	.850 (.016)	.867 (.003)	.887 (.016)	.900 (.002)
Has individually purchased insurance	.102 (.011)	.061 (.002)	.068 (.009)	.074 (.001)
Has Medicaid	.085 (.009)	.061 (.002)	.073 (.011)	.091 (.002)
Has ESI in own name	.595 (.019)	.611 (.003)	.641 (.022)	.443 (.003)
Has ESI in someone else's name	.038 (.006)	.115 (.002)	.073 (.010)	.279 (.003)
Age	41.2 (.034)	42.9 (.075)	42.9 (.422)	43.5 (.064)
White	.525 (.019)	.451 (.003)	.523 (.024)	.454 (.003)
Black	.051 (.008)	.050 (.001)	.046 (.010)	.060 (.001)
Latino	.082 (.011)	.121 (.002)	.072 (.012)	.106 (.002)
Asian/Pacific Islander	.057 (.009)	.085 (.002)	.022 (.007)	.089 (.002)
Less than HS degree	.030 (.007)	.083 (.002)	.031 (.007)	.071 (.002)
HS degree	.151 (.016)	.230 (.003)	.137 (.015)	.222 (.002)
Some college	.264 (.017)	.260 (.003)	.263 (.021)	.298 (.003)
College degree or more	.555 (.019)	.426 (.003)	.570 (.023)	.408 (.003)
Partnered (married or living with a partner)	.405 (.018)	.726 (.003)	.584 (.024)	.695 (.003)
Works full time	.691 (.017)	.778 (.003)	.690 (.021)	.522 (.003)
N	1783	47733	1140	67460

Notes: Author calculations, 2001-2007 CHIS, adults age 25-64.

Table 2. Health insurance outcomes by partnership status prior to AB205, CHIS 2001-2003

	(1) Non- partnered gay men	(2) Partnered gay men	(3) Non- partnered straight men	(4) Partnered straight men	(5) Non- partnered lesbians	(6) Partnered lesbians	(7) Non- partnered straight women	(8) Partnered straight women
Has any insurance	.857 (.021)	.864 (.026)	.759 (.007)	.906 (.003)	.799 (.034)	.890 (.027)	.855 (.005)	.922 (.003)
Has individually purchased insurance	.108 (.016)	.081 (.018)	.065 (.003)	.059 (.002)	.073 (.023)	.079 (.018)	.078 (.003)	.079 (.002)
Has Medicaid	.108 (.017)	.051 (.016)	.102 (.005)	.047 (.002)	.069 (.019)	.040 (.015)	.175 (.005)	.057 (.002)
Has ESI in own name	.619 (.026)	.611 (.036)	.543 (.008)	.646 (.005)	.599 (.041)	.655 (.036)	.571 (.006)	.381 (.004)
Has ESI in someone else's name	.012 (.007)	.093 (.021)	.018 (.002)	.150 (.004)	.016 (.007)	.110 (.023)	.027 (.002)	.395 (.004)
Works full time	.672 (.026)	.721 (.034)	.670 (.008)	.817 (.004)	.710 (.036)	.728 (.033)	.604 (.006)	.470 (.004)
Works part time	.109 (.018)	.082 (.021)	.085 (.005)	.048 (.002)	.068 (.016)	.079 (.019)	.112 (.004)	.146 (.003)
N	644	292	8372	16428	292	280	13493	21012

Notes: Author calculations, 2001-2007 CHIS, adults age 25-64.

Table 3. Regression-Adjusted Gaps in Health Insurance Coverage Overall and by Partner Status, 2001-2003 CHIS (Pre-AB205)

	(1)	(2)	(3)	(4)	(5)	(6)
		Males			Females	
Sample is →	All	Not partnered	Partnered	All	Not Partnered	Partnered
Outcomes are ↓						
Any insurance						
GAY/LESBIAN	.020 (.017)	.070** (.021)	-.063* (.026)	-.061** (.021)	-.069* (.034)	-.053* (.026)
R-Squared	.08	.05	.06	.05	.03	.06
Individually purchased						
GAY/LESBIAN	.027* (.012)	.029 [†] (.016)	.019 (.018)	-.011 (.014)	-.017 (.023)	-.007 (.018)
R-squared	.01	.03	.01	.01	.03	.01
Medicaid						
GAY/LESBIAN	.033** (.012)	.037* (.017)	.033* (.016)	-.020 (.013)	-.051* (.021)	.010 (.015)
R-squared	.07	.07	.06	.13	.15	.08
Own-name ESI						
GAY/LESBIAN	.003 (.023)	.035 (.027)	-.065 [†] (.036)	.124** (.028)	-.028 (.041)	.244** (.038)
R-squared	.04	.06	.03	.08	.08	.05
Else-name ESI						
GAY/LESBIAN	-.035** (.010)	-.005 (.007)	-.069** (.022)	-.167** (.016)	-.008 (.008)	-.295** (.024)
R-squared	.05	.00	.02	.16	.01	.02
N – all entries in column	26123	9038	17085	35134	13831	21303

Notes: *, **, *** indicate statistical significance at the 10, 5, and 1 percent levels, respectively. Robust standard errors below in parentheses. Each entry is from a separate regression. Models also include controls for: age and its square, race, education, and urban location.

**Table 4. Changes in partnership and employment surrounding AB205, 2001-2007
CHIS**

Outcome is →	(1) Partnered	(2) Employed at all	(3) Employed full-time
Males			
GAY	-.302** (.022)	-.067** (.018)	-.116** (.021)
POST AB205	.007 (.006)	-.000 (.005)	.008 (.006)
GAY*POST AB205	.016 (.035)	-.035 (.030)	.004 (.032)
R-squared	.07	.08	.09
N	49631	49631	49631
Females			
LESBIAN	-.153** (.027)	.100** (.020)	.169** (.024)
POST AB205	.003 (.005)	-.003 (.005)	.025** (.006)
LESBIAN*POST AB205	.076 [†] (.045)	-.032 (.034)	-.071 [†] (.039)
R-squared	.05	.05	.04
N	68797	68797	68797

Notes: *, **, *** indicate statistical significance at the 10, 5, and 1 percent levels, respectively. Robust standard errors below in parentheses. Each column within each panel is a separate regression. Models also include controls for: age and its square, race, education, and urban location.

Table 5. AB205 and changes in health insurance, 2001-2007 CHIS

	(1) Any insurance	(2) Individually purchased insurance	(3) Medicaid	(4) ESI in own name	(5) ESI in someone else's name
Males					
GAY	-.018 (.016)	.032** (.012)	.043** (.012)	-.029 (.021)	-.068** (.010)
POST AB205	-.006 (.005)	-.006 [†] (.003)	.004 (.003)	-.013 (.007)	-.001 (.004)
GAY*POST AB05	-.012 (.029)	.011 (.022)	-.009 (.018)	-.018 (.035)	-.012 (.013)
R-Squared	.06	.01	.05	.04	.01
N	49631	49631	49631	49631	49631
Females					
LESBIAN	-.072** (.021)	-.008 (.014)	-.006 (.013)	.150** (.028)	-.223** (.014)
POST AB205	-.010* (.004)	-.016** (.003)	.011** (.003)	.001 (.006)	-.015** (.005)
LESBIAN*POST AB205	.076* (.031)	-.003 (.018)	-.024 (.021)	.016 (.042)	.030 (.021)
R-squared	.03	.01	.10	.05	.03
N	68797	68797	68797	68797	68797

Notes: *, **, *** indicate statistical significance at the 10, 5, and 1 percent levels, respectively. Robust standard errors below in parentheses. Each column within each panel is a separate regression. Models also include controls for: age and its square, race, education, and urban location.

Table 6. AB205 and changes in employment and health insurance, 2001-2007 CHIS

	(1) FT worker & ESI in own name	(2) PT worker & ESI in someone else's name	(3) Not working & ESI in someone else's name
Males			
GAY	-.075** (.022)	-.003 (.003)	-.008 (.006)
POST AB205	-.006 (.007)	.001 (.001)	-.006** (.002)
GAY*POST AB05	.019 (.035)	-.002 (.005)	.0001 (.008)
R-Squared	.06	.00	.01
N	49631	49631	49631
Females			
LESBIAN	.169** (.028)	-.043** (.005)	-.106** (.010)
POST AB205	.012* (.005)	-.002 (.002)	-.011** (.004)
LESBIAN*POST AB205	-.024 (.044)	.012 (.010)	.0003 (.011)
R-squared	.04	.01	.01
N	68797	68797	68797

Notes: *, **, *** indicate statistical significance at the 10, 5, and 1 percent levels, respectively. Robust standard errors below in parentheses. Each column within each panel is a separate regression. Models also include controls for: age and its square, race, education, and urban location.

Appendix Table 1: Expanded set of coefficients, Outcome is any health insurance, CHIS 2001 and 2003 only

	(1) Males	(2) Females
GAY/LESBIAN	.020 (.017)	-.061** (.021)
Year 2003	-.007 (.006)	-.007 [†] (.005)
Age	.009** (.003)	.006** (.002)
Age squared	-.00008** (.00003)	-.00006* (.00002)
Less than HS degree	-.100** (.018)	-.085** (.015)
Some college	.034** (.010)	.023** (.006)
College	.084** (.009)	.060** (.006)
Masters/PhD Degree	.107** (.009)	.072** (.007)
Black	-.014 (.013)	.025** (.009)
Latino	-.051** (.011)	-.062** (.010)
Asian/Pacific Islander	-.019 [†] (.010)	.008 (.007)
Other/multiple race	-.018 (.020)	-.045* (.019)
Partnered (Married or living with a partner)	.120** (.008)	.065** (.005)
Secondary city	-.098 (.073)	.055 (.097)
Suburban	-.067 (.073)	.060 (.097)
Small town	-.059 (.073)	.081 (.097)
Rural	-.093 (.073)	.046 (.097)
Urban status not ascertained	-.126 [†] (.074)	.012 (.098)
Constant	.589** (.091)	.612** (.107)
R-squared	.09	.05
N	26123	35134

Notes: *, **, *** indicate statistical significance at the 10, 5, and 1 percent levels, respectively. Robust standard errors below in parentheses. Omitted categories are: year 2001, high school degree, white race, not partnered (i.e., never married, widowed, divorced, or separated), and urban location.