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The Effects Of Unequal Access To Health Insurance For Same-Sex Couples In California

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ABSTRACT Inequities in marriage laws and domestic partnership benefits may have implications for who bears the burden of health care costs. We examined a recent period in California to illuminate disparities in health insurance coverage faced by same-sex couples. Partnered gay men are less than half as likely (42 percent) as married heterosexual men to get employer-sponsored dependent coverage, and partnered lesbians have an even slimmer chance (28 percent) of getting dependent coverage compared to married heterosexual women. As a result of these much lower rates of employer-provided coverage, partnered lesbians and gay men are more than twice as likely to be uninsured as married heterosexuals. The exclusion of gay men and women from civil marriage and the failure of domestic partnership benefits to provide insurance parity contribute to unequal access to health coverage, with the probable result that more health spending is pushed onto these individuals and onto the public.

As the Patient Protection and Affordable Care Act of 2010 (PL 111-148) moves the United States toward a health care system of universal coverage, employer-sponsored health insurance will continue to be the main source of health care coverage for nonelderly employees and their spouses and families. At present, having access to employer-sponsored health insurance could be strongly tied to the legal institution of marriage. This article advances evidence that this is the case, and that as a result, nonmarried dependents of employed gay men and lesbians may end up bearing more of the costs of their health care than if they were married or otherwise eligible for full dependent coverage. It is uncertain to what extent this situation will be alleviated by the provisions of the health reform law that will take full effect in 2014.

Health Insurance Benefits

Central to the debate on benefit equality are factors affecting who has access to dependent employer-sponsored health insurance. Employees who are legally and heterosexually married have an advantage over those in registered or nonregistered domestic partnerships, in civil unions, or legally married to a same-sex spouse in obtaining insurance from employers that covers dependents. This happens in two ways.

ADVANTAGES FOR THE LEGALLY, HETEROSEXUALLY MARRIED First, many employers do not offer coverage for an employee's unmarried domestic partner, civil-union spouse, or legal same-sex spouse, regardless of state laws calling for equal insurance treatment of same-sex partners. And when employers do offer same-sex partner/spousal coverage, there are often unequal eligibility rules, such as requiring cohabitation of varying duration and proof of financial entwinement.¹ Heterosexual married couples do not face such scrutiny and are free to live in

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separate households should career or other needs require it.

Second, in contrast to benefits acquired through heterosexual marriage, the federal and most state governments treat dependent benefits for domestic partners, civil-union spouses, and same-sex spouses as taxable earned income. This means that dependent coverage for same-sex partners is not equivalent in price to insurance provided for heterosexual married partners.² Even in states with equal marriage laws or civil union/domestic partner protection, the Defense of Marriage Act (DoMA) of 1996 keeps the federal government from recognizing same-sex couples' marriages.³ Thus, all same-sex couples face a federal income tax burden on dependent employer-sponsored health coverage, and sometimes a state income tax burden as well, regardless of their marital or partnership status under state law.⁴

This privilege accorded dependents with legally married heterosexual status in employer-sponsored health insurance has a direct impact on adults in same-sex durable relationships. Effects on unmarried heterosexual employees in partnered relationships are mitigated by the option of marriage to access dependent insurance benefits, if the burden becomes too great.

COST IMPLICATIONS To the extent that dependents are ineligible for or cannot afford employer-sponsored health insurance, this may lead to uninsured status and its attendant health and societal costs—notably, increased preventable disease costs and premature mortality.⁵⁻⁷ In fact, the literature supports this, as discussed below. Lack of coverage also may increase the uptake of public coverage if the partner qualifies—through disability or low-income parent status⁸—and participates in the Medicaid program or when emergency room care is used as a last resort.⁵⁻⁷

Finally, although purchasing coverage directly in the nongroup health insurance market is an ostensible option, this is viable only for those who can absorb the higher cost of nongroup premiums. Prior to the Patient Protection and Affordable Care Act, purchasing nongroup health insurance was further limited because insurers could deny coverage based on preexisting conditions. Under that new law, which as of 2014 will prohibit coverage denials based on preexisting conditions, more people will gain insurance over time, but it is uncertain at this point what the premiums and level of coverage will be and whether these will be comparable to those of employer-sponsored coverage.

PREVIOUS RESEARCH These issues have not gone unnoticed in the health literature. Julia Heck and colleagues used data from the National Health Interview Survey, 1997–2003, to examine

vulnerability to lack of health insurance, finding that women in same-sex cohabiting relationships were less likely than women in different-sex relationships to be insured.⁹ Using data from the Current Population Survey, 1996–2003, Michael Ash and Lee Badgett reported that men and women in cohabiting, same-sex partnerships have higher uninsurance rates than married, different-sex partners.¹⁰ This finding is consistent with recent analysis by Thomas Buchmueller and Christopher Carpenter using data from the Behavioral Risk Factor Surveillance System.¹¹ Ash and Badgett further found lower rates of receiving employer-sponsored health insurance for dependents among members of same-sex couples.¹⁰ However, whether this latter finding explains the overall health insurance disadvantage by people in same-sex couples is unknown.

To date, studies of the extent of the coverage disadvantage are generally constrained because of the way lesbians and gay men are classified within health surveys. Most often this is done through identifying same-sex cohabiting relationships in household rosters.¹² But this yields an incomplete picture of the gay, lesbian, and bisexual population because it excludes many noncohabiting individuals.

Recently, population-based health surveys have begun to include a measure of self-identified sexual orientation at the individual level.¹³ This creates an opportunity to model health insurance coverage among all lesbians, gay men, and bisexuals, whether or not they are currently in a cohabiting relationship. Moreover, most studies on sexual orientation–related health disparities report only on the dichotomous outcome of insured versus uninsured status, rather than on the ability to get access to health insurance from multiple sources.¹⁴

What constitutes a legally recognized union in the United States—whether a marriage, registered domestic partnership, civil union, or other status—is state-specific. Thus, we focus on a single state, California. Our work uses a population-based survey of this large state that contains information on individual-level sexual orientation; differentiates between same-sex partnered and different-sex married relationships; and identifies all possible sources of health insurance coverage, including coverage as a dependent through employer-sponsored health insurance.

The California Context

LEGAL DEVELOPMENTS In May 2008, the California Supreme Court ruled that same-sex couples must be allowed to marry and have their valid out-of-state marriages respected. This

Benefits for domestic partners and same-sex spouses are not financially equivalent to those offered to heterosexual spouses.

decision was partially negated 4 November 2008 with the passage of Proposition 8, which amended the state constitution to eliminate same-sex couples' right to marry. In May 2009, the California Supreme Court upheld Proposition 8 and its prospective restriction of marriage to different-sex couples, but it held that same-sex couples who married between 17 June and 14 November 2008 remain validly married under state law.¹⁵

Despite the passage of Proposition 8, California is a state where registered domestic partnership laws extend marriage-like rights and responsibilities, where laws regulating health insurance and health plans require equal treatment of spouses and domestic partners, and where registered domestic partners—whether same- or different-sex registered partners—receive the same state income tax breaks for dependent coverage that spouses receive. Domestic partner health benefits were authorized for public employees statewide as of 1 January 2000. A later domestic partnership law that took effect 1 January 2002 required, among other things, equal treatment of dependent health benefits under state tax law for both public- and private-sector employees.

The California Insurance Equality Act, which took effect 1 January 2005, mandated that all group health insurance policies and health care service plans offering spousal coverage provide similar coverage for state-registered domestic partners. However, this law's ability to improve insurance access is reduced somewhat by the fact that employers maintaining self-insured plans (approximately 31 percent of California's employers; see Appendix A)¹⁶ are exempt.

Other advances in state law that recognize and protect same-sex partners and prohibit discrimination based on sexual orientation or marital status, or both, are also not as effective at securing equal health insurance access as they may appear to be. The problem is that state laws seem-

ing to require employers to offer equal health benefits to lesbian and gay employees with a dependent partner or same-sex spouse often are blocked by the federal Employee Retirement Income Security Act (ERISA) of 1974.¹⁷ ERISA requires that most discrimination claims about employee health benefits be litigated in federal court under federal law, which does not yet include protection against sexual-orientation discrimination or recognition of same-sex partner or spousal rights.¹⁸

EFFECT OF FEDERAL LAW Accordingly, although insurers and health plans in California are required by state law to offer equal coverage to same-sex registered partners and spouses, it often is unclear how state and federal laws interact and to what extent employers and plan fiduciaries are required to purchase that coverage.

EMPLOYERS' RESPONSES Recent data from the California Health Benefits Survey suggest that more California employers are choosing to offer dependent coverage to domestic partners. The percentage of firms, including self-insured firms, offering dependent health insurance coverage to same-sex domestic partners grew from 34.4 percent in 2004 to 64 percent in 2006. As of 2009, 66.9 percent of California's self-insured employers offered employer-sponsored insurance to their employees with a same-sex partner (Appendix B).¹⁶

However, it remains true that these benefits for domestic partners and same-sex spouses are not financially equivalent to those offered to heterosexual spouses as a result of the income tax discrimination imposed by federal law. Uptake of domestic partner health insurance benefits generally has been lower than anticipated.¹⁹ The differential federal tax treatment, posited as one possible reason, was addressed in the House health reform bill but not in the final version of the health reform legislation.

Our goal is to inform policy directions by determining whether and to what extent there is a health insurance disadvantage for same-sex orientation, and how this may arise. We examined a recent period in California, where coverage variations by sexual orientation may reflect disadvantages faced by same-sex couples associated with access to or denial of civil marriage under state law, and recognition or not of one's true marital status under federal law.

Study Data And Methods

DATA SOURCE We used data from the California Health Interview Survey, the largest population-representative state health survey in the nation. The survey is a stratified random sample of households, for which one randomly selected

adult from each sampled household is surveyed.²⁰ Its biennial administration facilitates pooling of data to examine health access needs of smaller subpopulations. The survey's large sample and multiethnic/geographical representation are achieved by telephone administration, multiple language interviews, and oversamples of small counties and ethnic groups.

We combined three years of adult files from the California Health Interview Survey (2001, 2003, and 2005) to maximize the number of observations of sexual-orientation minorities. We excluded adults age sixty-five and older, who typically are covered by Medicare ($n = 29,623$), respondents who did not report their sexual orientation ($n = 1,024$), and those interviewed by proxy or who had other missing values ($n = 433$). The final sample, after exclusions, contained 63,719 females and 46,535 males.

THEORETICAL BASIS AND EMPIRICAL APPROACH Coverage disparities in employer-sponsored health insurance may result from employment discrimination or compensation discrimination. Employment discrimination is manifest when employers who offer health insurance are less likely to hire employees with minority sexual orientation. If employers are discriminating against gay men, lesbians, and bisexuals, we would expect a lower likelihood of obtaining own or personal employer-sponsored insurance in this group compared to heterosexuals, after accounting for education, skill level, and other relevant individual characteristics and labor-market factors.

Compensation discrimination, as described by Badgett, is manifest in the customary practice of covering different-sex spouses and not domestic partners or same-sex spouses, thus penalizing employees with a same-sex spouse or partner. Evidence of compensation discrimination can be observed if the likelihood of acquiring dependent health insurance from the employer is lower for employees with a same-sex partner than for those with a different-sex spouse.¹⁹

Our study design addressed the empirical challenges in identifying the association of sexual orientation with the uptake of dependent and own health insurance. First, because the California survey includes information on a randomly sampled adult and not all household members, if we were to restrict our study only to partnered or married employees, then nonworking partners and spouses—who rely most on dependent coverage—would be excluded. Our analysis therefore examines both the overall nonelderly adult population and the employed nonelderly adult population. This approach detects potential disparities in dependent health insurance coverage both at the population level and among

California's employees.

MEASURES We coded three categories of sexual orientation: gay or lesbian, bisexual, and heterosexual. Partnered/married status was determined from a single interview item that assessed current marital status. Those responding as married were coded as married, and those responding as living with a partner were coded as partnered. In the employed sample, we excluded self-employed adults and those who typically work zero hours per week.

Our dependent variable was health insurance status, constructed as a categorical variable: uninsured, public insurance (Medicaid and other public programs), own employer-sponsored insurance, dependent coverage, and privately purchased health insurance from the nongroup market. We ascertained health insurance status through a series of questions that probed coverage status at the time of the survey interview.

In the multivariate models, we examined other factors relevant to health insurance coverage, including sociodemographic covariates such as race and ethnicity, age, income, education, citizenship status, partnership status, presence of minor children in the household, language of interview, and rural or urban status. Labor-market characteristics—including hours worked per week, firm size, and industry—were also factors. Possible health care need based on self-rated health status was also examined.

STATISTICAL ANALYSIS We estimated weighted multivariate multinomial logit models for the full sample, partnered or married adults, employed adults, and partnered or married employed adults. Each model was stratified by sex, yielding a total of eight models. Based on the regression models, we also estimated predicted probabilities of each health insurance status outcome and computed relative risks with bootstrapped 95 percent confidence intervals to evaluate whether there were significant differences by type of coverage by sexual orientation. In the partnered or married models, we compared gay and lesbian partnered adults with heterosexual married adults.

We excluded lesbians, gay men, and bisexuals who reported being married in our partnered or married analyses. Because lesbians and gay men rarely reported being married, as opposed to partnered, we anticipate small, but still potentially biasing, effects from this restriction. In contrast, a sizable minority of bisexual individuals reported current married status. Many of these, we suspect, were heterosexual marriages, but their precise classification as such was not possible. The California surveys did not assess the sex of spouses or partners.

Although we assumed that the great majority

of partnered lesbians and gay men are in same-sex partnerships and married or partnered heterosexuals are in different-sex partnerships, this is indeterminable. We assumed that greater potential misclassification errors exist for bisexuals. For both brevity and clarity, we limit our detailed presentation of predicted probabilities and relative risks to comparisons between lesbians or gay men and heterosexuals. Results from the full regression models that include comparisons between bisexuals and heterosexuals are available in the Appendix.¹⁶

Study Results

POPULATION CHARACTERISTICS Fifty-one percent of lesbians and 38 percent of gay men reported being in a partnered or married relationship (Exhibit 1). This compares to 64 percent of female heterosexuals and 64 percent of male heterosexuals. Among bisexuals, 44 percent of females and 43 percent of males reported being in partnered or married relationships.

A greater proportion of heterosexuals (47 percent of women; 40 percent of men), compared to gay men (2 percent) and lesbians (17 percent) reported living with minor children in their households (Exhibit 1). Mean age was comparable for gay men, lesbians, and heterosexual men and women, but bisexual men and women

tend to be younger. Compared to their heterosexual counterparts, gay men and lesbians were more likely to be nonelderly adults who were non-Latino white, had at least a college degree and incomes of 300 percent of poverty and above, were interviewed in English, were U.S.-born citizens, and worked for a firm with more than 100 employees.

Fewer gay men than heterosexual men resided in rural areas and towns (Exhibit 1). Across the three sexual-orientation groups, estimates of the characteristics of bisexuals generally fell between the estimates for gay men and lesbians and for heterosexual individuals.

LIKELIHOOD OF HEALTH BENEFITS We computed predicted probabilities and relative risks with bootstrapped 95 percent confidence intervals from our multivariate models to assess whether the predicted values of the health insurance rate differed significantly by sexual orientation (Exhibits 2 and 3; complete versions of the exhibits, with confidence intervals, are available in Appendix D and Appendix E).¹⁶ In the overall population, compared to heterosexual women, lesbians were at higher risk of being uninsured (Exhibit 2).

However, we found no significant differences in lesbians with dependent health insurance coverage or own employer-sponsored health insurance compared to heterosexual women. In our

EXHIBIT 1

Sample Characteristics By Sexual Orientation And Sex, Nonelderly Adults Ages 18-64, California, Average Of Years 2001, 2003, And 2005

	Women			Men		
	Bisexual	Lesbian	Heterosexual	Bisexual	Gay	Heterosexual
Sample size	1,070	866	61,783	543	1,402	44,590
PARTNERED/MARRIED STATUS						
Married	29%	3%	56%	31%	2%	57%
Partnered	15	48	8	12	36	7
Not married or partnered	56	48	36	58	62	36
OTHER CHARACTERISTICS						
Minor children in household	34%	17%	47%	23%	2%	40%
Age (years)	34.1	40	39.4	37.7	39.1	38.8
Non-Latino white	52%	65%	46%	49%	63%	46%
College graduate plus	36	49	31	32	53	32
Income: 300% of FPL or more	50	67	52	49	75	56
English-language interview	93	96	81	85	97	80
U.S.-born citizen	80	86	65	68	83	64
Town/rural residence	9	10	11	9	4	12
Works 35 or more hours per week	43	63	46	68	69	73
Works for firm with more than 100 employees	32	46	34	36	48	42
"Fair" or "poor" health	19	19	18	18	16	17

SOURCE California Health Interview Surveys, 2001, 2003, and 2005. **NOTES** Not all totals equal 100 percent because of rounding. FPL is federal poverty level. A complete table of variables is available in the Appendix, which can be accessed by clicking on the Appendix link in the box to the right of the article online.

EXHIBIT 2

Predicted Probabilities And Relative Risk Of Insurance Status Among Lesbians Compared To Heterosexuals, Nonelderly Women Ages 18-64 In California, Average Of Years 2001, 2003, And 2005

	Entire population				Employed population			
	All women		Partnered/married women		All women		Partnered/married women	
	Lesbians/ hetero- sexuals (PP, %)	Lesbians compared to hetero- sexuals (RR)						
Sample size	63,719		33,930		36,344		17,938	
HEALTH INSURANCE STATUS								
Uninsured	18/14	1.39**	17/11	2.11**	15/10	1.59	12/7	2.23
Public insurance	13/14	0.95	14/8	2.37	5/8	0.72**	6/5	1.78
Own ESI	41/41	0.98	47/36	1.36**	59/60	0.97	70/55	1.32**
Dependent ESI	21/23	0.9	12/37	0.28**	17/17	0.98	8/30	0.23**
Privately purchased	7/8	0.82	10/8	1.11	3/4	0.71	3/4	0.73

SOURCE California Health Interview Surveys, 2001, 2003, and 2005. **NOTES** We bootstrapped 95 percent confidence intervals (available in the full version of this exhibit in Appendix D, which can be accessed by clicking on the Appendix link in the box to the right of the article online), by sampling stratum. Relative risks (RR) were computed from multinomial logit models that adjusted for age, race/ethnicity, language of interview, education, income as percentage of federal poverty level, minor children in household, town/rural residence, employment status/work hours, working for a firm with more than 100 employees, industry (in employed group), citizenship, and survey year. Employed group excludes self-employed. Samples include bisexuals. PP is predicted probability. ESI is employer-sponsored insurance. **p < 0.05

models that included all males, we also found no significant differences between gay men and heterosexual men in the likelihood of obtaining dependent insurance coverage or own employer-sponsored health insurance coverage.

The overall insurance disadvantage driven by the lower dependent coverage rates among lesbians and gay men, however, emerges in our

partnered or married sample.

Among partnered or married women, lesbians were more than twice as likely to be uninsured as heterosexual women. Among partnered or married women, lesbians were also significantly less likely than heterosexuals to have dependent employer-sponsored health insurance but had a greater likelihood of having coverage from their

EXHIBIT 3

Predicted Probabilities and Relative Risk of Insurance Status Among Gay Men Compared To Heterosexuals, Nonelderly Men Ages 18-64 In California, Average Of Years 2001, 2003, And 2005

	Entire population				Employed population			
	All men		Partnered/married men		All men		Partnered/married men	
	Gays/ hetero- sexuals (PP, %)	Gays compared to hetero- sexuals (RR)						
Sample size	46,535		26,063		31,100		18,260	
HEALTH INSURANCE STATUS								
Uninsured	15/17	0.88	17/11	2.02**	13/14	0.82**	14/9	1.9
Public insurance	12/10	1.21	11/7	2.00**	4/6	0.66	3/5	0.67
Own ESI	56/55	1.03	58/61	0.9	73/69	1.09**	75/74	0.99
Dependent ESI	8/11	0.78	6/14	0.42**	8/8	0.93	5/11	0.44**
Privately purchased	8/7	1.07	8/6	1.23	3/3	0.82	4/2	1.96

SOURCE California Health Interview Surveys, 2001, 2003, and 2005. **NOTES** We bootstrapped 95 percent confidence intervals (available in the full version of this exhibit in Appendix E, which can be accessed by clicking on the Appendix link in the box to the right of the article online), by sampling stratum. Relative risks (RR) were computed from multinomial logit models that adjusted for age, race/ethnicity, language of interview, education, income as percentage of federal poverty level, minor children in household, town/rural residence, employment status/work hours, working for a firm with more than 100 employees, industry (in employed group), citizenship, and survey year. Employed group excludes self-employed. Samples include bisexuals. PP is predicted probability. ESI is employer-sponsored insurance. **p < 0.05

Legal processes that limit gay couples' access to marriage can cause harmful effects on insurance coverage.

own employer (Exhibit 2).

Our findings further indicate that having one's own employer-sponsored health insurance and public coverage did not fully offset the penalty in dependent coverage experienced by lesbians. Consequently, we see a higher uninsured rate among this group than in heterosexual women (Exhibit 2).

Among partnered or married men, gay men had a lower likelihood of dependent coverage than did heterosexual men. They also had higher risk of having public coverage and being uninsured (Exhibit 3). Unlike partnered lesbians, who were more likely to have own employer-sponsored health insurance compared to heterosexual women, gay men did not differ significantly from heterosexual men in their rates of own employer-sponsored health insurance.

In the employed sample, the likelihood of obtaining own-employer coverage among lesbians was comparable to that among heterosexual female workers (Exhibit 2). Gay men were slightly more likely than heterosexual men to have own employer-sponsored insurance (Exhibit 3).

Finally, we found the same disadvantage of lower dependent coverage among employed partnered lesbians and gay men compared to their married heterosexual counterparts. But unlike the overall partnered or married population, this dependent coverage disadvantage did not lead to significantly higher uninsurance rates in the employed group.

Discussion

SUMMARY OF FINDINGS Partnered gay men are less than half as likely (42 percent) as married heterosexual men to get employer-sponsored dependent coverage, and partnered lesbians have an even slimmer chance (28 percent) of getting dependent coverage compared to married heterosexual women. This dependent coverage disparity by sexual orientation is the source of half of the uninsurance gap for all lesbians and a

substantial source of the uninsurance gap for partnered lesbians and gay men in both the overall population and among employees.

Our findings on dependent employer-sponsored insurance as the driver of the coverage disparity support Ash and Badgett's earlier work examining same-sex cohabiting couples.¹⁰ With the California data used in this study, we extend their findings more precisely to sexual-orientation minorities.

We found no strong evidence to suggest that employers in California are discriminating in providing health insurance to gay and lesbian workers. However, our results on the dependent coverage disadvantage in the partnered or married population provide strong evidence of compensation discrimination, in which employers setting coverage rules for dependents favor legally and heterosexually married employees. Moreover, we suspect that the dependent disadvantage we observed is a consequence of not just compensation discrimination, but also the unequal federal tax burden that influences employees to enroll their dependent spouse or partner for health insurance at different rates.

Another possible factor is that enrolling a same-sex partner or spouse as a dependent frequently requires that an employee "come out" as lesbian or gay if the employee has not done so already. Some employees are likely to find this a deterrent.

STUDY LIMITATIONS Several study limitations are relevant to our discussion. First, as a result of data limitations, we had to assume that the sexual orientation of relationships was consistent with individual sexual-orientation identities. Unpublished data from reinterviews of a subset of the 2003 California survey respondents suggest that this is a reasonable assumption.²¹

Second, we were unable to distinguish between unmarried but partnered couples who were in civil unions or registered domestic partnerships and those who were not. The former would be more likely to qualify for dependent employer-sponsored health insurance given California's domestic partner laws. Recent estimates suggest that perhaps half of cohabiting lesbian couples in California, but only about a quarter of cohabiting gay male couples, are registered with the state.¹²

Because many of our data were collected before full implementation of the California Insurance Equality Act of 2005, it is possible that the differences we observed have lessened somewhat in disadvantaging lesbians and gay men. Since enactment of the law, the percentage of California firms offering health insurance to same-sex domestic partners has increased markedly (Appendix B).¹⁶

Third, our study's comparison of partnered lesbians and gay men with married heterosexual women and men does not take into account the fact that an unknowable proportion of partnered lesbians and gay men would choose to marry should California again offer them that opportunity.¹⁹ Thus, although we have documented a disadvantage arising out of barriers to obtaining equal spousal or partner coverage, we do not know the extent to which this problem would be remediated by civil marriage equality for same-sex couples. However, again allowing same-sex couples to marry in California still would not remove the federal taxation of benefits for a same-sex spouse.

PROSPECTS FOR MORE-EQUAL COVERAGE Gay men and lesbians constitute an estimated 5.2 percent of the California population and 4.1 percent of Americans nationwide. In 2005, there were approximately 107,772 same-sex couples in California and 770,000 same-sex couples in the United States who, in many ways, live lives similar to those of their heterosexual counterparts. They work, they partner, and they create families.²² And, like other Americans, they seek the protection of health insurance both to maintain health and to indemnify themselves against financial ruin.

Legal processes that limit gay couples' access to marriage can cause cascading harmful effects on health insurance coverage. As of 2010, same-sex couples are permitted to marry in only five states—Connecticut, Iowa, Massachusetts, New Hampshire, and Vermont—and the District of Columbia, with at least New York and Maryland respecting lesbian and gay couples' out-of-jurisdiction marriages.²³ Civil union and broad domestic partnership laws protect same-sex couples in a few more states—California, Nevada, New Jersey, Oregon, and Washington State—and more limited protections are offered in Colorado, Hawaii, Maine, Maryland, and Wisconsin.²⁴

At the same time, more than forty states have acted to explicitly exclude same-sex couples from marriage with special statutes or constitutional amendments, or both, that not only limit in-state marriage to heterosexual couples but also create exceptions to long-standing rules providing for in-state recognition of out-of-state marriages.¹⁸

In addition to states with civil union or domestic partnership laws, a handful of other states—Alaska, Illinois, Montana, New Mexico, and Rhode Island—offer domestic partner health insurance to state employees, and various municipalities nationwide do the same.²⁵ Yet it appears that passage of restrictive laws and constitutional amendments can undermine these benefit plans. For example, the year after Arizona voters

The new national health reform law may alleviate some of the sexual-orientation disparities observed here.

amended the state constitution to limit marriage to heterosexual couples, a new state law ended health coverage for domestic partners of state employees.²⁶

Our findings from California, a state that is generally welcoming to sexual-orientation minorities, suggest that the effect of restrictive, differential treatment of same-sex relationships pushes the costs of coverage not just onto the individuals in those relationships but also into the public domain, as evidenced by higher uninsurance rates among partnered gay men and lesbians and higher public coverage among partnered gay men.⁵⁻⁷ This may be the case for HIV-seropositive gay men, who are twice as likely as seronegative gay men to lose their employment, forcing them to rely on public insurance when dependent coverage through a partner or spouse's employment is not accessible.²⁷

EFFECTS OF NATIONAL HEALTH REFORM The new national health reform law may alleviate some of the sexual-orientation disparities that we observed here. Privately purchased health insurance through the exchanges may prove to be an affordable, viable option because of new restrictions against denials and underwriting based on preexisting conditions, as well as subsidies for low-income gay men and lesbians who are not employed or covered by their own or their spouse's employer's plan.²⁸ However, subsidies to purchase from the health insurance exchanges end at 400 percent of the federal poverty level. Thus, among middle-income families, heterosexuals who can access their partner's or spouse's employer coverage will still be in a much better position than gay men and lesbians who cannot.

Although the health reform law also mandates that large employers provide health insurance to their employees and their dependents, how both the U.S. Department of Health and Human Services and employers define *dependents* continues to be a relevant underlying structural determi-

nant of whether or to what extent sexual-orientation minorities will have more equal access to employer-sponsored insurance. One immediate step would be to ask federal agencies to clarify that group health plans would not lose their grandfathered status by expanding coverage to include domestic partners.²⁹

With this clarification, employers might be more likely to broaden their definition of *dependents*. Without clear federal guidance on coverage expansions under the Patient Protection and Affordable Care Act, employers' decisions may continue to be driven by discriminatory state laws, and the current state of unequal access that we demonstrate in our study is likely to persist.

Finally, inequities in the tax burden remain prime for reform: The Patient Protection and Affordable Care Act did not include the Tax Equity for Domestic Partners and Health Plan Beneficiaries Act, a still-pending bill that would end the federal taxation of health insurance benefits for domestic partners and same-sex spouses.³⁰

OTHER FEDERAL-LEVEL ACTIONS To date, the Obama administration has called for more equitable treatment of lesbian and gay couples throughout federal law. One example of a step forward is the 15 April 2010 presidential memorandum requiring equal visitation rights for same-sex partners, and respect for the medical decision-making authority of lesbian, gay, bisex-

ual, and transgender patients' designated representatives, in hospitals that receive Medicare or Medicaid funding.³¹ On 2 June 2010, President Barack Obama issued a memorandum ordering the extension of a number of employment benefits to federal employees with a same-sex domestic partner, but not health insurance benefits.³² In a statement accompanying the memorandum, President Obama called for swift passage of the Domestic Partnership Benefits and Obligations Act,³³ which would require equal employment benefits for all federal workers, including equal health insurance for the same-sex spouses/partners of federal employees and is currently under consideration in Congress.³⁴

Finally, repeal of the federal Defense of Marriage Act is currently being considered by Congress, and the statute is being challenged in federal lawsuits on several grounds, including the equal protection clause of the U.S. Constitution.³⁵⁻³⁷

CONCLUSION Achieving the goal of universal coverage depends, in part, on remedying inequities in state and federal marriage-related rules. In our efforts to rebuild economic strength and security in the United States, it is important to consider the role of public policies in unfairly disadvantaging some minority classes of individuals and their families, and to recognize society's interest in righting the balance of who bears those costs. ■

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NOTES

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 - 36 Gill v. OPM, Case no. 1:09-cv-10309 JLT, U.S.D.C. for the District of Massachusetts.
 - 37 Commonwealth of Massachusetts v. U.S. Dept. of Health & Human Svcs., Civ. A. no. 1:09-11156-JLT, U.S.D.C. for the District of Massachusetts.