Differences in Insurance Coverage and Access to Health Care for Married Persons and Same-Sex and Different-Sex Unmarried Partners: Evidence from the National Health Interview Survey, 2007-2011.

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Disparities in health status, health behaviors, and health care access on the basis of sexual orientation have been largely ignored by researchers until recently. Reviews of articles in public health, medical, and nursing journals note a dearth of studies relating to the lesbian, gay, bisexual, and transgender (LGBT) population and report disproportionate focus on HIV/AIDS and other sexually transmitted diseases (Boehmer, 2002; Snyder, 2011; Johnson, Smyer, and Yucha, 2012). Recently, however, health disparities on the basis of sexual orientation have become recognized as important. For example, in June 2011, the U.S. Department of Health and Human Services called for eliminating health disparities affecting the LGBT population (as well as other minority groups). A question on sexual identity is slated for inclusion in the 2013 National Health Interview Survey (NHIS), the leading source of information on the health of the non-institutionalized civilian population of the United States.

The 2011 volume published by the Institute of Medicine on "The Health of Lesbian, Gay, Bisexual, and Transgender People" noted an unfortunate reliance on convenience samples in much LGBT health research, called for more population-based representative studies, and identified "health care inequities" as one of four "priority research areas." Our study satisfies these criteria by using nationally representative NHIS data from 2007-2011, evaluating differences in insurance coverage and access to basic health care, and considering the effect of both union type (married versus unmarried partnership) and sexual orientation (same-sex versus different-sex union) on health care access.

Identifying Persons in Same-Sex Relationships and Main Research Questions

Questions about respondents' sexual orientation and/or the gender of their sexual partners have been included in some U.S. health surveys, primarily those covering a single urban area (such as Los Angeles County, New York City, or Hennepin County, Minnesota) (Diamont et al., 2000; Kerker et al., 2006; Burgess et. al, 2007), a single state (such as the California Health Interview Survey [CHIS] or the Washington State Behavioral Risk Factor Surveillance System [BRFSS]) (Dilley et al., 2010; Ponce et al., 2010), or a population subgroup such as adults at midlife or female nurses (Cochran, Sullivan, and Mays, 2003; Case et al., 2004). These surveys often include fewer than 100 persons identified as gay and/or bisexual and cover limited geographic territory. They have yielded inconsistent findings on whether LGBT persons are disadvantaged in terms of such basic indicators as having insurance coverage, and the generalizability of their results to the national level is questionable.

Alternatively, persons living with same-sex partners can be identified in large nationally representative datasets such as the U.S. Census, the Current Population Survey (CPS), the American Community Survey (ACS), the Medical Expenditure Panel Survey (MEPS), and national BRFSS data, via variables on relationship to head of household (i.e., persons identified as head and head's unmarried partner). (For examples of this approach to studying LGBT health disparities, see Buchmueller and Carpenter, 2010; Ash and Badgett, 2006; Heck et al., 2006; Clift and Kirby, 2012; Gonzales, 2012.) While such an approach identifies only ***partnered/coresident*** persons in same-sex relationships (and ignores gay-identified

persons living without a partner), this disadvantage is countered by the large nationally representative samples available and by the illuminating comparisons that can be drawn between coresiding persons in different types of committed relationships.

Unlike most other federal surveys, the National Health Interview Survey has a question on marital status that includes the category "living with unmarried partner." We have used that marital status variable (together with the variable on sex) to identify persons in different-sex married couples, in same-sex married couples, in different-sex unmarried partnerships, and in same sex-unmarried partnerships. By pooling data from the five most recent years of the survey, we created a dataset of adults age 18-64, distributed among different-sex unmarried partners (n= 19,442), same-sex unmarried partners (n= 1,439), different-sex married persons (n= 141,499), and same-sex married persons (n=182). (Because the number of same-sex married persons is small, we retain this category only in an initial model evaluating the likelihood of having current insurance coverage.) To simplify pooling data across samples, we used the version of NHIS data disseminated through the Integrated Health Interview Series (www.ihis.us), which is created by researchers at the Minnesota Population Center.

We address two broad research questions using NHIS data for 2007-2011:

1) ***How does individuals' access to insurance coverage vary by union status (married versus unmarried partner) and sexual orientation (in same-sex versus different-sex couple)?***

2) ***After controlling for differences in insurance coverage (and other demographic and SES characteristics), how do persons in same-sex unmarried partnerships differ from either different-sex married partners or from married persons, in terms of their access to basic health care?***

Question 1: Results from Previous Research and from our Research

In the first publication to use a large population-based dataset to study health care access among persons in same-sex relationships, Heck and her co-authors used a pooled sample from the National Health Interview Survey for 1997-2003 (with 614 persons in same-sex relationships). They found that women in same-sex relationships were less likely to have insurance coverage and more likely to have unmet need for medical care than women in different-sex relationships; by contrast, men in same-sex relationships had the same or better access to health care than men in different-sex relationships.

We chose to employ NHIS data again--albeit for 2007-2011--to evaluate insurance coverage and access to care for persons in same-sex relationships, for a number of reasons. First, unlike Heck et al., we distinguish between different-sex unmarried partners and different-sex married persons as comparison groups for persons in same-sex relationships. Persons who are legally married have easier access to insurance coverage largely because they can claim spousal benefits (usually through a partner's workplace), not just because they avoid the stigma of being gay. Thus, we chose to use logistic regression to evaluate the likelihood of being uninsured for each of the four union categories: same-sex spouse, different-sex spouse, same-sex partner, and different-sex partner. The strategy of differentiating between heterosexual couples who are married and those who form unmarried partnerships, as a comparison group to same-sex couples, has been followed in other recent studies

based on the CPS (Ash and Badgett, 2006), on BRFSS (Buchmueller and Carpenter, 2010), and on CHIS data (Ponce et al., 2010). In each of these studies, persons in different sex-partnerships as well as those in same-sex partnerships were far more likely to be uninsured than different-sex married persons.

In our first logistic model for NHIS data from 2007-2011, we use likelihood of being uninsured as the dependent variable. We controlled for age, race/ethnicity, education, employment status, region, presence of children in family, self-rated health status, and family income, as well as for relationship type (with different-sex married couples as the reference category). With the exception of presence of children, the non-relationship independent variables were significant predictors of the likelihood of being uninsured. Controlling for other characteristics, the odds ratio of being uninsured was about twice as high, and statistically significant, for both same-sex partners and different-sex partners, compared to different-sex married persons. Same-sex married persons (which included just 182 cases) had a likelihood of uninsurance in-between the different-sex married persons and the unmarried partners, but their coefficient was not statistically significant.

When we grouped all married persons together and reran the models separately for men and women, we found that women in both same-sex partnerships and different-sex partnerships were 1.6 times as likely to be uninsured as married women (coefficients significant at the .001 level). Men with a same-sex partner were 2.8 times as likely to be uninsured, and men with a different-sex partner were 2.2 times as likely to be uninsured, as married men (coefficients significant at the .001 level). While the exact estimates and model specifications vary across research projects, our results are broadly consistent with those that researchers have reported using CHIS, BRFSS, and CPS data.

We plan to run the second model (separately by sex, not distinguishing same-sex married persons) again for earlier NHIS pooled samples from the period 1997-2006. We will evaluate whether the insurance disadvantage of being in an unmarried partnership has lessened over time, and, if so, whether the magnitude of that shift differs between same-sex and different-sex partners.

There are strong reasons to believe that same-sex partners may be less disadvantaged today, in terms of their insurance coverage through a partner's workplace, than they were in the past. In large companies, domestic partnership benefits policies have become more common. The number of Fortune 500 companies offering domestic partnership benefits rose from 1 company to one-third of those companies between 1991 and 2004 (Davidson and Rouse, 2012); the percentage of California firms offering dependent health insurance coverage to same-sex domestic partners grew from 34 percent in 2004 to 64 percent in 2006 (Ponce et al., 2010). Various state laws offer same-sex couples a modicum of protection against discrimination in accessing workplace benefits. (For a discussion of such protections and their limitations in the case of California, see Ponce.) Opinion polls show increasing public acceptance of homosexuality, creating a more hospitable climate for workers in same-sex relationships to "come out" publicly and claim employee benefits for their partners.

We will also analyze the NHIS data to evaluate how the characteristics of one's unmarried partner (such as full-time employment, industry, and occupational status) affect the likelihood of receiving insurance coverage through the partner's policy. Some large health surveys--such as BRFSS, MEPS, and CHIS--

collected data on insurance coverage via a sample of individual adults; thus, they cannot provide information on partner characteristics (other than sex and marital status). NHIS, by contrast, is a household survey, with information on insurance coverage and many other characteristics of all household members, and thus allows consideration of the effect of partner characteristics.

Question 2: Results from Previous Research and from our Research

Insurance status is important because it predicts and facilitates access to affordable health care. If the only health disparity affecting the LGBT population were unequal access to insurance coverage (either in one's one name or through one's partner), then differences in unmet need for care, and in the receipt of preventive and basic health care, would disappear after controlling for insurance coverage. In fact, this is not the case.

We ran logistic regressions to predict the likelihood that the person needed but did not get medical care due to cost in the past 12 months. We used the same independent variables noted for model 2, above, along with a variable for insurance coverage (i.e., no coverage, private coverage, or public coverage). Coefficients for at least some categories of all the independent variables were significant. After controlling for insurance coverage (with married couples as the reference category), both male and female same-sex partners were 1.6 times more likely to report needing but not getting needed medical care in the past year. Different-sex male partners had greater unmet need for care than married males, but their statistically significant coefficient was lower, at 1.13. Different-sex female partners were no more likely than married females to report unmet need for care due to cost.

Previous research has used a wide range of measures to evaluate whether males and females in same-sex relationships have more need, less access, or differential use of medical care than persons in different-sex relationships. Lesbian women are reportedly less likely to receive timely Pap tests, physical breast exams, and age-appropriate mammograms (Buchmueller and Carpenter, 2010; Heck et al., 2006; Diamant et al., 2000; Case et al. 2004). Gay men and lesbians are both reportedly more likely to smoke, drink heavily, and have mood disorders such as depression and anxiety than non-LGBT persons, which most researchers ascribe to the chronic stress of being in a stigmatized minority group (Dilley et al., 2010; Institute of Medicine, 2011; Cochran, Mays, and Sullivan, 2003; Burgess et al., 2007). Other indicators of LGBT health disparities used in various studies include having a regular source of medical care, needing but not receiving mental health care, and having a doctor visit in the past year. Not all research has revealed substantial disadvantages for health care access among persons in same-sex couples; MEPS data analyzed by Clift and Kirby (2012) show few significant differences between persons in same-sex couples compared to those in married different-sex couples on many indicators of health care access and satisfaction (including, surprisingly, no difference in insurance coverage).

Our work in this area is still preliminary, but the rich NHIS data allow us to replicate any of these indicators of health status and health care access and use for our sample. In line with the results presented here already, we will compare men and women in same-sex partnerships to both married persons and persons in different-sex partnerships. In some cases, we will restrict the dataset to "sample persons," namely, the one adult per family who was asked many additional questions in NHIS.