Measuring the Influence of Legally Recognized Partnerships on the Health and Well-Being of Same-Sex Couples: Utility of the California Health Interview Survey

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Abstract

Purpose: This study explored the utility of the California Health Interview Survey (CHIS) to compare health-related outcomes among gay men, lesbians, and heterosexuals who reported being in a legally recognized partnership.

Methods: We regressed sexual identity and marriage/legally recognized partnership status on seven different outcomes related to health insurance coverage, medical services access and use, and general health and well-being using CHIS data collected between 2009 and 2013.

Results: There were 1432 respondents who identified as gay, lesbian, or homosexual, and 67,746 who identified as heterosexual. The percentage of participants who reported being married/legally partnered was 54.06% for heterosexual women, 52.93% for heterosexual men, 38.83% for lesbians, and 23.56% for gay men. Legally partnered/married gay and lesbian respondents were more likely to have health insurance and use healthcare than their counterparts not in such partnerships; few trends were statistically significant. Gay men in legally recognized partnerships were more likely than their heterosexual counterparts to report continuous health insurance coverage, a usual medical care source, and at least one provider visit within the past 12 months. We found statistically significant poorer health status outcomes among lesbians in legally recognized partnerships compared to married heterosexual women.

Conclusions: Lesbians in legally recognized partnerships did not fare as well as married heterosexual women. Gay men in legally recognized partnerships fared better than married heterosexual men on some measures. CHIS questionnaire structures limited our sample and analyses. We recommend that CHIS and other researchers ask partnered status-, marriage-, and sexual identity-related questions en bloc to ensure more robust representation, analyses, recommendations, and policy resolutions.

Keywords: healthcare use, health insurance coverage, health status, legal partnerships and marriage

Introduction

AS THE ISSUE of marriage equality progressed across the United States, citizens cited legal precedents and research findings that the lack of legal recognition for same-sex couples had negative health consequences^{1–4} in comparison to opposite-sex couples for whom the health benefits associated with marriage are well-documented.^{5–7} Policy and health literature reviews acknowledged the need for data to support the

idea that legal recognition could facilitate health benefits for lesbian and gay male couples,^{2–4,8} yet rigorous studies had been limited due to the piecemeal, state-based legalization process in the United States and the lack of large representative surveys that include same-sex couples in survey language.⁹

Researchers previously explored the relationship between cohabitation and health status between same- and opposite-sex cohabiters through sexual identity questions in large U.S. population-based studies. For example, Liu et al.¹⁰

A version of this study using only 2009 data was presented at the 35th annual meeting of the Society of Behavioral Medicine, April 23–26, 2014, Philadelphia, PA. A version of this study using 2009–2012 data was presented at the 37th annual meeting of the Society of Behavioral Medicine, March 30–April 2, 2016, Washington, DC.

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pooled 1997–2009 National Health Interview Survey (NHIS) data and found that same-sex cohabiting couples reported better health than unpartnered adults and opposite-sex cohabiting couples, although socioeconomic status explained that difference. Similarly, Denney et al.¹¹ examined 1997–2008 NHIS data yet found that same- and opposite-sex cohabiters reported poorer health than heterosexual married couples. At the time, legal recognition for same-sex couples was so rare that the studies focused only on *cohabitation*. In 2013, NHIS¹² began regular implementation of sexual identity questions on its entire sample, and has published on lesbian, gay, and bisexual health indicators, health-related behaviors, access, and use, but not yet marriage.

The U.S. Supreme Court's 2015 decision that the Constitution's "Fourteenth Amendment require[s] a state to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out-of-state,"^{13(p1)} ceased piecemeal legalization of same-sex marriage in the United States. We believe it is now incumbent upon LGBT health researchers to assess the influence of marriage on the health and well-being of same-sex couples and their immediate families. To achieve these aims, standardized wording for same-sex marriage needs to be implemented and tested in population-level studies.

The purpose of this study is to compare health-related outcomes among gay men, lesbians, and heterosexuals who reported being part of a legally recognized partnership versus other gay men, lesbians, and heterosexuals.

Hypothesis 1: Adults who are in legally recognized partnerships, compared to those who are not, are more likely to report general good health, health insurance coverage, and use of medical services regardless of sexual identity.

Hypothesis 2: Legally recognized, partnered lesbian and gay (LG) adults are as likely as married heterosexuals to report general good health, health insurance, and use of medical services.

The exploratory aims of this article are to describe the survey instrument and skip pattern used to assess same-sex marriage/legal partnership and document any benefits or concerns for adaptation of the measure to other populations. California Health Interview Survey (CHIS) is a unique dataset, as its questions on legal partnership and marriage for same-sex couples stayed abreast of legal California events.

Methods

CHIS is an ongoing, independent, cross-sectional telephone survey that monitors the health status of California residents. Multiple U.S. Department of Health and Human Services agencies have provided financial support to CHIS. First fielded biennially, CHIS became a continuous survey in 2011.^{14–17} We combined and analyzed CHIS data collected between 2009 and 2013; CHIS labels these two waves of data as "CHIS 2009" and "CHIS 2011–2012," respectively.^{16,17} The University of California, Los Angeles (UCLA) Center for Health Policy Research made the data available upon our request. The survey's multistage probability design collects a comprehensive sample representative of sex/gender and race/ethnicity for all California counties. The California Information Practices Act (section 1798.24) permits the release of CHIS data only for statistical research and reporting, and precludes the release of geography-related information to

ensure participant confidentiality.^{14–17} UCLA obtained original CHIS human subjects approval. The National Institutes of Health Office of Human Subjects Research Protection determined that our project was exempt from review.

Dependent variables

We explored the relationship of marriage and legally recognized partnership with seven binary, dependent variables. We dichotomized (1) *self-reported general health status* as excellent/very good/good and poor/fair¹⁵; (2) *health insurance* as insured over all past 12 months versus lack of continuous coverage during the same period; (3) *usual source of care* as having a regular place to visit when sick or need health advice versus no usual source; (4) *seen a medical doctor* as ever in the past 12 months; (5) *mammogram* as having an examination within the past 2 years for women aged 50 and older; (6) *delay in medical care* in past 12 months; and (7) *delay in prescription* in past 12 months. We recoded responses to variables 2–7 as *yes* or *no*.

Independent variables

Sexual identity. CHIS asked participants, "Do you think of yourself as straight or heterosexual, as gay, lesbian, or homosexual, as bisexual, or other?" We included only those participants who identified as gay, heterosexual, homosexual or lesbian.

Marital or partnered status. All respondents were asked the standard marital question "Are you now married, living with a partner in a marriage-like relationship, widowed, divorced, separated, or never married?"

Legally recognized couple status. In 2009, CHIS added the following question for adults who reported having sex with someone of the same sex over the preceding 12 months: "Are you legally registered as a domestic partner or legally married in California with someone of the same sex?"¹⁵ The CHIS interview schedule placed its question on (heterosexual) marital status within sociodemographics and its question on same-sex marriage and/or legal partnership within the context of recent same-sex sexual activity.

We recoded legally recognized couple status based on responses to both the standard marital status question and the legally registered and married question. If participants responded as legally partnered or married, that response superseded their response to the standard marital status question. The ensuing relatively small number of legally partnered or married responses led us to combine responses into two categories: (1) *legally recognized* and (2) *other*, a category that includes unmarried people who may be divorced, widowed, never married, or living with another person without legal recognition. We created this binary variable to correspond to our other binary variables and focus on cohabiting couples with legally recognized partnerships, because at the time that CHIS collected these data, statewide, same-sex legal partnerships and marriage were permitted inconsistently. To simplify the reading process, we use *legally recognized*, *partner(s)*, and *partnerships* to refer to people who are legally married, legally partnered, or in another civilly recognized union.

Covariates

Sociodemographics included age, education, race/ethnicity, employment status of respondent and partner, household

income, presence of children at home, and gender to explore variations within and across lesbian, gay, and heterosexual couples. We recoded educational achievement into three categories: less than high school or equivalency, high school diploma, including some college coursework, or a 4-year college degree or higher. Participant race/ethnicity was categorized as Latina/Latino, African American, White, Asian, Native (American Indian/Native American, Alaska Native, and Pacific Islander), multiple race, and other. We recoded employment as employed, unemployed looking for work, or unemployed not looking for work and applied the same trichotomy to the employment status of the respondent's legal partner. Participants reported household income ranges and the number and age of children in the home; we created binary variables to reflect whether household incomes were above or below 350% of the U.S. Federal poverty level (a standard marker for public assistance) and whether a household included at least one child under age 18.

Statistical analysis

Descriptive statistics for sociodemographic, gender, and sexual identity variables appear in Table 1. We used chi-square tests to assess the significance of difference in proportions and ANOVA to test for difference in means by sexual identity for women and men separately. We constructed separate logistic regression models for each of the seven dependent variables, with separate models for women and men. Each model included sexual identity, partnership status, and the interaction term of sexual identity and partnership status, adjusted for the above-described sociodemographic covariates. We used the interaction term of sexual identity by legal partnership status to compare if regression coefficients for legally recognized status differed by sexual identity (e.g., does legal recognition relate to health insurance differently for lesbians in legally recognized partnerships compared to their heterosexual counterparts?). We could have conducted separate regressions for each sexual identity, but we would have been unable to compare the relationship between legal partnership and the dependent variable for persons of different sexual identities. The interaction term allows us to formally test if legal recognition relates to a health outcome differently for various statistical conditions¹⁸—in this case, *sexual identity*.

Model-based estimates and unadjusted prevalences appear in Table 2. We analyzed each variable in discrete models to test our two hypotheses: the “Association of Legal Recognition” column presents the association of this status within each sexual identity group. “Legal Recognition” is a binary variable, comparing legally partnered participants to “other,” which includes unmarried and nonlegally partnered individuals. For example, we compared legally partnered lesbians to other (i.e., not legally partnered) lesbians. The “Association of Sexual Identity” column presents the comparison between legally partnered gay men and lesbians, respectively, to the reference group, heterosexual respondents in legally recognized partnerships. For example, we compared legally partnered lesbians to legally partnered heterosexual women.

Adjusted odds ratios (AOR) are reported. We rejected the null hypothesis if a *P* value is less than or equal to 0.05. Our two-

tailed analyses were programmed in SAS V9.2 and SAS-callable SUDAAN software (SAS Institute Inc., Cary, NC).

Results

Sample characteristics

There were 90,549 Californians aged 18 and older in our sample. This study focused on Californians who identified as gay, heterosexual, or lesbian—to be consistent with both the CHIS sexual identity question as well as the 2011 Institute of Medicine's sexual identity definition.^{9(p28)}

To create this subsample, we excluded participants who identified as nonsexual/celibate (*n*=456) and other (*n*=53). We also excluded participants who self-identified as bisexual (*n*=985) and participants who provided no response to the sexual identity question (*n*=51) because the interview schedule did not ask systematically for their legal partner status. As CHIS asked no sexual identity questions of participants older than 70 (*n*=19,826), we excluded them, leaving a sample size of 69,178 for our analyses. The retained respondents identified as gay, lesbian, homosexual (*n*=1432), or heterosexual (*n*=67,746).

Table 1 shows 2.45% of the adult (aged 70 or younger) male and 1.28% of the adult female California sample identified as gay or lesbian, respectively. The percentage of participants who reported being married using the standard marital wording was 54.06% for heterosexual women, 52.93% for heterosexual men, 22.2% for lesbians, and 9.7% for gay men. However, when participants were asked the legally partnered or legally married same-sex question, the prevalence increased to 38.83% for lesbians and 23.56% for gay men. The percentage of lesbians reporting having a child younger than 18 years was almost twice that of gay men, although heterosexuals overall were more likely to report children at home.

Lesbians differed somewhat demographically from heterosexual women. Although lesbians were approximately the same average age as heterosexual women, they were more likely to be white, to report higher educational attainment, to be in the labor force (employed or unemployed and looking for work), to have a partner in the labor force, and to have higher overall household income, all *P* values <0.01. More gay than heterosexual men reported being white (51%–43%). Gay men were significantly more likely than heterosexual men to report holding at least one college degree (55%–34%), to have a working partner (81%–59%), and to have higher household incomes (67%–48%), all *P* values ≤0.01.

Comparisons of self-reported health and healthcare use between respondents in legally recognized partnerships and other respondents

We explored the relationship between legally recognized partnership status and health-related variables. We compared legally partnered versus other respondents within gender and sexual identity strata (legally partnered vs. other lesbians; legally partnered vs. other gay men). These results appear in Table 2, in the “Association of Legal Recognition” column. AORs and their 95% confidence intervals (CIs) for statistically significant relationships among gay and lesbian respondents also appear in Table 2.

TABLE 1. SOCIODEMOGRAPHIC CHARACTERISTICS OF GAY, HETEROSEXUAL, AND LESBIAN PARTICIPANTS, AGED 18–70: CALIFORNIA HEALTH INTERVIEW SURVEY 2009–2012

	Women			Men		
	Lesbian	Heterosexual	P value	Gay	Heterosexual	P value
Sample size (%)	583 (1.28%)	39,323 (96.06%)		849 (2.45%)	28,423 (95.91%)	
Legally recognized partner status—four levels						
Legally recognized partnerships	224 (38.83%)	21,092 (54.06%)	<0.001	203 (23.56%)	16,598 (52.93%)	<0.001
Living with partner without legal recognition	89 (19.72%)	2105 (7.81%)		126 (20.88%)	1557 (7.59%)	
Widowed/divorced/separated	79 (10.86%)	9976 (15.43%)		68 (3.77%)	4035 (9.23%)	
Never legally partnered	191 (30.59%)	6150 (22.70%)		452 (51.79%)	6233 (30.25%)	
Legally recognized partner status—dichotomized						
Legally recognized partnerships	224 (38.83%)	21,092 (54.06%)	<0.001	203 (23.56%)	16,598 (52.93%)	<0.001
Other	359 (61.17%)	18,231 (45.94%)		646 (76.44%)	11,825 (47.07%)	
Age						
Mean (standard error)	41.81 (0.90)	42.08 (0.05)	0.773	40.57 (0.71)	41.25 (0.05)	0.358
Race/ethnicity						
Latino	104 (29.32%)	9142 (34.57%)	<0.001	141 (26.95%)	6416 (35.93%)	0.060
Asian/PI/AI/AN	31 (7.20%)	4656 (15.61%)		54 (14.19%)	3513 (13.68%)	
African American	29 (4.90%)	1793 (5.84%)		31 (4.71%)	1156 (5.35%)	
White	398 (53.61%)	22,795 (42.13%)		602 (51.46%)	16,651 (43.11%)	
Other	21 (4.97%)	937 (1.86%)		21 (2.69%)	687 (1.93%)	
Have child aged 0–17 in household						
Yes	117 (28.94%)	15,095 (49.34%)	<0.001	66 (15.51%)	10,257 (44.45%)	<0.001
No	466 (71.06%)	24,228 (50.66%)		783 (84.49%)	18,166 (55.55%)	
Educational attainment						
< High school education	29 (8.50%)	4413 (15.66%)	<0.001	26 (4.28%)	2984 (16.14%)	<0.001
High school diploma or some college	231 (46.48%)	19,191 (48.82%)		328 (41.17%)	13,665 (49.93%)	
College degree or above	323 (45.03%)	15,719 (35.52%)		495 (54.55%)	11,774 (33.93%)	
Working status						
Employed	368 (63.73%)	22,603 (61.09%)	0.009	526 (71.42%)	19,566 (74.59%)	0.448
Unemployed, looking for work	53 (13.75%)	2556 (8.92%)		64 (10.96%)	2258 (10.21%)	
Unemployed, not looking for work	162 (22.51%)	14,164 (29.99%)		259 (17.62%)	6599 (15.20%)	
Household income						
Household income under 350% FPL	231 (40.62%)	19,960 (55.55%)	<0.001	299 (33.27%)	13,077 (52.45%)	<0.001
Household income greater than or equal to 350% FPL	352 (59.38%)	19,363 (44.45%)		550 (66.73%)	15,346 (47.55%)	
Partner's working status (among participants with a legally recognized partner)						
Employed	89 (85.23%)	15,324 (78.90%)	<0.001	58 (80.50%)	9722 (59.14%)	0.010
Unemployed, looking for work	0 (0.00%)	829 (4.74%)		5 (3.23%)	582 (4.05%)	
Unemployed, not looking for work	19 (14.77%)	4933 (16.36%)		20 (16.27%)	6290 (36.81%)	

Except for age, numbers in cells are weighted frequencies and percentages for variables. Response rates are estimates of the percentage of sampled persons who participated in the survey, where the sample may be across the entire state, restricted to a county, or some other subgroup. To estimate response rates, CHIS takes the probability of sampling persons into account. Thus, response rates are weighted percentages of the entire number of CHIS participants rather than percentages of a subsample—in this case, gay, heterosexual, and lesbian California adults younger than 70 years. For age, we report means and standard deviations. Chi-square and *t*-tests for each variable by sexual identity were conducted separately for men and women. *P* values less than 0.05 are discussed as significant within the text.

CHIS, California Health Interview Survey; FPL, Federal Poverty Level (U.S.).

Participants in legally recognized partnerships reported higher odds of consistent health insurance over the past 12 months; odds were significantly higher among legally partnered lesbians (AOR = 1.58; 95% CI: 0.80, 3.11) and gay men (AOR = 2.67; 95% CI: 1.26, 5.68) than among other lesbians and gay men. Gay and heterosexual men in legally recognized partnerships were more likely to report a doctor's visit in the past 12 months (AOR = 3.21; 95% CI: 1.35, 7.64 among gay men); however, this legal status was not re-

lated to visiting a doctor for women of either sexual identity. Heterosexual women in legally recognized partnerships were more likely to report a mammogram within the past 2 years; this association was not significant for legally partnered lesbians. We found a higher OR for legally partnered heterosexuals to report good or excellent health and lower odds for delay in prescriptions compared to unmarried heterosexuals. Odds of delay in medical care were lower among legally partnered heterosexuals.

TABLE 2. HEALTH AND ACCESS VARIABLES REGRESSED ON SEXUAL IDENTITY AND LEGALLY RECOGNIZED STATUS:
CALIFORNIA HEALTH INTERVIEW SURVEY 2009–2012

Outcome	Sexual identity	Partnership status	Women		Men	
			Association of legal recognition, AOR [95% CI]	Association of sexual identity, AOR [95% CI]	Association of legal recognition, AOR [95% CI]	Association of sexual identity, AOR [95% CI]
Good/very good/excellent health, self-reported	Lesbian/gay	Legally partnered	0.77 [0.35, 1.68] 1.00 (REF)	0.45 [0.25, 0.81]**	0.91 [0.42, 1.97] 1.00 (REF)	0.70 [0.36, 1.40] —
	Heterosexual	Legally partnered	1.26 [1.12, 1.43]*** 1.00 (REF)	1.00 (REF)	1.25 [1.06, 1.47]** 1.00 (REF)	1.00 (REF) —
Have usual place to go when sick or needing health advice	Lesbian/gay	Legally partnered	1.11 [0.37, 3.33] 1.00 (REF)	0.68 [0.26, 1.78] —	1.73 [0.70, 4.25] 1.00 (REF)	2.78 [1.27, 6.05]* —
	Heterosexual	Legally partnered	1.20 [1.03, 1.41]* 1.00 (REF)	1.00 (REF)	1.38 [1.15, 1.65]*** 1.00 (REF)	1.00 (REF) —
Visited doctor during past 12 months	Lesbian/gay	Legally partnered	0.88 [0.38, 2.03] 1.00 (REF)	0.68 [0.33, 1.39] —	3.21 [1.35, 7.64]** 1.00 (REF)	5.27 [2.34, 11.85]***** —
	Heterosexual	Legally partnered	1.07 [0.95, 1.21] 1.00 (REF)	1.00 (REF)	1.17 [1.01, 1.35]* 1.00 (REF)	1.00 (REF) —
Insured all past 12 months	Lesbian/gay	Legally partnered	1.58 [0.80, 3.11]***** 1.00 (REF)	0.72 [0.42, 1.24]***** —	2.67 [1.26, 5.68]***** 1.00 (REF)	1.62 [0.82, 3.18]***** —
	Heterosexual	Legally partnered	1.32 [1.17, 1.49] 1.00 (REF)	1.00 (REF)	2.30 [1.96, 2.69] 1.00 (REF)	1.00 (REF) —
Delayed medical care in the past year	Lesbian/gay	Legally partnered	0.59 [0.31, 1.12] 1.00 (REF)	1.31 [0.79, 2.16] —	0.55 [0.29, 1.04]# 1.00 (REF)	1.15 [0.74, 1.80] —
	Heterosexual	Legally partnered	0.86 [0.77, 0.98]* 1.00 (REF)	1.00 (REF)	0.79 [0.69, 0.90]*** 1.00 (REF)	1.00 (REF) —
Delayed getting prescription in past year	Lesbian/gay	Legally partnered	1.47 [0.72, 3.00] 1.00 (REF)	2.19 [1.26, 3.83]** —	1.10 [0.56, 2.16] 1.00 (REF)	1.42 [0.83, 2.45] —
	Heterosexual	Legally partnered	0.79 [0.69, 0.90]*** 1.00 (REF)	1.00 (REF)	0.81 [0.66, 0.99]* 1.00 (REF)	1.00 (REF) —
Had mammogram in the past 2 years (universe: women 50+)	Lesbian/gay	Legally partnered	2.34 [0.94, 5.85]# 1.00 (REF)	0.87 [0.44, 1.75] —	—	—
	Heterosexual	Legally partnered	1.63 [1.41, 1.89]***** 1.00 (REF)	1.00 (REF)	—	—

Each row displays results for a separate multivariate regression for one of the seven dependent variables. For all AORs, the logistic regression models included age, race, education, children in household, employment status, household income, insured past 12 months, sexual identity, legally partnered status (or not), as well as the interaction of sexual identity by partnered status. When insured in the past 12 months was the dependent variable, we did not include insurance as an independent variable.

Numbers in cells represent (1) AORs for people in legally recognized partnerships and (2) AORs for sexual identity among respondents in legally recognized partnerships. For the column, “Association of Legal Recognition, AOR,” legally partnered respondents are compared to other respondents (reference group) within each sexual identity and gender combination (e.g., lesbians in legally recognized partnerships compared to other lesbians). For the column, “Association of Sexual Identity, AOR,” lesbians and gay men in legally recognized partnerships are compared to heterosexuals in legally recognized partnerships compared to other lesbians. For the column, “Association of Sexual Identity, AOR,” legally partnered lesbians compared to heterosexual women in legally recognized partnerships.

* $P \leq 0.05$; ** $P \leq 0.01$; *** $P \leq 0.001$; **** $P \leq 0.0001$; ***** $P < 0.10$.

AOR, adjusted odds ratios; CI, confidence interval.

Comparisons of self-reported health and healthcare use between legally recognized same-sex and heterosexual couples

We explored relationships among legally recognized same-sex and heterosexual couples and health insurance coverage, and healthcare use. These results appear in the Table 2 column “Association of Sexual Identity.” AORs and their 95% CIs are included for statistically significant relationships.

Lesbians in legally recognized partnerships were substantively less likely than their heterosexual counterparts to report good or excellent health (AOR=0.45; 95% CI: 0.25, 0.81), and to be insured consistently over the past 12 months (AOR=0.72; 95% CI: 0.42, 1.24). Moreover, these lesbians were much more likely to report delays in filling prescriptions (AOR=2.19; 95% CI: 1.26, 3.83). In addition, lesbians in legally recognized partnerships had lower odds of reporting a usual source of care, any healthcare visits, and mammograms.

We found significantly higher odds for gay men in legally recognized partnerships (than heterosexual men in legally recognized partnerships) to have continuous health insurance coverage (AOR=1.62; 95% CI: 0.82, 3.18), a usual source of medical care (AOR=2.78; 95% CI: 1.27, 6.05), and at least one doctor’s visit over the past 12 months (AOR=5.27; 95% CI: 2.34, 11.85). Yet, only legally partnered heterosexual men were significantly more likely to report good through excellent health.

Discussion

Before same-sex marriage became legal nationwide in June 2015,¹³ clinical researchers recommended marriage equality as one way to promote LGBT health.^{19,20} Concurrently, scientists demonstrated the lack of comprehensive, representative datasets to explore this opinion rigorously.^{3,4,9,10,21} Several population-level surveys ask about sexual identity, but do not include same-sex marriage or legal partnership as options to answer marital status questions. These datasets may miss marriage as an important moderator or confounder in their analyses.

Although California began to provide legal partnership protections for same-sex couples in 1999,²² in 2008, its Supreme Court guaranteed marriage equality and associated benefits for same-sex couples, including couples married earlier and out-of-state. As same-sex legal partnerships and marriage emerged in California and CHIS quickly implemented corresponding questions before most other United States, we thought an immediate examination of available CHIS data could refine current knowledge and facilitate future representative U.S. studies to explore health and well-being benefits associated with legal same-sex marriage and partnerships.

Our findings replicate previous findings that heterosexuals in legally recognized partnerships report better health, health insurance coverage, and use of medical services compared to their counterparts who are not in such partnerships. Among CHIS participants in legally recognized same-sex partnerships, however, we found significant positive results only in regard to health insurance coverage for both LG same-sex couples. Our analysis did not find uniformly positive results. For example, although gay men in legally recognized

partnerships were more likely than other gay men to report a doctor’s visit in the past 12 months, we did not find similar results among lesbians in this sample.

Subsequently, our findings did not support our second hypothesis that lesbians and gay men in legally recognized partnerships would report equally good health outcomes as married heterosexual couples. We found gay men in legally recognized partnerships to be more likely than legally partnered heterosexual men to have continuous health insurance coverage, a usual medical care source, and at least one provider visit over the past 12 months. However, we found statistically significant poorer health status outcomes among lesbians in legally recognized partnerships compared to their heterosexual female counterparts.

Minority stress theory^{23–25} posits that homophobic experiences over the life course influence actual and perceived mental and physical health among lesbians and gay men who, nonetheless, also display stores of strength and resilience.⁹ An analysis of 2009 CHIS data found that respondents in legally recognized same-sex partnerships reported lower levels of psychological distress than their single LG counterparts, although married heterosexuals in this sample reported the lowest levels of psychological distress.²⁶ Moreover, recent studies have found that people in legally partnered same-sex relationships have higher relationship stability, more financial resources, and better health outcomes than couples who cohabit without legal recognition.^{27,28} In addition, LeBlanc et al. have hypothesized that lesbians and gay men may not experience the health benefits of marriage exactly as their heterosexual counterparts, as the individuals in these same-sex partnerships may experience individual- and/or couple-level stressors related to internalized homophobia, homophobia, and/or the lack of universal support for same-sex rather than opposite-sex marriage.²⁹ It is not possible to explore these ideas with this small sample; nevertheless, active studies as described above and future work may continue to find disparate health and other outcomes for legally recognized same- and opposite-sex partners—perhaps even future analyses with a larger sample that includes recently released CHIS data. Indeed, this framework and corresponding analyses may be extended to analyze the health outcomes for other marginalized couples, for example, interfaith, interracial, or age-discordant couples.^{29,30}

Limitations

Our decision to combine legal partnerships and legal marriage as one convenient status, *legally recognized*, is a limitation as these discrete legal statuses did not convey identical rights and privileges between 2009 and 2012, a period that included concurrent, limited periods of city-, county-, or state-based same-sex marriages in California. We conflated legal partnerships and marriage as a small proportion of sampled Californians identified as gay or lesbian, and an even smaller proportion reported being in a legally recognized partnership. To place our findings in context, we included heterosexuals as a comparison group given the data-driven tenet that marriage provides property and health benefits for heterosexuals and the recent societal argument, now law, that marriage can provide similar benefits for same-sex couples. We could have conducted separate regressions for each sexual identity, but would not have been able to compare the relationship

between marriage and the dependent variable for persons of different sexual identities. The interaction term allows us to formally test if marriage relates to a health outcome differently for lesbian and gay male CHIS participants—an interaction we could not test given the structure of the questionnaire and corresponding dataset.

Another limitation is the need to exclude bisexually identified Californians because the survey's order and skip pattern complicate notions of self-identification and self-report of sexual behavior. Thus, a respondent who identified as bisexual may not have had sex with a same-sex partner in the last 12 months; consequently, the CHIS questionnaire would not have prompted such a participant to answer the question of legal partnership/marriage with someone of the same sex.

Conclusions

Our exploration of CHIS data demonstrates that the survey schedule provides a set of questions that researchers can adapt rapidly to conduct population-based research on the health and well-being of married same-sex couples and their families. The rate of legally partnered or married same-sex individuals almost doubled by including legally recognized partnerships instead of only the standard marital status question.

Our findings and limitations lead us to strongly recommend that researchers adapt CHIS questions on same-sex marriage and skip patterns to ensure complete and accurate responses. For example, the interview schedule for the CHIS data we analyzed placed same-sex partnership/marriage questions only after questions about same-sex sexual encounters within the preceding 12 months. This questionnaire structure precludes asking legal partnership status of all bisexual participants as it is possible that some participants had no same-sex relationships within that limited time period. Also likely is that same-sex couples may not have had sex within the preceding 12 months due to distance, illness, and other myriad reasons. Any LG Californians who reported no such sex during this time period would have lacked the opportunity to answer these legal partnership/marriage questions as well—thus limiting the representativeness of this study.

We also recommend that CHIS and other researchers ask marriage- and sexual identity-related questions en bloc to ensure the representativeness of a sample. The interview schedule that collected the data we analyzed asked about same-sex marriage and partnerships only after respondents confirmed having sex with a same-sex partner within the preceding 12 months; it asked about presumed heterosexual marriage in the sociodemographics section. En bloc placement of these questions ensures more robust representation, analyses, recommendations, and policy resolutions.

Although sexual identities other than heterosexual have been commonplace in the United States for decades, the National Center for Health Statistics finalized the development of a valid and reliable question on this topic in this decade³¹ and began to ask Americans this question in 2013.¹² The 2015 U.S. Supreme Court decision had direct implications for American lesbians and gay men. This change also affects healthcare providers and policymakers who expect researchers to provide data-driven recommendations. We can begin to provide these recommendations expeditiously by

beginning with tested measures. Nevertheless, to explore the influence of legally recognized partnership on the health and well-being of all people, we recommend proposing the question consistently regardless of participants' sexual identity.

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Disclaimer

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