Health Insurance Experiences of Gay Father Families: Perceptions, Disclosure, and Roles

Emma C. Potter

Thesis submitted to the faculty of the Virginia Polytechnic Institute and State University in partial fulfillment of the requirements for the degree of

Master of Science
In
Human Development

Katherine R. Allen, Chair
April L. Few-Demo
Christine E. Kaestle

September 3, 2013
Blacksburg, VA

Keywords: Gay Fathers, Health Insurance, Pilot Study, Qualitative Research, United States

Health Insurance Experiences of Gay Father Families: Perceptions, Disclosure, and Roles

Emma C. Potter

ABSTRACT

Recent developments in public debate, health policy, and research on nontraditional families have brought gay-parent families, especially gay fathers, into the cultural and political spotlight. Existing research and literature on LGBT families and gay fatherhood have emphasized relationship dynamics within the families but there are gaps in the literature regarding the health and well-being of these families, specifically as it relates to health insurance. Using symbolic interactionism, life course theory, and grounded theory methodology, I conducted a qualitative pilot study to investigate gay fathers' health insurance experiences. I collected responses from 10 White, gay fathers across the United States and asked questions about access to health insurance, the process of providing insurance for their families, access and use of community resources, and unique factors of their health insurance story. This research adds to the same-sex parent knowledge based by (a) gaining an understanding of the family decisions gay fathers make around health insurance, (b) identifying obstacles and subsequent solutions to health insurance problems, (c) discussing issues of disclosure and outness in gay father families, and (d) uncovering continued gender associations with the division of labor. This study has more broad implications for theoretical concepts like intersectionality and agency, but also provides insights into policy inequalities that continue in the United States.

Acknowledgements

I would like to first thank my committee chair, Dr. Katherine Allen for her continued support, encouragement, and guidance in my academic pursuits. Your knowledge and understanding provided a professional yet grounded experience for my thesis and I truly value your input and guidance through this entire process. You put in so many hours for me; this thesis would not be what it is today without your guidance. You pushed me when I needed to be pushed, and eased me into the process of qualitative research when I was not sure which way to go. When I sit down with you, I know I am working with the best. Words cannot fully express my gratitude.

I would like to thank my committee members Dr. April Few-Demo and Dr. Christine Kaestle for their invaluable input into this thesis. Their guidance in and out of the classroom has provided me with the tools to pursue this project in ways that consider the diversity of issues, complications, and worldviews surrounding this topic. Without your combined input, this project would fall flat. Instead, I remain passionately devoted to producing the best possible product for this thesis. I also want to thank Dr. Abbie Goldberg for her pioneering work on gay father families. You are an inspiration for my work.

I would like to thank my family for being supportive not only of my academic pursuits but my personal and career goals. Without the support of my mother, father, and brothers I would not be where I am today. Your prayers, advice, guidance, encouragement, and "positive energy" kept me going when I was not sure I could do another thing. In particular, my brother Dr. Daniel Potter was a real help in thinking through ideas, getting recruiting strategies together, and reflecting on the process of this thesis.

I also want to thank my friends both inside and outside of my department who have provided me with proof reading, support and encouragement, challenged my thinking, presented new ideas for recruiting, and for lots of laughs to keep me sane through this process. Thanks to all of you – you know who you are!

Finally, I want to thank the gay fathers who care for and provide loving and wonderful homes to so many children. Your stories and lives were inspiring and I thank you for sharing a part of your lives with me. I hope that my work now and in the future can bring equality to policy in ways that recognize the work, love, and support you provide to your families and your communities. Thank you.

Table of Contents

ABSTRACT ii
ACKNOWLEDGEMENTS iii
LIST OF TABLES vii
LIST OF FIGURES viii

CHAPTER 1: INTRODUCTION
Statement of Problem 1
Guiding Theoretical Perspectives 3
Symbolic Interactionism 3
Life Course Theory 7
Theoretical Application to Research Questions 9
Research Questions 9
Overview of the Study 11
Chapter Summary 13

CHAPTER 2: LITERATURE REVIEW
Health Insurance Policies and Laws in the United States 15
Health Insurance Options for Same-Sex Couples 16
Insurance Options by Employer 17
How Gays and Lesbians "Do" Family 21
Household Demographics and Family Formation 21
Household Division of Labor as Partners 23
Household Division of Labor as Parents 25
Gay Fatherhood 26
Stigma 27
Intersectionality 28
Internet and Mobile Technology in Qualitative Research 31
A Shrinking "Digital Divide" and Internet Use Trends 32
Gaps in the Literature 34
Chapter Summary 35

CHAPTER 3: METHODS
Overview of Research Design 37
Recruitment 38
Initial Recruiting Effort Success 40
Sample Selection and Sample Description 44
Sample Criteria 44
Sample Size 44
Sample 45
Data Collection Procedures 46
Online Process 46
Interview Process 47
Structured Collection of Experiences in Qualitative Research 49
Data Analysis 51
Coding 52

Chapter Summary 59

CHAPTER 4: FINDINGS
Sample Description 61
Narratives of Frustration 65
Family "Outings" 73
Insurance and the Use of Gendered Language 76
Chapter Summary 82

CHAPTER 5: DISCUSSION, IMPLICATIONS, FUTURE RESEARCH
Discussion 83
Intersecting Identities and Agency 83
"Outness" Among Fathers 85
Description, Not Identity 86
Conclusions 87
Limitations 89
Implications 90
Theory 90
Research 92
Policy 93
Future Research 94
Lessons Learned 94
Directions for Future Research 96

REFERENCES 98

APPENDIX A 113

APPENDIX B 117

APPENDIX C 119

APPENDIX D 125

APPENDIX E 128

APPENDIX F 129

APPENDIX G 130

APPENDIX H 132

APPENDIX I 135

Lists of Tables

Table 1. Open Coding Results by Participant 54

Table 2. Narratives of Frustration and Data Saturation 59

Table 3. Father and Partner/Husband Demographics 63

Table 4. Children Demographics 65

Table 5. Gendered Terms to Describe Provider Role 78

List of Figures

Figure 1. Twitter word cloud 43

Figure 2. Visualization of thematic analysis 57

CHAPTER 1: INTRODUCTION

Statement of Problem

Healthcare costs are increasingly affecting American families. In 2007, 62% of bankruptcies for American families were due to medical costs (Himmelstein, Thorne, Warrne, & Woodhandler, 2009). Complete and comprehensive health insurance coverage is therefore a lifeline for many American families (Bovbjerg & Hadley, 2007). While health insurance is a vital part of American families' lives, many Americans are unable to access insurance due to costs, policy denials, or legal recognition. In these ways, access is socially determined.

Access to health insurance is determined by a variety of influential factors including discrimination, racism, socioeconomic conditions, and availability of emerging technologies (World Health Organization, 2012). As the line between the *have* and the *have nots* continues to expand, the health inequities that exist today are a major concern of the U.S. government (U.S. Department of Health and Human Services, 2012). In fact, recently the Department of Health and Human Services established a *Healthy People 2020* initiative in an effort to address health inequities, including access to health insurance (U.S. Department of Health and Human Services, 2012).

Not all American families have equal access to health insurance. For example, Lesbian, Gay, and Bisexual, (LGB)-parent families experience unequal access to health insurance (Movement Advancement Project, 2012). Today LGB individuals are less likely to have health insurance compared to their heterosexual counterparts (Gates, 2013c). Same-sex male couples are less likely to have health insurance than heterosexual couples (Buchmueller & Carpenter, 2010), and gay males of color are twice as likely to be uninsured as gay White or heterosexual men of color (Dunn & Moodie-Mills, 2012). Several factors impact access to health insurance

for LGBT individuals and their families, including workplace policies (Dunn & Moodie-Mills, 2012), family policies (Mule et al., 2009), and socioeconomic inequalities (Gates, 2013a).

Most Americans receive health insurance benefits through their employer (National Bureau of Economic Research, 2009). Currently, only 29 states have laws prohibiting employment termination or discrimination on the basis of sexual orientation (Human Rights Campaign [HRC], 2013c). Without employment protection, LGBT individuals are susceptible to being fired and losing their insurance benefits (HRC, 2013c). Moreover, not every employer even offers same-sex domestic partner benefits to their employees (Japsen, 2013). LGBT individuals face more challenges to accessing insurance through their employer than heterosexual individuals (Dunn & Moodie-Mills, 2012).

Another contributing factor to LGBT individuals' unequal access to health insurance is "outdated family policies which bar gay and transgender parents from…access to safety net programs, family tax credits, and health insurance" (Dunn & Moodie-Mills, 2012). Same-sex parent families are susceptible to how society and policies view, recognize, and accept their families (Berkowitz, 2009; Movement Advancement Project, 2012). While the last few years have witnessed rapid and monumental changes in marriage equality, only 13 states perform same-sex marriages (National Conference of State Legislatures, 2013). When states and subsequently, health insurance policies do not recognize family and partnership forms, there are serious legal and financial consequences. Berkowitz (2009) articulates that:

> When a family looks like a family should, no steps need to be taken to ensure that others recognize and treat them like a family, [but] when a family does not resemble the Standard North American Family…tactics must be undertaken to ensure that outsiders accord them the validation of family. (p. 119)

Many lesbian and gay parents have a limited amount of tactics they can undertake to legitimize their family before the law (Goldberg, 2010). The current family policies and civil protections available to gay-parent families limits families' access to insurance and subsequently, adds to health disparities in the gay and lesbian population (Dunn & Moodie-Mills, 2012).

Lesbian women's and gay men's access to health insurance and partner benefits has improved over the last 10 years, but consequential inequalities remain (Ponce, Cochran, Pizer, & Mays, 2010). Moreover, researchers know relatively little about these processes in gay-parent families, especially among gay fathers. Health insurance is an important family issue that impacts all family members (Bovbjerg & Hadley, 2007) but is dependent on legal, and financial access (HRC, 2013a). Few scholars have researched the process, perceptions, and access to insurance for gay fathers and their families (Ponce et al., 2010). With families' savings at risk and increasing health disparities, researchers should turn their attention to the obstacles and perceptions of gay-parent families' experiences with health insurance.

Guiding Theoretical Perspectives

I used two theoretical perspectives to provide guidance to understanding gay fatherhood, family processes and relationships, and agency (White & Klein, 2008). Symbolic interactionism and life course theory provided useful frameworks and concepts to this qualitative study (Bengtson, Acock, Allen, Dilworth-Anderson, & Klein, 2005). In the following section, I review how the two theories led to the research questions and eventual findings of the study.

Symbolic Interactionism

True to its name, symbolic interactionism is concerned with explaining the connection between symbols and human interaction (LaRossa & Reitzes, 1993). The next section highlights

the epistemological foundations, assumptions, propositions, and major concepts of symbolic interactionism.

Epistemological foundations. In general, symbolic interaction is a theory that is non-deterministic (LaRossa & Reitzes, 1993), contextual, and centered on how humans make meaning in their lives (White & Klein, 2008). The epistemological foundation of symbolic interactionism posits that reality lies within the mind, and reality of the mind is a shared consciousness with others (i.e., there is consensus about expectations and meanings of symbols) (Turner, 2000).

Culture consists of symbols that humans define, understand, and act on in certain ways (White & Klein, 2008). Symbols are made up of signs (letters or gestures) and people assign meaning to each symbol by interacting with other people (White & Klein, 2008). Establishing meaning and finding consensus on symbols are essential to how humans make sense of something (White & Klein, 2008). For example, "family" is a symbol with a traditional meaning: a married man and a woman who have biological children (Smith, 1993). The Standard North American Family (SNAF) model is a powerful and prevalent symbol in Western culture (Smith, 1993) that continues to guide and permeate social and legal policy including health insurance (Goldberg, 2010).

In addition to symbols, symbolic interactionism also posits that humans have an evolving ability to conceptualize oneself as "I" and "me" (LaRossa & Reitzes, 1993). Humans are able to understand how others may perceive the "me" in positive and negative ways (LaRossa & Reitzes, 1993). Understanding one's place and expectations from others in society is key and is closely related to roles. For example, gay fathers are aware of and understand how society stigmatizes and perceives gay men (Mallon, 2004). As a result, gay fathers may adapt their

parenting roles (LaRossa & Reitzes, 1993) to adhere to traditional notions of fatherhood (Pleck, 2004) so as to avoid some degree of stigmatization (Oswald, Blume, & Marks, 2005).

Key concepts. Three key concepts in symbolic interactionism are roles, socialization, and situation (LaRossa & Reitzes, 1993; White & Klein, 2008). A role is a social position that "catalogues specific expected behaviors…and privileges" (Turner, 2000, p. 112). Burr, Leigh, Day, and Constantine (1979) argued that society establishes sets of expectations that go with every role and we pass on expectations through socialization. For example, a "husband" is a role, a "daughter" is a role, and a "woman" is a role. Certain expectations are associated with each of those roles (LaRossa & Reitzes, 1993). In the United States, the expectations for gay men in society do not include fatherhood (Berkowitz & Marsiglio, 2007). Gay fathers, therefore, contradict typical, expected roles for gay men (Berkowitz & Marsiglio, 2007) and do take part in role-making (Turner, 2000).

Role-making is the ability to take on roles in ways that "combine elements of creativity without conformity," allowing for within-role flexibility (Turner, 2000, p. 112). Theorists like Park (1864-1944), Blumer (1969), and Turner (2000) fall into the Chicago School of Thought, which would argue that gay fathers go through a "role-making" process (Turner, 2000). Using the Chicago School of Thought, I analyzed the roles, meaning-making, and agency gay fathers have as they navigate their roles as fathers and health insurance providers. I assumed gay fathers have role creativity and agency in defining their families and their position in society (Blumer, 1969; LaRossa & Reitzes, 1993).

One final concept in symbolic interactionism is situation. A debate in symbolic interactionism continues to be the following: Does the source of meaning making lie within the society or within the individual? Social context, while heavily influential, is not all-powerful

(Blumer, 1969). For example, two gay men raising children together make meaning of their household as a family, even if society does not legally or socially recognize their household as a "traditional" family (Gates & Cook, n.d.). The concept of situation helped me to understand gay fathers' perception of the choices and options available to form their families, and how gay fathers' understand and "do" family.

Propositions. The key propositions to symbolic interactionism rest on roles, consensus, and expectations. One particular proposition relevant to my research states that the more clarity about a role, the more likely a person is to enact that role (Stryker, 2001). If gay fathers have the language to describe their role, they can make meaning and understand the expectations of their role (Blumer, 1969). Those roles that have more ambiguity may be more difficult for gay fathers to take on (Stryker, 2001).

Role clarity extends into a second proposition: the more consensus around a role, the lower amount of role strain for the person (Turner, 2000). Society has clear expectations for roles. For example, the role of a firefighter is clear, and as a result, firefighters can perform their role without feeling conflicted or confused. In comparison, the role of a father is now in flux (Pleck, 2004). Gay fathers may have conflicted ideas about their roles as fathers and providers (Turner, 2000). A third related proposition states that multiple roles result in multiple expectations, and more confusion (Stryker, 2001). Keeping these propositions in mind, the roles and expectations for a gay, male, stay-at-home parent, conservative, and religious person may be conflicting and ambiguous, causing role strain (Stryker, 2001).

Symbolic interactionism gives an explanation to the roles people adopt, the meanings they attach to symbols and roles, and the attitudes they have towards experiences (White & Klein, 2008). This theory provided an inlet to understanding gay fathers' perceptions of

accessing health insurance, on their own family, and the social environment (White & Klein, 2008).

Life Course Theory

Life course theory attempts to explain how an individual's identity changes over the course of one's life, in relation to culture and within a certain historical time (Elder, 1985). I used life course theory as an orientation (Elder, Johnson, & Crosnoe, 2004) and framework to understand gay fathers' experiences as parents acquiring health insurance for their families.

Epistemological foundations. Elder et al. (2004) argued that development continues throughout one's life, beyond the formative years. According to life course theory, human development is "embedded in social institutions and history," meaning that gay fathers do not live in isolation from their social surroundings, but interact on individual, familial, and macro-societal levels (Elder et al., 2004, p. 4). As such, gay fathers' historical and social position throughout the life course is dependent on the specific timing in their individual life, family resources, and socio-historical time (Bengtson & Allen, 1993).

Concepts and propositions. Social pathways make up the overarching life course that individuals develop along (Elder et al., 2004). These pathways are "shaped by historical forms and…structured by social institutions" (Elder et al., 2004, p. 4) such as heteronormativity (Cohler, 2005). *Heteronormativity* dictates that men and women are expected to follow heterosexual, married, and procreating social pathways in life (Oswald et al., 2005). Gay fathers often develop along different paths because they create nontraditional families, may not be able to get married, or take on responsibilities that lie outside of traditional fatherhood (Oswald et al., 2005). Gay fathers' development may also vary according to other institutions such as age, race,

geographic location, and gender (Bengtson & Allen, 1993; Gecas, 2004). Social pathways reiterate the influence of historical time and place (Elder, 1994).

Transitions are also relevant for this study. Transitions are either a single event or series of events that usually result in a change in status, identity, or role (Elder, 1985). Transitions can alter social pathways for gay fathers in a variety of ways: on the macro level such as court decisions (i.e., DOMA and the passage of the Affordable Care Act); and micro-level, when couples decide to have children (Elder, 1994). Using a micro-level example, gay fathers' identities change when they have children because they are no longer gay *men*, but are gay *fathers* (Brinamen, 2000; Goldberg, 2012).

Agency is a key concept and proposition in life course theory as well (Gecas, 2004). The degree of agency gay men perceive depends on their social surroundings (Oswald, Cuthbertson, Lazarevic, & Goldberg, 2010). Life course theory emphasizes individuals' embeddedness and the impact that time and place have on individuals over their lifetime (Bengtson & Allen, 1993). As C. W. Mills stated, "biographies of men and women on the kinds of individuals they've become cannot be understood without reference to the historical structure" (as cited in Elder, 1978, p. 34). As such, gay fathers' lives and experiences must be considered in context with the historical (21st century) and geographic location (United States). Today, gay fathers are insuring their families in hostile social climates that may not legally recognize their families (Wadsworth, 2010). Gay fathers' agency is dependent on their individual development, their sociohistorical position, and also the options and resources society made available (Elder et al., 2004).

Life course theory also uses the concept of linked lives to underscore the importance of embeddedness and social support networks on an individual's development (Elder, 1994). How individuals interact with their surrounding communities is crucial to identity, plans, and family

outcomes (Bengtson & Allen, 1993). I used the concept of linked lives to examine gay fathers' transitions, agency, and use of community resources (Elder, et al., 2004). I also analyzed their degree of "outness," or the degree of their disclosure of their sexual orientation, to see how community acceptance could possibly influence their insurance plans and identity (Oswald, et al., 2010). The degree of community outness can reflect gay fathers' perception of the social climate for gay and lesbian parents.

Theoretical Application to Research Questions

Theorizing gay fathers' experiences allows me to go beyond just descriptive reporting and provide explanations for why and how gay fathers approach and navigate the health insurance system. The concepts and propositions of symbolic interactionism and life course theory used together equip me with the guidance to explain the attitudes, actions, agency, and experiences of my sample of gay fathers. This investigation into gay fathers' experiences with health insurance would be incomplete without both theoretical perspectives. I used symbolic interactionism to recognize, deconstruct, and interpret the meaning-making processes gay fathers go through as they reflect on their experiences with health insurance (White & Klein, 2008). I cannot, however, fully contextualize gay fathers' experiences without life course theory. Life course theory provided a sociohistorical lens that situates each gay father in context of their own individual time, social location as parents, and historical location (Elder, 1994). Combined, the two theoretical perspectives guided the analysis and explained these fathers' identities, positions of privilege and disadvantage, language, agency, and experiences as gay fathers in the 21st century.

Research Questions

The research questions address areas of interest related to interpersonal processes, perceptions, identities, and agency. In order to best understand gay fathers' experiences with

health insurance, I wanted to gather information about the process of getting insurance, perceptions of the experience, the ways in which intersecting identities influenced their experiences, and the amount of control these fathers had during the experience. With the help of my thesis committee, I created four research questions to explore gay fathers' health insurance experiences.

- *Research Question 1: In the United States, how do today's gay fathers perceive their access to health insurance for their families?*

I sought to identify the obstacles, challenges, and remaining barriers if any, that gay fathers perceive and face today when trying to provide their families with insurance. Using symbolic interactionism and life course, I uncovered their perceptions of the insurance system: Is it easy to access? What are their frustrations? Research Question One also considered the sociohistorical context of gay fathers living in the 21st century in the United States, with a rapidly changing social and legal climate.

- *Research Question 2: What are the communities in which gay fathers are embedded and can turn to for knowledge/instrumental resources to navigate the insurance system? How helpful are these community resources?*

Community embeddedness is crucial to the development of gay fathers' mental and familial well-being (Oswald & Culton, 2003). I sought to identify the gay fathers' access to and use of community resources and networks of support. My questions centered on: Who did gay fathers have to turn to for information or guidance? Which resources did they use and in what ways were they supportive or helpful? Did gay fathers disclose their sexual orientation to these community resources? Research Question Two sought to understand gay fathers' potential linked lives with family, friends, professionals, and their communities.

- *Research Question 3: In what ways and to what degree do gay fathers employ agency and innovation as they navigate the health insurance process?*

Research on LGBT families reveals that individuals have agency in creating their familial roles (Biblarz & Savci, 2010). I sought to uncover gay fathers' agency as they pursue health insurance for their nontraditional families. I uncovered the role-making and adaptations gay fathers employ in order to insure their families. How did these fathers overcome obstacles in health insurance, if at all? What were the ways in which gay fathers may have altered their roles and make sense of their family situation? I also recognized the limits to gay men's agency. What were the ways in which laws or health insurance policies limited the agency of gay fathers? I used this question to guide interview questions that probed the identity, perception, and decision making process gay fathers employ as they attempt to cover their families.

- *Research Question 4: What marginalized and privileged identities are at play for gay fathers?*

Gay fathers occupy positions of "both oppression and opportunity" (Shield, 2008, p. 302). Their social locations: gender, sexual orientation, race, class, and geographic locations intersect with each other (McCall, 2005). These social locations are determining factors of access, agency (Gecas, 2004), and power (Collins, 1990). In order to make better sense of my fathers' experiences, agency, and perceptions I considered their marginalized and privileged identities. Without considering their intersectionality, I would have missed a vital part of understanding the options available, perceived control of, and overall narratives of the fathers in my study.

Overview of the Study

This study used symbolic interactionism and life course theories to guide my understanding gay fathers' health insurance experiences. I designed a qualitative research project and collected data using a standardized questionnaire with open-ended and multiple choice questions. I utilized a variety of recruiting techniques, made changes to sample criteria and sample size, and altered data collection methods. While I originally integrated online and mobile technology to reach participants who may not otherwise have been able or interested in participating, I collected over half of my data via telephone interviews at the request of several gay fathers. The study asked participants to answer questions related to their perceptions and experiences with the process of getting insurance, unique family factors, family decision making, use of community resources, their degree of outness as a father and family, and roles as a provider for their family.

I collected responses from 10 gay fathers across the United States between the months of May and August 2013. I used sensitizing concepts from symbolic interactionism and life course theory in combination with grounded theory methodology for my data analysis. I conducted open coding, focused coding, and thematic analysis of my data. I organized my findings by three overarching themes: Narratives of Frustration, Family "Outings," and Insurance and the Use of Gendered Language. This study adds to the knowledge base of LGBT families, but specifically sheds light on the inequalities and obstacles in current health insurance policies, and the resources available. Finally, this study can inform health policy advocates and leaders on future steps to take in ensuring health insurance, and health equality.

Significance of the Study

This research provided insight into the lives of a relatively invisible population. Same-sex couples do not enjoy ubiquitous legal protections across the United States and are subject to

workplace discrimination (Dunn & Moodie-Mills, 2012), family formation bans (Goldberg, 2012), limited access to marriage equality (NCSL, 2013), and lack of legal recognition as a family under varying state laws (Goldberg, 2010). Addressing the health needs of all families, including gay father families, requires knowledge of the obstacles and unmet needs. Not only does this study showcase the obstacles of providing insurance to non-traditional families, but also highlights state and federal policies that can perpetuate health inequities.

Most research on LGBT families has focused on lesbian-parent households with relatively few studies specifically focused on gay fathers (Biblarz & Savci, 2010). Gay fathers face specific and differing obstacles in their quest for parenthood (Berkowitz & Marsiglio, 2007) for being oversexualized (Mallon, 2004) and unable to properly provide for their families (Gerber, 2010). This study provided insights into the ways in which gay fathers do provide for their families despite living in hostile environments. Moreover, this thesis uncovered processes, needs, community resources, and barriers specific to gay fathers.

In this study I also attempted to utilize online and mobile technology to reach a gay father population because of its promises to reach a more diverse and unavailable population (Brenner & Smith, 2013). The integration of mobile technology in this research on gay fathers' experiences with health insurance added methodological significance to the study, and the results highlight the ways in which online and mobile technology can be used in qualitative research.

Chapter Summary

In this chapter, I provided the background and significance of studying gay fathers' experiences with health insurance. I argued for the integration of symbolic interactionism and life course theory as a guide to my research questions, and eventual analysis. Using these theories as a guide, I could better understand the nuances of gay fatherhood as it relates to health

insurance and can place their experiences in the current sociohistorical context. Lastly, I highlighted the significance and innovation of my research. In the next chapter, I discuss prior research and its influence on my own work.

CHAPTER 2: LITERATURE REVIEW

While still the subject of public debate (Biblarz & Savci, 2010), same-sex parent families are an increasingly visible family type in the United States. Declining social stigma (Gates, 2013c) has resulted in an increased visibility of gay-parent families. These social factors have coupled with emergent research methods and theoretical perspectives to improve and expand the amount of research on lesbian and gay families (Goldberg & Allen, 2013). I sought to use this study to contribute to the gay father research field, and in this chapter I review the relevant and influential prior research. Understanding the health insurance experiences of gay fathers requires knowledge of the health insurance options available to gay father families. I begin by reviewing the health insurance options in the United States. Secondly, in order to understand health insurance, I examine how LGB-parents "do family" (Perlesz, Brown, Lindsay, McNair, deVause, & Pitts, 2006): who counts as family, who does what (division of labor) as partners, and who does what as parents. In addition, I cover research that specifically discusses the nuances of gay fatherhood research, social determinants of health, and the use of Internet technology in qualitative research. I conclude by identifying gaps in the literature.

Health Insurance Policies and Laws in the United States

In the United States, adults under the age of 65 have access to health insurance through privately purchased plans like health maintenance organizations (HMOs), social welfare programs (Disability), employer-provided plans, and the military (U.S. Census Bureau, 2011). In 2011, however, 21% of adult Americans aged 19 to 64 had no health insurance (Kaiser Family Foundation, 2011). Children have access to health insurance through their parent's plans, Medicaid, or state-sponsored Children's Health Insurance Program (CHIP) (U.S. Census Bureau, 2011) and in 2011, 10% of children were without insurance (Kaiser Foundation, 2011). In 2011,

the number of uninsured Americans decreased by 1.4 million to 48.6 million (U.S. Census Bureau, 2011). While the number of Americans without insurance has been declining in recent years (U.S. Census Bureau, 2011), the inability to access insurance continues to propagate health inequities especially in the LGBT community (U.S. Department of Health and Human Services, 2012).

Two recent U.S. Supreme Court decisions impact LGB individual's access and ability to afford health insurance: the 2012 Affordable Care Act and the 2013 *Windsor* (DOMA) decisions. On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act (Baker, 2012). Adults benefit from the upholding of the Affordable Care Act because the act lowers the cost of insurance, eliminates coverage denials based on preexisting conditions, and pushes for health companies to provide more policies to same-sex partners (U.S. Department of Health and Human Services, 2012). On June 26, 2013, the *Windsor* decision struck down language in the Defense of Marriage Act that defines marriage as solely between a man and a woman (U.S. Office of Personnel Management [U.S. OPM], 2013). As a result, the U.S. government now recognizes same-sex marriage on federal tax returns, and is in the process of eliminating the extra tax burden on same-sex couples (U.S. OPM, 2013). These two recent events provide same-sex couples with decreased economic burden, increased legal protections, and federal recognition (Baker, 2012; HRC, 2013a).

Health Insurance Options for Same-Sex Couples

In the United States, same-sex couples can be covered by same-sex spousal or domestic partnership benefits (HRC, 2013a). According to the Williams Institute, there are over 650,000 same-sex couples in the United States today (Gates, 2013a). Of those 650,000 couples, one-third

(34%) are either legally married or in registered civil unions or domestic partnerships (114,100 married, 108,600 civil union or domestic partnership) (Gates, 2013a).

Benefits with legal recognition. Health insurance companies consider same-sex marriage a qualifying event; after a legal marriage, both partners are eligible to enroll in health insurance benefits (HRC, 2013d). Same-sex couples that reside in states that recognize their marriage can more easily access health insurance. Currently 13 states (California, Connecticut, Delaware, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island, Vermont and Washington, the District of Columbia) recognize and allow same-sex marriage in the United States (NCSL, 2013). Those legally married couples living in states without marriage equality may not be able to access state benefits and until recently, were also subject to a federal tax (HRC, 2013a).

According to federal law, a domestic partnership is a "committed relationship between two adults, of the same sex, in which the partners" are (a) at least 18 years of age, (b) able to give consent, (c) co-residing with partner, (d) share financial responsibilities, (e) not married to anyone else, (f) not in domestic partnership with anyone else, and (g) not related in a way that would bar marriage (U.S. OPM, 2013). Localities and businesses began offering domestic partnership benefits in 1982 (HRC, 2013b), and currently, Colorado, Hawaii, Illinois, and New Jersey allow civil unions, and California, Oregon, Nevada, Washington, and the District of Columbia offer domestic partnerships to same-sex couples (NCSL, 2013). The IRS and Office of Management and Budget are continuing to determine the status of these couples as it relates to the recent DOMA decision (U.S. OPM, 2013).

Insurance Options by Employer

In a comparison study using the U.S. Census Bureau's American Community Survey, Gates (2013a) found that 76.5% of same-sex couples compared with 84% of opposite-sex couples have both spouses or partners covered through one health insurance policy. Moreover, same-sex couples are twice as likely to have one spouse or partner without insurance (17% vs. 8% of opposite-sex couples) (Gates, 2013a). More than 90% of both same-sex and opposite-sex couples are employed, with 75% employed in the private sector, 15% employed in the public sector, and 10% self-employed (Gates, 2013a). The health insurance options for many LG individuals are, however, dependent on the employer-provided health insurance options and policies that exist outside of state laws. No laws bar private employers from offering domestic partnership benefits, but federal and state laws affect if and how employers offer domestic partner health insurance benefits (HRC, 2013b).

Insurance within Fortune 500 companies. The workplace environment for LGBT individuals is improving (HRC, 2012). In the United States, large scale employers or those with 500+ employees are improving their employees' access to same-sex partner benefits (Japsen, 2013). In 2012, 62% of all Fortune 500 companies provided domestic partnership benefits and offered equal opposite-sex and same-sex partner benefits (HRC, 2012). According to data from the Aon and Mercer databases, which include data from employers' health insurance providers like Humana, UnitedHealth, Cigna, Aetna, and Blue Cross Blue Shield, a growing number of employers are offering same-sex domestic partnership health insurance benefits (Japsen, 2013). Mercer's 2012 National Survey of Employer-Sponsored Health Plans found 45% of employers with 500+ employees offered domestic partnership coverage (up from 27% in 2008), and five percent of employers offered tax reimbursement for domestic partnership benefits (Mercer,

2013). Aon's survey of over 1300 employers found that 78% offered domestic partnership benefits, and of those, 71% offering same-sex coverage (Japsen, 2013).

Insurance within small businesses. Outside of the Fortune 500 companies, small businesses employers employing 3 to 499 persons also offer same-sex health insurance benefits to their employees. Mercer's (2013) National Survey of Employer-Sponsored Health Plans found that 50% of small business employers with 50 to 499 employees offered same-sex partner benefits. The percentage of small business employers offering same-sex partner benefits has increased nearly 100% since 2008 (up from 27%) (Mercer, 2013). Only two percent of employers offered tax reimbursements on domestic partnership benefits (Mercer, 2013). Researchers at the Center for American Progress also found that in 2011 51% of small business employers with 3 to 100 employees offered equal coverage to opposite-sex and same-sex partners, and of the 49% that did not, over 51% indicated that they *would* extend coverage to same-sex partners *if* they had an employee that was in a same-sex relationship (Burns & Krehely, 2011a).

Gaps in employer-provided insurance. While insurance options for same-sex couples are improving, not every employer or insurance company offers same-sex couple coverage (Japsen, 2013). For those employed in these businesses, their insurance options are limited. Research on those businesses that do not provide same-sex couple coverage cite multiple and varied reasons for not offering benefits. Some economists have speculated that providing same-sex partner benefits adds burdensome costs to employers, but repeated studies indicate that a majority of employers experience an increase in costs that totals less than one percent increase (HRC, 2013b). Public or government employers cite state laws banning the recognition of any

union other than a legal marriage between a man and a woman as the reason for not offering same-sex benefits (HRC, 2013c).

In the United States a majority of LGBT individuals either are unable to receive coverage on their partner's plan or pay extra to receive the benefits (Ponce et al., 2010). Access limitations through laws and extra costs disproportionately impact LGBT families who are not the stereotypical White, highly educated and financially secure participants common in research (Gates & Newport, 2012). Moreover, children with no legal relation or biological connection to their LGB parent are ineligible to be on the parent's insurance policy (Goldberg, 2010). Insurance regulations and family laws limit who has access to much needed coverage (Ponce et al., 2010). In fact, most LGBT individuals are more likely to face poorer economic conditions; thus making the financial and legal access to health insurance one of the biggest social determinants of health (Mule et al., 2009).

Geographic Determinants

As discussed above, access to health insurance for LGBT individuals and especially families can be geographically (HRC, 2013) and employer-specific (Japsen, 2013). Contrary to popular culture, LGBT families do not reside in urban, gay "meccas" (Oswald & Culton, 2003), and instead are more likely to raise children in conservative, rural areas of the United States (Gates & Newport, 2012). The highest proportion of LGB parents raising children reside in states in the South, the Mountain West, and the Midwest (Gates, 2013b; Oswald & Lazarevic, 2011). Most of these states do not have protections for same-sex couples or LGB parents, and do not legally recognize these family forms (NCSL, 2013). Moreover, state-by-state variations hinder the availability of insurance policies to same-sex couples and their families (HRC, 2013d).

How Gays and Lesbians "Do Family"

As discussed above, health insurance benefits extend to those who are recognized as a family. This seemingly easy definition becomes increasingly complicated as the "stereotypical concepts of family are in flux" (Davis, 2013, p.384). More and more heterosexual and LGB families have shifted away from the biological, nuclear family unit (Smith, 1993) to families that involve cohabitation, divorce, and remarriage (Davis, 2013). In the last half of the 20th century, lesbian and gay individuals most commonly created family through a heterosexual marriage and then subsequent divorce or dissolution (Bigner & Jacobsen, 1989) but in the first decade of the 21st century, lesbian women and gay men have utilized in vitro fertilization (Gartrell, Banks, Hamilton, Reed, Bishop, & Rodas, 1999), surrogacy (Bergman, Rubio, Green, & Padron, 2010), adoption, or foster children to create families (Goldberg, 2012; Mallon, 2004). A review of lesbian and gay family composition and formation highlights the ways in which lesbian and gay parent households define family in both old and new ways (Goldberg & Allen, 2013).

Household Demographics and Family Formation

Using data from the 2002 National Survey of Family Growth, Riskind and Patterson (2010) concluded that lesbian women and gay men are less likely than their heterosexual childless counterparts to have children. Their study examined the desires and intentions for 294 childless lesbian, gay, and heterosexual men and women and found that gay men in particular were less likely than lesbian women or heterosexual men and women to express desires or intentions to become parents (Riskind & Patterson, 2010). Researchers have speculated about why gay men and lesbian women are less likely to have children that steer away from stereotyping gays and lesbians as anti-family (Goldberg, 2010). Research shows that lesbian and

gay-parent families have had to use creativity rather than simple biology to form their families (Goldberg, 2010).

Lesbian and gay-parent couples have various ways of constructing their families. Today, more than 111,000 same-sex couples are raising over 170,000 biological, step, or adopted children (Gates, 2013b). As such, children in same-sex parent households come from a variety of backgrounds, families, and racial and ethnic backgrounds (Goldberg, 2010).

Racial make-up. Same-sex parent households are racially diverse (Gates, 2013B). Nearly half of children under 18 in same-sex households are White, and the other half of children represent a variety of racial and ethnic backgrounds: 25% Latino/a, 16% Black/African American, 2% Asian/Native Hawaiian/Pacific Islander, and the remaining 9% split between American Indian/Alaska Native and Other (Gates, 2013b). One explanation for racially diverse families could be the increasing rates of transracial adoption among LGB parents who form families of choice rather than biology (Farr & Patterson, 2013).

Adoption. Same-sex couples are more likely to report having children that are not biological or stepchildren but are instead adopted (Gates, 2013b). An increasing amount of adopted children come from state foster care systems rather than private adoption agencies (Goldberg, 2010). Adoption agencies have been known to reject applications from same-sex partners (Goldberg, 2012), but foster cases typically use the court system to determine what is "in the best interests of the child" (Davis, 2013, p. 387). The court system provides gays and lesbians greater access to bringing children into their families (Davis, 2013). Adoption and foster care laws for same-sex couples vary state by state (Davis, 2013). Thus, while same-sex couples are four times more likely to be raising adopted children than opposite-sex couples,

adopted children make up only 10% of children under 18 raised by same-sex parents (Gates, 2013b).

Biological. Biological children continue to make up the largest percentage of children under age 18 in same-sex households (59%) (Gates, 2013b). Most biological children have come from a previous heterosexual marriage or partner (Bigner, 1989) but some biologically related children are from in vitro for lesbian women (Gartrell et al., 1999) and surrogacy for gay men (Bergman et al., 2010; Berkowitz, 2013). With surrogacy costing upwards of $150,000 (Berkowitz, 2013), having biological children does require a certain socioeconomic status, limiting who can create biological and chosen families. For example Berkowitz (2013) found that in studies of surrogate gay fathers, samples were not racially diverse. Typically, 80% of surrogate fathers were White, nearly eight percent were Asian American, another eight percent Latino, and five percent Middle Eastern. Interestingly, zero percent of surrogate fathers were African American. The lack of racial diversity illustrates the limited population of gay fathers that can pursue surrogacy.

Other. Sometimes children may not have legal or biological ties to both or either LGB parent (Goldberg, 2010). For example, children with "other" forms of relation (grandchild, sibling, or no relation) account for a substantial 22% of children under the age of 18 in same-sex households (Gates, 2013b). LGB parents rely on social and alternative means to establish ties to their children (e.g., legal guardianship, assuming the same last name, and incorporating them into their wills) (Goldberg, 2012). Those children with no legal or biological ties to their parent have no entitlement to parent's estate or health insurance benefits (Goldberg, 2010).

Household Division of Labor as Partners

The division of labor (DOL) integrates issues related to gender (Goldberg, 2013), power, and resources (Hochschild & Machung, 1989) with the home still remaining a feminized space (Luxton, 2006). Even before children, the division of labor between two people in a household is a source of conflict (Koivunen, Rothaupt, & Wolfgram, 2009). The division of labor in same-sex households is a widely studied area that shows the possibility of egalitarian-like relationships and de-gendered division of labor (Brinamen, 2000), but researchers have recognized differing power dynamics between partners (Patterson, 2000).

Research on the division of labor among same-sex couples has shown mixed results as to how these couples divide labor and determine power between the partners (Goldberg, 2013). Solomon, Rothblum, and Balsam (2005) used a 19-item DOL subscale to compare 413 Vermont heterosexual-married couples with 336 same-sex couples without civil unions and 238 same-sex couples with civil unions. Same-sex couples were more likely to have an egalitarian division of labor with household tasks (e.g., taking out the trash, cooking, and cleaning) than their heterosexual counterparts (Solomon et al., 2005). Goldberg (2013) conducted an analytic review on household division of labor research among same-sex couples and found gendered and de-gendered DOL patterns.

Researchers have theorized about why sexual orientation appears to be a predictor of egalitarianism. Patterson (2000) proposed exchange theory where the more financial or social resources one partner has determines the division of labor. Money resources accounted for an unfair division of labor for heterosexual and gay men couples, but not for lesbian couples (Patterson, 2000). While offering no formal theory, Solomon et al. (2005) argued that lesbians and gay men may instead reject gender socialization and therefore have more egalitarian role division. Goldberg (2013) contends that same-sex couples go beyond "doing" or "undoing"

gender in DOL and that "social temporal contexts that shape how same-sex couples give meaning to and enact housework" (Goldberg, 2013 p. 85). For example, researchers who study gendered divisions of labor either inappropriately "assume same-sex couples are gender-free or uninfluenced by dominant (hetero)gendered meaning systems" (p. 88) or dichotomize roles and identities into male or female meanings (Goldberg, 2013).

Household Division of Labor as Parents

Understanding the literature on the division of childcare in same-sex parent households informed my data analysis on the fathers' description of the division of labor in their households. The division of childcare and labor in the home is a widely studied topic and research has shown that heterosexual parents tend to divide up the labor according to specialized, gendered roles (Patterson, Sutfin, & Fulcher, 2004). Meanwhile, gay men and lesbian women divvy up childcare responsibilities in a variety of ways (Patterson, 2000). In their interviews with gay men, Schacher, Auerbach, and Silverstein (2005) found gay men's de-gendered, hybrid parenting roles do not use gender as the deciding factor, but use a formal decision making process. Panozzo (2010) found that in gay male parent households, typically the partner who contributed less income to the household usually had a greater desire for children and would end up staying home with the child. Similar patterns of DOL could occur in areas such as health insurance coverage. Goldberg (2012) also found that gay men divide responsibilities according to income, but sometimes one partner will stay home if the couple can afford this arrangement. Other gay men and lesbian women have enough resources to hire out childcare and both partners can continue working (Goldberg, 2010).

Other studies, however, found that specialized roles do emerge in same-sex parent households (Goldberg, 2010). Most research has focused on lesbian role specialization and

found biology is a "silent marker of difference" and inequality (Downing & Goldberg, 2010, p. 116). The mother with biological ties to the child took on more childcare responsibilities (Downing & Goldberg, 2010). The division of childcare based on biological-relatedness has resulted in lesbian partners being dissatisfied with the division of childcare (Downing & Goldberg, 2010) and in some cases, jealous of the bond between a partner and their biological children (Gartrell et al., 1999). Research has shown that gay men practice different divisions of parenting (Brinamen, 2000; Johnson & O'Connor, 2002). Gay fathers tend to divide childcare by income and availability (Goldberg, 2012); Johnson and O'Connor (2002) found that gay fathers were more satisfied than lesbians with the division of childcare (Johnson & O'Connor, 2002).

Gay Fatherhood

Of the research on lesbian and gay parent families, researchers have mostly focused on the experiences and child outcomes of lesbian mothers (Biblarz & Savci, 2010; Goldberg, 2010). One explanation for this research pattern is the lower number of gay fathers in the United States (Biblarz & Savci, 2010). In a comparison of 294 lesbian, gay, and heterosexual women and men, gay men were the least likely of all the comparison groups to express desire or intention to have children (Riskind & Patterson, 2010). Today over 48% of LGBT identified women and 20% of LGBT identified men are raising children (Gates, 2013b). The lower percentage of gay fathers uncovers issues of access, stigma, and intersecting identities that gay fathers specifically encounter.

Gay men are not anti-family (Goldberg, 2010) but encounter legal, financial, and physical limits to their opportunities to have children. In divorce, the courts often award custody to biological mothers, meaning that gay fathers typically have a joint custody or visitation rights agreement with biological mothers, rather than sole or primary custody (Cordell, 2011).

Knowledge of gay fathers' roles and responsibilities post-divorce is relatively low (Tasker, 2013). As previously discussed, the avenues by which gay men can become fathers outside of heterosexual marriage are limited by prejudiced adoption agencies (Goldberg, 2012), court decisions with foster care (Davis, 2013), and costs of surrogacy (Berkowitz, 2013). The limited avenues through which gay men can become fathers are one reason they are a hard to reach, and an understudied population.

Stigma

In addition to limited avenues of family formation, gay men have to overcome internalized and external stigma. For many men coming out as gay is equivalent to giving up on having a family (Berkowitz & Marsiglio, 2007). Rabun and Oswald (2009) argued that gay men must come into their procreative consciousness, or the mental capacity to see oneself having children. In a study of 19 childless and 20 gay fathers, some fathers encounter their procreative consciousness as a result of personal experience: caring for relatives' children, tragic events such as the death of a loved one, and personally wanting to debunk myths about gay men (Berkowitz & Marsiglio, 2007). For many gay men, homosexuality and fatherhood are mutually exclusive (Petroski & Edley, 2006) and those fathers who do not overcome internalized homophobia and enter their procreative consciousness are less likely to have children (Berkowitz & Marsilgio, 2007).

External stigma also hinders the ability for gay men to become fathers. In the mid-20th century, homosexuality was highly stigmatized (D'Emilio & Freedman, 1997) meaning that many lesbian and gay individual concealed their sexual orientation. Stigma and concealment of sexual orientation continue to exist, but for many the two have declined (Gates, 2013c). Today, adoption agencies, policy makers, and religious leaders accuse gay fathers of being too

sexualized or being pedophiles (Mallon, 2004). Ideologies surrounding gender, fatherhood, and sexual orientation in conjunction with race, class, and geographic location influence not only family formation, but the day to day functioning of gay fathers in the United States (Goldberg, 2012).

The large amount of social stigma and the lack of social support are added stressors for many gay fathers in the transition to parenthood (Tornello, Farr, & Patterson, 2011). In a study of 320 gay fathers, Tornello et al. (2011) found that having social support was crucial to gay fathers' disclosure or coming "out." Moreover, they found that coming out alleviated stress in their families. Gay fathers explained that hiding their sexuality made them feel like they were raising their child(ren) in a false environment (Tornello et al., 2011). While the cultural climate is improving, stigma, harassment and discrimination continue in the workplace, in housing, in policies, and daily lives (Oswald & Culton, 2003).

Intersectionality

According to intersectionality theory each and every person occupies social locations of privilege and disadvantage (McCall, 2005). We have identities that place us in positions of power (e.g., male, White, parent, straight) and disadvantage (e.g., female, Hispanic, single, lesbian). Gay fathers occupy simultaneous positions of privilege and disadvantage (Zinn & Dill, 1996) in the home, in their communities, in the health insurance system, and in society at large (Goldberg, 2012).

Matrix of identities. Gay fatherhood is not solely about sexual orientation, but how it intersects race, class, geographic location, position within the family, religion, age, and parental status (Connell, 2005; Pleck, 2010). Becoming a parent provides some fathers with an elevated status in the world as "a parent," but their sexual orientation does not adhere to our society's

traditional notion of masculinity and lowers the father's status (Goldberg, 2012). If this same father is a gay father of color, this status introduces another simultaneous dimension to consider in the matrix of privilege and oppression (Collins, 1998). As a gay father of color, this father exists in a societal position that differs from a white, straight woman with no children.

Privileged identities. Some gay fathers may occupy more positions of privilege than marginalization (Carbado, 2013). In another example, gay fathers that have children via surrogacy occupy "interlocking privileged positions [that] can shield them from some of the vulnerabilities that face gay men of color, lesser incomes, or adopt" (Berkowitz, 2013, p. 83). Because most surrogate fathers are White and willing and able to spend upwards of $150,000 for a child via surrogacy, they occupy multiple privileged positions (Berkowitz, 2013), but could be considered in a disadvantaged position due to their sexual orientation. What is important to understand is that gay fathers occupy positions of privilege and marginalization within the home (Patterson, 2000), in the division of labor (Johnson & O'Connor, 2002), in the public work sector, and within policy and law (Connolly, 2002).

White masculinity. Other issues to consider when examining intersectionality in the context of gay father are hegemonic masculinity and its intersection with other identities (Connell, 2005). Hegemonic masculinity is the "pattern of practice" that defines men's roles, expectations, and identities as superior to women (Connell & Messerschmidt, 2005, p. 832). Hegemonic masculinity is also a normative ideology and position that defines what it means to be a man in White, middle-class, aggressive, successful, and fathering (having children) terms (Connell & Messerschmidt, 2005). Very few men achieve hegemonic masculinity, and men who do not have varying levels of disadvantage (Connell & Messerschmidt, 2005). For example, a White, middle-class gay father experiences disadvantage and oppression relative to

some groups "because of divergence from the heterosexual norm and standard," (Shields, 2008, p. 302) but continues to have racial privilege (Carbado, 2013).

Gay fathers enact and express different forms of masculinity (Connell, 2005; Connell & Messerschmidt, 2005). White, middle class gay men, however, can more readily access normative, hegemonic masculinity because of their race (Carbado, 2013) and class (Connell & Messerschmidt, 2005). Gender expression, beliefs about gender and roles, or gender enactment are especially dependent on fathers' social positions in race, gender, and class (Carbado, 2013; Shields, 2008). Understanding White masculinity in context of gay fatherhood is relevant for analyzing this study's sample and "allows for…the responses of individuals [to] act as a reflection of the identities that form them" (Shields, 2008, p. 310).

Coming out. The positions of gay fathers also encompass ideas of "outness," community, and agency. Many gay fathers have had to conceal their gay identity (Burgess, Lee, Tran, & van Ryan, 2008; Goldberg, 2012). The degree to which gay fathers are involved in, out, and able to thrive in their communities is dependent on their intersecting identities. The stigma and discrimination that gay fathers face may not be a result for having a gay identity, but may be a result of combined identities like race, class, or religion (Ibañez, Van Oss Marin, Flores, Millett, & Diaz, 2009). Typically those fathers that occupy more privileged positions have a greater degree of agency about disclosure (Goldberg, 2012), identities (Berkowitz, 2007), and handling external stigma and stress (Johnson & O'Connor, 2002).

The literature on lesbian and gay parenthood and gay fatherhood in particular has covered family formation, the interpersonal processes of the division of labor, stigma, and intersectionality. Each of these areas of research sheds light on the experiences gay fathers have had with health insurance. Gay fathers are a hard to reach population due to remaining social

stigma, disperse population, and relatively low proportions of gay males raising children. As such, my challenge was to reach out to this population in new ways, and so I incorporated online technology to this study. The next section discusses the potential and use of online and mobile technology in qualitative research.

Internet and Mobile Technology in Qualitative Research

Online and mobile technologies present both possibilities and obstacles to qualitative researchers (Markham, 2011). Typically, qualitative researchers utilize in-person or telephone interviews to conduct research (Patton, 2002), but researchers can also use Internet and mobile technologies as a means to conduct the research and attempt to access a hard to reach population (Zickuhr & Smith, 2012). Of those researchers who conduct qualitative research online, most conduct research in Internet chat rooms, using instant messenger, or concurrent email correspondence (Markham, 2011). The drawbacks to synchronous online interviewing include schedule coordination (participant and researcher online at the same time), needing participants to have strong keyboard and typing skills, and unnecessary pressure on the participant to respond quickly to each question (rather than have time to reflect and organize their answer) (Evans, Elford, & Wiggins, 2007).

Other qualitative researchers use asynchronous Internet interviews such as email, surveys, or blog posts where the researcher and the participant do not communicate in real time (Evans et al., 2007; Markham, 2011). Much like mail-in questionnaires, the participant freely chooses when, where, and the amount of time required to complete the questionnaire (Patton, 2002). Asynchronous interviews provide flexibility for the participant and allow participants to provide "lengthier, more discursive texts that are said to be thorough and considered" (Evans et al., 2007, p. 325). Moreover, participants with busy lives can "reflect on their lives and identities

in the midst of their experiences" and shape and structure their own responses (James & Busher, 2006, p. 415). Control over identity, Internet use patterns, and convenience were factors that could increase participants' response rate (Markham, 2011). Mobile and Internet technology gives participants control over identity disclosure, time to complete the questionnaire, and is just as likely to reach a diverse population (e.g., those making less than $30,000, non-White, rural and urban) (Zickuhr & Smith, 2012).

A Shrinking "Digital Divide" and Internet Use Trends

The digital divide. Experts and researchers in the field of media and computer science coined the term "Digital Divide" in the late 20th century to describe an economic, geographic, and connectivity inequity among Americans (Norris, 2001). In 2000, only four percent of Americans claimed they had broadband Internet via desktop computer in their homes, meaning those of a certain class had access to the Internet (Zickuhr & Smith, 2012). Researchers conducting online qualitative research in the 20th century most likely drew from a pool of privileged, Internet-savvy, educated, and typically White men (Zickuhr & Smith, 2012). I wanted to ensure I drew from a diverse population and studied the shrinking digital divide and the possibilities of online qualitative research today.

Shrinking divide. Today, access to the Internet has expanded dramatically in two ways: in-home access and mobile technology (Zickuhr & Smith, 2012). In August 2011, 62% of Americans reported having broadband Internet access in their homes. Today, only one in five Americans does not use the Internet (Zickuhr & Smith, 2012) and access, however, is not the main reason for non-use. A recent Pew Research Institute survey found that those who do not use the Internet revealed that they do not use the Internet because they believe the Internet is not relevant to their lives (Zickuhr & Smith, 2012). The digital divide appears to be diminishing with

the rise of mobile technology and provides more Internet access options available to populations outside of the "traditional" Internet users in the past (i.e., White, male, upper-middle class).

Mobile Internet use. The second way access to the Internet has expanded is through mobile technology. In the first decade of the 21st century access to the Internet became "no longer synonymous … with a desktop computer" because cell phones and mobile technology provided new access options (Zickuhr & Smith, 2012, p. 2). In the summer of 2011, the Pew Institute revealed that 88% of American adults reported having a cellphone, while only 57% reported having a laptop (Smith, 2012). "Mobile is changing the story" of the digital divide by providing access to groups that do not typically have access to the Internet (i.e., younger adults, those with no college education, and lower household incomes) (Zickuhr & Smith, 2012, p. 2). Both African Americans (62%) and English-speaking Latinos (63%) are just as likely as their White counterparts (63%) to own a mobile phone and use it in a variety of activities such as texting, going online, e-mail, recording video, and taking pictures (Zickuhr & Smith, 2012). As of May 2011, young adults, minorities, those with no college education and who owned smartphones reported using their smartphone as their main source of Internet access (Zickuhr & Smith, 2012). Moreover, nearly one-third reported having no desktop or "traditional" connection to the Internet at their home (Zickuhr & Smith, 2012).

Social media use. The use of online social communities as a recruiting tool can improve the likelihood of response for this study. One of the newest developments of Internet usage is adults' use of social networking sites (Zickuhr & Smith, 2012). In the newest report released by the Pew Institute, researchers found that 72% (up from 65% in 2012) of online adults from a variety of age groups, demographic backgrounds, and race and ethnic groups use online social networking sites like Facebook, Twitter, and Instagram (Brenner & Smith, 2013). Those with at

least some college education and adults with minor children living at home are more likely to take part in social networking online (Zickuhr & Smith, 2012, p. 13). Of adult Internet users aged 30 to 49, 78% used social networking sites. Of those Internet users aged 50-64, 60% used social networking sites (Brenner & Smith, 2013). Currently, there are no significant differences in all social media use across race, household income, or educational attainment (Duggan & Brenner, 2013).

As of August 2013, 18% of online adults are Twitter users, a more than 100% increase from 2010 (Brenner & Smith, 2013 p. 1). Not surprisingly, adults aged 18-29 are most likely to use Twitter (30%), but 17% of Internet users aged 30-49 use Twitter and 13% of Internet users aged 50-64 use Twitter. Moreover, those who identify as African American and Hispanic are twice as likely to be on Twitter than those who identify as being White (28% Hispanic Internet users on Twitter and 27% of Black/African Internet users on Twitter, compared with 14% of White Internet users on Twitter) (Brenner & Smith, 2013). Twitter provides better possibilities of reaching more diverse populations without having to join groups or gain membership.

Gaps in the Literature

The research on parenting as it relates to heterosexual and same-sex parenting is far reaching and expanding, but there are still limitations and future directions for research (Biblarz & Savci, 2010). As noted in many scholarly books, articles, and chapters, the populations typically included in the studies of lesbian and gay parents is limited to a small number of participants who have higher socioeconomic status, are predominantly White, and live in urban areas (Biblarz & Savci, 2010). While recent work has addressed racial invisibility in LGBT research (Goldberg, 2012; Ibañez et al., 2009; Mays, Chatter, Cochran, & Mackness, 1998;

Moore, 2011), researchers are also attempting to reach out to more diverse populations who would otherwise not have access to take part in research.

Research on LGBT health and health insurance access rarely consider intersecting identities of participants (Ibañez et al., 2009), the influence of state laws that allow for same-sex relationships (Goldberg, 2010), and the extra tax burden for LGB-parent families under DOMA (HRC, 2013a). Previous research has shown the many legal implications surrounding same-sex marriage, divorce or separation of same-sex parents (Bigner & Jacobsen, 1989; Gartrell, Bos, Peyser Deck, & Rodas, 2011). As gay fatherhood increases in prevalence and visibility, researchers can also consider health implications. Goldberg (2012) pointed out that gay adoptive fathers have children with unknown biogenetic histories, and are more likely to receive children from foster programs. Gay fathers' health insurance experiences have rarely been studied (Ponce et al., 2010), but have major policy implications for all families (Goldberg, 2010).

Chapter Summary

The availability and access to health insurance for gay fathers is dependent on employers, the ability to afford health insurance, legal relationship status, and a variety of state and federal laws. LGB-parent families take part in a variety of family formation strategies, resulting in diverse and complex households. The existing research and literature on LGB families and gay fatherhood have mostly focused on the intra- and interpersonal relationships within the families and the relationship dynamics as it relates to the division of labor (Biblarz & Savci, 2010). Same-sex parenting remains an important and relevant focus, but as identified in this chapter, there are gaps in the literature regarding the health and well-being of these families, specifically as it relates to health insurance. Gay fathers' experiences are unique due to the high amount of stigma from society, and researchers should consider the intersecting identities of gay fathers in

their approach and analysis of their experiences. The inclusion of online and mobile technology in this study provided the tools to reach out to a potentially more diverse gay father population. As I began to plan, development, and carry out my study, I used prior research and the use of online technology in qualitative research to inform each step of the study and eventual analysis.

CHAPTER 3: METHODS

Overview of Research Design

I conducted a qualitative study using online technology and telephone interviews to uncover and understand the health insurance experiences of gay fathers in the United States. Qualitative research takes many different forms, with researchers typically interviewing face-to-face or over the telephone (Seidman, 2006), but for this research I wanted to prioritize my participants' privacy and convenience by using online and mobile mediums. I purchased a domain, created, and hosted a website using GoDaddy.com, a website hosting company. My site, www.fatherfamilies.org, provided information about and consent for the study and acted as a gatekeeper for my online research. I also used the Virginia Tech Qualtrics Secure Server, an online questionnaire creator, to host, conduct, and collect the online questionnaire responses of interested fathers. I engaged in a variety of recruitment methods including online announcements, flyers/business cards, personal contact, and social media postings. While the online and mobile mediums provided my participants with anonymity, I had several fathers request interviews. As such, I modified my IRB to also allow for telephone interviews to collect information from fathers wishing to speak about their experiences.

Prior to answering any questions, I collected informed consent from my participants, in accordance with IRB ethical guidelines (See Appendix A). My instrumentation for this study consisted of a standardized questionnaire for both the online and telephone interviews and included both open-ended and multiple-choice questions (Patton, 2002). After each participant completed the questionnaire or interview, I downloaded and transcribed responses. For my analysis, I used grounded theory methodology and coded my participants' responses using Atlas TI 5.2. I began with a word-by-word and line-by-line open coding process, followed by a multi-

step focused coding analysis, and using themes that emerged from my data, I organized and completed my thematic analysis. Throughout the analysis process, I used my research questions and sensitizing concepts from symbolic interactionism and life course theory. I will discuss the process of my methods, detail the sampling technique, and present my final coding scheme before I present my findings in the next chapter.

Recruitment

I engaged in varied, numerous, and widespread recruiting strategies between the months of late May and early August of 2013. My methods included in-person contact, posting flyers, online list serves, direct email contact, personal referral, and social media like Facebook and Twitter. Based on personal experience at PRIDE festivals, and low response rates, I expanded my study to include the United States. Next, I trace my recruitment process starting with my focus in Virginia; discuss the low response, and then my recruiting efforts as I expanded my population to the United States. In order to determine which methods produced a greater number of participants I collected data on how my fathers found out about the study, and discuss the more promisingly recruiting strategies in my discussion chapter.

Flyers. In addition to business cards, I posted flyers around the state of Virginia in the early weeks of recruiting. I developed two prototypes of flyers, each with basic information about the study, a listing of the website, a QR code for mobile access, contact information, a drawing of gay father couple (so as to create a race-neutral couple), and a pink triangle, indicative of someone who supports gay rights. My two flyers differed in the language and overall style of the flyer. One flyer did not contain the word "gay," framed the study to look at same-sex father couples, and contained masculine colors of blue, brown, and yellow. A second flyer contained the word "gay father," and included rainbow triangles as bullet points. To see

both flyers, refer to Appendix B. In Virginia, I cast a wide net to reach the gay father population, but focused my postings to areas with higher concentrations of LGBT parents. I posted flyers in the Harrisonburg, Blacksburg, Charlottesville, Arlington, Del Ray, Alexandria, and Springfield areas at Starbucks, local coffee shops, pet stores, multiple grocery store community boards, Panera Bread locations, several locally owned LGBT-deemed friendly restaurants. I received permission to hang my flyers from each of the businesses with exception of the community boards at grocery stores where permission was not necessary.

Online contact. In addition to in-person and posting flyers, I used email list serves and online LGBT parent groups to reach potential participants. I directly contacted numerous LGBT organizations via email in Virginia asking for their help in dispersing information about the study and to contact gay fathers directly. This included Gay Cville, the Gay Fathers Coalition of Richmond, Alexandria Gay and Lesbian Community Action center, and PFLAG (of Blue Ridge, Richmond, New River Valley, Roanoke, Hampton Roads, Alexandria). I also contacted the LGBTCaucus at Virginia Tech and their chairperson emailed the announcement out to nine major public university list serves across the state of Virginia, the LGBT graduate student and faculty list serve at Virginia Tech, researchers at the University of Virginia, and researchers at Virginia Tech with personal connections to gay fathers. For an example of online recruitment see Appendix B.

In-person contact. During the summer months, LGBT groups across the country take part in PRIDE festivals, bringing together community groups, local organizations, churches, and LGBT rights groups, and businesses in major cities. I attended two metropolitan PRIDE festival events in Washington D.C. and San Francisco. During these PRIDE events, I talked with fellow festival attendees and visited the tents and tables of over 100 groups and organizations at the

PRIDE festival. Of the 100 tables, I gave business cards and flyers to over 30 groups in DC and 3 LGBT family adoption groups in San Francisco. I chose these groups and organizations because they focused specifically on gay men, communities of faith with gay fathers in the congregation, LGBT rights organizations, LGBT parents, or provided adoption services. In addition, I had several people approach me with questions, and I handed business cards out to individuals who expressed an interest or knew a gay father who might be interested.

Personal contacts. I also recruited fathers using my own personal network of peers, family, professors, and researchers in the University community. I contacted these individuals asking them to forward information on my study to any gay fathers they knew. Of those gay fathers I met or who participated in my study, I also asked that they forward information about the study onto other gay fathers they may know.

Initial Recruiting Effort Success

After attending the DC PRIDE festival in mid-June and having had no respondents in over 3 weeks of recruiting, I decided to expand my population to the United States. I met with several gay fathers at the DC PRIDE festival and felt that I was missing out on an opportunity to reach a large number of gay fathers by limiting my study to only Virginia residents. I amended my IRB to include fathers from the United States and began to focus my efforts on nation-wide recruiting. Even after expanding my study to the United States, by early July I had no additional responses to my online study. I sought advice from my committee chair and she made several recommendations of further organizations and groups to contact in Virginia. Through her suggestions, I contacted a member of a local LGBT-friend group who also offered suggestions of further groups and organizations to contact. Finally, I sought advice from a fellow colleague also conducting research on LGBT family issues and she described her use of the social media

site Twitter. The next step in my recruitment process details the new avenues I sought out, endorsements I received, and use of social media to recruit participants.

Online groups. In the second half of my recruitment I reached out to several more organizations across the country to recruit for my study. These groups included PFLAG groups (Winchester, Washington County, Danville, Floyd, Norfolk, San Francisco, Los Angeles, and DC), the Metropolitan Community Church of Blue Ridge, three LGBT-family therapists across the state of Virginia, the Roanoke Diversity Center, Roanoke PRIDE, Gay Fathers of Seattle, Gay Chicago, Equality Virginia, and Fairness West Virginia. I received official endorsements from the Roanoke Diversity Center, Roanoke Pride, and Equality Virginia who posted announcements and electronic copies of my flyers and links to the study on their websites, Facebook pages, and twitter feeds.

Social media. As discussed in the literature review, Twitter users make up a variety of age, racial, geographic, and socioeconomic groups (Brenner & Smith, 2013). In mid-July I created a twitter account entitled Gay Father Study or @GayDadsStudy. I used this as a tool that created a safe space for LGBT identified individuals and potential participants, an interactive face to the research, and as a networking tool (Drushel, 2010). I reached out to additional PFLAG organizations across the country (an additional 26 PFLAG chapters), health organizations, men who self-identified as gay fathers, other LGBT individuals, allies, LGBT rights groups, celebrities, and politicians to raise awareness about and recruit for my study.

I tweeted short information-filled posts about the study, its intentions, and my donation to the Human Rights Campaign and Equality Virginia. Both the Human Rights Campaign and Equality Virginia followed my account, with retweets by Equality Virginia. This was a more successful form of advertising and recruiting as four of my participants (nearly half of my

sample) came from my twitter conversations alone. My tweets were limited to 140 characters and I conveyed the point of the study in concise terms. I utilized hashtags to help advertise because hashtags appear in a list that overlaps with other people's posts with the same hashtag. This means that my tweets with hashtags had more of a chance of being seen by others. A typical tweet would be as follows,

> #Research on #gay #father families. Got 15-20 min? Share your #healthinsurance story #online or #phone. #Donation @HRC & @EqualityVA.

In addition to tweeting about my study, I also retweeted posts by other LGBT organizations and individuals who posted LGBT rights and health insurance related articles. In all, I had 151 tweets, 6 retweets, and 143 followers that included LGBT organizations, gay fathers, allies, friends, family, and other LGBT individuals. I received twitter support from both the Virginia Tech Human Development department twitter account and a fellow colleague's twitter account (@gaysiblingstudy) in the form of retweets, twitters that referenced my study, and favorites. In order to demonstrate the tone and language of my twitter account, I created a word cloud. I used this word cloud to exemplify themes on my twitter page, but also as a way to reflect on the possible use of gendered, racialized, classed, or biased language in my tweets. My twitter word cloud revealed language that heavily relied on practical and legal ideas of equality, insurance, and research; cultural ideas of LGBT, gay, and the NoH8 campaign; and empowerment ideas like share, advocate, and support. See Figure 1 for my Twitter word cloud.

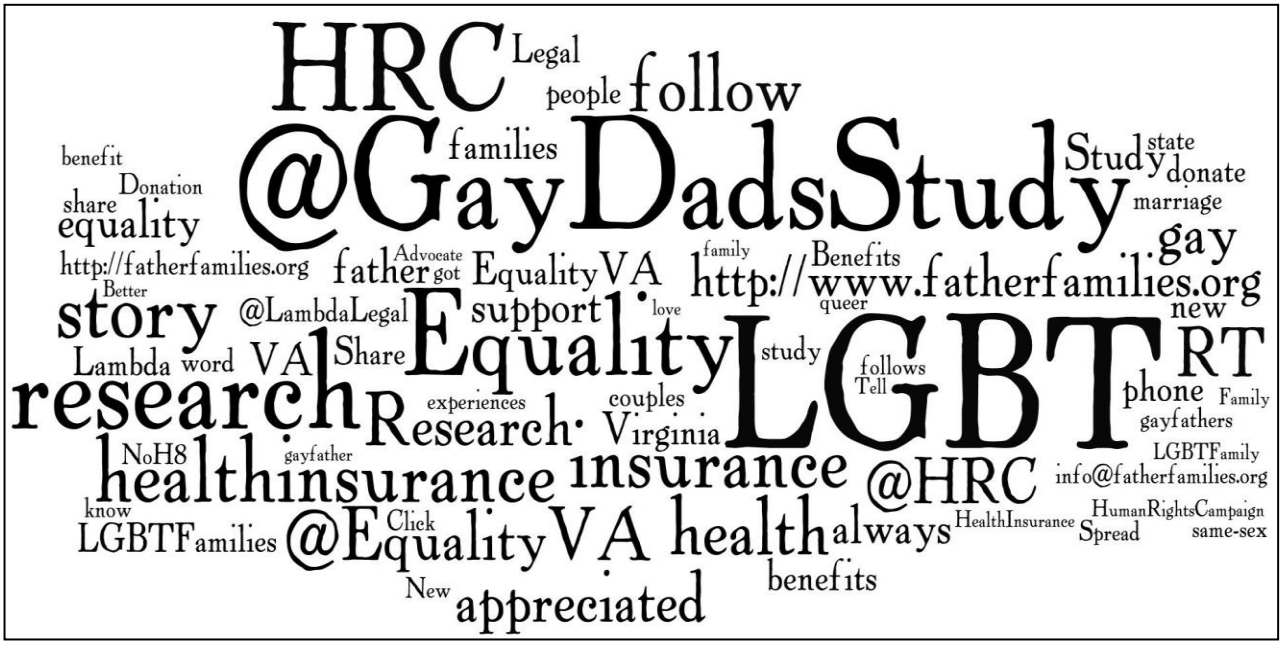

Figure 1. Twitter word cloud that depicts language of the @GayDadsStudy Twitter account. Includes common hashtags and retweets.

My recruitment was an extensive, time intensive process, and as indicated on my questionnaire, a majority of my sample found out about the study either through direct twitter contact (4 fathers), direct emails (2 fathers), in-person contact (2 fathers), a colleague (1 father), and word of mouth (e.g., one father indicated he found out about the study through a "friend"). The online messaging and social media services allowed me to reach a wider audience with the option of direct messaging and were very helpful in recruiting hard to reach participants (Ayling & Mewse, 2009). A few of the community boards and locations in the businesses where I was able to hang flyers were in high traffic areas, but according to my results, none of these flyers brought participants to the study. My personal contacts did yield one participant, but because most of my peers are under 30 years of age, the chances of having contact with gay fathers over the age of 30 were low. In all, I found that throughout my recruiting process, the more personalized or direct contact, the more promising recruitment success. I discuss more of my reflections and lessons learned on the recruiting process and my participants in Chapter Five.

Sample Selection and Sample Description

Sample Criteria

I required the following eligibility requirements for my sample of fathers: (a) identify as a gay man, (b) be between 30 and 60 years old, (c) be in a committed, same-sex relationship, (d) reside in the United States, and (e) have children under their care. These sample criteria shaped my sample to be more family-oriented and allow for a variety of insurance stories. I sought out coupled gay fathers because they would have a family, rather than a single-parent narrative. Moreover, single gay fathers may have fewer complications insuring children, whereas same-sex couples may have a harder time with insurance due to their family structure and restricting laws and policies (Movement Advancement Project, 2012). Originally I required my fathers and their families to reside in Virginia, because there are no legal protections in this state. After struggling to acquire a large sample size, visiting PRIDE festivals, consulting with my committee chair, and receiving IRB approval in mid to late June, I expanded the study to include gay fathers from across the United States.

My fathers also needed to be caring for, providing support to (i.e., more than simply child support payments), or raising children aged 26 and younger. To account for the variety of family formation strategies of gay fathers, I allowed for children who were biologically related, legally adopted, foster, or socially-adopted (no legal or biological relation). I chose my age requirement as a result of the Affordable Care Act. Today, children can remain on their parents' health insurance policies until the age of 26 (U.S. Department of Labor, n.d.).

Sample Size

The gay father population is a hard to reach population due to issues of disclosure, busy family life, widespread and dispersed population (Goldberg, 2012), and the relatively low

number of gay men raising children. Today, 20% of gay men are raising children compared to 48% of lesbian women (Gates, 2013c). With less than a month left to collect data, I had several contacts lined up, but doubted I would collect responses from 20 fathers, my original target sample size. I consulted with my committee chair and decided to reduce my sample size from to between 8 and 10 participants. Because some of my fathers' online responses were shorter and provided fewer details than interviews, I speculated about the quality of my findings if my sample size was only 8 to 10 fathers. Interviews often result in more in-depth answers and analysis (Patton, 2002), and several fathers requested interviews with me to discuss their health insurance experiences. I conducted interviews with over half of my sample population (n = 6) and gained more information and insight than I would through 8 to 10 fathers who completed only online surveys. The interviews coupled with the online questionnaires provided enough rich and detailed accounts of these gay fathers' experiences that my committee chair and I felt confident enough to proceed and conclude the study with a smaller sample size.

Sample

My thesis sample consisted of 10 gay fathers from across the United States. I interviewed one couple separately, and therefore my sample represents nine gay father families with a total of 15 children. The ages of my sample ranged from 33 to 57, with an average age of 46.9 (SD = 5.5) years. The partner's or husband's ages ranged from 34 to 52 with an average age of 46.1 (SD = 7.8) years. Of the 10 participants, 2 were from the New England, 4 from the Southeast, one from the Mideast, one from the Southwest, and one from the West coast regions of the United States. The average highest education level completed was between Bachelor's degree and Attended graduate school ($\mu = 6.6$), with education responses ranging from "Some College"' to "Master's or Doctorate degree" (for full range of education categories refer to Appendix C.

All of the fathers were White (n = 10). Eight of the men had a White partner, and two of the men had a Black partner.

My fathers claimed to currently be responsible for a total of 15 children. The number of children in each household ranged from 1 to 4, with an average of 1.5 children in a household. The children's ages ranged from nine months to 21 years old with an average age of 8.63 years old. Nine of the children were male and six of the children were female. The slight majority of children were White (53.3%, n = 8) and almost half of the children represented a variety of racial and ethnic backgrounds (26.6% Black/African American, n = 4, 6.6% Latino, n = 1; 6.6% Biracial, n = 1; and 6.6% Multiracial, n = 1). I will discuss more of my sample characteristics in Chapter Four.

Data Collection Procedures

Online Process

The online questionnaire went live to the public starting on May 26th, and I left the site open to collect data for this thesis until August 10th. I designed the study to only be accessible to participants through my website www.fatherfamilies.org using a referring URL tool, available through the Virginia Qualtrics website. I personally purchased the domain name, created, and designed the website. The father families website acted as a gatekeeper to ensure no participant could circumnavigate the consent process or encounter the study with no information. I required participants to visit an informed consent page on the website that reviewed the study and their rights and had them agree to participate. The website then directed them to a page that notified participants that the study would take place on Virginia Tech's secure Qualtrics server (meaning that no third party could view their results). I chose Virginia Tech's Qualtrics server due to its built-in secure server capacity and its low-cost availability to me as a student at this institution.

The Father Families website was available via online and mobile technology to help ensure my potential participants would have easy access to information about the study and questionnaire. It also included a Home page, a Frequently Asked Questions page (FAQ), and a Background page. The site included a FAQ page providing answers to 15 questions (see Appendix D for full list of FAQs). I consulted with peers to review the FAQs in order to see what the average lay person's questions might be and adjusted the list of questions according to the responses I received. The website also included an About and Background page that gave information about my intent with the study, provided my CV, and links to other information regarding LGBT parenting. In addition, I consulted with peers on the style and layout of the website and made some adjustments to the site based on their feedback as well. In all, the website had 124 visits (94 via computer, 30 via mobile) over the period of 87 days.

The Virginia Tech Qualtrics server hosted and collected the typed responses of the four fathers who participated online. The survey consisted of five eligibility questions on the first page. If the participants appropriately answered the eligibility questions, I had the site proceed to the start of the actual questionnaire.

The questionnaire had a total of 16 web pages that fathers navigated with "next" and "back" buttons, with an average of 2.125 questions on each page. Three pages had zero questions and only provided brief instructions or direction for the next set of questions, 10 pages had only one or two questions, while three pages had a maximum of 5 multiple choice and open ended questions. I enlisted the help of my peers to go through the questions to ensure the wording was clear, provide feedback on the aesthetics of the site (e.g., was it easy to read?), and confirm that there were not too many questions per page.

Interview Process

When considering the option to conduct the study via telephone interviews, I considered the ways in which I would maintain reliability and credibility due to the fact that I would be using two different data collection methods. *Reliability* refers to the ability of researchers and other readers to find similar results in repeated studies (Rossman & Rallis, 2011). Because I had two methods of collecting data, I wanted to ensure my results from my online sample would be similar enough in terms of on-topic responses to the results from my interview sample. Every participant has a different experience with qualitative research (Bogdan & Biklen, 2007), but I wanted to ensure that my interview data did not over power my online data with tangent stories and personal experience. *Credibility* in qualitative research refers to the trustworthiness of my data. To ensure credibility, I asked myself if I carried out my research according to "norms for acceptable and competent research practice" (Rossman & Rallis, 2012, p. 60). In addition to ensuring reliability and credibility, I conducted my research according to the ethical guidelines set forth by the IRB.

The interview began with a review of the study and collected each participant's verbal informed consent prior to beginning the interview (See Appendix A). The interview process followed the exact flow of the online questionnaire. I audio recorded each of the interviews, after gaining the participant's permission prior to the start of the interview, and I alone conducted the interview with individual gay fathers.

In the interest of consistency and to ensure transferability between phone interviews and online responses, I conducted the interview to follow the question order and format of the online questionnaire. By doing this, my questions and participants' answers corresponded similarly. In my interviews, I asked follow-up questions to gain more information from the fathers such as "Do you mind telling me a bit more about what you mean by that," and for fathers with complex

insurance processes, I asked clarifying questions to ensure I understood their responses. I maintained credibility of my study by having: (a) a standardized questionnaire with consistent question and answers across participants, and (b) the exact instrument available for external (committee) review and scrutiny (Patton, 2002).

Structured Collection of Experiences in Qualitative Research

While structured questionnaires or interview guides are more common for quantitative research studies or qualitative focus groups, I carried out my study in ways that adhere to the qualifications for qualitative research in the following ways. First, I sought to collect qualitative responses from my fathers and designed my questionnaire to elicit descriptive rather than numerical data for more than half of the questions (Bogdan & Biklen, 2007). Open-ended questions provided gay fathers with the opportunity to reflect on and articulate their first-hand experiences. By framing questions in terms of "how" and "in what ways," I reduced the chance of fathers answering dichotomously "yes" or "no" (Patton, 2002). My open-ended questions also allowed fathers to express both their positive and negative experiences (i.e., "What was your experience like?"), reflections (i.e., "In what ways did this experience make you feel more "out" as a family, if at all?"), and specific and unique insights (i.e., "What is unique about your family's health insurance story?"). Moreover, I notified participants that there were (a) no right or wrong answers, and (b) no word limits to any of the questions. My findings, as such, are narratives and words, rather than simply numbers (Bogdan & Biklen, 2007).

Secondly, I focused my study to draw out the experiences and the process of getting insurance, rather than whether or not my fathers had insurance (Bogdan & Biklen, 2007). I asked questions about family formation, attempting to be on the same policy as his partner or husband, adding children to policies, deciding who would cover the children, and any difficulties

he encountered during this process. Thirdly, I sought to understand how the fathers made meaning of their experiences with health insurance (Bogdan & Biklen, 2007). I asked questions about how they saw themselves as a provider, how this process may have made them feel more "out" as a family, and who they considered to be in their family or under their responsibility. In my data analysis, I combed over my participants' words looking for meaning making, or how they made sense of their world and experiences (Bogdan & Biklen, 2007). Finally, my data analysis was an inductive, bottom-up approach where I produced a picture that took shape and emerged from the data (Bogdan & Biklen, 2007; Charmaz, 2006). The structured questionnaire and interview are not common qualitative data collection techniques, but I methodically constructed my study to conform to the qualifications of qualitative research to as much of a degree as possible (Bogdan & Biklen, 2007).

Instrumentation

Participants completed my study through answering the questions of the structured questionnaire either online or orally (see Appendix C for questionnaire and interview guide). The questionnaire consisted of a total of 39 questions, with 18 multiple choice questions and 21 open-ended questions. I revised the questionnaire multiple times after I consulted with my committee chair for the wording, order, and format.

After deciding on a final set of questions, I created the questionnaire on the Virginia Tech Qualtrics server and used display logic, embedded HTML code, and skip logic functionality in my study. The display logic functionality corresponded each participant's previous answers to questions with further questions (e.g., if father answered they have two children under care, corresponding questions discussed two children). The HTML code provided participants with information buttons they could click on to get more information (See Appendix E). The skip

logic functionality recorded each participant's responses and then skipped certain questions based on previous answers (e.g., if the participant answered he was on same insurance plan with partner/husband, the question about being on different plans was not asked). I included these functionality features to provide participants with a more personal and appropriate questionnaire experience.

I chose to have both multiple choice and open-ended answers to give the study parsimony while allowing for the nuances of these fathers' experiences to come through the text or verbal narratives. The multiple choice, demographic data was not the central focus of my study, and was intended to provide context to the participants' responses. I collected information on the father's age, race, state of residence, job title, and health insurance status as well as partner demographics in a quick-to-answer format to ensure the study remained (for almost all participants) under 30 minutes in length. Because I was not providing my participants with any direct monetary benefits, I wanted to limit the amount of time participants needed to spend on some questions. See Appendix F for average length of online and interview completion.

Data Analysis

Data Clean Up and Storage

As participants completed questionnaires and interviews, I edited their responses on a secure, password protected computer and stored their responses on an external hard drive. I edited online questionnaire responses and transcribed my interview responses verbatim using Microsoft Word. I removed personally identifying information (i.e., specific locations, job titles, insurance companies, employers), changed names, and made any grammatical and spelling changes. The copied and edited versions of my data were separated from originals and given a pseudonym and numeric identification code (Patton, 2002). I then uploaded the de-identified,

cleaned narratives to an Atlas TI 5.2 qualitative data analysis software program on a password protected campus computer.

Participant as Guide

I created individual narratives and process notes for each of my participants to use as guides during the analysis process (Patton, 2002). Creating these individual files helped me organize my analysis prior to, during, and after the initial, open coding process. I could return to each of the narratives to compare and contrast the fathers' narrative against the ideas and themes that emerged from my data. In rereading the data, I made revisions to each narrative along the way to more accurately reflect their responses. For an example of my narratives and process notes see Appendix G.

Coding

I chose to use grounded theory methodology for my data analysis because of its roots in symbolic interactionism, its inductive methodology, and its focus on meaning making from participant responses (Bogdan & Biklen, 2007; Charmaz, 2006). I began with a series of open coding, proceeded with rounds of focused coding, and finally determined and organized the findings into overarching themes (Charmaz, 2006). The next section details my data analysis process.

Sensitizing concepts. I did not conduct an analysis that sought to answer hypotheses or showcase how the data adheres to my theoretical perspectives, and instead I used my research questions and theoretical perspectives as guides (Charmaz, 2006). Sensitizing concepts like meaning making, agency, perception, community, family, and process provided focus to my analysis, but I also allowed for codes, categories, and themes to emerge from the data apart from

the sensitizing concepts (Charmaz, 2006). I immersed myself in my data, but used the sensitizing concepts so I would not get lost or caught up in the data (Rossman & Rallis, 2011).

Open coding. The first step of my coding process was a word-by-word open coding. I read over each and every participant response and highlighted words and short phrases that were of interest. I chose word-by-word for my open coding because I had brief responses from some of my participants and I wanted to use each word as a "potential to unlock" their experiences and perceptions (Bogdan & Biklen, 2007, p. 105). My first round of open coding highlighted words and phrases that were related to my research questions. For example, the second research question centers on the community resources my fathers used, so I had open codes that were labeled "community resources" and defined as "the sources of information and help fathers used during the insurance process." I also had open codes related to theoretical perspectives, like "agency" which I defined as "perceived ability to have and make choices, perceived amount of control of the situation or circumstance." In addition I also had open codes that emerged from the data such as "we language", which I defined as "language or terminology that frames the experience in 'we' or 'our' terms rather than individual and the lived experience as a unit and in a 'we' lens." I produced 182 codes from my word-by-word open coding. These codes covered both expected and unexpected ideas, a signifier of grounded theory methodology (Charmaz, 2006).

I coded my responses and found, as expected, my interview data had more codes than my online data. In all, I had 1190 pieces (words or phrases) of code that I highlighted. Each response had a minimum of 60 codes and a maximum of 236 codes. In Table 1, I provide the total number of codes I had in each response in order of participant response. I have also indicated the length of interview, type of response: online or interview. I reviewed each

response multiple times, reviewed and defined all 182 codes, read over my memos, and deconstructed the open coding experience with my committee chair before I began the second stage of data analysis, that of focused coding.

Table 1

Open Coding Results by Participant

Participant	Number of Codes	Length of Interview (mm:ss)	Response Type
Anthony	162	39:50	Online
Bill	78	9:45	Online
Charles	77	11:51	Online
Daniel	117	19:32	Interview
Derrick	170	24:59	Interview
Eric	115	23:40	Interview
Franklin	90	22:42	Interview
Gregory	60	21:50	Online
Harold	85	17:37	Interview
Liam	236	48:07	Interview

Focused coding. In my second round of coding, focused coding, I sought to create codes that were more "directed, selective, and conceptual" (Charmaz, 2006, p. 57) and would begin to explain responses and categorical links across my participants (Charmaz, 2006). I focused on the most significant, most frequent, and also most interesting codes I created (Charmaz, 2006). I created a variety of conceptual categories, recognizing there was overlap between most of the categories. I ended my first round of focused coding with 22 categories, each with at least 4 associated codes. For example, my 21st category was entitled "Community" and had 5 codes associated with it: (a) community resources, (b) function of resource, (c) outness, (d) comfortable being out, and (e) better "out" than in. As I reviewed the "Outness" category, I recognized more overlap than differences between "Community" and "Outness." "Outness" had 7 codes: (a) outness, (b) comfortable being out, (c) community resources, (d) better "out" than in, (e) children

change everything, (f) more out?, and (g) pressure to be perfect parent. I then merged the two conceptual categories into a larger category, and continued to call it "Outness." I critically analyzed each of the 22 categories finding overlap, combining categories, and recognizing other codes outside of the used categories began to fit under the newly formed category. This was my 2nd round of focused coding. After processing this step with a my thesis chair, I continued to rake over the data, referring to transcripts, finding overlap in codes and narrowed my coding categories down to 10 categories (Charmaz. 2006).

These 10 coding categories captured the essence of the story my data had to tell (Charmaz, 2006). In the interest of organization and moving on to a thematic analysis, I created definitions of each coding category and then merged together different codes and their definitions as they related to the category I assigned them. For example, one of my 10 categories was entitled *Perceptions* and was defined as "the expression of opinion, views, evaluation, & reflection." Rather than have 12 or 14 codes associated with *Perceptions*, I condensed 4 codes, *perception of access, perception of access for children, attempt to be on same policy (partner),* and *not on same policy,* down to just one code now labeled as Perception of Access. I then defined *Perception of Access* to be "father's view of his ability to access insurance for ALL family members (self, partner/husband, and children)." Some codes I did not condense. For example, under the category *Discrimination*, I defined the subcategory *Puzzled* as "being surprised by any problems with health insurance in 'this day and age'" and I did not combine it with other codes because it was a unique experience by only one father. These 10 categories (see Appendix H) represented the concepts, ideas, and codes that had the most thick, rich detail and covered the experiences of most, if not all of my participants (Charmaz, 2006). The process of finding categorical codes was an intensive and detailed process that required reviewing not only

my codes, but the corresponding highlighted pieces of transcript and the entirety of the transcript so as to place the codes into their entire context (Bogdan & Biklen, 2007). Thus, in reviewing, condensing, and refining each category and its subcategory codes, I pursued the strategy of focused coding, which was to recognize larger conceptual overlap between categories and subcategories.

Thematic analysis. The goal of my thematic analysis was to discover what overarching stories emerged from my fathers' data (Charmaz, 2006). After constructing 10 focused categories, I had organized my data, but at this point I had no stories to tell, only bits and pieces. I had 10 highly variable father families in terms of state of residence, family formation, and avenues to health insurance. I used thematic analysis to make sense of the variation and identify (a) what stories emerged from the data, and (b) in what ways did these stories come together or divert apart? My final criterion for my thematic analysis was to search for stories that went beyond the obvious and provided deeper narratives and meanings of these fathers' health insurance stories.

Beginning with 10 categories, I focused on the "possible relationships between categories" (Charmaz, 2006, p. 63) that included a variety of coding categories (Bogdan & Biklen, 2007). I asked myself, "Were there ways in which setting, activity, perception, and process codes related to each other (Bogdan & Biklen, 2007)? Were pieces of code related to each other on a higher level?" By asking these questions and reviewing my data, I searched for the ways in which different actions, perceptions, and descriptions from different focused categories could be related to each other under an umbrella for a larger theme (Charmaz, 2006).

For example, I found that category 100, *Frustration*, dealt mostly with the presence or absence of frustration involved with access to insurance, and so I looked for the ways in which

category 200 *Access* and 100 *Frustration* might fit together. In reviewing those two categories, I recognized that three subcategories in 300 *Perceptions*, 300a, 300b, and 300g also related to stories about access and frustration. In addition, 500a, *State Variation*, 700a *Discrimination*, 900a *Agency*, 900d *Position*, and 900f *Feeling Marginalized* were also subcategories that related to the stories of frustration and access. The actions, perceptions, experiences, and settings surrounding *Access* and *Frustrations* related to each other on a larger scale when I considered them as part of a theme entitled, "Narratives of Frustration." Figure 2 gives a visual representation of my thematic analysis for my third theme "Insurance and the Use of Gendered Language" to illustrate the same critical process.

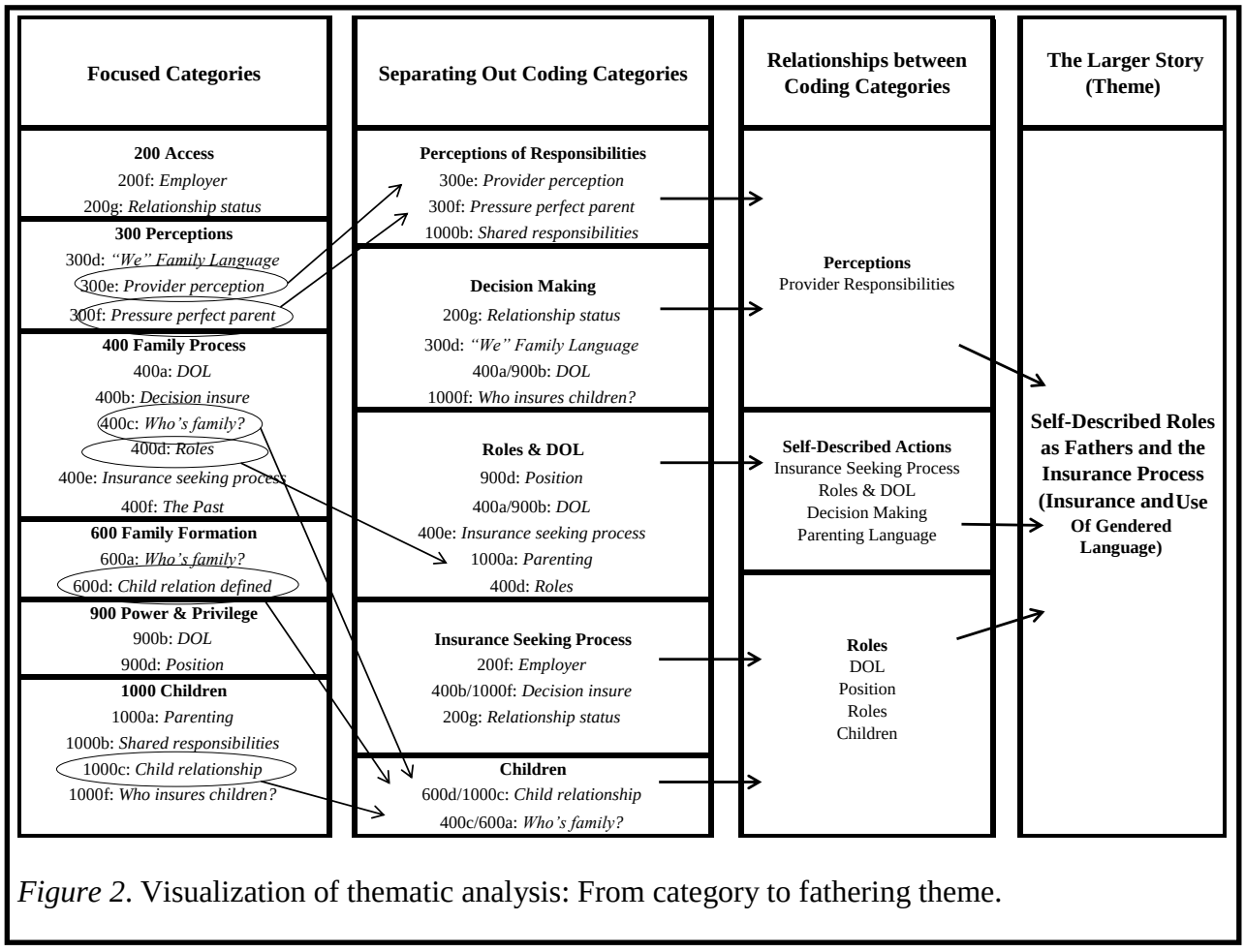

Figure 2. Visualization of thematic analysis: From category to fathering theme.

Data saturation. I had two goals in my data analysis: identify themes and reach data saturation. Data saturation is when the data "no longer sparks new theoretical insights…nor new properties" within larger categories (Charmaz, 2006, p. 113). My criterion for data saturation was not pattern recognition, but creating themes that had finite properties (Charmaz, 2006). I dissected each of my themes and created subtheme categories or experiences of each until I had distinct, not overlapping stories to tell. For example, at first my Narratives of Frustration had 10 different stories. In order to reach data saturation, I needed to be able to organize the 10 stories into conceptual categories that capture the experiences of all of the fathers. I looked for the similarities between experiences, and the nuances that not only made the experience unique but that may connect it with another father's experience. I created subthemes of my Narratives of Frustration until I had no new categories or I could not "yield different properties of the pattern" (Charmaz, 2006, p. 113). Table 2 presents my Narratives of Frustration theme, revealing that my four subthemes cover the experiences of all my fathers and I was unable to make any more conceptual comparisons among my data.

Table 2

Narratives of Frustration and Data Saturation

Participant	Narratives of Frustration				Total Number of Sample
	No Frustrations at All	Separate, Yet Unequal	Taking Action for Change	Resigned to Frustrations	
Anthony			**X**		
Bill				**X**	
Charles				**X**	
Daniel	**X**				
Derrick	**X**				
Eric		**X**			
Franklin		**X**			
Gregory	**X**				
Harold		**X**			
Liam			**X**		
Representation of Sample:	3	3	2	2	10

Throughout the data analysis process, I met and conferred with my committee chair to discuss my analysis process at each step. We reviewed my initial coding schemes, referred to the transcripts, critically analyzed the categories that were emerging, and she guided me through the analysis process. I conducted a data analysis that concluded with the development of three themes by which I organized my findings and will discuss in the next chapter.

Chapter Summary

In this chapter, I detailed my process for the thesis from initial development to final analysis. I reviewed my initial recruiting strategies, changes in my sample criteria, and a revised recruiting strategy that included social media such as Twitter. I also discussed my data collection methods, the inclusion of interview data, and how I ensured the integrity of my data in my data collection processes. Despite the changes to my sample criteria, sample size, and data collection methods, I collected rich and descriptive data from my father sample. In the second half of this chapter I detailed my data analysis process in which I used Grounded Theory

Methodology to deconstruct and reconstruct my data (Charmaz, 2006). I gave an overview of each step of my qualitative data analysis and presented the process of how I achieved my three overarching themes. In all, I provided a detailed account of how I created, carried out, and conducted a qualitative research project that used both online and interview data, and my methods of analyzing the data as a qualitative researcher.

CHAPTER FOUR: FINDINGS

I organized and present my findings in three thematic areas. The first finding focuses on the fathers' narratives and stories of frustration in seeking out, accessing, and providing insurance for their families. The second finding demonstrates the degree and ubiquity of the fathers' outness or the disclosing of their gay father identities. Finally, the third finding uses the fathers' language to suggest that fathers who are the insurance carriers for their family tend to enact traditionally masculine language to describe their role as fathers. Before reviewing my thematic findings, I will review the descriptive findings of my sample.

Sample Description

In Chapter 3, I gave an overview of the father and children demographics from my sample. To briefly review, all of the fathers were White (n=10), two had Black partners/husbands and eight had White partners/husbands. The fathers' average age was 46.9 years and the average highest completed education was between "Bachelor's Degree" and "Attended Graduate School." The average age of the partners/husbands was 46.1 years. The sample of fathers was responsible for a total of 15 children, ranging from ages of 9 months to 21 years old. The racial make up for the children was eight White children, four African American children, one Latino child, one Biracial child, and one Multiracial child.

Father and Partner/Husband

Every household of the sample had at least one employed father. Two families had both fathers working full-time, four families had one father working full-time and the other working part-time, and four families had one father working full-time and the other was a stay-at-home dad. See Table 3 for father and partner employment results. Three fathers (1 individual, 1 couple) were unmarried partners living together, two fathers were in domestic partnerships, and

the remaining six fathers were legally married in one of 13 states that now has marriage equality (National Conference on State Legislature, 2013). As shown in Table 3, nearly all fathers lived in a different state than their marriage license, and most had been recently married in the last year. This variation of legal relationship status highlights the effects of state variation in marriage equality. Lastly, while not a prerequisite for the study, every father in my study had health insurance coverage, and Table 3 displays the different sources of insurance coverage for each father and his partner or husband.

Table 3

Father and Partner/Husband Demographics

Employment Status				
	One Full-time	One Part-time	One Stay-At-Home Dad	Total
One Full-time & …	2	4	4	10

Relationship Status				
	Legally defined relationship status	Married in state of residence?	Length of marriage (in years)	Total length of relationship (in years)
Anthony	Legally Married	No	1	At least 3
Bill	Legally Married	Yes	1	At least 7
Charles	Unmarried Partners, living together	--	--	Unknown
Daniel	Unmarried Partners, living together	--	--	9
Derrick	Unmarried Partners, living together	--	--	9
Eric	Domestic Partnership	--	--	14
Franklin	Legally Married	No	5	8
Gregory	Legally Married	No	1	13
Harold	Legally Married	No	2 ½	6
Liam	Domestic Partnership	--	--	29

Insurance Source(s)				
	Father on Partner/Husband's plan	Partner/Husband on Father's Plan	On Separate Insurance Policies	Total
Insured	5	3	2	10
Uninsured	--	--	--	0

Children

The fathers formed their families in a variety of ways including divorce from previous marriage, surrogacy, open and closed adoption, and foster care adoption. As such, the children had a variety of legal ties to their fathers, as shown in Table 4. Most children had legal ties to both fathers, but partners and husbands of fathers' biological children had a variety of

relationships. Nine children were legally adopted by both fathers, four children were biologically related to one father and no relation to the second father (e.g., no relation, social stepfather). Two children shared biological connection and legal guardianship from their fathers. One father described his husband as the "stepfather" to his children, while another father labeled his partner as "their mentor, and [jokingly laughing] the evil stepmother." These descriptions showcase the ways in which partner relationship status and parent-child relationship status are defined in different ways. Moreover, the father's children had a range of contact with the biological or birth mother. Some children had no contact with their birth mothers, while others had regular contact with their birth mother. Finally, every child had health insurance coverage from at least one source whether it be one of the study participants, his partner/husband, or the state. The fathers in this sample made sure their children had health insurance coverage. See Table 4 for results relating to the children's demographics.

Table 4

Children Demographics

Parent-Child Relationships	
Biological Relatedness	
Previous Heterosexual Relationship	4
Surrogate	2
Adoption Sources	
State Foster Care	6
Agency	3
Children's Contact with Birth Mother	
No Contact	7
Contact via Fathers Only	5
Frequent Contact	3
Insurance Sources	
Father Funded[a]	6
State Health Insurance	2
Father and State Insurance[b]	4
Birth mother	3

[a] Children are either on participant's or partner/husband's insurance plan
[b] Children are on both private insurance through father AND state foster care health insurance

I collected the demographic data to provide context to the analysis and eventual findings. In this next section I present the substantive findings of the data in three sections. The findings use both participant quotes and contextual data to provide thorough and rich evidence.

Narratives of Frustration

One of the most prominent findings to emerge from the data was the fathers' narratives of frustration while seeking out health insurance. As part of the questionnaire and interview, I asked fathers to describe different steps of the insuring process such as attempting to be on the same policy as their partner/husband, attempting to access health insurance for their child(ren), and the difficulties or frustrations with any part of the insurance seeking process. The following

findings reveal four variations in the fathers' experiences and perception of the health insurance process: (a) No Frustrations at All, (b) Separate, Yet Unequal, (c) Taking Action for Coverage, and (d) Resigned.

No Frustrations at All

In the first variation, three fathers expressed no frustrations or difficulties in their health insurance experiences. Their stories are marked by the absence of frustration. The fathers who reported no frustrations shared the following experiences: (a) they were successfully able to cover all members under one health insurance plan, (b) they had no complaints about the process of insuring their family, (c) they had no complaints about extra costs associated with the plan, and (d) they did not mention geographical limitations (e.g., state laws). Gregory, Derrick, and Daniel provided their no-hassle health insurance experience throughout their narratives.

Gregory and his husband Geoffrey are a couple in the Southwest region of the United States who adopted their son, Grant, in the past year. Gregory works full-time as a divisional Vice President at a company and Geoffrey is a stay-at-home dad. Before adopting Grant, Gregory stated that he placed Geoffrey on his plan with "no difficulties as [his] employer offer[ed] coverage for domestic partners." Gregory had "no frustration at all" when he attempted to cover his family under his plan because as Gregory offered, "my employer embraces diversity." The simple process was a success and Gregory had "nothing [he] could think of" that made his experience stand out.

Derrick, a part-time medical specialist, owns his own medical business and purchased his family's health insurance policy through his own company. Derrick has two children via surrogacy and Daniel, his partner of 9 years, is the legal guardian to Derrick's two children. Years ago when Daniel was without health insurance and just before their daughter Debra was

born, Derrick placed Daniel on his insurance plan. For Derrick, health insurance "was not even an issue – it never has been an issue."

Just before Debra was born, Derrick went to a broker company that specialized in helping people identify health insurance plans for families. Derrick described his hassle free experience as "amazing" and,

> [reenacting his conversation] I went in and said, "This is the situation." And – "No problem." "Okay, I need a family plan." "Okay, we've got a family plan." ... "I've got so and so and this preexisting condition," and then they just farm[ed] it out…and then provided [me] with a couple of choices of plans.

Derrick was simply able to add Debra and Dean, his youngest son, to his health insurance plan with no problems. Derrick made no mentioned of any frustrations and added that he and Daniel have also not had to deal with the burden of extra taxation by the federal government. Derrick did not have to search through endless possibilities of plans and instead, the brokerage company took care of the work and Derrick picked the plan that worked for him.

Daniel, Derrick's partner, is on Derrick's plan and he also does not "think [they've] really had any difficulties…which has been nice." In addition, Daniel also has insurance experiences for his own biological children, and he detailed that experience as an easy process as well. Daniel, a full-time minister, shares financial and medical costs for Danielle and Danny with his ex-wife Doris and has not had to worry about insuring his children.

After divorcing his wife, Doris and Daniel had joint custody of Danielle and Danny. Because the children primarily lived with her, Doris covered their children "because it just made sense for her to have it." Daniel explained that Doris had no issues insuring her children and there have not been "great fluctuation in out of pocket costs." Moreover, he added, Doris has

Daniel as added financial support to cover extra medical costs. Daniel recalled how his financial contribution has had to vary at times, but they "split costs that aren't met by the deductible," and his children have "both been relatively healthy."

Separate, Yet Unequal

For three of the fathers, their experiences with health insurance were straight forward and they were able to successfully cover their families, but there were aspects of the process they found frustrating, puzzling, or aggravating. Eric, Franklin, and Harold were able to access insurance, but for them, it was an unnecessarily frustrating process. As they reflected on the process, each of them assessed the process as involving more work and higher taxes in comparison to heterosexual, married couples.

Eric, a self-described "full-time dad, part-time hairstylist," had both his partner, Edward, and their adopted daughter, Ella, on his insurance policy. Eric's employer has provided domestic partnership benefits for same-sex couples for years, and as soon as it became available to them seven years ago, Eric added Edward to his plan. In all, Eric thought his story was unique because "it was *simple* [original emphasis]." Though Eric did note two points of difficulty: proof of relationship and extra taxes. Eric compared his experience to the experiences of heterosexual, married couples,

> I had to *prove* [original emphasis] that I was in a domestic partnership, whereas with a married couple, they could say, 'Oh, I'm married.' And then they're done. I had to submit all the paperwork… and prove our domestic partnership. We couldn't just check a box.

So while his employer provided domestic partnership benefits, Eric felt like heterosexual, married couples had an unfair advantage. Eric's "biggest frustration" with the separate, yet unequal domestic partnership benefits were the taxes. While "straight, married couples get to

claim that as taxable income," Eric had to pay extra for his family's benefits. These extra burdens were not, however, overwhelming, as Eric admitted that he was lucky he did not have to go to court, and "it was pretty simple, pretty cut and dry."

Franklin is a stay-at-home dad whose health insurance experiences have spanned three different states and changed from domestic partnership benefits to legal spousal coverage over the last 10 years. He and his husband, Felix "have been very lucky" and did not find the process of proving their domestic partnership burdensome. "As far as health insurance goes,…it's not something we had to spend a lot of time thinking about," but one problem did arise in Franklin's health insurance story: taxes. Since they have been married, Franklin and Felix have paid more in taxes because of their same-sex status. As Franklin stated, "Before the June 26th Supreme Court ruling this year, the federal government did not recognize our marriage [and] my health benefits were counted as income." Franklin estimated he and his family have paid over $10,000 in extra taxes in the last five years. Until recently, Franklin's insurance story has included a heavy financial burden, but as a result of recent court decisions Harold believes their "problems [are] solved."

Harold and Henry are both employed full-time, and Henry just recently added Harold to his insurance plan. Harold works in a senior position at a consulting firm and Harry is a department director at his job. Their children, Helena and Hector, have insurance through the state insurance system because they were adopted through foster care. Health insurance for their children was an important, but hassle-free process. Harold's frustration narrative involved a very recent, single-event problem: getting rejected by a health insurance company because they were a same-sex couple. Originally, Harold and Henry chose their provider because the company was known for providing same-sex spousal coverage, but the company turned them down because of

their same-sex status. Harold and Henry have been legally married for over two years, and have been "fortunate… with no issues" around insurance but this experience made Harold feel "just discriminated against when we found out that we couldn't [have coverage] as a same sex couple." Harold was puzzled, "We had no answers, and I just found it very odd. Especially in this day and age… it was very shocking and surprising and I didn't quite understand it." Thankfully, Henry's employer had more than one health insurance provider, "so we switched."

The frustrations described in these three fathers' narratives highlighted the inequalities that exist between domestic partnership and legally married benefits. While Eric, Franklin, and Harold were successful in getting family coverage, their experiences were tainted by the reminder of the inequalities that remain for many same-sex couples in the United States. All three fathers felt they were fortunate to have easy access to insurance for their families, but they experienced some bumps along the way.

Taking Action for Coverage

Two of the fathers' stories involved them taking action to change either the insurance policies or their family's situation. Their experiences focused on frustrations in the past in which both partners were unable to be on the same insurance policy, but rather than feel defeated, the fathers and their partners used this experience as a catalyst for change. Today, these fathers have no problems with their health insurance access or coverage.

Anthony, a recently unemployed lawyer, and his husband, Arin, reside in the southeast where marriage equality does not exist. In the last year, however, Anthony and Arin got married in a state where marriage equality does exist. Despite their legal marriage, Anthony "could not be covered under [his] husband's university insurance because of state-sponsored gender discrimination." The frustrating truth of Anthony's situation rested on his family's state of

residence, and the fact that his husband was employed by a state university that would not recognize his family due to their same-sex status. So, Anthony and Arin changed their lives and their story. "Once [Arin] got a job outside the state at a state university where marriage equality exists, there was absolutely no problem." Anthony and Arin sought out a new job in a state where they could take advantage of marriage equality. By taking on a new job in a new state, Anthony and Arin took action and control of their health insurance story.

Liam and his partner Larry now live on the west coast, but their health insurance story begins in the Midwest. Liam also works in a university system and when he started his first job, Larry was unable to be on his plan due to university regulations. Larry sought out a separate insurance policy, but also joined together with other unmarried partners to form a committee. This committee "built the case for providing coverage to unmarried partners…which the university eventually adopted." Liam and Larry "formed a team of people to build a case" that would change their health insurance narratives.

Secondly, Liam and Larry also took action to change not only their insurance but their family circumstance when they moved to the west coast. Moving to the west coast was "not just about insurance of course, but so we could co-adopt the children and have joint status as parents here." Liam and Larry's children both have health conditions that require an extensive team of medical professionals. Their children's health makes health insurance very important to Liam and Larry's story. In the Midwest, Liam and Larry's family was vulnerable in areas of legal ties to their children and insurance. When their Midwest state passed new laws banning marriage equality, Liam and Larry made the move to "have the supports and protections [they] need now." Liam and Anthony were able to "actively choose [their] places to work that [knew] the kind of

life [they were] building and the people that come with [them] are valued and important parts of the equation" (Liam).

Resigned

Finally, for Bill and Charles, their health insurance experiences were aggravating, and overwhelming. They describe instances of discrimination and the inability to be on the same plan as their partner or husband. Bill and Charles did not take on the costs of moving or seek out opportunities to find other employment that would recognize their situations. Their experiences with discrimination were not, however, a rallying call for change but instead resulted in an angry resignation to the inequalities of state laws and health insurance policies.

Bill's account of his insurance story was rife with frustration and disappointment. Bill works full time and Brian is a stay-at-home dad. He and his husband Brian adopted their son Billy over 7 years ago, and as a result of the new addition to the family, Bill sought out what his family's insurance options were. Bill recalls that, "as a then 40-something year old, I was told that to insure my spouse and my son on MY policy, [it] would be more costly than a separate one from them [due to] my HIGH AGE [original emphasis]." As a result, Bill and Brian continue to remain on separate, independently purchased insurance policies, and Brian covers Billy on his insurance. While Bill and Brian are saving money with two policies, Bill remains frustrated by the inability to have his family on one plan. Rather than seek out a different plan or pursue a family plan through his partner, Bill has resigned to the health insurance system and "its age discrimination." Even after getting married last year, Bill and Brian did not revisit their health insurance options as a now legally wed couple, an indication of ongoing frustration and resignation with this health insurance experience.

Charles and Craig are both working fathers living together in a southeastern state that does not have marriage equality. Together, they are raising Charles' daughter, Christina. Charles purchased his insurance independently and is not covered by his employer. He also covers Christina as she is his biological daughter, but recently Charles attempted to put Craig on his insurance plan. When Charles and Craig attempted to be on the same plan, the insurance company rejected their application. Charles explained that they were denied benefits based solely on the fact that they were a same sex couple. Charles does not have insurance through his employer, meaning he has access only to the plans he can afford. So even though Charles was "very disappointed" in his experience with health insurance, he has not sought out other insurance options. Today, Craig, who works part-time, has had to buy his own insurance policy. When asked if there was anything unique about his family's story, Charles said, "Nothing." Charles sees his experience as the rule rather than the exception and expressed no intention or desire to seek out other insurance options or make changes to his family's situation. He is resigned. His account was a blatant example of policy discrimination, but Charles, unlike Anthony or Liam, has not, and perhaps cannot, change his circumstances.

The narratives of frustration capture the range of gay fathers' experiences with health insurance that illustrate the influence of agency, geographic location, and discrimination at varying levels. Some fathers had little or no problems with insurance. Others had problems with insurance, and two fathers chose to take action, and two fathers resigned to the policies and inequities of the insurance system. While their experiences with health insurance varied, the next section of findings demonstrates one common thread among all of the fathers.

Family "Outings"

The unifying factor for all of the fathers was that each one of them indicated they were very out in their communities. Not a single father discussed the need to feel closeted (Tornello et al., 2012), the worry of having to hide their sexual orientation (Goldberg, 2012; Mallon, 2004), or a worry about having to shield their families from their surrounding communities (Goldberg, 2010). In this section I present the findings that reveal the sample's ubiquitous community outness, and how the status as a family (e.g. having children) made it hard *not* to be out.

Everybody Knows

I asked fathers to indicate the contexts and the degree to which they were "out" or had disclosed their sexual orientation. I asked about general contexts like family, work, children's school, and friends and the community. The fathers were, as Daniel stated, "out all over the place." Anthony even incorporated a "close-knit extended family and network of friends" in his sons' life. He prided himself on showing his sons "how to be an honorable, *honest*, responsible, caring, *open* adult, and good partner [emphasis added]." Raising his children with openness and community gave his children "as close to an ideal growing up as possible." Eric explained that he and Edward have also been out in their communities. "[Edward] was on my policy even pre-Ella… and we were together for 11 years before we started the adoption process…we're out and yeah, [laughingly] *everybody knows* [original emphasis]."

My second question about outness asked fathers to indicate what community resources they turned to for information and guidance at any point during the insurance process, and again, the degree to which they were "out" to these community resources. For example, when I asked Liam if he was out to the resources he used, he emphatically said, "Yep. Out. Out. Out. Out. Yeah, there's nobody we would ever hide it from." And, Franklin said, "Absolutely! We have told everyone in every context that I'm aware of." Bill clarified his answers about community

outness by declaring, "I AM OUT! SIMPLE [original emphasis]." Father after father indicated that they did not have reservations about disclosing their identities and none of the fathers in my sample indicated having to hide their sexual orientation. Their responses highlight the fathers' overall philosophy about disclosing one's sexual orientation. For this sample of fathers, it is indeed better to be "out" than in.

Hard *Not* to be "Out"

While the data did not delve into questions about the life history and coming out experiences, I did ask if the insurance seeking process made the fathers feel more out as a family. Almost all fathers did not feel more out as a family. Many of the fathers explained that their status as parents had already made it nearly impossible to conceal their "alternative family" status, as Derrick stated.

When alone or outside of the family context, their sexual orientation was not obvious, but people "DO know, if we happen to talk about family [original emphasis]" (Harold). Derrick provided his philosophy on concealment pre and post children.

> Having children outs you in a way that nothing does. I've known I was gay since I was 10, 12, 14? Something like that – and always went about living my life the way I wanted to…I didn't necessarily talk about it [gay identity] with a lot of people…but when you have children, you show up – [pause] we're an alternative family. So you're just – you're just *out* [original emphasis] from the second that your foot is in the door.

Liam said his family found it tremendously difficult to hide due to their intersection of race and same-gender parenting.

> As a couple, I think things can hide, but if you have children, you really can't hide for the good of yourself, or for the good of your children. And in our case, because we're two

> White guys with two Black kids – Ain't *no way* [original emphasis] you can hide it. I just don't think that once you have kids you can really hide.

As single men, they saw more possibilities of hiding their sexual orientation. As partnered or married men, they felt they still had the ability to conceal their status, but once children entered the equation, these fathers not only did not want to but could not conceal their family's alternative status.

Insurance and the Use of Gendered Language

I also asked the fathers about their role as a provider: How do you see yourself as a provider (i.e., what do you think your main responsibilities are as a father)? Because this study was about health insurance, I somewhat expected the fathers to include being able to insure their family on their plan in their role. Instead, the fathers' responses discussed the division of labor for the home and their children, leaving out health insurance.

The division of labor in both heterosexual and same-sex parent households often involves issues surrounding gender (Luxton, 2006), and among this sample, I found that the 8 of the 10 fathers used traditionally and easily recognizable gendered language to describe roles (Scott, 1988). Eight fathers made meaning of their roles using culturally recognizable, gendered language (Blumer, 1969; Luxton, 2006; Scott, 1988). For example, the father who tended to describe his role in ways that reflected more traditional fathering was the insurance provider for the family. Likewise, those fathers who did not provide insurance were prone to using "mothering language" to describe their role. This use of language may reflect how providing insurance can be more closely associated with fathering than mothering (Scott, 1988).

Enacting Traditional Masculine Language

Of the six fathers who carried children on his plan, five of the fathers' responses tended to enact language that connotes more traditionally masculine responsibilities. Traditionally masculine roles include being the financial provider for the family (Pleck, 2004) and authoritative figurehead (Luxton, 2006). Table 5 presents excerpts of the words the fathers used to describe their role as a provider for their family. These five fathers framed their contribution to their families in terms of their financial contributions, decision making authority, and overseer of family well-being. Anthony spelled out his duties as having "coached, cooked, helped with homework, doctored, disciplined, read stories, and taught" his sons. Of the roles Anthony takes on, five of the responsibilities were gendered towards traditionally masculine responsibilities: coach, doctor, discipliner, reader, and teacher (Pleck, 2004). Derrick says he is the "paterfamilias," referring to a highly authoritative, "male head of the *familias* said to have the power over all of those under his jurisdiction" dating back to Roman times (Parkin & Pomeroy, 2007, p. 73). He is "the big guy who makes sure everyone is taken care of…because that's just what I do." For Anthony, Charles, Derrick, Gregory, and Liam, the financial responsibilities to their families were their primary responsibilities as fathers.

Table 5

Gendered Terms to Describe Provider Role

Participant	Description of Self – Traditionally Masculine Roles	Family Insurer	Description of Self – Traditionally Feminine Roles
Anthony	"provided significant financial support" "I coached, helped with homework, doctored, disciplined, and taught" "primary breadwinner until recently"	Self (Until *very* recently)	
Charles	"responsible for everything"	Self	
Daniel		Partner (Derrick)	"provide stability" "consistent love" "I keep him sane"
Derrick	"primary breadwinner" "paterfamilias" "the big guy making sure everyone is taken care of"	Self	
Eric		Self	"more of the mother role" "coparent" "more emotional personal" "the one she runs to when she gets hurt"
Franklin		Husband	"stay-at-home-dad" "provide the environment, food, structure" "taxi-driver"
Gregory	"responsible for taking care of my husband and son" "both financially and emotionally"	Self	
Liam	"primary provider…a stable income" "taken on primary load of providing"	Self	

Comparison to Partner

In addition to describing their roles with traditionally masculine terms, these fathers also tended to compare their role to their partner or husband, highlighting the difference and their traditionally masculine self-descriptions (Scott, 1988). Gregory and Geoffrey decided that Geoffrey "would be a stay-at-home dad, mean[ing] that [Gregory's] partner and son would be covered on my plan." Liam also compared he and his partner's roles as providers.

> As in many couples, there's a leader and a follower…and there have been times when my role has been carrying the primary load of providing and now is a good example of that. The move here meant Larry left his job behind…and I've been serving as the primary provider because he hasn't had a stable income.

Liam, the insurance provider and head of the household described both he and his partners' roles, and tended to enact more authoritarian language to describe his role as a provider.

Enacting Traditional Feminine Language

The two fathers included in this analysis that were not the family insurers tended to enact language that connotes traditional feminine responsibilities to describe their role as providers. Table 5 provides examples of how Franklin and Daniel described their roles in far right column. The feminized home is the center of nurturing, cooking, staying at home, and attending to the mental and emotional needs of the family (Luxton, 2006). Franklin, a self-described stay-at-home dad, stopped working a few years ago before he and Felix adopted their children. Today, Franklin described "the biggest, one of [his] current responsibilities [as] providing the environment for the kids, providing for the day-to-day needs. The food. The structure. The taxi-driver." Franklin prepares the home-environment, cooks, and tends to the needs of his children

and his description of his role as a provider evokes the traditional responsibilities associated with stay-at-home mothers (Luxton, 2006).

Daniel works full-time outside of the home, but described his role as a provider using traditionally feminine language as well.

> I provide stability, consistent love, presents. [pause] And I think we [Derrick and Daniel] and my former spouse are very complementary of each other in terms of different gifts and abilities and skills we bring to the kids…What else do I do? How else do I provide? [playfully] I keep [Derrick] sane.

Daniel's description of his role as a provider evokes traditionally feminine responsibilities such as love and nurture for children, providing emotional and mental support to Derrick, and maintaining emotional stability in the household (Luxton, 2006).

Comparison to Partner

In addition to describing their roles in traditionally mothering terms, Franklin also used gendered language to compare his role to Felix, highlighting their different provider roles. While Franklin described himself as the stay-at-home dad, he described Felix, his husband, as "the financial fuel" for the family structure (Franklin, 2013). Not only did Franklin use recognized terms for himself (stay-at-home dad) but also evoked language that signified Felix's traditional breadwinner responsibilities (Pleck, 2004). The language the fathers used provided insight into how gendered responsibilities may continue to delineate the division of labor in their households.

Exceptions to the Rule

The one outlier of this finding of gendered provider language is Eric. Unlike the other insurance-providing fathers, Eric more often described his roles in mothering terms.

> I guess I would say that I've taken on more of the mother role. I'm more caring, more emotional person…I'm the one that…stays home more often, the one that knows the ins and outs [of parenting] better. [pause] I'm the one she runs to when she gets hurt.

Eric's description of his role even used the term "mother role" to describe his contribution and was the most detailed and primary description of his role as a provider. Eric's language aligned more closely with those fathers who were not providing insurance, but because Eric is the father providing insurance for his family, he is an outlier of this finding.

Other fathers also showed some flexibility and fluidity in their roles. While Anthony has tended to see himself in terms of the masculine, primary breadwinner, he believes "[his] responsibilities are far more than financial." Secondly, Franklin noted that if Felix's "financial fuel" ever stopped, bringing in an income "would obviously be my responsibility too." The Insurance and the Use of Gendered Language provides a look at the tendencies of fathers to describe their roles in gendered terms, but also reveals the fluidity of their role descriptions and identities as fathers. These fathers' roles are not set in stone, but give and take according to the needs of their families. As such, the current roles and responsibilities are not static identities, but malleable positions within the home.

Two of the fathers from this sample did not enact gendered language to describe their roles. Bill's and Harold's descriptions contained gender neutral language such as "we try to provide the best care for our children day-in and day-out," (Harold) and "I provide financially, mentally, and just about every other way" (Bill). These two fathers' stories also differed in other ways from the eight fathers. Neither Bill nor Harold were the insurance providers for their family. And secondly, neither of these fathers had one family insurance plan. Brian and Bill were on separate plans, with Brian covering their adopted son, Billy. Harold and Henry were on

one plan, and their children were insured solely through the state insurance system. These two fathers' experiences were not a part the analysis on the use of gendered language.

Chapter Summary

The results of this study cover the experiences of 10 White, gay fathers from across the United States. These 10 fathers claimed responsibility for 15 children and all members of the families had health insurance. The narratives and health insurance stories that emerged from the data reveal a diverse and complicated picture of gay fathers' experiences with health insurance. There is not a homogeneous gay father experience, and each fathers' social position, community, and role-making abilities influence how each story will turn out. Chapter Five places these fathers' narratives, lives, and experiences into context and provides further insights into the findings.

CHAPTER 5: DISCUSSION, IMPLICATIONS, FUTURE RESEARCH

Discussion

Intersecting Identities and Agency

The fathers' narratives with health insurance frustrations demonstrate the ways in which class, race, education, and employment intersect to provide gay fathers with the highest degree of agency and access, and subsequently, the lowest levels of frustrations. The social positions as White, upper middle class men provided these fathers with the most normative father experience with insurance (Shields, 2008). Gregory's insurance process was an easy, frustration-free process and marked the privilege that comes with full-time employment at a company with domestic partnership benefits. As a fully employed, recently married, White father, Gregory has the legal and employment protections (employer provides benefits) that place Gregory in a privileged position in society (Collins, 1998).

Derrick's experience with health insurance highlights the ways in which Derrick occupies "interlocking positions of privilege" (Berkowitz, 2013). Derrick is a White, highly educated, self-employed gay father of two (via surrogacy) who was able to "farm" out his insurance seeking process. As a self-employed medical specialist, Derrick had the opportunity and agency to investigate and choose the plan that he wanted (Gecas, 2004). Adding Daniel and his two children to his plan was a hassle-free experience. Derrick had a tremendous amount of control and agency in his insurance process because of his social class status and resources.

The frustrations described in the three Separate, Yet Unequal narratives highlighted the inequalities that exist between domestic partnership and legally married benefits. While Eric, Franklin, and Harold were successful in getting family coverage, their experiences were tainted by the reminder of the inequalities that remain for many same-sex couples in the United States.

All three fathers were fortunate to have easy access to insurance for their families, but experienced some bumps along the way.

Anthony's and Liam's Taking Action stories illustrate the fathers' perceived agency and ability to create new situations in which they *could* provide health insurance for their families. Interestingly, both stories involved fathers involved in university communities, and fathers with a great sense of action and control. The two fathers' connections to universities are privileged positions due to the rapidly changing and flexible university systems. These "progressive minded" systems along with Liam's and Anthony's class and status as highly educated individuals provided both of them with the tools to have more agency in the resolutions of their ability to provide insurance. Today, Anthony's and Liam's stories have been resolved due to their own actions.

Bill's and Charles's Resigned health insurance stories conveyed their frustrations, but lacked agency or control. In contrast to Anthony and Liam, Bill and Charles did not pursue other insurance options or make changes in their lives to allow for other insurance options. Their concessions reveal the intersections of class, age, and geographic location. Bill's age, "as forty-something year old" coupled with his status as a member of a same-sex couple placed him in a unique, but not uncommon position for gay fathers. As many adoptive gay fathers form their families at a later age than heterosexual fathers (Goldberg, 2012), Bill's story illustrates the ways in which same-sex coverage can intersect with age to create a double jeopardy of extra costs and marginalization.

Charles' family illustrates the intersections of socioeconomic status and geographic location; he had limited options for his family. After completing some college but not earning a college degree, working full-time but without employee benefits, and having a daughter from a

previous marriage (as opposed to surrogacy), Charles is most likely not in a high income bracket like some of the fathers in my sample. His situation represents the ways in which those families who may not be able to access legal marriage, afford different policies, and pay extra taxes are limited and not surprisingly, resigned to remaining in their current insurance circumstance.

Outness Among Fathers

A tremendous amount of social change towards acceptance, tolerance, and empowerment of the LGBT community has occurred in the United States (EqualityVirginia.org, 2013). Stigma is declining (Gates, 2013c), but gay fathers still encounter homophobia (Goldberg, 2012), prejudice, and stereotypes (Mallon, 2004; Mule et al., 2009). Some of the fathers expressed having past experiences with hatred and prejudice years ago. Despite having felt "that [they're] kind of watched and judged as a family," as Liam stated, all of the fathers in my sample chose to be open and out to their surrounding communities. Their degree of outness reflects the declining power of stigma for these gay fathers, and the rapid change in the attitudes and perceptions about same-sex parenting (Biblarz & Savci, 2010).

Secondly, most fathers in the sample had privileged identities that enabled them to be out in their communities (McCall, 2005). As discussed in Chapter 2, White men can more readily access normative masculinity (Carbado, 2013). Each of the fathers' experiences cannot be considered in isolation from their race (being White) and class (mostly middle or upper-middle class). Their race, occupational privilege (working for universities, medical specialists, senior-management, and lawyer), educational attainment, and gender (being male versus female) provided the fathers with safeguards against most homophobia and discrimination (Berkowitz, 2013). For these fathers, outness is a marker of sociohistoric (Elder, 1994) and individual privileged positions (Connell & Messerschmidt, 2005).

Description, Not Identity

Insurance and the Use of Gendered Language findings reveal intersecting ideas about roles, language, and identities (White & Klein, 2008). For the insurance providers, they used language to describe their role that is connected to more traditional, middle class, and White notions of fatherhood (Pleck, 2004). For Franklin and Daniel, their language connotes more traditional, middle class, and White notions of motherhood (Luxton, 2006). These fathers' beliefs and language to make meaning of these roles as fathers reflect their status as White, middle class fathers (Shields, 2008). The language they used to delineate their responsibilities and their partner's or spouse's responsibilities cannot be understood without recognizing the social identities and positions of this sample (Shields, 2008). This finding signifies where insurance fits into the continued association of racialized and gendered language (Scott, 1988) and role as a provider (Stryker, 2001; Turner, 2000).

As previously discussed, Eric's case is an outlier for this finding. His case, however, illustrates that occupation may determine who provides insurance. Eric's story exemplified how employers determined insurance coverage for families. In analyzing his story, Eric and Edward's health insurance decisions were without choice. Edward's employer did not offer domestic partnership benefits, and so Eric became the insurance provider because of his employer benefits, not because of his ideas of fatherhood and role-making.

The Insurance and the Use of Gendered Language provides insights into the way gay fathers make meaning of their roles (Blumer, 1969). Specifically, their use of language is a meaning making process about how our society organizes roles and responsibilities among parents (Scott, 1988; Turner, 2000). The use of gendered language showcases how same-sex couple fathers are not "gender free" (Goldberg, 2013, p. 88). And the types of masculine and

feminine descriptors employed reflect a middle-class and White picture of family (Shields, 2008).

While there continues to be association of gender and provider role (Brinamen, 2000), the fathers' language does not mean they necessarily identify as the masculine father-figure. Their language also revealed "strange mixture[s] of mother and father" (Derrick). The fathers use gendered and traditional language to make their roles understandable and recognizable to the heteronormative, outside world, but we should not conflate their language with their identities (Blumer, 1969).

Conclusions

I began this study with four research questions. While most of the findings and discussion have addressed the research questions in some way, I want to clearly articulate the findings for each research question.

- *Research Question 1: In the United States, how do today's gay fathers perceive their access to health insurance for their families?*

The Narratives of Frustration findings provide insight into how today's gay fathers evaluate their access to health insurance. All fathers were able to successfully access insurance, but law and policy inequalities continue to presented barriers to some fathers. While frustrating, the barriers were still surmountable. Rather than be on the same family policy, Bill and Charles had to settle for two separate policies. Rather than have the same avenues of access as straight, married couples, Anthony and Liam had to seek out the right opportunities and take action. Rather than being able to "check a box" and pay equally, Franklin, Eric, and Harold had extra work, higher costs, and limited options to health insurance benefits because of their same-sex status. Lastly, Daniel, Derrick, and Gregory had no perceived barriers to access at all.

- *Research Question 2: What are the communities in which gay fathers are embedded and can turn to for knowledge/instrumental resources to navigate the insurance system? And how helpful are these community resources?*

The findings showed that gay fathers are fully integrated into and out to their communities, and can and did turn to a variety of resources before and during the insurance process. These gay fathers were open, fully disclosing their family's same-sex status to most, if not all of the community resources they used. While not fully discussed in the findings, the fathers utilized at least one community resource, and most fathers explained that they found multiple resources helpful for each part of the insuring process: finding a plan, adding their partner or husband to the plan, adding children to their plan, and understanding what providers took their insurance. This sample of gay fathers sought out a variety of resources and felt they could (a) be open and honest about their family, and (b) get helpful, more personalized answers about their insurance options.

- *Research Question 3: In what ways and to what degree do gay fathers employ agency and innovation as they navigate the health insurance process?*

The results of this study revealed a range of agency from withdrawal and resignation, to complete and transformative action. Fathers chose their occupations (Liam, Anthony, Gregory), found providers that cover their families (Derrick, Harold, Eric), and arranged their policies to meet the needs of family (Bill, Charles, Daniel, Franklin). As previously discussed, the amount of agency and agentic paths fathers could take depended on intersections of class, race, age, occupation, and state of residence. Each father's story articulated ways in which these identities and positions of privilege afford varying degrees of agency.

- *Research Question 4: What marginalized and privileged identities are at play for gay fathers?*

As with Research Question Three, the gay fathers' intersecting identities placed them in simultaneous positions of privilege and disadvantage (Collins, 1990). This study identified privileged positions for gay fathers in their race (White), educational attainment (mostly college graduates), occupation (upper-management), class, and state of residence (recognitions of same-sex couples, access to marriage equality), class, occupation (employers that did not offer benefits), and age.

Limitations

There are several limitations to this research related to population, data collection, and instrumentation. Gay fathers are a hard-to-reach population (Goldberg, 2012), increasing the difficulties of successfully recruiting a diverse sample. While I utilized a variety of techniques that had promising opportunities of reaching a socioeconomic, geographic, and racially diverse population, the sample consisted of only White fathers. Therefore, this study can only address the experience of White fathers, who immediately occupy two privileged spaces: male and father (Collins, 1990). Secondly, this sample does not cover a diverse socioeconomic class of gay fathers. All of the fathers had some form of higher education beyond high school and had at least one source of income for each household. The sample also only includes fathers who are partnered and currently caring for children. This study did not capture the experiences of older adult fathers who dealt with insurance in the past (beyond 15 years). This study no doubt produced different results than one would find with single gay fathers. My interest, however, was on a family narrative, and therefore I chose to limit my sample to partnered gay fathers.

In addition, all members of these families had insurance coverage. The narratives provided in this research do not include the experiences of fathers who did not have coverage for an extended period of time, or currently do not have insurance coverage. I would expect the experiences of those who are or who have a partner who is without insurance to be different from this sample.

There were also limitations from my methods and instrument of data collection. I used a variety of recruiting techniques, but I recruited nearly all of the sample using online techniques (n = 7). These are fathers who are more Internet-savvy and online quite frequently. I was probably unable to reach those fathers who may not be virtually connected or frequent users of the email or Internet. Secondly, while I aimed to maintain reliability and credibility in my study, there were differences between online and interview experiences. The data from my interviews provided more detail, but also provided me with the opportunity to ask clarifying questions. Therefore, I recognize that the online data is limited by the information I was provided. Lastly, my structured questionnaire did not allow for fathers to provide a full and complete narrative at times and a semi-structured interview may provide better data and responses in the future.

Implications

Despite the study's limitations, I was able to collect relatively rich data from the participants. Moreover, there are several theoretical and research implications of this study. In this next section, I detail the ways in which this study contributes, contradicts, or complicates theory and prior research. Lastly, I discuss how this thesis has evident and relevant policy implications.

Theory

My research connects to the theoretical ideas of agency, intersectionality and the two guiding perspectives: symbolic interactionism and life course theory. The daily lives of gay fathers involve intersecting identities and powers at play (Johnson & O'Connor, 2002), and each set of identities is different for each man. Gay fathers grapple with their identities as fathers, gay men, partners or husbands, and as men (Panozzo, 2010). As such, there is no homogeneous, gay father experience. In this study, the narratives and experiences of the fathers revealed the intersections of class, race, and gender that operate on different levels (Zinn & Dill, 1996). This study does not produce a single gay father experience but by allowing for more diverse experiences to be a part of the research, I did provide a more accurate characterization of this marginalized, invisible population (Collins, 1998). The fathers' experiences varied "in amounts of penalty and privilege" (Collins, 1990, p. 287), reaffirming the concept and tenets of intersectionality.

I used symbolic interactionism as a guide to help understand how gay fathers construct, negotiate, and make sense of their roles and social surroundings (Berkowitz & Marsiglio, 2007). This study affirms the role-making concepts in symbolic interactionism (LaRossa & Reitzes, 1993). Fathers' descriptions of their role as a provider utilized a variety of gendered and degendered role language (Scott, 1988). They both relied on and redefined traditional gender role language (Lehr, 1999) to construct their experiences as providers for their family (Turner, 2000). Their narratives provide evidence for fluidity in roles, changing ideas about fatherhood, and adoption and adapting recognized labels for parenting (Blumer, 1969; Stryker, 2001).

Several of the fathers in my sample operationalized life course by tracing family processes in the past (Elder et al., 2004), describing actions they took to make decisions and changes to their lives (Gecas, 2004), and reflecting on their current situation. The findings in my

research, however, affirm the importance of the fathers' sociohistoric positions (Elder, 1994) and transitions (Elder et al., 2004). The responses I received were definitely dependent on how things are "in this day and age," as Harold aptly noted. In the last 10 years, the United States has gone from no states offering marriage equality to 13. The historic timeframe in which these fathers created and managed their families is a significant factor in the choices available to the fathers, the social climate, and civil protections.

The fathers' outness was also a result of the transitions (Elder et al., 2004) into fatherhood. The change in parental status resulted in a change in identity and position in society (Elder et al., 2004; Pleck, 2010). Partly a result of the historic time, this sample of fathers had an extended community of linked lives (Elder et al., 20004) in which they felt comfortable and able to be out. Community and support networks outside of the immediate family continue to play an important part in the lives of these gay fathers (Oswald et al., 2010).

Research

There are ways in which the study affirms, contradicts, and complicates previous research. The findings affirm past research that shows gay fathers take part in a variety of family formation strategies (Berkowitz, 2013; Biblarz & Savci, 2010; Goldberg, 2012) by having biological, surrogate, adopted, and foster care children within my small sample. This work also affirms research that gay fathers adopt and adapt to the variety of parenting roles children require (Schacher et al., 2005). Their role-making and language does complicate research around roles. As some research has shown, some gay fathers willingly take on more effeminate roles (Brinamen, 2000), and some fathers in my study labeled their role in mothering terms. Others took on the hybrid parenting role (Miller, 2004) but continued using traditional gendered

language. Fathers did enact gendered language, but it may not be equivalent to how they see their identity as a gendered or de-gendered parent (Brinamen, 2000).

In addition, this study provides some variation to prior research on gay fathers and their rates and degree of disclosure. While some research has shown gay fathers were unable to disclose their sexual identity (Goldberg, 2012) or actively hide their sexual identity (Mallon, 2004), my sample of fathers were completely out in a variety of contexts. This sample of fathers is unique because they did not hide throughout the family formation and insurance process but instead, openly described and defined their family. Tornello et al. (2011) found that gay fathers' degree of outness reduced stress and provided honest "not false" communities where they could raise their children. In present study, the stress of disclosure and defining family for surrounding communities was not a factor in the insurance process.

The results of this study also expand the knowledge of gay fathers' experiences not only with health insurance, but outside of the "gay meccas" (Oswald & Culton, 2003) of San Francisco, New York City, and Los Angeles. The variety of health insurance experiences spanned states with marriage equality, domestic partnership benefits, and explicit bans on same-sex marriage. As such, the research contributes the experiences of fathers from a variety of geographic locations.

Policy

Many of the frustrations, obstacles, and challenges facing my sample of gay fathers dealt with policy issues. The state-by-state variation in marriage equality creates a number of impediments and confusion for gay father families. Some of my fathers described moving from one state to another, or having legal marriage certificates in a different state than they currently reside. These state variations complicate the options and access to family recognition and health

insurance. These fathers are at the mercy of their employers or their bank accounts because of policy inequalities and state variation in marriage equality.

This study also highlights the work that needs to be done regarding employment protection, tax laws, and family law. As discussed earlier, currently only 29 states offer workplace protections that prohibit a gay father from getting fired because of his sexual orientation (HRC, 2013c). For some of these fathers, their benefits were dependent on their employers. The link between salary and health insurance benefits demands more workplace protections in order to protect the health and wellbeing of these gay-parent families and their children (Dunn & Moodie-Mills, 2012).

Another policy issues relates to tax reform. In the midst of this study, the Supreme Court overturned the Defense of Marriage Act, and brought an end to federal tax inequalities facing married gay-parent families (HRC, 2013a). For those gay fathers who are not legally married or do not have access to legal marriage, they continue to remain excluded from upcoming tax reform. In considering the next steps to insure health insurance equality, those family forms that do not have access to the same legal recognitions need to be considered.

And lastly, this study also has implications for family law. While all of the children in this sample had health insurance coverage through an adoptive or biological parent, those parents who do not have the access to adoption rights (bans on second parent adoption) would be limited to who could provide health insurance to their child (Dunn & Moodie-Mills, 2012). Providing legal ties of both adoptive parents ensure children can have access to the best insurance policy either parent can provide (EqualityVirginia.org, 2013).

Future Research

Lessons Learned

At the start of this research project I had high expectations of the success of my recruiting, data collection, and sampling methods. As time passed and my recruiting efforts resulted in low response rates, I made the necessary changes to successfully carry out my research. During this process, I took away several lessons learned during this study. The first lesson revolves around recruitment methods. I found that flyers and business cards are one of the toughest forms of recruitment. Posting flyers was a time-intensive process, and depended so much on the location available, locations permitting, and customer demographics (e.g., would any gay fathers see the flyer? Would other customers tear the flyer down?).

I found that online recruiting techniques were more successful, but needed to be more direct. Contacting organizations was a good start, but I need a gatekeeper or an insider who can help promote the study. Moreover, gatekeepers can help reach out to fathers who are less "out" in their communities and online. For example, my Twitter sample consisted of fathers that boasted about their identities (e.g., PROUD father of two, gay dad of one, loving husband to a wonderful man).

Future partnerships with LGBT, gay parenting, and religious communities can help reach a more diverse gay father population. Moreover, my success with Twitter stemmed from the ability to direct message with fathers once they followed the study. I had no fathers initiate conversation with me, but once I sent a short direct message I had several fathers express interest, and three participated. The more direct contact I made, the more promising outcome.

Another lesson learned centers on the importance of interviews. Most fathers did not have problems with completing the interview or response, but my questions about community resources and pressure did raise questions from more than a couple of the fathers. For example, the community resource question asked fathers to check those resources that applied, but several

fathers provided unclear answers. They would be completely out to some (e.g., community), but not out at all to others (e.g., friends). Fathers, did however, clarify that any resource they said they were not out to, was their way of saying they did not *use* this resource. This was a problem for the online participants, but because I conducted the interview I could go through and clarify with each father (a) which resources they used, and (b) how "out" they were to the resource. Interviews allowed me to make sure I more accurately and appropriate represented my fathers. The lessons learned provide ways and ideas for me so I can improve my next study.

Directions for Future Research

In reflecting on the entire research process, the data collection, and findings there are several avenues for future research. From a methodological standpoint, future research could continue to utilize Internet and mobile technology but more as a form of research and eligibility screening. This process revealed the fruitfulness of interview data when addressing complex family processes and a future study could use the Internet and social media to recruit potential fathers and possibly screen for sample criteria, but the bulk of the research would rely on interview data. Interviews provided me with the opportunity to ask follow-up, clarifying, and some tough questions about the topic. Moreover, I could establish rapport with my sample and received positive feedback and a willingness to be contacted in the future for a follow-up study.

Future research could also take a variety of directions. Researchers, including myself could take a more comprehensive look at insurance and healthcare experiences of gay fathers. Some of the fathers I talked to mentioned their hesitations or in-person experiences they had with doctors, nurses, and the healthcare system. A future project could look at both access to healthcare through insurance and lived experiences of their healthcare plan. Other research ideas could examine the experiences of older fathers who are now older then 60. This kind of research

project could analyze experiences with the healthcare system that occurred prior to the rapid social changes of the 21st century. Their experiences could be compared with experiences of younger gay fathers to examine cohort effects. Another direction for research could take a more dyadic approach to issues related to health insurance and healthcare. While one partner or spouse may carry children on his plan, the division of labor when it comes to going to doctor appointments and using the health services available to them may reveal new family processes.

The rapidly changing social and legal atmosphere for gay-parent families places this and future research in an exciting time. More and more states and more and more employers are providing same-sex couples with the tools they need to fulfill their responsibilities as parents. Until this June 2013, however, same-sex parents had an additional tax burden. The recent overturning of DOMA sets up the possibilities of uncovering health insurance and healthcare inequalities for gay-parent families that go beyond the financial. The next step can provide an in-depth look at health policy and care in the United States. Looking to the future, the implications of marriage equality, healthcare law, and changing social climates will become increasingly vital to the health and well-being of all families.

References

Ayling, R., & Mewse, A. J. (2009). Evaluating Internet interviews with gay men. *Qualitative Health Research, 19,* 566-576. doi:10.1177/1049732309332121

Baker, K. (2012, March 26). Top 10 things health reform does for gay and transgender Americans: The Affordable Care Act is 'strongest foundation' for closing LGBT disparities. *Center for American Progress.* Retrieved from http://www.americanprogress.org/

Bengtson, V. L., Acock, A. C., Allen, K. R., Dilworth-Anderson, P., & Klein, D. M. (2005). Theory and theorizing in family research: Puzzle building and puzzle solving. In V. Bengtson, A. Acock, K. Allen, P. Dilworth-Anderson, & D. Klein (Eds.), *Sourcebook of family theory and research* (pp. 3-33). Thousand Oaks, CA: Sage.

Bengtson, V. L., & Allen, K. R. (1993). The life course perspective applied to families over time. In P. Boss, W. Doherty, R. LaRossa, W. Schumm, & S. Steinmetz (Eds.), *Sourcebook of family theories and methods: A contextual approach* (pp. 469-499). New York, NY: Plenum.

Bergman, K., Rubio, R. J., Green, R. J., & Padron, E. (2010). Gay men who become fathers via surrogacy: The transition to parenthood. *Journal of GLBT Family Studies, 6*, 111-141. doi:10.1080/15504281003704942

Berkowitz, D. (2007). A sociohistorical analysis of gay men's procreative consciousness. *Journal of GLBT Family Studies, 3*, 157-190. doi:10.1300/J461v03n02_07

Berkowitz, D. (2009). Theorizing lesbian and gay parenting: Past, present, and future scholarship. *Journal of Family Theory & Review, 1*, 117-132.

Berkowitz, D. (2013). Gay men and surrogacy. In A. E. Goldberg & K. R. Allen (Eds.), *LGBT-parent families: Innovations in research and implications for practice* (pp. 71-85). New York, NY: Springer.

Berkowitz, D., & Marsiglio, W. (2007). Gay men: Negotiating procreative, father, and family identities. *Journal of Marriage and Family, 69*, 366-381. doi:10.1111/j.1741-3737.2007.00371.x

Biblarz, T. J., & Savci, E. (2010). Lesbian, gay, bisexual, and transgender families. *Journal of Marriage and Family, 3*, 480-497. doi:10.1111/j.1741-3737.2010.00714.x

Bigner, J. J., & Jacobsen, R. B. (1989). Parenting behaviors of homosexual and heterosexual fathers. *Journal of Homosexuality, 17*, 173-186.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theories and methods* (5th ed.). New York, NY: Pearson.

Bovbjerg, R. R. & Hadley, J. (2007). *Why health insurance is important* (Report No. 1). Retrieved from The Urban Institute website: http://www.urban.org/UploadedPDF/411569_importance_of_insurance.pdf

Bozett, F. W. (1989). Gay fathers: A review of the literature. *Journal of Homosexuality, 18*, 136-162. doi:10.1300/J082v18n01_07

Brenner, J., & Smith, A. (2013, August). *72% of online adults are social networking site users*. Retrieved from http://www.pewinternet.org/~/media//Files/Reports/2013/PIP_Social_networking_sites_update.pdf

Brinamen, C. F. (2000). *On becoming fathers: Issues facing gay men choosing to parent* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 9973822)

Buchmueller, R., & Carpenter, C. S. (2010). Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *American Journal of Public Health, 100,* 489-495. doi:10.2105/AJPH.2009.160804

Buchmueller, T. C., & Monheit, A. C. (2009). Employer-sponsored health insurance and the promise of health insurance reform. (Report No. 14839). Retrieved from National Bureau of Economic Research website: http://www.nber.org/papers/w14839.pdf?new_window=1

Burgess, D., Lee, R., Tran, A., & van Ryn, M. (2008). Effects of perceived discrimination on mental health and mental health services utilization among gay, lesbian, bisexual, and transgender person. *Journal of LGBT Health Research, 3*, 1-14. doi:10.1080/15574090802226626

Burns, C., & Krehley, J. (2011a, October 19). Equal benefits for gay couples are inexpensive: Small businesses report low costs offering health insurance to employees and their families. Center for American Progress Retrieved from http://www.americanprogress.org/issues/lgbt/news/2011/10/19/10537/equal-benefits-for-gay-couples-are-inexpensive/

Burr, W., Leigh, G., Day, R., & Constantine, J. (1979). Symbolic interaction and the family. In W. Burr, R. Hill, I. Nye, & I. Reiss (Eds.), *Contemporary theories about the family* (pp. 42-111). New York, NY: Free Press.

Carbado, D. W. (2013). Colorblind intersectionality. *Signs, 38*, 811-845. doi:10.1086/669666

Carrington, C. (2002). *No place like home: Relationships and family life among lesbians and gay men*. Chicago, IL: University of Chicago Press.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, England: Sage.

Cohler, B. J. (2005). Life course social science perspectives on GLBT families. In J. Bigner (Ed.), *An introduction to GLBT family studies* (pp. 23-50). Binghamton, NY: Haworth Press.

Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Boston, MA: Unwin Hyman.

Collins, P. H. (1998). *Fighting words: Black women and the search for justice*. Minneapolis, MN: University of Minnesota Press.

Connell, R. W. (2005). *Masculinities* (2nd ed.). Berkeley, CA: University of California Press.

Connell, R. W. & Messserschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society, 19*, 829-859. doi:10.1177/0891243205278639

Connolly, C. (2002). The voice of the petitioner: The experiences of gay and lesbian parents in successful second-parent adoption proceedings. Law & Society Review , 36 (2), 325–346.

Cordell, J. E. (2011, August 18). My ex is homosexual, does this affect child custody? Retrieved from http://www.huffingtonpost.com/joseph-e-cordell/my-spouse-is-homosexual-d_b_929913.html

Davis, M. A. (2013). Demographics of gay and lesbian adoption and family policies. In A. K. Buamle (Ed.), *International handbook on the demography of sexuality* (Vol. 5), (pp. 383-401). New York, NY:Springer.

D'Emilio, J. & Freedman, E. B. (1997). *Intimate matters: A history of sexuality in America* (2nd ed.). New York, NY: University of Chicago Press.

Downing, J. B., & Goldberg, A. E. (2010). Lesbian mothers' constructions of the division of paid and unpaid labor. *Feminism & Psychology, 21,* 100-120. doi:10.1177/0959353510375869.

Drushel, B. (2010). Virtually supportive: Self-disclosure of minority sexualities through online social networking sites. In C. Pullen & M. Cooper (Eds.), *LGBT identity and online new media* (pp. 62-74). New York, NY: Routledge.

Duggan M., & Brenner, J. (2013, February). The demographics of social media users – 2012. Retrieved from Pew Research Institute website: http://www.pewinternet.org/~/media//Files/Reports/2013/PIP_SocialMediaUsers.pdf

Dunn, M., & Moodie-Mills, A. C. (2012, April 13). The state of gay and transgender communities of color in 2012: The economic, educational, and health insecurities these communities are struggling with and how we can help them. CAP Retrieved from http://www.americanprogress.org/issues/lgbt/news/2012/04/13/11493/the-state-of-gay-and-transgender-communities-of-color-in-2012/

Elder, G. H., Jr. (1978). Family history and the life course, In T. Hareven (Ed.), *Family history and the life course perspective* (pp. 17-64). New York, NY: Academic Press.

Elder, G. H., Jr. (1985). *Life course dynamics*. Ithaca, NY: Cornell University Press.

Elder, G. H., Jr. (1994). Time, human agency, and social change: Perspectives on the life course. *Social Psychology Quarterly, 57,* 4-15.

Elder, G. H., Jr., Johnson, M. K., & Cosnoe, R. (2004). The emergence and development of life course theory. In J. T. Mortimer & M. J. Shanahan (Eds.), *Handbook of the life course* (pp. 3-22). New York, NY: Springer.

EqualityVirginia.org. (2013). Protecting families. Retrieved from http://www.equalityvirginia.org/what-we-do/protecting-families/

Evans, A., Elford, J., & Wiggins, D. (2007). Using the Internet for qualitative research. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 315-333). Thousand Oaks, CA: Sage.

Farr, R., & Patterson, C. J. (2013). Lesbian and gay adoptive parents and their children. In A. E. Goldberg & K. R. Allen (Eds.), *LGBT-parent families: Innovations in research and implications for practice* (pp. 39-58). New York, NY: Springer.

Gartrell, N., Banks, A., Hamilton, J., Reed, N., Bishop, H., & Rodas, C. (1999). The national lesbian family study: 2. Interviews with mothers of toddlers. *American Journal of Orthopsychiatry, 69*, 362-369.

Gartrell, N., Bos., H., Peyser, H., Deck, A., & Rodas, C. (2011). Family characteristics, custody arrangements, and adolescent psychological well-being after lesbian mothers break up. *Family Relations. 60*, 572-585. doi:10.1111/j.1741-3729.2011.00667.x.

Gates, G. J. (2013a, February). Same-sex and different-sex couples in the American Community Survey: 2005-2011. Retrieved from The Williams Institute website: http://williamsinstitute.law.ucla.edu/wp-content/uploads/ACS-2013.pdf

Gates, G. J. (2013b, February). LGBT parenting in the United States. Retrieved from The Williams Institute website: http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Parenting.pdf

Gates, G. J. (2013c). Demographics and LGBT health. *Journal of Health and Social Behavior, 54*, 72-74. doi:10.1177/0022146512474429

Gates, G. J., & Newport, F. (2012, October 18). Special report: 3.4% of U.S. adults identify as LGBT. *Gallup Politics*. Retrieved from: http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx

GayDadsStudy. (2013, July 16). Research on gay father families. Got 15-20 min? Share your healthinsurance story. Donation to HRC & EqualityVA. [twitter post]. Retrieved from https://twitter.com/GayDadsStudy

Gecas, V. (2004). Self-agency and the life course. In J. T. Mortimer & M. J. Shanahan (Eds.), *Handbook of the life course* (pp. 369-390). New York, NY: Springer.

Gerber, P. (2010). The best interests of children of same-sex families. *Law in Context, 28*, 28-42.

Goldberg, A. E. (2010). *Lesbian and gay parents and their children: Research on the family life cycle*. Washington, DC: American Psychological Association.

Goldberg, A. E. (2012). *Gay dads: Transitions to adoptive fatherhood* [Kindle Edition]. Retrieved from www.amazon.com

Goldberg, A. E. (2013). "Doing" and "undoing" gender: The meaning and division of housework in same-sex couples. *Journal of Family Theory & Review, 5*, 85-104. doi:10.1111/jftr.12009

Goldberg, A. E., & Allen, K. R. (2013). Conclusion: Reflections on the volume and visions for the future. In A. E. Goldberg & K. R. Allen (Eds.), *LGBT-parent families: Innovations in research and implications for practice* (pp. 359-366). New York, NY: Springer.

Himmelstein, D. U., Thorne, D., Warren, E., & Woolhandler, S. (2009). Medical bankruptcy in the United States, 2007: Results of a national study. *American Journal of Medicine, 122*, 741-746.

Hochschild, A. R., & Machung, A. (1989). *The second shift*. New York, NY: Viking.

Human Rights Campaign. (2012). Corporate equality index 2013: Rating American workplaces on lesbian, gay, bisexual, and transgender equality. Retreived from The Human Rights Campaign website: http://www.hrc.org/files/assets/resources/CorporateEqualityIndex_2013.pdf

Human Rights Campaign. (2013a, July 3). After DOMA: What is means for you. Retrieved from the Human Rights Campaign website: http://www.hrc.org/files/assets/resources/Post-DOMA_FSS_Federal-Taxes_v3.pdf

Human Rights Campaign. (2013b). Domestic partnership benefits: Related laws and regulations. Retrieved from http://www.hrc.org/resources/entry/domestic-partner-benefits-related-laws-and-regulations

Human Rights Campaign. (2013c). Employment non-discrimination act. Retrieved from http://www.hrc.org/laws-and-legislation/federal-legislation/employment-non-discrimination-act

Human Rights Campaign. (2013d). Recognizing same-sex spouses for benefits programs. Retrieved from http://www.hrc.org/resources/entry/spousal-benefits-recognizing-same-sex-spouses-for-benefits-programs

Ibañez, G. E., Van Oss Marin, B., Flores, S. A., Millett, G., & Diaz, R. M. (2009). General and gay-related racism experienced by Latino gay men. *Cultural Diversity and Ethnic Minority Psychology, 15*, 215-222. doi:10.1037/a0014613

James, N., & Busher, H. (2006). Credibility, authenticity, and voice: Dilemma in online interviewing. *Qualitative Research, 6*, 403-420. doi:10.1177/1468794106065010

Japsen, B. (2013, April 1). As Supreme Court weighs DOMA, more employers provide same sex benefits. Retrieved from http://www.forbes.com/sites/brucejapsen/2013/04/01/as-supreme-court-weighs-doma-more-employers-provide-same-sex-benefits/

Johnson, S. M., & O'Connor, E. (2002). *The gay baby boom: The psychology of gay parenthood*. New York, NY: New York University Press.

Kaiser Family Foundation. (2011). Health insurance coverage for children 0-18. Retrieved from http://kff.org/other/state-indicator/children-0-18/

Kaiser Family Foundation. (2011). Health insurance coverage for adults 19-64. Retrieved from http://kff.org/other/state-indicator/adults-19-64/

Koivunen, J. M., Rothaupt, J. W., & Wolfgram, S. M. (2009). Gender dynamics and role adjustment during the transition to parenthood: Current perspectives. *The Family Journal, 17*, 323-328. doi:10.1177/1066480709347360.

LaRossa, R., & Reitzes, D. C. (1993). Symbolic interactionism and family studies. In P. Boss, W. Doherty, R. LaRossa, W. Schumm, & S. Steinmetz (Eds.), *Sourcebook of family theories and methods: A contextual approach* (pp. 135-166). New York, NY: Plenum Press.

Luxton, M. (2006). Feminist political economy in Canada and the politics of social reproduction. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neo-liberalism* (pp. 11-44). Quebec, Canada: McGill-Queen's University Press.

MacDonald, J. (2013). DOMA gay marriage ruling and health insurance. Retrieved from http://www.bankrate.com/finance/insurance/doma-gay-marriage-ban-health-insurance.aspx

Mallon, G. P. (2004). *Gay men choosing parenthood*. New York, NY: Columbia University Press.

Markham, A. N. (2011). Internet research. In D. Silverman (Ed.), *Qualitative research* (pp. 111-128). Thousand Oaks, CA: Sage.

Mays, V. M., Chatters, L. M., Cochran, S. D., & Mackness, J. (1998). African American families in diversity: Gay men and lesbians as participants in family networks. *Journal of Comparative Family Studies, 29,* 73-87.

McCall, L. (2005). The complexity of intersectionality. *Signs, 30,* 1771-1800. doi:10.1086/426800

Mercer. (2013, February). Mercer's national survey of employer-sponsored health plans. Retrieved from Mercer's website: http://benefitcommunications.com/upload/downloads/Mercer_Survey_2013.pdf

Miller, J. C. (2004). Fathers, gay. In M. Kimmel & A. Aronson (Eds.), *Men and masculinities: A social, cultural, and historical encyclopedia* (pp. 284-286). Santa Barbara, CA: ABC-CLIO, Inc.

Moore, M. (2011). *Invisible families: Gay identities, relationships, and motherhood among black women*. Berkeley, CA: University of California Press.

Movement Advancement Project, Family Equality Council and Center for American Progress. (2012, March). Obstacles and opportunities: Ensuring health and wellness for LGBT families. Retrieved from Movement Advancement website:

http://action.familyequality.org/site/DocServer/LGBTFamiliesHealthandWellnessBriefFinal03222012.pdf?docID=2801

Mule, N. J., Ross, L. E., Deeprose, B., Jackson, B. E., Daley, A., Travers, A., & Moore, D. (2009). Promoting LGBT health and wellbeing through inclusive policy development. *International Journal for Equity in Health, 8*, 18-29.

National Center for Lesbian Rights. (2012). Adoption by lesbian, gay, and bisexual parents: An overview of current law. Retrieved from National Center for Lesbian Rights website: http://www.nclrights.org/site/DocServer/adptn0204.pdf?docID=1221

National Center for Lesbian Rights. (2013). Marriage, domestic partnerships, and civil unions; An overview of relationship recognition for same-sex couples within the United States. Retrieved from National Center for Lesbian Rights website: http://www.nclrights.org/site/DocServer/Relationship_Recognition_Update_-_09_03_08.pdf?docID=881

National Conference on State Legislatures (NCSL). (2013, June 26). Civil unions & domestic partnership statutes. Retrieved from http://www.ncsl.org/issues-research/human-services/civil-unions-and-domestic-partnership-statutes.aspx

Norris, P. (2001). *Digital divide: Civic engagement, information poverty, and the Internet world-wide.* Cambridge, MA: Cambridge University Press.

Oswald, R. F., & Lazarevic, V. (2011). "You live where?!" Lesbian mothers' attachments to nonmetropolitan communities. *Family Relations, 60*, 373-386. doi:10.1111.j.1741-3729.2011.00663.x

Oswald, R. M., Blume, L. B., & Marks, S. R. (2005). Decentering heteronormativity: A model for family studies. In V. Bengtson, A. Acock, K. Allen, P. Dilworth-Anderson, & D. Klein

(Eds.), *Sourcebook of family theory and research* (pp. 143-165). Thousand Oaks, CA: Sage.

Oswald, R. F., & Culton, L. S. (2003). Under the rainbow: Rural gay life and its relevance for family providers. *Family Relations, 52*, 72-81.

Oswald, R. F., Cuthbertson, C., Lazarevic, V., & Goldberg, A. E. (2010). New developments in the field: Measuring community climate. *Journal of GLBT Family Studies, 6*, 214–228.

Panozzo, D. (2010). *Gay male couples who decide to parent: Motivations, division of child care responsibilities, and impact on relationship and life satisfaction* (Doctoral dissertation). Available from ProQuest Dissertation and Theses database. (UMI No. 3432808)

Parkin, T. G., & Pomeroy, A. J. (2007). *Roman social history: A sourcebook*. New York, NY: Routledge.

Patterson, C. J. (2000). Sexual orientation and family life: A decade review. *Journal of Marriage and the Family*, *62*, 1052 - 1069.

Patterson, C. J., Sutfin, E. L., & Fulcher, M. (2004). Division of labor among lesbian and heterosexual parenting couples: Correlates of specialized versus shared patterns. *Journal of Adult Development, 11*, 179-189. doi:10.1023/B:JADE.0000035626.90331.47

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Perlesz, A., Brown, R., Lindsay, J., McNair, R., de Vaus, D., & Pitts, M. (2006). Family in transition: Parents, children and grandparents in lesbian families give meaning to ‘doing family.’ *Journal of Family Therapy, 28*, 175-199. doi:10.1111/j.1467-6427.2006.00345.x

Petroski, D. J., & Edley, P. P. (2006). Stay-at-home fathers: Masculinity, family, work, and gender stereotypes. *The Electronic Journal of Communication, 16*. Retrieved from http://www.cios.org/EJCPUBLIC/016/3/01634.HTML

Pleck, J. H. (2004). Two dimensions of fatherhood: A history of good dad-bad dad complex. In M. E. Lamb (Ed.), *The role of the father in child development* (4th ed.), (pp. 32-57). Hoboken, NJ: John Wiley & Sons.

Pleck, J. H. (2010). Fatherhood and masculinity. In M. E. Lamb (Ed.), *The role of the father in child development* (5th ed.), (pp. 27-57). Hoboken, NJ: John Wiley & Sons.

Ponce N. A., Cochran S. D., Pizer J.C., & Mays, V. M. (2010). The effects of unequal access to health insurance for same-sex couples in California. *Health Affairs, 29*, 1-10.

Rabun, C., & Oswald, R. F. (2009). Upholding and expanding the normal family: Future fatherhood through the eyes of gay male emerging adults. *Fathering, 7*, 269-285. doi:10.3149/fth.0703.269

Riskind, R. G., & Patterson C. J. (2010). Parenting intentions and desires among lesbian, gay, and heterosexual individuals. *Journal of Family Psychology, 24*, 78 – 81. doi:10.1037/a0017941

Rossman, G. B., & Rallis, S. F. (2011). *Learning in the field: An introduction to qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Schacher, S. J., Auerbach, C. F., & Silverstein, L. B. (2005). Gay fathers expanding the possibilities for us all. *Journal of GLBT Family Studies, 1*, 31-52.

Scott, J. W. (1988). Deconstructing equality-versus-difference: Or, the uses of post-structuralist theory for feminism. *Feminist Studies, 14*, 33-50.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and social sciences* (3rd ed.). New York, NY: Teachers College Press.

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59,* 301-311. doi:10.1007/s11199-008-9501-8

Silverstein, L. B., Auerbach, C. F., & Levant, R. F. (2002). Contemporary fathers reconstructing masculinity: Clinical implications of gender role strain. *Professional Psychology: Research and Practice, 33,* 361-369. doi:10.1037/0735-7028.33.4.361

Smith, A. (2012 June). 17% of cell phone owners do most of their online browsing on their phone, rather than a computer or other device. Retrieved from Pew Institute website: http://pewinternet.org/Reports/2012/Cell-Internet-Use-2012.aspx

Smith, D. E. (1993). The standard North American family: SNAF as an ideological code. *Journal of Family Issues, 14,* 50-65. doi:10.1177/0192513X93014001005

Solomon, S. E., Rothblum, E. D., & Balsam, K. F. (2005). Money, housework, sex, and conflict: Same-sex couples in civil unions, those no in civil unions, and heterosexual married siblings. *Sex Roles, 52,* 561-575. doi:10.1007/s11199-005-3725-7

Stryker, S. (2001). Traditional symbolic interactionism, role theory, and structural symbolic interactionism: The road to identity theory. In J. H. Turner (Ed.), *Handbook of sociological theory* (pp. 211-231). New York, NY: Springer.

Tasker, F. (2013). Lesbian and gay parenting post-heterosexual divorce and separation. In A. E. Goldberg & K. R. Allen (Eds.), *LGBT-parent families: Innovations in research and implications for practice* (pp. 3-20). New York, NY: Springer.

Tornello, S. L., Farr, R. H., & Patterson, C. J. (2011). Predictors of parenting stress among gay adoptive fathers in the United States. *Journal of Family Psychology, 25*, 591-600. doi:10.1037/a0024480

Turner, R. (2000). Role theory. In A. E. Kazdin (Ed.), *Encyclopedia of psychology*, Vol. 7. (pp. 112-113). Washington, DC: American Psychological Association.

U.S. Census Bureau, (2011). Health insurance: Highlights, 2011. Retrieved from http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2011/highlights.html

U.S. Department of Health and Human Services. (2012). Social determinants of health. Retrieved from http://www.healthypeople.gov/2020/

U.S. Department of Labor [DoL]. (n.d.). Young adults and the Affordable Care Act: Protecting young adults and eliminating burdens on businesses and families. Retrieved from http://www.dol.gov/ebsa/faqs/faq-dependentcoverage.html

Wadsworth N. D. (2010). Intersectionality in California's same-sex marriage battles: A complex proposition. *Political Research Quarterly, 64*, 200-216.

White, J. M., & Klein, D. M. (2008). *Family theories* (3rd ed.). Thousand Oaks, CA: Sage.

World Health Organization, Commission on Social Determinants of Health. (2012). Closing the gap in a generation: Health equity through action on the social determinants of health. Retrieved from http://www.who.int/social_determinants/en

Zickuhr, K., & Smith, A. (2012, April). *Digital differences*. Retrieved from Pew Research Institute website: http://pewinternet.org/Reports/2012/Digital-differences.aspx

Zinn, M. B., & Dill, B. T. (1996). Theorizing difference from multiracial feminism. *Feminist Studies, 22*, 321-331.

Appendix A

[To be posted on www.fatherfamilies.org prior to start of questionnaire]
VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Consent for Participants

Gay Dads' Health Insurance and Family Well-Being

Researcher: Emma Potter

Purpose of this Research: The purpose of this study is to investigate the ways in which gay fathers provide health insurance for their families.

Procedure: I am asking you to spend 15-20 minutes telling me about health insurance (who has it, what has the process of getting health insurance been like) for you and your family. Some questions will be multiple choice, other questions will be open-ended. There are no right or wrong answers, I am interested in **your experience**. This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Tech. My faculty sponsor is Katherine R. Allen.

Risks: You may become upset or uncomfortable while filling out information about your experiences providing health insurance. You do **not** have to answer any questions that make you feel uncomfortable. You can stop at any time.

Benefits: In return for your completion of the questions and interview, I will personally be donating $1 to the Human Rights Campaign and $1 to the LGBT rights organization, Equality Virginia.

Extent of Anonymity and Confidentiality: Your participation in this study is **confidential**. The survey will take place on the Virginia Tech Qualtrics site, and is a secure network. This means that no one, except this researcher and faculty advisor will see or read your answers to the questions. All names will be changed and at no time will I release the results of the study to any other individuals not working on the project.

Freedom to Withdrawal: You can withdraw from a study at any time without penalty.

If you have questions about the study, visit the FAQ section of this site or contact at info@fatherfamilies.org.

If you have any questions about your rights as a participant, please feel free to contact

Emma Potter	540-231-6817	ecp3f@vt.edu
Dr. Katherine R. Allen	540-231-6526	kallen@vt.edu
Dr. David Moore, IRB Chair	540-231-4991	moored@vt.edu

Permission
By clicking NEXT, you are agreeing that you have read and understand

1) the study,
2) your rights, and
3) agree to participate.

AGREE

The next set of questions will determine if you are eligible to participate.

Are you between the ages of 30 and 60 years old?
_____ YES _____ NO

Do you identify as a gay man?
_____ YES _____ NO

Are you in a committed, same-sex relationship?
_____ YES _____ NO

Do you have any children under your care?
_____ YES _____ NO

Do you reside Virginia?
_____ YES _____ NO

IF NO,
Please type below and indicate which state you and your family reside.
_____

[To be read aloud to the participant prior to start of questionnaire]
VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Verbal Consent for Participants

Gay Dads' Health Insurance and Family Well-Being

Researcher: Emma Potter

Purpose of this Research: The purpose of this study is to investigate the ways in which gay fathers provide health insurance for their families.

Procedure: I am asking you to spend 15-20 minutes telling me about health insurance (who has it, what has the process of getting health insurance been like) for you and your family. Some questions will be multiple choice, other questions will be open-ended. There are no right or wrong answers, I am interested in **your experience**. This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Tech. My faculty sponsor is Katherine R. Allen.

Risks: You may become upset or uncomfortable while answering about your experiences providing health insurance. You do **not** have to answer any questions that make you feel uncomfortable. You can stop at any time.

Benefits: In return for your completion of the questions and interview, I will personally be donating $1 to the Human Rights Campaign and $1 to the LGBT rights organization, Equality Virginia.

Extent of Anonymity and Confidentiality: Your participation in this study is **confidential**. This interview will be recorded for transcribing purposes. All names will be changed and at no time will I release the results of the study to any other individuals not working on the project. The interview is taking place over the phone, and I will input your answers after transcribing them onto the Virginia Tech Qualtrics site. This a secure network. This means that no one, except this researcher and faculty advisor will see or read your answers to the questions.

Freedom to Withdrawal: You can withdraw from a study at any time without penalty.

If you have questions about the study, visit the FAQ section of this site or contact at info@fatherfamilies.org.

If you have any questions about your rights as a participant, please feel free to contact

Emma Potter	540-231-6817	ecp3f@vt.edu
Dr. Katherine R. Allen	540-231-6526	kallen@vt.edu
Dr. David Moore, IRB Chair	540-231-4991	moored@vt.edu

Permission

By saying, “I Agree” you are agreeing that you understand

1) the study,
2) your rights, and
3) agree to participate.

The next set of questions will determine if you are eligible to participate.

Are you between the ages of 30 and 60 years old?
_____ YES _____ NO

Do you identify as a gay man?
_____ YES _____ NO

Are you in a committed, same-sex relationship?
_____ YES _____ NO

Do you have any children under your care?
_____ YES _____ NO

Do you reside Virginia?
_____ YES _____ NO

IF NO,
Please tell me which state you and your family reside.
_____

Appendix B

Recruitment Materials

Out-Of-Closet Costs in Health Insurance

Only **76% of same-sex couples** have **both partners covered** by health insurance*

Same-sex couples are *twice as likely* to have **only one partner covered** by health insurance*

- **What's Your Health Insurance Story?**
- **Are you a father caring for children in Virginia?**

Share Your Story

VISIT **OR** **SCAN**

www.fatherfamilies.org

All Responses Confidential

Use smartphone barcode scanner to access

For more information contact

info@fatherfamilies.org

Research to Benefit

Equality Virginia

*Williams Institute

Sample Email Recruitment

My name is Emma Potter and I am a graduate student at Virginia Tech studying the health insurance experiences of gay father families. I am looking for community groups and organizations for support and assistance in getting the word out about my research. If you could send this out to your group members or any fathers who might be interested, I'd greatly appreciate it.

Pasted below is a short announcement about the study. You can contact me at _____Thank you for your time.

Research on Gay Fathers' Health Insurance Experiences
www.fatherfamilies.org

Nearly 20% of gay male couples are raising children, yet we know very little about their health insurance experiences.

Are you a gay father children under your care?

Share your health insurance story by visiting www.fatherfamilies.org.

Participate online or via mobile technology.

Research project conducted by Virginia Tech graduate student. Collecting data until Mid-August. All Responses Confidential. Research to benefit the Human Rights Campaign and Equality Virginia.

Questions? Visit the www.fatherfamilies.org/FAQs.html.

Not a gay father? Spread the word. www.fatherfamilies.org.

Appendix C
Interview Questions/Questionnaire Content

Part I: Introduction

Q1 Let's get started. How did you find out about the study? Please provide brief summary (e.g., email, friend, flyer).

_____

Q2 What is your age? _____

Q3 What is your partner's age? _____

Q4 What is your employment status and job title? (e.g., Full-time, Information Security Analyst)

_____

Q5 What is your partner's employment status and job title?

_____

Q6 How do you have health insurance coverage? Check all that apply.

- ❑ Insurance through social programs (e.g., Medicaid, Disability)
- ❑ Private insurance (purchased independently)
- ❑ Private insurance (e.g., military, TRICARE)
- ❑ Employer-provided insurance (private)
- ❑ Private insurance through my partner's plan
- ❑ No health insurance coverage of any kind
- ❑ Other _____

Q7 How does your partner have health insurance coverage? Check all that apply.

- ❑ Insurance through social programs (e.g., Medicaid, Disability)
- ❑ Private insurance (purchased independently)
- ❑ Private insurance (e.g., military, TRICARE)
- ❑ Employer-provided insurance (private)
- ❑ On your health insurance plan
- ❑ No health insurance coverage of any kind
- ❑ Other _____

Q8 Who do your children have health insurance through? Check all that apply.

- ❑ Insurance through social program (e.g., Medicaid, CHIPRA)
- ❑ Private insurance through myself
- ❑ Private insurance through my partner
- ❑ Private insurance through another family member
- ❑ No health insurance coverage of any kind
- ❑ Other _____

Part II: Family The following set of questions is about family, children, and insurance.

Q1 To begin, tell me a little bit about your family household. Who do you feel responsible for?

_____

Q2 How many children are under your care? _____

Q3 How you are related to each of the children under your care. (e.g. biological, legally adopted, extended kin, no relation) [Answers correspond as if father answered "4"]
Child 1 _____
Child 2 _____
Child 3 _____
Child 4 _____

Q4 Please describe how your partner is related to each of the children under your care.
Child 1 _____
Child 2 _____
Child 3 _____
Child 4 _____

Q5 Are any of the children under your care from a previous heterosexual partner or marriage? (you or your partner's) Please indicate below. If you would like to provide further detail, please use text block provided.

	Yes, from MY previous partner/marriage	**Yes, from MY PARTNER'S previous partner/marriage**	**No**
Child 1	❑	❑	❑
Child 2	❑	❑	❑
Child 3	❑	❑	❑
Child 4	❑	❑	❑

Q6 Is there a biological mother involved in your children's lives? If so, please describe her level of involvement as a co-parent (e.g., joint custody, holiday visitation only, no contact).
Child 1 _____
Child 2 _____
Child 3 _____
Child 4 _____

Q7 How do you see yourself as a provider for your family? (i.e., What do you think are your main responsibilities as a father?)

_____

Part III: Insurance Stories

Q1 [ONLY IF] You indicated that you and your partner are not on the same insurance policy.
1a) Did you and your partner try to be on each other's policies and were unable to?
_____

1b) What were the difficulties of being on the same plan?
_____

Q2 [ONLY IF] You indicated that you and your partner are on the same health insurance policy. What were some of the difficulties of getting on the same plan?
_____

Q3 [ONLY IF] You indicated that either you, your partner, or your children do not have health insurance. Why do these members not have insurance? (e.g., What were the barriers to getting insurance?)
_____

Q4A So I want to follow up with your insurance process. Please tell me more about your family's insurance difficulties. Were any of your children more difficult or complicated to insure than other children?
_____

Q4B What were the most frustrating parts of getting health insurance for your family?
_____

Q6 How did you decide who would cover your child(ren)?
_____

Q7 Is there more pressure to provide insurance for your child(ren) and partner, and in what ways? (i.e., Were you worried that others would judge you more harshly?)
_____

Q8 What is unique about your family's insurance story?
_____

Part IV: Community Where did you turn for information about your insurance options and how "out" you are in your community. Sexual identity can be a very personal and private matter.

Q1 For the following question, indicate your current experience as a gay father. I am "out" in the following contexts:

	Yes, to most/all	**Yes, to select people**	**No, indifferent, would not care if people knew**	**No, not at all**

Family	❑	❑	❑	❑
Work	❑	❑	❑	❑
Children's School	❑	❑	❑	❑
Community/Friends/Church	❑	❑	❑	❑

Q2 The insurance process can be very complicated for same-sex couples. 1) Please check the resources you used at any time to help navigate or get answers about the insurance process, and 2) Indicate how "out" you were to these resources. Check all that apply

	Yes, to most/all	**Yes, to select people**	**No, but indifferent, would not care if people knew**	**No, not at all**
My current partner (1)	❑	❑	❑	❑
Other LGBT friends with children (2)	❑	❑	❑	❑
Health insurance agent (3)	❑	❑	❑	❑
Lawyer/legal advice (4)	❑	❑	❑	❑
Patient navigator/Community health worker (5)	❑	❑	❑	❑
Online healthcare community groups (non-LGBT) (6)	❑	❑	❑	❑
Online LGBT community groups/networks (7)	❑	❑	❑	❑
Other family members (not partner) (8)	❑	❑	❑	❑
Community (friends in church, schools) (9)	❑	❑	❑	❑
Co-workers (10)	❑	❑	❑	❑
Other (11)	❑	❑	❑	❑

Q3 From the list above, which resource was most helpful and in what ways did this resource help you navigate the health insurance process? You can talk about more than one resource if you would like.

_____

Q4 In what ways did your experience with health insurance make you feel more "out" as a family, if at all?

_____

Part V: Final Thoughts

Q1 Is there anything else you can tell me to help me understand your experience with health insurance and your family?

_____

Part VI: Demographics Continued

Q1 [If answered from Virginia] What Virginia region do you and your family primarily reside?

- ❍ Central (area code 434)
- ❍ Hampton Roads/Chesapeake (area code 757)
- ❍ Northern Virginia/DC Metro (area codes 703 or 571)
- ❍ Piedmont (area code 804)
- ❍ Southwest (area code 276)
- ❍ Shenandoah Valley (area code 540)
- ❍ Prefer not to answer/ Not applicable

Q2 What is the highest level of education you have completed?

- ❍ Completed 8th grade or less
- ❍ Some high school
- ❍ Completed high school (or high school equivalent GED)
- ❍ Associate's degree (community/technical college)
- ❍ Some college
- ❍ Bachelor's degree (college)
- ❍ Attended graduate school
- ❍ Completed graduate school (Masters' or Doctorate)
- ❍ Other _____

Q3 What is your race and ethnic background?

Please check one or more boxes (all that apply) and provide brief description of your racial or ethnic origin in the space provided.

- ❑ WHITE _____
- ❑ BLACK, AFRICAN AMERICAN _____
- ❑ HISPANIC, LATINO, SPANISH ORIGIN _____
- ❑ ASIAN _____
- ❑ AMERICAN INDIAN OR NATIVE ALASKAN _____
- ❑ OTHER RACE OR ORIGIN _____

Q4 What is your partner's race and ethnic background?

Please check one or more boxes (any that apply) and provide brief description of your racial or ethnic origin.

- ❑ WHITE _____
- ❑ BLACK, AFRICAN AMERICAN _____
- ❑ HISPANIC, LATINO, SPANISH ORIGIN _____
- ❑ AMERICAN INDIAN OR NATIVE ALASKAN _____
- ❑ ASIAN _____
- ❑ OTHER RACE OR ORIGIN _____

Q5 Please provide your children's
1) sex (M for male, F for female),
2) age (round to the closest year), and
3) race and ethnic origin (refer to racial and origin definitions link above).

	Sex of Child (M or F)		**Age (in years)**	**Race & Ethnicity**
Child 1	**M**	**F**	**_____**	**_____**
Child 2	**M**	**F**	**_____**	**_____**
Child 3	**M**	**F**	**_____**	**_____**
Child 4	**M**	**F**	**_____**	**_____**

Q6 What is your current relationship status? Mark which one best describes your current committed same-sex relationship.

- ❍ Same-sex husband/spouse (marriage license from another state/country/District of Columbia)
- ❍ Same-sex civil union/domestic partnership (from another state/country/District of Columbia)
- ❍ Same-sex unmarried partner (living together)
- ❍ Same-sex partner with commitment ceremony (no legal holding)
- ❍ Same-sex separation
- ❍ Other _____

Q7 Length of current committed same-sex relationship?
_____ years

Part VII: Follow Up

Q1 Would you be willing to be contacted in the future for a potential follow up study related to healthcare experiences (to be possibly conducted online or over the telephone)? [If yes, If maybe then displays the following options]

EMAIL _____
PHONE _____
MAIL ADDRESS _____

Appendix D

Frequently Asked Questions

1. About Me

I am a graduate student at Virginia Tech in the Department of Human Development and Family Studies. My work focuses on marginalized families, health disparities, and LGBT-parent families. I intend to use this research to expand what we know about gay-father families, policy inequalities, and improve the health and well-being of families. For more information on my work, visit the About/Background section.

2. Alright, I'm ready.

If you do not have other questions and are ready to begin, please review the consent form, scroll to the bottom, and agree to the study. **CLICK HERE.**

3. Can my partner also complete the survey?

Yes. If your partner is also interested in sharing his story, please pass along my study. I do ask that you and your partner provide separate (complete 2 different surveys) answers, and *do not* complete it as a couple.

4. How do I know if I'm eligible?

If you meet the following criteria, you are eligible to participate:

- Identify as a gay man
- Are between the ages of 30 and 60
- Are in a committed same sex relationship
- Have children under your care
- You and your family live in the United States

There will be eligibility questions at the beginning of the survey as well.

5. I'm not eligible, but know someone who is.

If you know a father who may be eligible, but did not receive information on this study, please feel free to pass along the study. He can simply visit www.fatherfamilies.org.

6. I'm not interested in doing this online, but want to take part in the study.

No problem. Contact the researcher at info@fatherfamilies.org to set up a phone interview. Please include "Interview" in the subject line and provide some contact information, and indicate some days/times that work best for you.

The interview should last about the same amount of time as the online survey and I will make a $2.00 donation for each completed interview as well.

7. I want more information on the study.

Visit the About/Background page for more information or contact at info@fatherfamilies.org.

8. My sexual identity is very private for me, is this confidential?

Yes. All information is collected using Virginia Tech's SECURE SERVER Qualtrics software. This means no third parties can access your information.
Your responses are CONFIDENTIAL. All names will be changed and I will not share your responses with anyone outside of the research project.

9. What information will you be collecting?

I will collect information on your

- demographics (age, race, occupation);
- your health insurance coverage for you, your partner, and children;
- the difficulties and issues with getting health insurance;
- where you got information and help during the insurance process;
- your role as a father; and
- your opinion and thoughts on getting health insurance.

I will not collect information about
- you, your partner's, or children's health, illnesses or diseases;
- pre-existing conditions;
- health behaviors;
- specific insurance policies;
- your health history;
- any personal contact information (optional); or
- insurance outside of basic health insurance.

All responses are confidential. Any and all names you provide **will be changed** and none of your information will be shared.

10. What's in it for me?

I cannot fully repay you for your contribution to research, but I will be making a personal donation. For each completed survey, I will donate $1.00 to Equality Virginia **and** $1.00 to the Human Rights Campaign (i.e., 20 completed surveys equals $20.00 donation TO EACH organization).

I want to use this as an opportunity to give back to the LGBT community through this donation.

11. What are my rights as a participant?

As a participant, you do not have to answer questions that make you feel uncomfortable.

There are 5 eligibility questions you must answer to begin the survey.

There are no right or wrong answers.

You have the right to stop at any time. If you do not finish the survey, however, your response will not be considered complete.

You are entitled to confidentiality. Any names will be changed and your information will not

be shared with others. Virginia Tech Qualtrics has a https:// domain, meaning third parties cannot access the site.

You may feel uncomfortable or upset as you recall your health insurance experiences, this is a risk of the study.

There is no monetary reward for participating. Instead, your response will result in my own personal donation to Equality Virginia and the Human Rights Campaign ($2 for EACH completed survey). The benefits to you are knowing that you contributed to the scientific community and are making your voice heard. Your responses benefit my research and the broader LGBT community!

If you have questions or concerns regarding your rights as a participant, email info@fatherfamilies.org with your question and I will guide you to the appropriate resources.

12. What do you mean by committed same-sex relationship?

What do you mean by committed same-sex relationship?
This is up to you. You do not need to be legally married or in a civil union.

We **do assume** that you are in a relationship with another man (male-male same-sex relationship).

13. What do you mean by "children under your care"?

If you are a caregiver for children who may or may not live with you full-time, you are eligible.

Children can be:
- biological
- legally adopted
- foster children
- children of extended kin in your care
- children from previous marriage
- children from surrogacy or in vitro fertilization

14. When does the study end?

I will be collecting **data through August of 2013** for my master's thesis. So be sure to share your story soon.

15. I still have unanswered questions.

Please contact at info@fatherfamilies.org. You will receive an automated message, and a follow-up email within 48 hours.

Appendix E

Information Buttons on Online Questionnaire

Are you in a committed same-sex relationship? 

This is up to you. You do not need to be legally married or in a civil union. We **do assume** that you are in a relationship with another man (male-male same-sex relationship).

Do you currently have children under your care? 

If you are a caregiver for children who may or may not live with you full-time, you are eligible.

Children can be:

- biological
- children of extended kin in your care
- children from surrogacy or in vitro fertilization
- legally adopted
- foster children
- children from previous marriage

What is your race and ethnic background?... your partner's race and ethnic background? … child's racial and ethnic background? Please check one or more boxes (any that apply) and provide a brief description of your racial or ethnic origin in the space provided. 

Racial Definitions (U.S. Census Bureau, 2010)

WHITE refers to a person having origins in Europe, the Middle East, or North Africa. It includes people who indicated their race(s) as "White" or reported entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

AFRICAN AMERICAN OR BLACK refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicated their race(s) as "Black, African Am., or Negro" or reported entries such as African American, Kenyan, Nigerian, or Haitian.

HISPANIC, LATINO, OR SPANISH ORIGIN refers to a person having origins in Central and South America, or Spain. It includes persons of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.

ASIAN refers to a person having origins in the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian" or other detailed Asian responses.

AMERICAN INDIAN OR ALASKA NATIVE refers to a person having origins in North and South America (including Central America) and who maintains tribal affiliation or community attachment. It includes Navajo, Blackfeet, Inupiat, Yup'ik, or Central American Indian groups or South American Indian groups.

OTHER RACE OR ORIGIN includes all other responses not included in the White, Black or African American, Hispanic, Latino, or Spanish origin, American Indian or Alaska Native, and Asian race categories described above.

Appendix F

Average Length of Time for Participants to Complete the Questionnaire or Interview

Online (n=4)	
Average Time to Complete	21 minutes
Interview (n=6)	
Average Time to Complete	26 minutes

Appendix G

Narrative Examples

Participant #1: Anthony, Arin, & Arnie (Ashley – ex-wife)
Narrative

Anthony lives with his husband Arin and has seen himself as a financial and primary breadwinner for his family up until his recent job loss. Anthony has two biological children and one stepson, but today is only responsible for his youngest son, Arnie. Anthony thinks his "has been the primary breadwinner until recently…I coached, cooked, helped with homework, doctored, disciplines, and taught my sons how to be …open and honest adults." For years, Anthony and his ex-wife Ashley have had 50/50 custody of Arnie, and throughout the years, Anthony and Ashley have maintained good contact and they see each other as "equal co-parents in every sense." They have split costs for health insurance, daily living expenses, and will split the cost for Arnie's college. Currently, Arnie is on Ashley's health insurance policy.

After losing his own health insurance, Anthony attempted to be on Arin's insurance, provided through the university where Arin worked. Due to state restrictions and University policy, however, Anthony was unable to be on Arin's policy, despite having a legal marriage certificate from another state. Anthony had to purchase his own separate health insurance policy until Arin got another job in another state. Anthony was frustrated with "state-sponsored gender discrimination." Today Anthony's husband, Arin, is employed full-time by a university in a different state and now covers Anthony on his insurance. The insurance process for Anthony in another state was problem-free with "no questions asked."

Participant #5: Eric, Edward, Ella
Narrative

Eric is a happy, engaged gay father who brags about his status on social media outlets. He is 33, partnered for 14 years, and is the proud father of an adopted baby girl, Ella who is 2 ½ years old. Erick works part-time and his partner, Edward works full-time. Eric's family is made up of his partner Edward, his daughter Ella, and their two beagle dogs that he refers to as his "first kids." Both he and Edward are the legally adoptive parents of Ella and have a joint adoption. Ella's biological mother picked Eric and Edward as the parents of Ella, but only maintain contact through the letters and photos Eric and Edward give to the state adoption agency. Eric considers he and Edward to be "co-parents." Eric, however, "takes on more of the mother role" because he's an emotional and caring person, but qualifies his role by saying, "I'm a full-time dad, but part-time hairstylist." He believes that he and Edward split the breadwinner role 50/50 because he "actually [does] pretty well working part-time" but that they do have insurance through "MY JOB" [original emphasis] not his."

Eric's health insurance story is also one that was relatively easy. He has coverage through his employer and was able to place his partner on his insurance in 2004, and simply added his daughter to their policy when she was born. One frustration Eric described with his health insurance benefits was having to prove that he and Edward were in a domestic partnership. He compared his experience to straight married couples by saying they be married and "then they're done" but "we had to prove our domestic partnership. We couldn't just check a box." A second frustration for Eric was taxes for health insurance benefits. "Straight married couples get to claim that as income, but I have to pay." Even with the extra taxes and paperwork, Eric recognizes the insurance process was "simple…pretty cut and dry."

"Everybody knows" about Eric and his family. Eric and his partner were out for 11 years prior adopting Ella. He is out to his friends, family, work, and community. When seeking out community resources, Eric turned to his partner, the health insurance agent from his company, other family, and co-workers. Of those, the health insurance agent was the most helpful is going over the options, requirements, and going through the process of getting domestic partnership benefits.

Appendix H
Focused Coding Categories

100 Frustration [expression of, use of term, answer to "difficult" question, causes of, presence or absence of frustration]
- 100a: *Frustration perception*: absence or presence of frustration
- 100b: *Angry language*: language that expresses frustration, anger, disappointment
- 100c: *Resigned*: language that does not express agency, action, or seeking improvement
- 100d: *State health insurance difficulties*: difficulties and frustrations of moving to a new state
- 100e: *Taxes*: a frustrating point or the unique part of story (having to pay more)
- 100f: *Tedious/extra work*: having to do more work to be on same insurance than married, straight couple

200 Access [ability to, perception of access to insurance for all members of family]
- 200a: *Perception of access*: expression of opinion or view of father's ability to access insurance
- 200b: *Perception of access for children*: father's view of his ability to access insurance for children
- 200c: *Ability to pay*: cost was not a factor prohibiting father from accessing insurance
- 200d: *State foster care insurance*: attitudes of access and use of state foster insurance
- 200e: *Refreshing*: finding the insurance process hassle-free, and "refreshing"
- 200f: *Employer*: finding insurance easy or difficult to access due to employer offerings
- 200g: *Relationship status*: legal status as a way to ease access to insurance (legally married, domestic partnership, joint adoption)
- 200h: *Geography*: Ability or prohibition of access to insurance based on state laws

300 Perceptions [expression of opinion, views, evaluation, & reflection]
- 300a: *Perception of access*: father's view of his ability to access insurance for ALL family members
- 300b: *Frustrations perception*: absence or presence of frustration
- 300c: *Philosophy of "outness":* view of disclosing sexual orientation
- 300d: *"We" Family Language*: expression of experiencing something from viewpoint of family/unit
- 300e: *Provider perception*: view of father and partner/husband responsibilities and how enacted by both in family
- 300f: *Pressure to be perfect parent*: feelings and view's of outside pressures to be perfect parent
- 300g: *Unique*: view of what makes family's story unique
- 300h: *Community*: view of how "out" and involved in surrounding community of peers, friends, and family

400 Family Process [events, trajectories, action, changes, or performances of family]
- 400a: *DOL*: decision-making process & division of labor within the household
- 400b: *Decision insure*: decision making process of how to insure ALL family
- 400c: *Who's family?:* Relationships between parents, children, birth mothers, & other family

- 400d: *Roles*: carrying out of masculine and feminine-trait roles and responsibilities of parents (father, partner/husband/birth mom)
- 400e: *Insurance seeking process*: list of events, narrative of seeking out insurance for self, partner/husband, and children
- 400f: *The Past*: narrative taking from past to present as it relates to family, family formation, insuring family

500 Geography [rights, abilities, and limitations according to state and federal laws]
- 500a: *State variation*: Laws and policies that vary state by state and either prohibit or allow for legal connection to partner and children and impact insurance access and use
- 500b: *State foster health insurance system*: description and explanation of the uses of state health insurance
- 500c: *Geographic worries*: expression of concerns about moving to a new area/state
- 500d: *Taxes*: Discussion of federal laws regarding taxation of same-sex couple health insurance benefits
- 500e: *Legal relationship*: ability to access legal marriage, domestic partnership, or civil union
- 500f: *Discrimination*: experience of discrimination based on state laws, not personal prejudice

600 Family Formation [process, detailing, or description of creating current family and who is considered family]
- 600a: *Who's family*: who does the fathers count as family, answer to "who is in your household, who do you feel responsible for?" (who's family, why not included in family, contact with child)
- 600b: *Biological mom*: mentioning, description, and explanation of relationship and contact with biological or birth mother (contact with, relation with, mom relation defined, bio mom, no bio mom)
- 600c: *Father's age*: age of father at time of family formation, older or younger
- 600d: *Child relation defined*: description of the relation of each father to child, detailing how children became a part of family (legal adoption, joint adoption, surrogacy, previous heterosexual partner, foster care, child relation defined, family defined in legal or bio terms)
- 600e: *Recently married*: whether or not the fathers are recently legally married, partnership formation

700 Discrimination [expression, perception, or description of experiences with discrimination, unfair, or disappointing treatment]
- 700a: *Discrimination*: perception and description of events or situations where fathers felt discriminated against (discrimination, perception of discrimination)
- 700b: *Angry language*: language that expresses frustration, anger, disappointment
- 700c: *Feeling marginalized*: low level of agency, description of feeling discriminated against
- 700d: *Knowledge of LGBT issues/marriage equality/DOMA*: fathers' awareness and mentioning of legal inequality
- 700e: *Not on same policy*: prohibited from being on same policy due to state laws
- 700f: *Puzzled:* being surprised by any problems with health insurance in "this day and age"
- 700g: *Unfair treatment*: having to pay extra taxes, do extra work, provide more proof of partnership on health insurance and comparing experience to that of married straight couples

- 700h: *Past experience with hatred or prejudice*: Mentioning of previous times where fathers encounter hatred or prejudice from persons, not laws

800 Outness [discussion, degree, locations, perception of disclosing identity; philosophy on disclosing gay identity in relation to surrounding community and people in lives]
- 800a: *Comfortable being out*: expressing comfort in being "out" before, during, and after insurance process (life history, comfortable being out)
- 800b: *Philosophy*: expression of the value of being "out" to those you meet (combines better out than in, philosophy, doctor is trustworthy, reflecting on past, importance of disclosure)
- 800c: *Outness*: degree of outness (everybody knows, outness, always out)
- 800d: *Community*: discussion of LGBT and non-LGBT community experiences
- 800e: *Family Outs You*: discussion that having children as gay partners makes it difficult to conceal sexual orientation (children change everything, young children change everything, more out?, no real additional pressure, father/partner unit)

900 Power & Privilege [function or action of privilege and position; research identified markers of position, both privileged and marginalized]
- 900a: *Agency*: perceived ability to have and make choices, perceived amount of control in insurance situation
- 900b: *DOL*: division of labor within the household, children and financial responsibilities
- 900c: *Privilege*: researcher-identified, markers of higher socioeconomic status, privileged identity due to race, occupation, geographic location, partnered status; more power gives father more agency
- 900d: *Position*: researcher-identified markers of position within family, within partnership, within society; includes BOTH privileged and marginalized identities
- 900e: *Community access*: access to insurance and knowledge sources based on employment; occupation & employment as full-time, part-time, or stay-at-home dad
- 900f: *Feeling marginalized*: expression of feelings where father felt ignored by law, discriminated against, felt like second-class citizens, low expression of agency

1000 Children [mentioning of, actions related to, and processes around children]
- 1000a: *Parenting*: use of language to describe roles and responsibilities as fathers to children (gendered language, mothering, masculine traits, more feminine traits, gender neutral language)
- 1000b: *Shared responsibilities*: description of responsibilities and duties to children by father and partner/husband ("we" language, perception of partner contribution, perception of child responsibilities, DOL)
- 1000c: *Child relationship*: legal or biological connection defined, contact with child described
- 1000d: *Biological mother*: contact and relationship quality with biological/birth mother, role described (no bio mom, bio mom relation defined, contact with bio mom, bio mom role)
- 1000e: *Perception of Access for children*: attitude and viewpoint of father's access to insurance FOR his children; was it easy, was it hard?
- 1000f: *Who insures children?*: Decision making process surrounding who insures the children in the household if one partner does NOT have sole legal or biological connection to child

Appendix I

Institutional Review Board Approval

VirginiaTech

Office of Research Compliance
Institutational Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website http://www.irb.vt.edu

MEMORANDUM

DATE: July 17, 2013

TO: Emma C Potter, Katherine R Allen

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)

PROTOCOL TITLE: Health Insurance Experiences of Gay Father Families in Virginia

IRB NUMBER: **13-408**

Effective July 17, 2013, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the Amendment request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As:	**Expedited, under 45 CFR 46.110 category(ies) 7**
Protocol Approval Date:	**May 2, 2013**
Protocol Expiration Date:	**May 1, 2014**
Continuing Review Due Date*:	**April 17, 2014**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Date*	OSP Number	Sponsor	Grant Comparison Conducted?

* Date this proposal number was compared, assessed as not requiring comparison, or comparison information was revised.

If this IRB protocol is to cover any other grant proposals, please contact the IRB office (irbadmin@vt.edu) immediately.