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RESEARCH STATEMENT

I am an experimental and applied microeconomist with research interests at the intersection of health, labor, and public economics. In my research, I utilize both large nationally representative population data as well as restricted employer-level data coupled with the latest developments in causal inference methods to explore how LGBTQ+ populations navigate healthcare and health insurance markets, and I attempt to quantify the downstream effects that public policy affecting those markets has on these populations. I also utilize my training in experimental economics to design, execute, and evaluate field experiments aimed at detecting discrimination against gender, racial, and ethnic minorities in access to mental healthcare markets as well as how the COVID-19 pandemic both affected discrimination in and access to those markets. Finally, I conduct research on pedagogical innovations aimed at improving learning outcomes for undergraduate and graduate economics students. In [“Teaching Controversial and Contemporary Topics in Economics Using a Jigsaw Literature Review Activity.”](#) my coauthors and I present an activity for teaching sensitive topics upper-level economics courses.

In my job market paper, “Conversion Therapy Bans, Suicidality, and Mental Health”, I explore how statutory bans against sexual orientation and gender identity change efforts (SOGICE, colloquially “conversion therapy”) affect deaths by suicide and self-reported mental health in states where they are passed. I calculate suicide mortality rates from the US Vital Statistics National Center for Health Statistics Multiple Cause of Death Files using the International Classification of Disease (ICD) Code provided in underlying cause(s) of death at the year by state level and assemble data on the effective date, scope, and date of passage of conversion therapy bans and other state-level LGBT policies (such as same sex marriage legislation, non-discrimination acts, hate crime acts, and sodomy law repeals) from the Movement Advancement Project (MAP). I use these data to assemble a state by year panel in which I utilize innovations in the difference-in-differences/two-way fixed effects literature to estimate the effect of the passage of these bans on suicidality, finding modest reductions (about 5% over the baseline), driven mainly by reductions in death by suicide among young men (under age 24). For suggestive evidence on mechanisms driving these reductions, I turn to a combination of Google trends data and self-reported mental health data from the Behavioral Risk Factor Surveillance System (BRFSS). I show that while there is a small increase (about .15 standard deviation) in search intensity for the search term “conversion therapy” following conversion therapy bans, I find a larger decrease (about .25 standard deviations) in search intensity for an index of search terms including organizations known to offer these services and colloquialisms for conversion therapy. Finally, using data from BRFSS, I show modest improvements in self-reported mental health, mainly driven by improvements in young men. Taken together, these results imply that banning conversion therapy has modest positive effects on the relative risk of suicide for young adults, likely driven by lowered risk of severe psychological distress arising from efforts to change their sexual orientation or gender identity.

One clear throughline in my research agenda is in how changes in public policy affect the health insurance status of LGBTQ+ populations, and how health insurance policy (specifically public health insurance expansion) affects LGBTQ+ insurance status and health. The first paper illustrating this (revisions requested at *The American Journal of Health Economics*) is “The Effects of Legal Same-Sex Marriage on Employer Offers of Domestic Partner Health Benefits” (with Kitt Carpenter and Thomas Hegland). In this paper, we use restricted employer-level data from the Medical Expenditure Survey Insurance Component (MEPS-IC) to track offers of same-sex domestic partner employer-sponsored health insurance benefits (SSDPB) before and after *Obergefell v. Hodges*, the landmark Supreme Court decision that legalized same sex marriage (SSM) across the U.S. find that, prior to *Obergefell*, employers in states that legalized SSM were far more likely to offer these (and indeed any domestic partner benefits) compared to states who had not legalized SSM. Surprisingly, however, we find that offers of SSDPC fall precipitously following the *Obergefell* decision, irrespective of whether states had previously legalized SSM at the state level, converging to be statistically indistinguishable from offer rates of comparable benefits to employees with different-sex partners.

Another paper illustrating this throughline is “The Effects of the Affordable Care Act’s Medicaid Expansion on Health Insurance Coverage for Individuals in Same-Sex Couples” (with Sam Mann, Kitt Carpenter, Gilbert Gonzales, and Cameron Deal; under review), in which my coauthors and I estimate large expansions in eligibility for public health insurance differentially affected the insurance status of same-sex couples (SSCs). We use data from the 2008-2018 American Community Survey (ACS), which allows us to identify large samples of survey respondents in SSC and employ difference-in-differences methodology to show that Medicaid expansions significantly increased health insurance coverage among low-income men and women in SSCs. Additionally, we find suggestive evidence that these effects were larger for low-income women in same-sex couples compared to their counterparts in different-sex couples. Taken together, these results imply that further public health insurance expansions may reduce documented sexual orientation-based disparities in health insurance status. Similarly, in “Public Insurance and the Spread of Infectious Disease” (with Shyam Raman, Sam Mann, Alex Hollingsworth, and Katherine Wen), my coauthors and I again use identifying variation from Medicaid expansions under the Affordable Care Act, this time to examine how expanded access to public health insurance can improve sexual health. First, we link data from a variety of sources: STI surveillance data from the Centers for Disease Control and Prevention (CDC), information on counts of prescription drugs reimbursed by Medicaid from the Centers for Medicare and Medicaid Services (CMS), the number of practicing physicians and healthcare availability from the Area Health Resource File, and information on state-level prescription medication monitoring and programs from the RAND-USC Schaeffer Opioid Policy Tools and Information Center (OPTIC). Next, estimate a difference-in-differences model to examine the effect of Medicaid expansions on sexual health, uncovering a 6.8% reduction in annual HIV incidence among men in states that expanded Medicaid, driven mainly by men 25-34 and men who have sex with men (MSM). We explore potential mechanisms, determining these effects were largely driven by increased access to pharmaceutical innovations.

Another distinct feature of my research agenda is the utilization of field experiments to detect and quantify discrimination in access to mental healthcare. In “Gender Identity Discrimination in Access to Mental Health Care: Evidence from a Pilot Field Experiment” (with Patrick Button, David Schwegman, Luca Fumarco, and Eva Dils) my coauthors and I present the design and preliminary results the first wave of an audit field experiment designed to detect discrimination against gender (transgender and nonbinary) and racial/ethnic minorities in access to mental healthcare appointments. We scrape contact information from a popular clearinghouse of over 250,000 mental health providers (MHPs) and experimentally vary the characteristics of 100 fictitious patients, each of whom contact 10 MHPs ($n=1,000$) from a nationally representative constructed list of MHPs. We document differential patterns of MHP response to transgender and nonbinary and cisgender potential patients, especially transgender and nonbinary patients that are also racial and ethnic minorities. The full-scale experiment ($n=25,000$) is currently in the field with data collection finalizing late 2023. In a second paper “The Effects of the COVID-19 Pandemic on Access, and Discrimination in Access, to Mental Healthcare” (forthcoming in AEA Papers and Proceedings), we utilize the data from this pilot experiment, which coincided with the first wave of the COVID-19 pandemic to estimate how COVID-19 intensity affected access to mental health appointments. We link our experimental data to both Pulitzer Prize-winning data from the New York times on daily cases and mortality as well as data from the CDC on estimated weekly excess deaths and find that a one SD increase in COVID-19 intensity (as measured by daily cases/deaths or weekly deaths) is associated with about a 5-7.5 percentage point decrease in the probability of an appointment or consultation, and that once we account for Covid-19 intensity, nonwhite prospective patients are about 10-13 percentage points less likely to receive an appointment or consultation.

Looking forward, I plan to continue developing a robust research program on LGBTQ+ health and health policy. Additional works in progress include estimating the effect on HIV prophylactic medication uptake following the *Lawrence v. Texas* Supreme Court decision, which ruled sodomy laws unconstitutional; the effect of same-sex marriage legalization on non-labor time use; and how gender, ethnicity, race, and place determine uptake of PrEP in at-risk communities.