Introducing a State-Level Dataset on Gender-Specific Healthcare: Do Women Legislators Expand Post-ACA Coverage?

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Abstract

The Affordable Care Act (ACA) requires both public and private insurers to cover ten essential health benefits for their policyholders. Some gender-specific health benefits are exempt from this obligatory coverage, leaving the issue of mandated coverage to the states. Prior work has found that the gender composition of state legislatures affects policies related to reproductive rights, family and child-related policies, economic security, and broader equality measures. However, we do not have an understanding of how legislative gender composition affects coverage for gender-specific healthcare policies. I collect a state-level dataset of insurance coverage mandates for women's, men's, and transgender healthcare services that are excluded from the ACA, along with data on the gender composition of state legislatures to estimate the relationship between women's legislative representation and the adoption of these policies. I expect that an increased presence of women legislators will notably raise the likelihood of women-friendly policies being enacted, followed by transgender health related policy and then men's health related policy.

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Replication materials and dataset available at:

https://github.com/emmadotrmdfile/gendered-healthcare-policy-project

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1 Introduction

In 2010, the Affordable Care Act (ACA) was successfully signed into law and fully implemented in 2014 by President Barack Obama to reform the American healthcare system. Today, it is debated as the most significant and extensive federal health policy since Medicare (Manchikanti et al, 2017). The ACA prohibited insurance companies from implementing annual limits and discriminating against individuals with pre-existing conditions (Assistant Secretary for Public Affairs, 2022a; Assistant Secretary for Public Affairs, 2022b), mandated that insurance providers must provide a public reason if they intend on raising premiums by 10% or more (U.S. Centers for Medicare & Medicaid Services, 2024), and required that public and private insurers cover a minimum of ten essential health benefits for all enrollees (HealthCare.gov, 2025b). Although the ACA aimed to address a multitude of the public's health insurance coverage gaps, ambiguity remains within this policy that distinctly affects women and transgender individuals. For example, there are religious and moral exceptions for faith-based organizations and qualifying non-profits, as these groups are able to request exemption from providing their employees insurance coverage, such as for contraceptive services (the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department, 2018).

Additionally, the ACA's ten essential health benefits policy exempts some gender-specific healthcare services and resources completely from obligatory coverage. This consequently leaves the responsibility to require compensation for such services to the states (HealthCare.gov, 2025b), where the politics of coverage are particularly imperative for women (Nicholas, 2000) and transgender individuals (Slagstad, 2021), whose healthcare needs have been historically overlooked and highly politicized. Although men's healthcare is generally less politicized, research shows that reproductive and preventive services for men, such as vasectomies and prostate cancer screenings, are inconsistently covered and often underutilized due to policy-level gaps (Moyer, 2012; Sandman, Simantov, & An, 2000). For this reason, male reproductive services can be dismissed or not taken seriously, latently reinforcing the

expectation that reproductive responsibilities should fall mostly on women.

The primary goal of this paper is to examine these gaps and inconsistencies in the ten essential health benefits policy through political institutions, focusing in particular on women's representation in state legislatures. Existing research lends support to the belief that women contribute uniquely to policy advancement in areas that disproportionately affect them, a phenomenon known as descriptive representation (Schwindt-Bayer et al., 2005; Swers, 2002). Such areas include reproductive rights, family and child-related policies, economic security, and broader equality measures (Caiazza, 2008; La, 2023). Because women have historically held a minority of seats in state legislatures, this naturally supports examining increased levels of women's legislative representation as a potential mechanism for passing more inclusive healthcare coverage policies. I include transgender and men's healthcare coverage laws to evaluate the extent to which women legislators' influence extends beyond women-specific policies, allowing me to compare effects across different gendered constituencies.

I introduce a novel state-year panel dataset (2010–2024) containing information on insurance mandates for contraceptives, abortion, fertility treatments, vasectomies, erectile dysfunction treatments, prostate cancer screenings, gender-affirming surgery, and transgender hormone therapy, along with data on the gender composition of state legislatures to interrogate this relationship. Using two-way fixed effects models, I estimate the effect of higher proportions of women in state legislatures on the passage of these gender-specific healthcare mandates, before and after adjusting for partisanship.

The average treatment effects from the models indicate that increased women's representation in state legislatures is linked to a higher likelihood of enacting women's health-related policies. In other words, I find that women legislators significantly enhance the possibility of policy passage when it relates to women's healthcare. This effect is similar for transgender healthcare policies, and the smallest effects were observed for men's healthcare policies. Adjusting for partisanship produced only minor changes in the estimated effects, often resulting in slightly higher observed outcomes.

2 Related Literature

There is a large body of literature on the effects of women's political involvement. Certain cross-country analyses yield that the promotion of women's political empowerment (WPE) and greater proportions of women in governmental positions leads to better economic outcomes, such as subsequent growth in GDP per capita, technological advancements, and greater economic equality (Dahlum et al., 2022; Kim, 2022). Other global studies corroborate this, demonstrating that greater representation of women in policymaking is associated with improved outcomes in areas such as child health, maternity leave policies, work-family balance, and gender-sensitive laws (Asiedu et al., 2018; Rustagi & Akter, 2022; Kittilson, 2008; Weeks, 2017). Such a body of literature suggests that women's leadership, legislative participation, and institutional empowerment, can lead to substantial societal benefits, not only for women specifically, but for the country as a whole, as these laws may be linked to broader national social and economic progress (IWPR, 2024; the World Bank, 2023; OECD, 2017).

Countries that implement institutional mechanisms to promote gender equality in political representation present a compelling case for examining the effects of women's political leadership. For example, India's reservation system in certain political offices requires positions to be filled by women on a rotating basis through random assignment. Hessami & Lopes da Fonseca (2020) found that women who lead at this level are more likely to allocate resources in ways that reflect their own preferences, which subsequently results in greater educational attainment for girls. Specifically in Rwanda, where 30% of parliamentary seats have been reserved for women since 2003, women representatives discussed how the increased representation has made it easier for them to introduce and discuss women's issues (Devlin & Elgie, 2008). Bauer and Burnet (2013) strengthen this idea, claiming that women's perspectives are no longer dismissed as they were in the past and that their increased presence has transformed perceptions of women as political leaders. They also note that gender quotas have contributed to greater access to education for women and girls, a pattern similarly

observed by Hessami & Lopes da Fonseca (2020).

In the context of the U.S., women currently hold 28.2% of seats in the 119th Congress, a record high (Center for American Women and Politics, 2025a). However, the protracted timeline of this progress reflects the persistence of patriarchal norms that are ingrained in U.S. society, making it challenging for women to circumvent the structural inequalities that place them in a disadvantageous position (Silalahi, 2024). Studies examining the effect of women's political power in the U.S. provide substantive evidence for favorable policy outcomes in areas pertaining to reproductive rights, family and child-related policies, economic security, and broader equality measures. Caiazza's (2008) OLS analysis found that states with higher proportions of women legislators were strongly associated with advances in women-focused policy areas even after controlling for institutional resources and political attitudes. More recent work by La (2023) refines this relationship, showing that women legislators exert significant influence on the percentages of these types of policies being introduced, though success depends on partisanship and the proportion of women in office. It is worth noting that existing literature on this topic within the U.S. has typically relied on only one to three years of observable data, providing a limited perspective on the policy implications of women's representation. This study seeks to offer a more extensive and comprehensive analysis of women's representation across all fifty states and over fourteen years.

This line of inquiry also resonates with feminist scholarship emphasizing the importance of incorporating marginalized voices into leadership spaces, as those who embody these lived experiences are best positioned to understand their associated constraints and complexities. In feminist and postcolonial theory, critiques of mainstream discourse invite us to reconsider the identities that are granted space within leadership roles, and those who have been excluded from them (Combahee River Collective, 1977; hooks, 1989; Spivak, 1988). These frameworks impart how the presence of historically excluded groups within dominant decision-making institutions may expand the range of issues recognized as politically salient. Applying this ideology to the legislative context in the U.S. suggests that women's representation may

sensibly shape gender-specific healthcare coverage laws.

On a similar note, defining what constitutes women's interests and the issues that reflect their needs and priorities within a legislative agenda is inherently context-dependent. Rather than assuming that "women" exist as a unified, pre-political group with fixed interests, the constitutive representation of gender (CRG) approach highlights how "women's interests" are constructed and contested through political claims-making (Celis et al., 2009). The ongoing contestation over reproductive rights in the post-Dobbs U.S. vividly illustrates this process. With abortion policy making devolved to the states, lawmakers have been tasked not only with setting policy but with actively defining what is necessary or permissible for women's bodies, thereby shaping what counts as "women's interests." As Bor et al. (2025) show, these policies do not reflect public preferences but instead reflect legislators' own claims about what women should want or need. At the same time, women's rights groups, activists, courts, and other civil society actors have mobilized to resist these definitions, offering competing constructions of gender and autonomy. This struggle demonstrates that "women's interests" are not natural or given but are constituted through ongoing, contested processes across multiple sites of representation. Therefore, what is defined as a "women-friendly" policy in this study should not be universally applied as "women's interests." Rather, it reflects what I view as politically and socially salient given the specific cultural and institutional context of women's healthcare in the U.S. at this moment. Similar dynamics apply to how policymakers construct and contest the interests of transgender healthcare, and while the analysis also includes men's healthcare policies, these have not historically been subject to the same forms of political regulation and contestation.

3 New Dataset

The following sections document the state-year dataset constructed by my coauthor and me for this analysis. I first describe the classification of gender-specific insurance mandates and then outline the assembly of the legislative gender composition data.

3.1 Policy Data

The policy dataset captures state-level mandates from 2010 to 2024 requiring insurance coverage for women's, men's, and transgender healthcare services.

Women's policies include a multitude of contraceptive coverage laws, abortion coverage, and in vitro fertilization (IVF) coverage. Even though contraceptives are included in the ACA, the interplay between state and federal policy is considerably nuanced (Tschann & Soon, 2015; Guttmacher Institute, 2025; Employee Benefits Security Administration, 2021). These inconsistencies between state-level mandates and federal policy leaves millions of women dependent on public assistance programs to access contraceptives, many of which face impinged access due to the Trump administration's changes to Title X funding (Smith et al., 2022; Kreitzer et al., 2018). Since the annulment of Roe v. Wade in 2022, abortion coverage has devolved to the states, making it a highly divisive issue. The impartial stance of the ACA on abortion coverage has already enabled many states to limit abortion coverage in private insurance plans and ban coverage from marketplace plans as well (Kaiser Family Foundation, 2025). IVF is included to reflect the widespread issue of infertility, state-level disparities in access, and to showcase how insurance policies shape reproductive healthcare availability (Maven Clinic, 2024; Centers for Disease Control and Prevention, 2025).

Men's policies include vasectomy coverage, prostate cancer screening coverage, and erectile dysfunction (ED) treatment coverage. Vasectomy coverage is included to discern the integrity of a state's legal framework to offer men realistic options for birth control, or if it passively reinforces reproductive responsibility on women alone (Caddy et al, 2023). Regular prostate cancer screening is recommended by the American Cancer Society (2023), emphasizing that men should have access to such services uninhibited by insurance coverage, cost, or accessibility. ED coverage is included to highlight the absence of comparable sexual and reproductive health mandates for men, and to address healthcare barriers that prevent ED treatments from being treated like any other medical concern (Burnett et al., 2020).

Transgender policies include coverage for gender-affirming surgery and hormone therapy.

Although the ACA prohibits any health facility, program, or activity receiving federal funding from denying insurance coverage or care on the basis of gender identity and expression, constant altercations to the language of Section 1557 has created inconsistencies and gaps in coverage specifically for transgender individuals seeking gender-affirming care (Dawson et al., 2024; Rogers, 2024). In addition, some private employer-sponsored plans, particularly self-insured plans, are exempt if they do not receive federal funds. Plans may also still limit access by defining what counts as "medically necessary" or by requiring extensive prior authorization. Because of this variability, I include gender-affirming surgery and hormone therapy to capture whether states require coverage for such services.

Because no existing dataset catalogues these insurance mandates, legislative text was collected directly from state-level bill archives using LegiScan. I used keyword searches that yielded the raw text of thousands of bills, which I then manually reviewed to identify legislation mandating essential health insurance coverage for the policies of interest. I read each qualifying bill to verify statutory language before being coded as a binary indicator, where "1" denotes passage in a given state-year and "0" otherwise. Counts for women-, men-, and transgender-friendly policies and all individual policies can be found in **Appendix A (Tables 1 and 2).**

3.2 Gender Composition Data

Gender composition data were obtained from the Rutgers Center for American Women and Politics, which provides annual counts of female state legislators by chamber and party. Total chamber size and partisan composition were compiled from the National Conference of State Legislatures. From these data, I calculate the proportion of women in each chamber and state-year.

3.3 Final Dataset

Once data collection was finished, I merged the policy and gender composition datasets by state and year, resulting in a balanced panel of all fifty states from 2010 to 2024. The final dataset includes binary indicators for individual policies, aggregated gender-specific policy counts, and measures of women's legislative representation. Replication materials, including the codebook, datasets, and code, are available online.[1]

4 Research Design

4.1 Indentification

"What would happen to the passage of a bill if women's representation increased, while removing the impact of other factors?"

A reasonable way to answer this counterfactual question is with a selection on observables research design. Rather than random assignment of women's representation levels in state legislatures (since that would be impossible and unethical), statistical inference generates the effect of the "treatment" of increased levels of women's representation. Through this, the average treatment effect (ATE) is estimated, written as $\tau = E[Y_1 - Y_0]$, which ascertains the relationship between increased levels of women's representation and the passage of the policies of interest. In this study, the ATE is measured as a change in probability of policy passage, which ranges from -1 to 1. A value of 1 indicates a 100 percentage point increase in probability due to the treatment (i.e., increased women's representation), while -1 indicates a 100 percentage point decrease.

4.2 Potential Confounding

Because this is observational data, states with higher proportions of women legislators may behave differently from those with lower proportions. A key observable confounder in

[1] Available at https://github.com/emmadotrmdfile/gendered-healthcare-policy-project

this setting is partisanship. States with higher proportions of women legislators are often more Democratic, and Democratic legislatures are also more likely to adopt inclusive healthcare mandates. Existing research demonstrates that party affiliation strongly structures legislative behavior, often constraining the independent influence of gender (Frederick, 2013; Osborn, 2012; Thomsen, 2015). To account for this source of confounding, I include measures of partisan composition in the adjusted model specification.

4.3 Identification Assumption

Unobserved heterogeneity exists across states and over time, potentially confounding this relationship as well. For instance, the Dobbs v. Jackson Supreme Court ruling in 2022 represents a shift in the national policy context that may have influenced both women's political representation and the enactment of gender-specific insurance mandates. As such, it functions as a time-varying confounder. Similarly, the subsequent state-level policy fragmentation introduces state-specific variation in the policy environment, potentially confounding the relationship between women's representation and policy enactment across states (Browne, 2024).

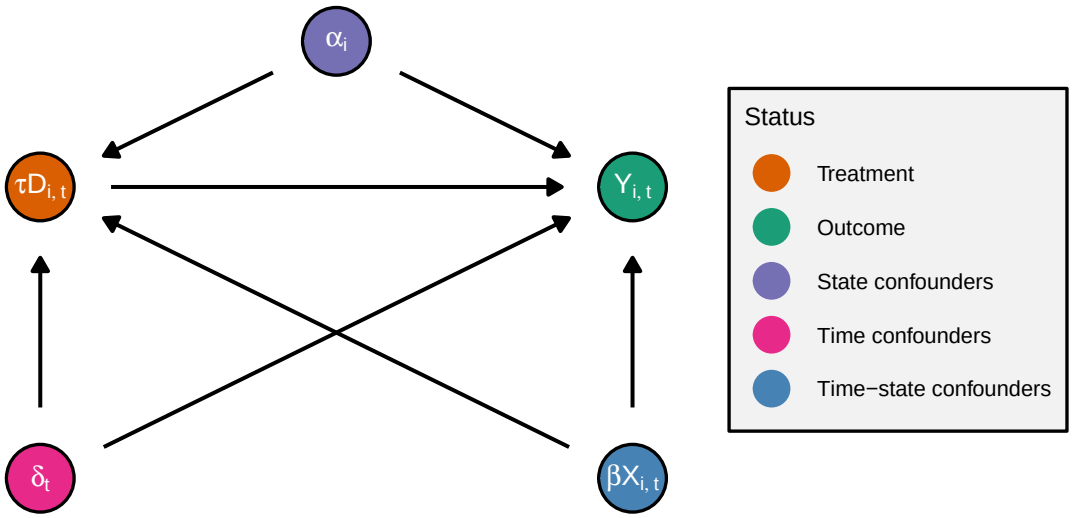


Figure 1: Directed Acyclic Graph

To address these concerns, I estimate two-way fixed effects models that include state

and year fixed effects. State fixed effects absorb time-invariant characteristics of states, such as long-established political culture or ideology, while year fixed effects account for common national shocks, including federal judicial rulings and national movements. Conditional on these fixed effects and observed confounders, there are no unobserved time-varying and state-specific factors that simultaneously affect women's legislative representation and policy enactment.

4.4 Estimation Strategy

I estimate the following two-way fixed effects model:

$$Y_{i,t} = \alpha_i + \delta_t + \tau D_{i,t} + \varepsilon_{i,t}. \qquad \textbf{(Model 1.1)}$$

An additional model will be used that builds on the previous specification, but also accounts for partisanship covariates that vary across both state and time:

$$Y_{i,t} = \alpha_i + \delta_t + \tau D_{i,t} + \beta_1 X^1_{i,t} + \beta_2 X^2_{i,t} + \varepsilon_{i,t}, \qquad \textbf{(Model 1.2)}$$

where $Y_{i,t}$ is the outcome of interest for state i in year t. This is a binary indicator equal to 1 if a qualifying gender-specific insurance mandate was enacted in state i in year t, and 0 otherwise. The terms α_i and δ_t represent state and year fixed effects, controlling for unobserved heterogeneity across states and over time. $D_{i,t}$ is a treatment indicator, and τ captures the average treatment effect, the main parameter of interest. β_1 and β_2 are the coefficients on observed state- and time-varying confounders: the proportion of Democratic legislators ($X^1_{i,t}$) and a binary indicator for Democratic legislative majority ($X^2_{i,t}$), respectively. $\varepsilon_{i,t}$ is the error term. **Model 1.1** represents the unadjusted model, while **Model 1.2** represents the adjusted model. I estimate all models using the `plm` package in R (Croissant & Millo, 2018).[2]

In the absence of TWFE, I sought to examine the outcomes using a straightforward ordinary least squares (OLS) regression. The motive behind this was to establish a baseline

[2]A description of my workflow is provided in Appendix C.

association between the policy outcomes and women's representation. This model includes the same two confounders discussed in **Model 1.2:**

$$Y_i = \beta_0 + \beta_1 D_i + \beta_2 X_{2i} + \beta_3 X_{3i} + \varepsilon_i, . \qquad \textbf{(Model 2)}$$

Recent research casts doubt on the common belief that TWFE nonparametrically adjusts for both unit- and time-specific unobserved confounders (Imai & Kim, 2021). They argue this justification critically hinges on the assumption of linear additive effects. As they argue, "the simultaneous adjustment for the two types of unobserved confounders cannot be done nonparametrically under the 2FE framework" (p. 406). This limitation arises because no observation can share both unit and time indices with another, making true nonparametric adjustment impracticable without strong functional-form assumptions. While this analysis relies on the traditional TWFE framework, these estimates are valid only under this linearity assumption. Therefore, these results are interpreted carefully and future work could build on these findings using more flexible estimators, such as those proposed by Callaway and Sant'Anna (2021) or Sun and Abraham (2021).

5 Results

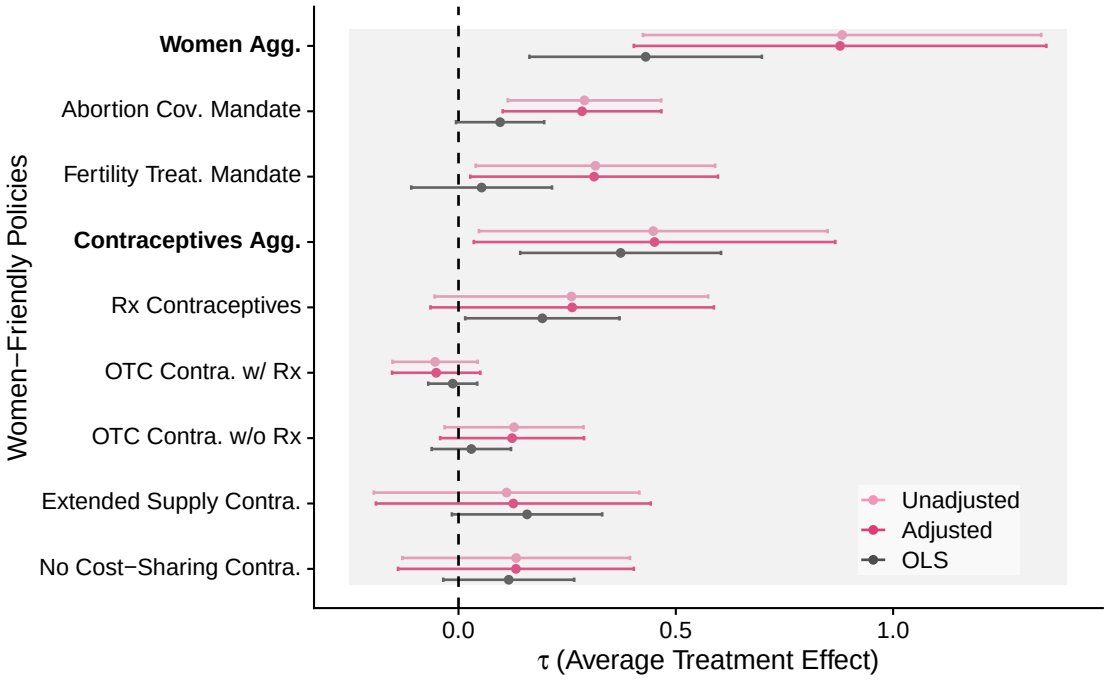
All figures in this section plot the effects on each policy from the unadjusted model **(Model 1.1)**, adjusted model **(Model 1.2)**, and OLS regressions **(Model 2)**. Aggregated variables are in bold, which represent a composite measure of all policies. This discussion will focus on the TWFE estimates.[3] Additional figures are provided in **Appendix B**.[4]

5.1 Outcomes for Women

Figure 2.1 displays the results for the women-friendly policies of interest. In addition, there is an aggregated contraceptives variable to encapsulate the five different contraceptive coverage policies.

[3] OLS results are similar, but with smaller effects. I included them in the main-text figures for comparison.
[4] You can zoom in on these; they are provided at a high resolution.

Figure 2.1: ATEs on Women-Friendly Policy



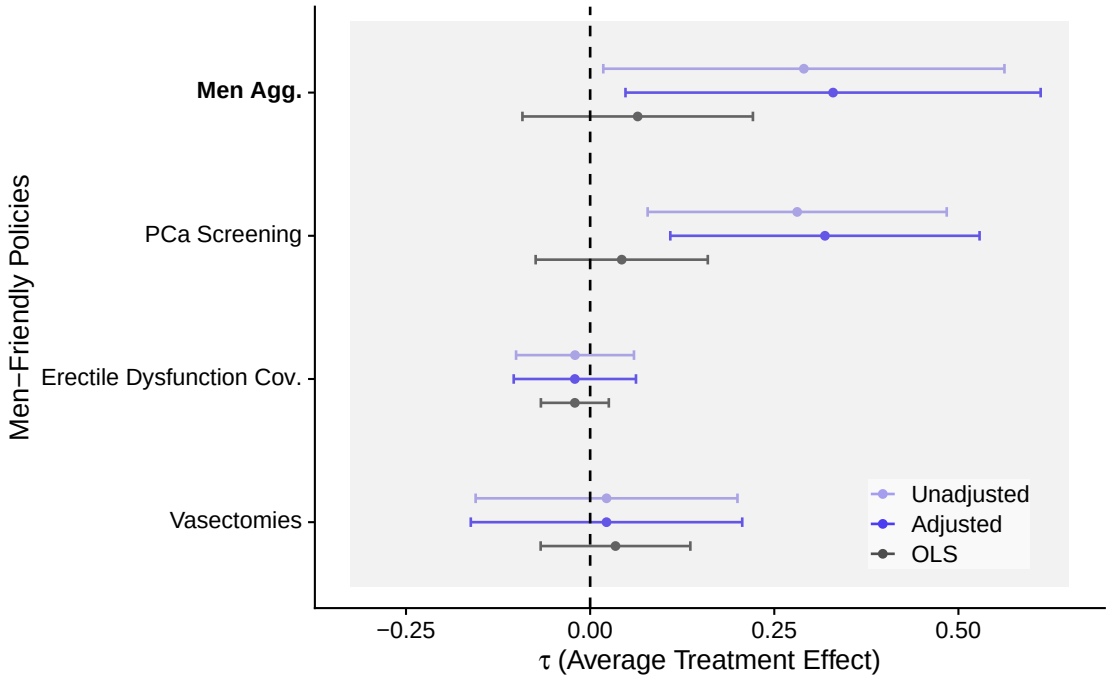
The unadjusted and adjusted ATEs were positive and statistically significant for both aggregated variables–women-friendly policies and contraceptives policies–as well as for abortion and fertility treatment coverage mandates. The remaining individual contraceptive policy variables were positively associated with women's representation but did not reach statistical significance, with the exception of the over-the-counter contraception with prescription policy, which showed an insignificant negative effect. This may be due to women legislators' attitudes towards acquiring contraceptives, making them more likely to advocate for a more accessible route to them, specifically without the need for a prescription. After controlling for Democratic representation, the ATEs remained largely stable, shifting by no more than one percentage point. The average treatment effects from the models indicate that increased women's representation in state legislatures is linked to a higher likelihood of enacting women's health-related policies.

For the aggregated women's-friendly policy variable, the estimated treatment effects were around 0.88 for both models, indicating that a 10 percentage point increase in women's

representation would make these policies 8.8 percent more likely to be enacted. Extending this logic, if state legislatures were entirely women-led, the likelihood of such policies being passed increases to 88 percent **(Appendix B, Figure 2.2).** For the aggregated contraceptives variable, the estimated treatment effect was 0.43 in both the unadjusted and adjusted models, indicating that contraceptive-related policies are 4.3 percent more likely to be enacted if there is a 10 percentage point increase in women's representation. Similarly, abortion coverage mandates yielded treatment effects of 0.29 (unadjusted) and 0.28 (adjusted), while fertility treatment mandates showed effects of 0.32 (unadjusted) and 0.31 (adjusted).

5.2 Outcomes for Men

Figure 3.1: ATEs on Men-Friendly Policy



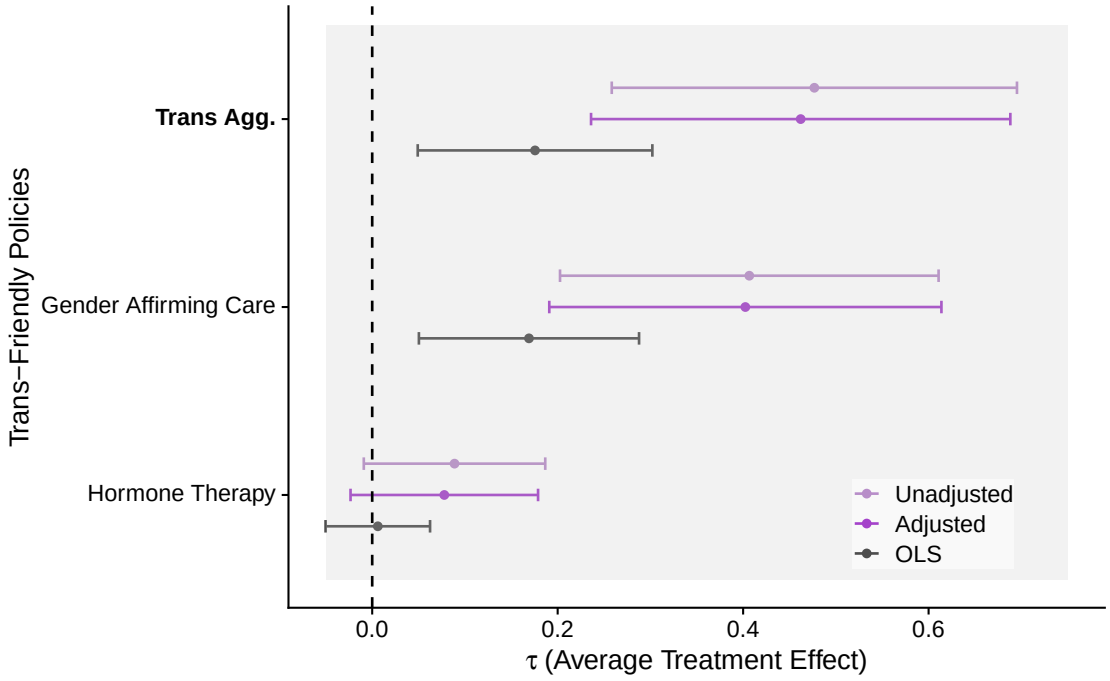
For the men's health-related policies, the average treatment effects from both TWFE models indicate that as women's representation increases, men's health-related policies also become slightly more likely to be enacted. The adjusted treatment effects changed minimally, with the largest shifts observed in the aggregated men's health variable and the prostate cancer screening coverage variable, though even these effects changed by only a few thousandths.

The aggregated men's health-friendly variable showed a statistically significant and positive treatment effect of 0.29 (unadjusted) and 0.33 (adjusted). This indicates that a 10 percentage point increase in women's representation corresponds to a 2.9 to 3.3 percent higher likelihood of these policies passing. In a legislature entirely composed of women, the likelihood of passage is 29 to 33 percent **(Appendix B, Figure 3.2).**

The prostate screening coverage variable also demonstrated a statistically significant and positive treatment effect–0.28 (unadjusted) and 0.32 (adjusted)–suggesting a 28 to 32 percent higher likelihood of adoption with a legislature full of women. The vasectomy coverage policy was also statistically insignificant but yielded a positive direction of effect.

5.3 Outcomes for Transgender

Figure 4.1: ATEs on Trans-Friendly Policy



For transgender policies, the adjusted and unadjusted treatment effects were positive and statistically significant for the transgender-aggregated variable and gender affirming care policy. On the other hand, the treatment effect for hormone therapy was positive

but statistically insignificant. The adjusted model's treatment effects remained relatively unchanged, both behaving in a similar manner as described above.

The treatment effect for the transgender-friendly aggregated variable was .46 (unadjusted) and .48 (adjusted), indicating that a 10 percentage point increase in women's representation would make transgender-friendly policies 4.6 to 4.8 percent more likely to be enacted. Therefore, if state legislatures were entirely composed of women, the TWFE models suggest that these policies would be 46 to 48 percent more likely to pass **(Appendix B, Figure 4.2).**

6 Discussion

6.1 Results Summary

Overall, the findings signal that an increase in women's representation in state legislatures has a positive and statistically significant impact on furthering healthcare policies that benefit all genders included in this analysis. The most substantial effects were observed for historically marginalized genders, implying that women legislators play a critical role in passing inclusive healthcare policies. More specifically, the largest treatment effect was observed for the aggregated variable summarizing women's healthcare policy adoption, underscoring the idea that women legislators are most effective in addressing the concerns and needs of the women they represent. Across all policy areas I examined, these effects remained largely unchanged after controlling for partisanship, reinforcing the conclusion that women legislators contribute uniquely to policy advancement beyond what party affiliation alone could predict.

These findings are consistent with prior research on descriptive representation (Schwindt-Bayer et al., 2005; Swers, 2002), as the effect of women's legislative representation on policy outcomes is not solely attributable to party affiliation, but reflects how women legislators are more responsive to issues that disproportionately affect them and are more persistent in advancing legislative solutions. Other studies demonstrate how social identities, such as race and gender, can have political effects distinct from party as well. Research has shown that these identities separately shape political efficacy and engagement (Merolla et al., 2012, on

race) and influence the sponsorship and advocacy of legislation that benefits marginalized communities (Bratton et al., 1999, on race and gender; Mansbridge, 1999, on gender). That being said, an increase in women's representation in state legislatures holds a remarkable ability to shape policy outcomes for women and transgender individuals.

6.2 Policy Implications

The near-maximum ATE for the overall measure of policy adoption related to women's healthcare demonstrates that women in state legislatures are highly effective at passing such legislation. Stated slightly differently, a strong presence of women legislators leads to a substantially higher probability of passing insurance mandates related to women's healthcare. This reflects the personal and political investment that women legislators have in reproductive autonomy. Moreover, breaking down the policy outcomes to specific focus areas, increased levels of women's representation are also linked to a higher likelihood of enacting contraceptive coverage policies, abortion coverage policies, and fertility treatment coverage policies. While the effects for these individual policy areas are all statistically significant, they are less substantial than the effect observed for the overall measure of policy adoption. Nonetheless, they still represent meaningful shifts in the likelihood of policy passage. This pattern is likely explained by the nature of the aggregated variable, which captures a broader range of women's healthcare policy activity. It may also reflect the idea that women legislators appear particularly committed to passing women's healthcare mandates as a whole. Even if they do not drive each individual policy equally, their overall presence substantially increases the likelihood that some form of women's healthcare legislation is enacted.

In contrast, the ATEs for men's health-related policies showed a smaller impact. The overall measure of policy adoption was still significant and positive, but the effect was less than half the size of the one observed for women's health policies. Among the individual policies in this group, only prostate cancer screening coverage reached significance, and its ATE was nearly identical to the overall measure, likely because the broader policy measure

absorbed much of its effect. This disparity in effect size may be explained by the growing urgency to protect women's reproductive autonomy, placing women legislators in a critical position to prioritize the concerns of their descriptive constituents over those related to men's healthcare. This is also facilitated by the reality that reproductive responsibility disproportionately falls on women, meaning that women legislators may be more receptive to the imperative of ensuring access to care, especially during a time where such services are under threat. Regardless, it can be said that women legislators have some influence on the passage of men's healthcare policy, though to a considerably lesser extent than they do on women's health issues.

While the results for transgender healthcare policies were smaller than those observed for women's healthcare policies, they were still statistically significant and positive. Considering that these policies apply to only about 0.6% of individuals aged 13 years and older within the U.S. (Herman et al., 2022), this impact is quite substantial relative to the size of the affected population. The stronger treatment effects for historically marginalized groups implies that women legislators may be more attuned to the needs of underrepresented communities. This tendency illustrates the connection between descriptive representation and substantive representation. Even though women legislators may not share the same identity as transgender individuals, they are still more likely to pass policies that concern this marginalized community. At the same time, these findings reaffirm the role of descriptive representation, as women legislators appear to prioritize women's health policy first and then gender-diverse health needs in ways that are not typically mirrored by men in office.

7 Conclusion

This study offers an extensive analysis of the effects of women's representation in state legislatures on the passage of women's, men's, and transgender healthcare insurance mandates through an original dataset. The subsequent analyses in this paper offer answers to the following question: *Does an increase in women's representation in state legislatures lead*

to more policies mandating insurance coverage for gender-specific healthcare? Overall, the empirical analyses show that the presence of women in state legislatures has a positive impact on all gender-specific insurance mandates, but most notably for women-friendly policies. This impact did not change significantly after adjusting for partisanship, providing support that women legislators do contribute uniquely to the passage of policies pertaining to their constituents.

Despite this conclusion, further research is required to determine why women's representation correlates with these policy outcomes. Possible avenues could explore whether women legislators are more likely to introduce such bills and feel more empowered to do so when working alongside other women, or if they keep their colleagues in close proximity to their policy agendas, or whether states that elect more women tend to have distinct policy priorities. The methodology of this study assumes a degree of similarity across states, despite the reality that they are unique to each other and contain different historical dispositions regarding healthcare coverage. Even with these limitations, this study seeks to contribute to understanding how legislative representation shapes the development of equitable healthcare policy.

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Appendix A Tables

Table 1: Aggregated Policy Counts

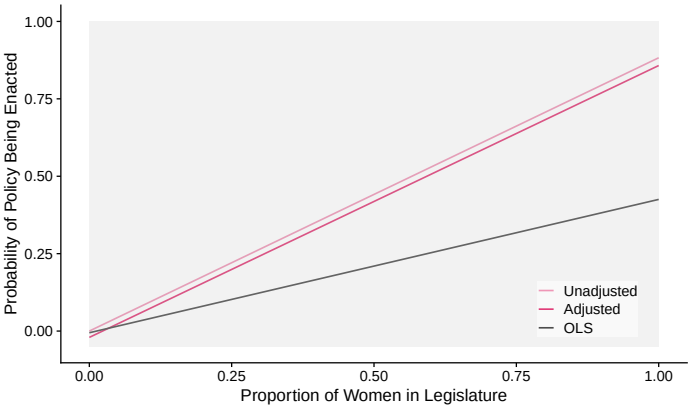
Policy Type	Count	Percentage of Total Policies
Women-Friendly Policy	81	76.42
Men-Friendly Policy	24	22.46
Trans-Friendly Policy	16	15.09
Total	106	100

Table 2: Individual Policy Counts

Policy	Count	Policy Type
Contraceptives (total)	58	Women-Friendly
Prescription Contraceptives	32	Women-Friendly
OTC Contraceptives w/ Prescription	3	Women-Friendly
OTC Contraceptives w/o Prescription	8	Women-Friendly
Extended Supply Contraceptives	30	Women-Friendly
No Cost-Sharing Contraceptives	23	Women-Friendly
Abortion	10	Women-Friendly
Fertility Treatments	26	Women-Friendly
Prostate Cancer Screenings	13	Men-Friendly
Erectile Dysfunction Treatments	2	Men-Friendly
Vasectomies	10	Men-Friendly
Gender-Affirming Care	14	Trans-Friendly
Hormone Therapy	3	Trans-Friendly

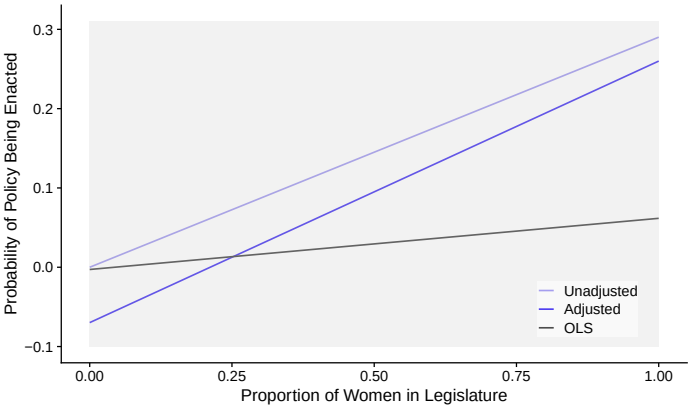
Appendix B Figures

(Figure 2.2) Estimated Effect of Women's Representation on Women-Friendly Policy



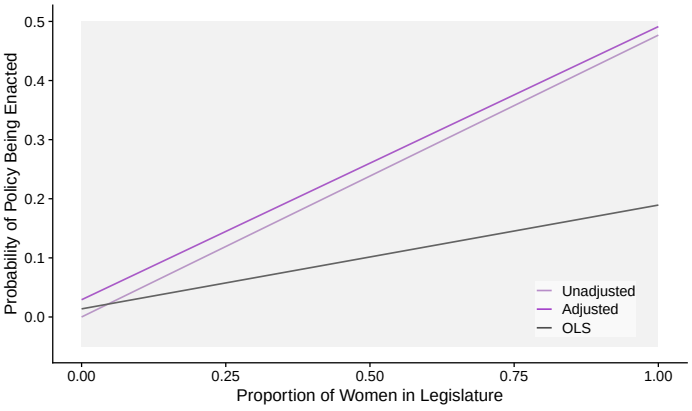
NOTE: Displays aggregated variable treatment effects only

(Figure 3.2) Estimated Effect of Women's Representation on Men-Friendly Policy



NOTE: Displays aggregated variable treatment effects only

(Figure 4.2) Estimated Effect of Women's Representation on Trans-Friendly Policy



NOTE: Displays aggregated variable treatment effects only

Appendix C Rstudio

Once data collection was finished in Excel, the datasets were saved as comma-separated value (csv) files and imported into RStudio for analysis. All data cleaning, merging, modeling, and visualization were conducted in a RMarkdown file. A total of forty-eight regressions were run, thirty-two of which were TWFE, using the `plm` package (Croissant & Millo, 2018). To efficiently manage the large number of models, separate vectors were created for each gender and their corresponding policies, such as dependent_variables_women, and for loops were utilized to systematically run regressions for every dependent variable in each group. For example, for the set of women-friendly policies, an empty list called models_women was created. Each dependent variable in this category (dependent_variables_women) was looped over, a formula was constructed relating the dependent variable to the main explanatory variable (prop_leg_women), and then a TWFE regression was ran using the plm() function, with state and year set as the panel indices. Once all the models were estimated, the results were tidyed, and confidence intervals were extracted and combined into a single data frame for easier interpretation and visualization.