

SEPARATE AND UNEQUAL: THE EFFECT OF UNEQUAL ACCESS TO EMPLOYMENT-BASED HEALTH INSURANCE ON SAME-SEX AND UNMARRIED DIFFERENT-SEX COUPLES

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Employers' health insurance coverage for legal spouses places unmarried couples at a disadvantage for obtaining coverage. Data from the Current Population Survey confirm that people with same-sex or different-sex unmarried partners are two to three times more likely to be uninsured than married people, even after controlling for factors influencing coverage. Universal partner coverage would cut that uninsured rate by as much as 50%. Employers offering domestic partner benefits would see a small enrollment increase: 0.1%–0.3% for gay and lesbian partners and 1.3%–1.8% for heterosexual partners. We find no evidence of adverse selection. (JEL J32, J38, J71)

I. INTRODUCTION

For most nonelderly people in the United States, health insurance and access to health care derive from one's own or a family member's employment. As a matter of customary compensation practice, many employers offer employment-based health insurance to spouses of employees. Gay, lesbian, or bisexual (GLB) people are at a significant disadvantage in this route to health insurance, however, because they cannot legally marry in the United States and are unable to claim benefits for a same-sex domestic partner from most employers. Employees who have a different-sex unmarried partner are at a similar disadvantage with respect to employment benefits, although they have the option of marrying. This article assesses the consequences of compensation inequality for GLB people's insurance status and for people with different-sex unmarried partners, as well as the impact of more equitable policies on those individuals

and their employers. Although the health insurance issue plays a central role in debates about the appropriate legal status of same-sex couples, we link questions about benefits for same-sex partners to unmarried different-sex partners because the two kinds of couples have been linked ethically, politically, and institutionally in the debate about employer benefits.

Because 80% of nonelderly insured people in the United States receive coverage through their own employment or through the employment-based health insurance of a family member (U.S. Bureau of the Census, 2002), the exclusion of domestic partners makes unmarried couples and their children likely to lack insurance at a rate higher than the 14% U.S. average for the nonelderly (U.S. Bureau of the Census, 2002). No study has yet established how much access to health insurance is limited because of the structure of employee benefits, but three reports suggest that rates of being uninsured may be significantly higher for GLB people, in particular. One study pooled data from seven nonrandom surveys of lesbian and bisexual women and

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ABBREVIATIONS

CPS: Current Population Survey
EBHI: Employer Benefit Health Insurance
ETR: Employer Take-up Rate
GLB: Gay, Lesbian, or Bisexual
LPM: Linear Probability Model
PTR: Partner Take-up Rate

determined that lesbians were less likely to have health insurance than were a similar sample of women in the National Health Interview Survey (Cochran et al., 2001). A second study using data from 1992 voter exit polls found that only 29% of heterosexual but 46% of GLB voters said that they “presently do not have health insurance” (Badgett, 1994). Third, a study of women in the Los Angeles County found that lesbian and bisexual women were significantly less likely to have health insurance, even after controlling for employment status, age, income, and education (Diamant et al., 2000). Finally, a 2002 nationwide probability sample of men and women aged 15–44 also showed that gay men and bisexual women were much more likely to report no current health insurance coverage than were their heterosexual counterparts (Mosher et al., 2005). Our study starts by measuring insurance disparities across sexual orientation but goes beyond the existing literature by including people with unmarried different-sex partners and by assessing the likely contribution of employer compensation practices to the sexual orientation insurance disparity.

In spite of the obvious health policy concerns raised by the lack of insurance for people with unmarried partners, regardless of sexual orientation, policy makers and many employers have most commonly addressed the issue of domestic partner benefits from the perspective of civil rights for GLB people. First, as employers themselves, many cities, counties, and states have adopted the practice of providing benefits to the domestic partners of GLB people and often to heterosexual employees’ unmarried partners, as well (Badgett, 2001). A 2004 survey found that the practice has spread to the private sector, with 14% of firms offering health-care coverage to same-sex domestic partners, and 12% of firms offering coverage to different-sex partners (Kaiser Family Foundation and Health Research and Educational Trust, 2004). Second, as purchasers of goods and services, the cities of Los Angeles, San Francisco, and Seattle, as well as the State of California, now require their contractors to offer equal benefits to domestic partners and to spouses, and other cities are considering similar laws (Rogers and Dunham, 2003). And finally, as the legal authority for creating family relationships, some states now recognize marriages between two people of the same sex (Massachusetts) or marriage-like partner-

ships between two people of the same sex (Vermont, California, Connecticut, New Jersey, and Hawaii), creating situations that sometimes have cost implications for a much wider set of private employers.

A common set of questions and concerns have arisen in each of the debates over compensation changes, contracting policies, and even same-sex marriage: How many people need this status? How much will it cost? In the debates focused specifically on employment benefits, the issue of different-sex partners also arises: Should employees with different-sex partners be given the domestic partner benefits even though they can marry, and how much will they add to the cost? The anecdotal experience of individual employers offering health benefits to partners suggests that fewer than 1% of employees sign up a same-sex partner when offered partner coverage, and those partners do not have higher than average health-care costs (Badgett, 2001), but as yet, we have no answers to the concerns about enrollment and the possibility of adverse selection based on rigorous empirical analysis.

This study uses data from the Current Population Survey (CPS), a large, nationally representative sample of households in the United States to address these questions that have important policy and even health implications. Comparing the detailed health insurance status of same-sex and different-sex couples—both married and unmarried—will allow us to estimate the relationship of employer-based health insurance to actual coverage of individuals. An analysis of couples provides data for a policy simulation of more widespread domestic partner coverage.

II. METHODS

A. Data

Few representative surveys include questions on sexual orientation, and of those that do, none ask detailed questions on health insurance. Because access to health insurance is tied so closely to family relationships, a practical strategy is to focus on surveys that allow us to identify couples—both same-sex and different-sex couples—and their health insurance sources. We will presume that individuals who declare that they have a same-sex “unmarried partner” are likely to be GLB (see

Black et al., 2000; Carpenter, 2004, for evidence that same-sex partners are likely to be GLB) and that people with a different-sex partner or spouse are heterosexual. When necessary, we distinguish between the two kinds of unmarried partnership—same-sex versus different-sex partners—but at other times consider the two together using the term “unmarried couples” or unmarried partners, as distinct from different-sex married “spouses.”

The Annual Social and Economic Supplement, formerly the Annual Demographic Survey, a supplement to the CPS, is conducted each March by the U.S. Census Bureau and interviews a representative sample of approximately 60,000 U.S. households. The survey includes detailed questions about health insurance coverage as well as partner relationship status. Since 1996, the CPS has included unmarried partner on its roster of household relationships, which also includes spouse. The survey respondent provides the relationship of each individual in the household to the reference person of the household or householder. We pool the CPS conducted between 1996 and 2003. By comparing the reported sex of the reference person and the partner, we can identify same-sex and different-sex unmarried couples as well as different-sex married couples. Unfortunately, we cannot identify the sexual orientation of individuals who are not married or partnered (although these individuals would not be affected by widespread partner coverage) or who are in couples not including a householder. The CPS also contains information on other social and economic characteristics, such as education, age, union status, and wage, as well as health insurance coverage and pensions. Because our main interest is employment-based health insurance, we exclude all people in partnerships in which either partner is aged 65 or more and thus eligible for Medicare.

In a small number of cases, the coding identified two or more persons in the household as potential partners of the reference person, and we examined these cases individually. If the survey specifically identified one of the potential partner matches as a spouse, then we selected this person as the partner. In most remaining cases, all but one of the reported partners were younger than 16 years of age and were, presumably, children misclassified as partners. After eliminating children, we selected any unique potential partner

match. In the still remaining cases, we used line number and the ages of partners and reference persons to establish the match; this final method created no additional same-sex partnerships.

By pooling CPS data across years, we find 482 observations of same-sex couples, or 486 men and 478 women in same-sex couples, and over the nine-year period, same-sex couples compose 0.26% of all couples. The rate in the CPS grows steadily over time, from 0.13% in 1996 to 0.36% in 2003, perhaps indicating a greater willingness to report same-sex status. Because we aggregate across years, we cannot directly compare the proportion of couples in our sample to other data sources, such as the 1990 or 2000 Censuses, but the share of same-sex couples in our sample is lower than either the 0.3% rate in the 1990 Census (G. Gates, pers. comm., October 24, 2002) or the 1.0% rate in the 2000 Census (U.S. Bureau of the Census, 2003). The 13,341 different-sex couples make up 7.4% of CPS couples across years, which is also lower than the 8.1% rate of unmarried different-sex couples in Census 2000. The larger difference between the Census and the CPS for same-sex couples, therefore, may reflect differences in willingness to report same-sex couple status on a self-administered Census questionnaire and on the CPS interview.

Comparisons with Census data provide some sense of possible biases in the CPS data, since fewer same-sex and different-sex couples appear in the CPS. The appendix Table-A1 compares data from the Census with our CPS sample for age, region, race, presence of children, education, income, and employment.¹ The two samples are very similar in average age and education for all couple types. The regional distributions are closely matched for married couples and unmarried different-sex couples in the two samples, but the same-sex couples are more likely to be found in the west and less likely in the south in the CPS than in the Census. The presence of children is also similar for different-sex couples, but same-sex couples in the CPS are much less likely to have children in their households than are same-sex couples in the Census.

1. We thank Dr. Gary J. Gates for providing us with summary statistics from the Census 2000 data for comparisons.

The comparisons of income and employment are more suggestive of possible sample selection issues. Those comparisons show that different-sex couples (both married and unmarried) have lower couple incomes in the CPS than in the Census, but the comparisons for same-sex couples suggest that the CPS sample might be biased toward higher income, better educated, and more employed same-sex couples. To the extent that the Census better captures the true characteristics of these different couple types, the CPS is biased toward same-sex couples with higher incomes and, perhaps, jobs that are more likely to have health insurance, but toward different-sex couples with lower incomes and, perhaps, jobs that are less likely to have health insurance. Thus, the potential CPS bias will tend to reduce differences in health insurance coverage between same-sex couples and married couples. In other words, since we find that the difference in health insurance coverage is large, the true difference might be even larger. Unmarried different-sex couples in the CPS differ from the Census in the same way that married couples do, suggesting that comparisons of health insurance for different-sex couples are not biased.

The partial panel structure of the CPS means that we observe most people in two adjacent years.² We use the panel structure to check the assignment of couple status with the concern that misclassification of sex, for example, due to keypunch error, may cause some couples to be misclassified as same sex or different sex. Households that report a same-sex couple in the first year are very likely to report a same-sex couple in the second year: 14 couples of the initially identified 496 same-sex couples switch between same-sex and different-sex status, which suggests a misclassification rate for same-sex couples of 3%.³

2. There are 356 unique men in same-sex couples, of whom 130 appear in two consecutive years, for 486 person-year observations. There are 357 unique women in same-sex couples, of whom 121 appear in two consecutive years, for 478 person-year observations. There are 225,066 unique people in different-sex marital couples, of whom 112,508 appear in two consecutive years, for 337,574 person-year observations. There are 20,930 unique people in different-sex unmarried couples, of whom 5,932 appear in two separate years, for 26,862 person-year observations.

3. This rate is comparable to the error rate for same-sex couples in the 1990 Census inferred by Black et al. (2000).

The error checking enabled by the panel structure of the CPS is not possible in the purely cross-sectional Census, but the low misclassification rate in the CPS data may help to validate Census-based research on same-sex couples. Almost all couples who appear to be same sex in cross-section are validated in the longitudinal data.

In our analysis we estimate standard errors that account for the nonindependence of the two observations on the same person. We weight all observations with the Census-provided probability weights that make the CPS representative of the U.S. population. Neither adjustment has an important effect on the sign, size, or significance of the results, and unweighted and unadjusted tabulations are available from the authors.

B. Measures of Health Insurance Status and Health

The CPS determines whether each household member had health insurance coverage at any time in the preceding year through a range of sources: current or former employer or union provided, private unrelated to employment, Medicare, Medicaid, military or veterans' care, or Indian Health Service. The survey also identifies each household member as covered as the policyholder or as a dependent. Unfortunately, the CPS only provides data on actual coverage, not employers' offers of coverage. Using the actual coverage information for each partnered adult, we collapse the many coverage categories into six: (1) employment-based health insurance as a policyholder; (2) employment-based health insurance as a dependent; (3) private coverage other than employment based as policyholder or dependent; (4) Medicaid coverage; (5) other government coverage (Medicare, military or veterans' care, or Indian Health Service); or (6) no coverage.

The CPS inquires about health status of all household members by asking the household respondent, "Would you say . . .'s health in general is excellent, very good, good, fair, or poor?" The health literature validates subjectively reported health as a strong predictor of mortality and of functional health status (Idler and Benyamini, 1997). The measure of health allows us to assess both the consequences of exclusion from employment-based coverage

TABLE 1
 Characteristics of People in Couples, by Couple Type

	Same-Sex Male	Same-Sex Female	Unmarried Different-Sex	Married Different-Sex
Sample size	486	478	26,862	337,574
Mean age	39.2	39.2	34.1	42.8
Region of residence (%)				
Northeast	21	25	18	19
Midwest	17	15	24	25
South	27	22	32	36
West	35	38	26	20
Percent nonwhite	8.8	11.0	18.0	12.4
Percent with children in household	7.6	19.0	39.8	53.2
Years of education	14.9	14.8	12.8	13.5
Percent with bachelor's degree or higher education	55.0	52.5	18.0	30.3
Median income of couple	70,160	56,565	39,278	54,143
Percent working full time (men)	78.4		78.4	84.2
Percent working full time (women)		71.7	62.8	53.3
Percent with at least one full-time worker in household	92.2	89.1	89.3	91.1

Source: Authors' tabulation of CPS Annual Social and Economic Supplement, pooled 1996–2003.

and the possibility of adverse selection, i.e., that individuals who would become eligible for employer-based domestic partner coverage would generate above-average health costs.

III. RESULTS

A. Characteristics of Individuals

Table 1 presents characteristics of people in different kinds of couples that are likely to influence health-care coverage. All calculations presented here are weighted by the CPS person weight to reflect the probability of being sampled. We split the same-sex couples by sex since men and women tend to have different labor force experiences. Also, employers and their insurers have expressed more concerns about providing partner coverage for gay men because their rates of HIV infection have been much higher than for lesbians (Spencer's Research Reports on Employee Benefits, 1992).

Individuals in unmarried partner relationships differ from married people in ways that might influence the likelihood of employer-based health insurance coverage. People with unmarried partners are significantly younger than those in married couples, although the average age for people in same-sex couples is closer to that of people in married couples than to that of people in different-sex unmar-

ried couples. Unmarried couples are slightly more likely to live in the northeast or west than are married couples.⁴ Because of these differences in age structure and in region of residence among couple types, we will present adjusted and unadjusted comparisons in Tables 2 and 5: the constant plus the coefficient on the couple-type indicators in a regression that also includes indicators for the four census regions and for five 10-year age categories. We note any case in which the nonadjusted results differ from the adjusted results.

Married men are somewhat more likely to work full time than are men in unmarried couples, and there is no difference in the full-time employment rates of men in same-sex or different-sex unmarried couples. Married women are somewhat less likely to work full time than are women in unmarried couples. Lesbians in couples are somewhat more likely to work full time than are women in different-sex unmarried couples. These patterns are consistent with 1990 Census data as well (see Allegretto and Arthur, 2001, for data on men). We expect higher rates of health insurance coverage through the individual's own employer for sex and couple types who are more likely to

4. For all couple types, the chi-square (DF = 9) test statistics is 482 (p -value = 0.000); for same-sex couples compared only to married couples, the chi-square (DF = 6) test statistic is 75 (p -value = 0.000).

TABLE 2
Health Insurance Status, Percentage by Couple Type

	Same-Sex Male	Same-Sex Female	Unmarried Different-Sex	Married Different-Sex
Unadjusted				
Own EBHI	62.5	65.2	52.6	43.9
Dependent EBHI	3.2	4.2	1.7	27.8
Both own and dependent	0	0	0	8.4
Medicaid	4.1	3.6	8.1	2.5
Other government coverage	3.4	1.1	1.3	1.7
Private or other	8.0	4.5	3.8	4.3
None	18.8	21.4	32.4	11.5
Adjusted				
Own EBHI	62.7	64.8	54.9	42.9
Dependent EBHI	5.2	6.2	4.0	30.2
Both own and dependent	0.7	0.5	1.3	9.0
Medicaid	3.3	2.8	6.5	2.2
Other government coverage	3.0	0.8	1.2	0.9
Private or other	7.9	4.4	4.3	4.1
None	17.0	19.5	27.7	10.7

Notes: Controls for five age categories and four census regions are included in the model but not shown. The regression-adjusted percentages report for a person between 35 and 44 years of age with composite region of residence.

Source: Authors' tabulation of CPS Annual Social and Economic Supplement, pooled 1996–2003.

be employed full time (U.S. Bureau of Labor Statistics, 2003). About 90% of all couple types have at least one full-time worker; only different-sex unmarried couples are significantly less likely to have a full-time worker, although the difference is small (2 percentage points).

Finally, while men and women in same-sex couples have higher levels of education than married couples, a factor that might suggest greater access to good jobs with health benefits (U.S. Bureau of the Census, 2002), unmarried different-sex couples have less education than married couples.

The last row of Table 1 presents the median combined earnings for the couples, which provides a measure both of the likelihood of coverage and of the affordability of alternative health insurance options. The average income of same-sex male couples is substantially higher than that of same-sex female couples and married or unmarried different-sex couples. These differences likely reflect several factors. Male same-sex couples have the highest proportion of full-time workers, and those couples combine two relatively large male incomes. Unmarried different-sex couples have substantially lower income than do same-sex female couples and married couples, where average income is approximately equal. Both women and men

in same-sex couples have higher educational attainments, which would also tend to increase earnings for those couples.⁵

B. Comparing Rates of Insurance Coverage across Couple Types

Table 2 presents the health insurance status for the four different couple types. Because of the large differences in age and region distributions of couples, which will influence the baseline likelihood of coverage, Table 2 shows percentages adjusted for age and region differences. A comparison of the two tables suggests that some of the stark differences for different-sex unmarried couples are because of their relative youth; the adjusted figures for the other couples are not terribly different from the unadjusted figures.

The characteristics of people in couples imply that people in unmarried couples should be more likely to have their own

5. Prior research on incomes by sexual orientation in the United States indicates that gay men and men in same-sex couples tend to have higher average levels of education but earn less than heterosexual men or married men with controls for education, location, race, etc. See Allegretto and Arthur (2001), Badgett (1995), Berg and Lien (2002), Black et al. (2003), and Klawitter and Flatt (1998).

employer-provided coverage than to have coverage through a partner, a prediction confirmed by Table 2. About 63%–65% of partnered gay men and lesbians receive health coverage through their own employer, while 53% of different-sex unmarried partners get such coverage, but only 52% of married individuals report their own employer as the source of coverage.⁶

Given employers' benefits practices, however, fewer people in unmarried couples receive employer-provided coverage as dependents, as Table 2 shows. Less than 5% of any category of unmarried partner has dependent coverage, but 36% of married people get coverage through a partner's employer-based coverage. The fact that any unmarried individuals get coverage as a dependent suggests that some employers provide spousal coverage to the domestic partners of employees, as noted earlier. Most employers providing partner coverage offer it to both kinds of couples (Human Rights Campaign, 2001), but a higher proportion of people in same-sex couples appear to be taking up the benefit.

In terms of absolute numbers, however, people with different-sex partners who have domestic partner coverage outnumber the same-sex partners with domestic partner coverage by a nine to one margin. The relative proportions of different-sex and same-sex couples with partner coverage are consistent with the experience of employers who offer coverage to both kinds of partners (Badgett, 2001). The absolute number of people covered by domestic partner benefits will partly determine both the cost to employers of expanding coverage and the public sector cost if domestic partnership health coverage were to receive tax exemption, as spousal and other family benefits now do.

The data summarized in Table 2 also show that unmarried couples do not (and possibly cannot) completely compensate for the lack of employer coverage for partners by purchasing private insurance. Complete adaptation would mean high rates of purchasing private coverage, but the rates of private coverage are similar for married couples, lesbian couples, and unmarried different-sex couples and are only a bit higher for gay male couples.

6. These figures combine individuals with "own EBHI" and "both own and dependent" coverage.

Instead, employers' practices result in less overall insurance coverage for people in unmarried couples. The last set of values for unadjusted health insurance status of Table 2 shows that 11.5% of married individuals lack any form of health insurance coverage. People in same-sex couples, however, are almost twice as likely to lack coverage: 20% have no health insurance. Unmarried heterosexuals are almost three times as likely as married couples to lack coverage.

Overall, Table 2 suggests that employer benefits practices do not simply rearrange the kind of coverage that unmarried individuals obtain. Those practices may result in less access to health insurance coverage for unmarried partners. Gay men and lesbians in couples are more likely to be uninsured than are married heterosexuals, and people with unmarried different-sex partners are the least likely to be insured.

One possible alternative explanation of the relatively low rates of being uninsured among married people is that they might have a greater demand for insurance coverage. The causes of greater demand by married people might include their higher average age, greater likelihood of having children, and higher incomes to purchase insurance (or to pay their share of coverage offered by an employer). To assess this possibility, we model the probability of an individual having no insurance as a function of five age-category dummies (to capture the nonlinear impact of age), income, health status (reporting fair or poor health), couple type, employment status (both own and partner's), and presence of children.

We estimate the dichotomous insurance coverage outcome with the linear probability model (LPM). (Probit models provide substantially the same results but make the issue of adjusting for the error structure of our data more complicated, so we provide linear models with standard errors corrected for correlated error instead.) In Table 3 we present the results of the LPM predicting no insurance coverage. First we report results for the pooled sample to demonstrate that the difference in coverage across couple types persists with multivariate controls. Then we report separate regressions for people in each couple type to distinguish the determinants of coverage. We find that own full-time employment, education, and total income of the couple are

TABLE 3
LPM Estimation of No Health Insurance Coverage

	Full Sample	Subsamples		
		Same-Sex	Different-Sex Married	Different-Sex Unmarried
Same-sex male	0.063 (0.021)	0.108 (0.020)		
Same-sex female	0.088 (0.023)	0.109 (0.023)		
Different-sex unmarried	0.170 (0.004)	0.152 (0.004)		
Under 25 years	0.175 (0.005)	0.128 (0.005)	0.182 (0.075)	0.110 (0.011)
25–34 years	0.036 (0.002)	0.029 (0.002)	0.070 (0.040)	0.012 (0.009)
45–54 years	–0.018 (0.002)	–0.021 (0.002)	–0.057 (0.034)	–0.067 (0.011)
55–64 years	–0.004 (0.002)	–0.051 (0.002)	–0.074 (0.047)	–0.150 (0.016)
Self full-time worker		–0.059 (0.002)	–0.172 (0.044)	–0.145 (0.008)
Partner full-time worker		–0.049 (0.002)	0.016 (0.034)	–0.048 (0.002)
Education		–0.0182 (0.0003)	–0.018 (0.006)	–0.0177 (0.0003)
Any children		–0.015 (0.002)	0.011 (0.048)	–0.0174 (0.0016)
Income (thousands)		–0.000544 (0.0000112)	–0.000492 (0.000114)	–0.000513 (0.0000111)
Constant	0.107 (0.001)	0.237 (0.003)	0.371 (0.054)	0.489 (0.012)
Sample size		365,400	964	337,574

Notes: Dependent variable is dichotomous, with one indicating no health insurance coverage, zero indicating some form of coverage. Controls for five age categories and four census regions are included in the model but not shown. The constant expresses the probability of no health insurance coverage for the omitted categories: a member of a different-sex married couple between 35 and 44 years of age with average years of education and composite region of residence.

Source: Authors' tabulation of CPS Annual Social and Economic Supplement, pooled 1996–2003.

statistically and materially important determinants of coverage.

As expected, personal characteristics affect the probability of having some form of health insurance. Older people, people employed full time, people with higher education, and people with children are significantly less likely to report being uninsured. The first two columns of Table 3 also show that after controlling for health insurance demand factors, such as children, and economic resources, such as income and education, same-sex unmarried partner couples are approximately 11 percentage points less likely than married individuals to have health insurance. Different-sex unmarried couples are still 15–17 percentage points less likely than married couples to be insured, as well. In other words, the coverage gaps for unmarried partner couples that we saw in the simple means in Table 2 remain after controlling for factors that might otherwise explain it. Overall, individuals who have an unmarried partner of either sex are twice as likely as a married person to lack insurance.

The last three columns of Table 3 provide a closer look within sets of couples. The presence of any children slightly but significantly decreases the probability of no coverage for people in married couples. For people in different-sex unmarried couples, the point estimate on children is the same as for people in married couples, but the estimate is not statistically significant. For people in same-sex unmarried couples, the presence of children has no measurable effect on the probability of coverage.

Income, education, and employment status matter for all three sets of couples, although to varying degrees. For people in married couples, the full-time employment of the partner is a statistically significant and very important predictor of coverage, reducing by 4.8 percentage points the probability of no coverage. For people in different-sex unmarried couples, the full-time employment of a partner reduces the probability of no coverage by only 2.6 percentage points. For people in same-sex partnerships, the full-time employment of a partner has no effect on the probability of coverage. For people in married couples, dependent coverage is a key route to health insurance and is almost as important a predictor of coverage as the individual's own full-time employment. In the absence of an institutional framework of widespread coverage for domestic partners,

coverage for unmarried couples is not strongly affected by the employment of an unmarried partner for different-sex couples, and a partner's employment is completely irrelevant for same-sex couples.

IV. PUBLIC AND PRIVATE POLICY IMPLICATIONS

A. Possibility of Adverse Selection

Early in the movement to expand employer health coverage to include domestic partners, employers and insurance companies worried that the individuals most likely to use that coverage would have higher than average health expenditures, thus increasing the cost of coverage for all workers. This fear of adverse selection appeared to be motivated primarily by concerns about HIV-infected gay men. However, employers have not publicly reported any adverse selection when adding partner coverage, and insurance companies have dropped premium surcharges designed to protect them from unexpected increases in expenditures from domestic partners (Blanton, 1993; Spencer's Research Reports on Employee Benefits, 1992). On the other hand, some public health studies have found differences in the prevalence of health problems for lesbians and gay men, although the authors also argue that lack of health insurance and vulnerability to stigma might be the underlying cause of those differences (e.g., Cochran, 2001; Cochran et al., 2003; Dean et al., 2000; Diamant et al., 2000; Mays and Cochran, 2001). Such studies are not strictly comparable to the current investigation, since we are focusing on a subset of the gay community, that is, those with partners.

The CPS data offer another opportunity to look at the possibility of adverse selection by directly examining health status of the insured and uninsured by couple type. Two perspectives are possible. In our first method, we compare the self-reported health status of all individuals by couple type to see if there are differences by broad group status. Of married men, 8.7% report being in fair or poor health, compared with 9.1% of men in different-sex couples and only 7.9% of men in same-sex couples. Similarly, 8.6% of married women report being in poor or fair health, compared with 9.8% of women with male partners and 10.2% of women with female partners. None

TABLE 4
LPM Estimation of Health Status

	Men Only		Women Only	
Fair or poor health status				
Same-sex male	0.037 (0.015)	0.020 (0.014)		
Same-sex female			0.049 (0.016)	0.038 (0.016)
Different-sex unmarried	0.024 (0.003)	0.005 (0.003)	0.030 (0.003)	0.015 (0.003)
Under 25 years	-0.053 (0.003)	-0.071 (0.004)	-0.043 (0.003)	-0.057 (0.003)
25-34 years	-0.028 (0.002)	-0.030 (0.002)	-0.021 (0.002)	-0.023 (0.002)
45-54 years	0.052 (0.002)	0.052 (0.002)	0.046 (0.002)	0.046 (0.002)
55-64 years	0.107 (0.003)	0.103 (0.003)	0.088 (0.003)	0.084 (0.003)
Education	-0.0177 (0.0003)	-0.015 (0.0003)	-0.0165 (0.0004)	-0.0138 (0.0004)
Health insurance				-0.074 (0.002)
Constant	0.062 (0.001)	0.140 (0.003)	0.069 (0.001)	0.130 (0.003)
Sample size	182,704		182,696	
Poor health status				
Same-sex male	0.020 (0.009)	0.012 (0.009)		
Same-sex female			0.007 (0.007)	0.003 (0.007)
Different-sex unmarried	0.006 (0.002)	-0.003 (0.002)	0.009 (0.002)	0.003 (0.002)
Under 25 years	-0.022 (0.001)	-0.031 (0.002)	-0.019 (0.001)	-0.025 (0.001)
25-34 years	-0.010 (0.001)	-0.011 (0.001)	-0.008 (0.001)	-0.009 (0.001)
45-54 years	0.020 (0.001)	0.020 (0.001)	0.015 (0.001)	0.016 (0.001)
55-64 years	0.043 (0.002)	0.041 (0.002)	0.033 (0.002)	0.031 (0.002)
Education	-0.0072 (0.0002)	-0.0058 (0.0002)	-0.0054 (0.0002)	-0.0042 (0.0002)
Health insurance				-0.029 (0.001)
Constant	0.0161 (0.0007)	0.055 (0.002)	0.0173 (0.0007)	0.041 (0.001)
Sample size	182,704		182,696	

Notes: Dependent variable is dichotomous, with one indicating general health reported as poor or fair, zero indicating general health reported as good, very good, or excellent. Controls for four census regions are included in the model but not shown. The constant expresses the probability of poor or fair health for the omitted categories: a member of a different-sex married couple between 35 and 44 years of age with average years of education and a composite region of residence.

Source: Authors' tabulation of CPS Annual Social and Economic Supplement, pooled 1996-2003.

of these differences are statistically significant. Because the respondents with unmarried partners are younger, have different levels of education from married respondents (a proxy for human capital and other forms of opportunity), and live in different places, we control for those factors when assessing the health differences.⁷ After controlling for those variables in Table 4, the health of men in same-sex couples appears slightly worse than that of men in married couples: At the average years of education, 8.6% of men in married couples report fair or poor health while 12.6% of men with male partners report fair or poor health. How-

ever, the bad-health rate of gay men remains statistically indistinguishable from the health of men in unmarried different-sex couples, of whom 11.3% report poor or fair health. For women, the impact is similar, with unmarried women significantly more likely to report poor or fair health than married women.

When we control directly for employment-based health insurance, either own or dependent coverage, we find evidence that the lack of health insurance may be a channel that explains the worse health of people in same-sex couples. For men in same-sex couples, the excess probability of reporting fair or poor health falls from 3.7 to 2.0 percentage points when insurance coverage is included. For women in same-sex couples, the excess probability falls slightly when the health insurance control is added. On net, we conclude that the

7. Employers can also select on those factors when choosing employees in many situations, so adjusting for these factors isolates the additional information that partnership status might convey.

health of people in same-sex couples is not substantially worse than the health of people in married couples. The disparity is small after controlling for education. The second models in each part of Table 4 show that health insurance is positively correlated with health status. While this correlation could reflect either the potential for adverse selection or the effect of past selection by employers and insurers (or for unmarried different-sex couples, selection into marriage), it is equally plausible that health insurance directly improves health (see Institute of Medicine, 2002). Furthermore, the probability of adverse selection is further reduced by the fact that some individuals in poor health who have conditions that qualify them for Medicare or Medicaid coverage might not take advantage of an offer of partner coverage.

Finally, because employers and insurers are likely to be most concerned by those in the poorest health, we isolate those reporting poor health. The unconditional means show no practically or statistically significant differences across couple type: 2.6% of married men, 2.8% of men with male partners, and 2.4% of men with female partners report poor health, and the same rates are 2.3%, 1.9%, and 2.5% for the corresponding groups of women. Using self-reported poor health as the dependent variable in Table 4,⁸ we again see that men with unmarried partners are more likely than married men to report poor health, although the effect is larger for men with same-sex partners compared to men with different-sex partners. Women with unmarried partners are also more likely to report poor health, although that difference is not statistically significant for GLB women. For both men and women, the difference in poor health status drops considerably and is statistically insignificant once health insurance is added to the controls. Finally, we also note that the magnitude of the difference in health status is roughly comparable to the difference in rates of Medicaid coverage for gay men and unmarried heterosexual when compared with married people in Table 2, suggesting that employers might not be likely to see those in the poorest health enroll in employer health programs.

8. We thank one of the referees for making this suggestion.

Overall, the raw reports of health status show no difference by couple type. Once we control for characteristics that employers might be able to use to screen employees, three of the four groups of people with partners show a very small and sometimes insignificant difference from married people with respect to having a poor health status. The group with the largest impact, men with same-sex partners, are more likely to report being in poor health only after controlling for age, region, and education. We argue that even this difference is small in percentage and in absolute number from an employer's perspective.

As a second method to assess the possibility of adverse selection, we compare the health status of individuals who are covered dependents of employees to see if unmarried partners are different from married partners in order to test whether substantial adverse selection has already occurred in the uptake of benefits by the small share of same-sex people who have partner benefits. Among people with dependent coverage, there are no statistically significant differences in health by couple type. Both perspectives provide some reassuring information to employers who want to know whether the new partners will have health-care costs that are higher than average. Our failure to find evidence of adverse selection is consistent with the experience of employers reported above.

B. Predicting the Impact of the Expansion of Partner Coverage

The detailed CPS data allow us to analyze two important sets of questions related to domestic partner benefits. Since increased enrollment will drive up employers' health benefit costs, employers want to know how many people would sign up an unmarried partner for health benefits if partners were covered. A policy maker, on the other hand, might also want to know how effective a blanket requirement to offer equivalent coverage to spouses and partners might be in reducing the number of uninsured people.

We estimate two different kinds of take-up rates, each of which is useful in different contexts. First, we estimate the proportion of employees who *take up* partner benefits among employees with partners who are *offered*

TABLE 5
Coverage of Partners of People with Own EBHI, Percentage by Couple Type

	Same-Sex	Married Different-Sex	Unmarried Different-Sex
Own EBHI	73.0	25.2	65.2
Dependent EBHI	5.4	53.1	3.0
Both own and dependent	0	16.0	0
Medicaid	2.2	0.4	4.2
Other government coverage	1.3	0.6	1.0
Private or other	4.5	0.7	3.4
None	13.6	4.0	23.1

Source: Authors' tabulation of CPS Annual Social and Economic Supplement, pooled 1996–2003. These percentages are based on raw data, that is, they are not adjusted for age and region.

benefits. We call this rate the “partner take-up rate,” or PTR. But because employers will almost never know how many of their employees have partners, in our second method we calculate a take-up rate that employers can use as a rule-of-thumb to estimate the number of new enrollees. This second take-up rate (the “employee take-up rate,” or ETR) calculates the proportion of *all* employees (i.e., not just those with partners) who will take-up partner benefits and will move from one insurance category (e.g., single coverage) to a more expensive category (e.g., family or employee-plus-one).

Partner Take-up Rate. Knowing the proportion of employees with partners tells us little about how many people will sign up for benefits if offered. In the short run, some employees with partners will not enroll their partner for a variety of reasons. Some partners will not need the newly offered coverage. Table 5 presents coverage for people whose partners have employer-provided health coverage. Table 5 suggests that most unmarried partners have health-care coverage through their own employers, and others might get coverage from a nonemployer source considered more desirable than the employer.⁹ Furthermore, as noted earlier, the Internal Revenue Service treats employer contributions for partner health coverage as taxable income, creating a disincentive for take-up above and beyond

any employee contribution for the coverage. Finally, it is possible that signing up a same-sex partner will expose an employee as being GLB or nontraditional, making the employee more vulnerable to stigma. All these influences will dampen the take-up of partner benefit offers, particularly for GLB employees.

As noted earlier, the CPS does not ask about offers of benefits but only about take-up of benefits. Here we use two methods, one indirect and one direct, to estimate the PTR. For the indirect method, we use offer data from a health benefits survey of a probability sample of firms that has been conducted since 1999 by the Kaiser Family Foundation and the Health Research and Educational Trust. From 1999–2001, the survey included questions about whether the firm offers health-care coverage to employees' same-sex and different-sex unmarried partners. From 1999–2001, the proportion of employees working in firms that offer partner coverage to same-sex partners increased from 11% in 1999 to 15% in 2000 and to 16% in 2001. Coverage of different-sex partners has remained lower and has bounced around from 12% in 1999 to 14% in 2000 to 11% in 2001.¹⁰ Unfortunately, the most recent Kaiser Family Foundation and Health Research and Educational Trust (2004) survey that asks about partner

9. Some married people sign up for double coverage from their own employer and a spouse's employer, a possibility that we incorporate below.

10. In this analysis, we assume that these survey proportions for all employees also accurately capture the proportion of employees with partners who are offered partner benefits. Note that if employers who have higher proportions of partnered employees are more likely to add domestic partner coverage, then the indirect PTRs we estimate below will be biased upward.

benefits reports a slightly different statistic, that is, that 14% of firms providing health insurance benefits also offer partner benefits, which is slightly different from the proportion of employees offered such coverage.

While we do not know the offer rates for earlier or later years, the average offer rates from these three years (14% for same-sex partners and 12.3% for different-sex partners) come from the middle of the range of years from the pooled CPS. Since the offer rate was likely lower from 1996–1998 and, perhaps, higher in 2002–2003, the average offer rate should be helpful in estimating the take-up rate for 1996–2003.

During this time period, there were no major changes in the influences mentioned earlier that would dampen short-run take-up rates, so we calculate the PTR by multiplying and dividing three relevant factors. We multiply the proportion of partnered people receiving employer-provided benefits as a dependent from 1996 to 2003 by the health-care take-up rate of employed partners, and we then divide that figure by the offer rate of partner benefits from 1999–2001. Table 5 shows that 5.8% of people with an Employer Benefit Health Insurance (EBHI)–receiving same-sex partner had dependent coverage. Findings from Medical Expenditure Panel Survey data suggest that the ETR for health insurance offers is approximately 80% (Sommers, 2004). Multiplying 5.4% times 80% and dividing by the 14% offer rate gives us a PTR of 30.9% for same-sex couples. The PTR for different-sex couples ($3.0\% \times 80\%/12.3\%$) is 19.5%. In other words, fewer than one-third of partners have signed up for benefits when offered them by a partner's employer. For comparison purposes, note that calculating the comparable rate for married couples gives a PTR of 62.6% since 88.3% of employees work in firms offering health insurance (Sommers, 2004).

As a check on these indirectly derived estimates, we can compare them to the possible take-up rates that can be calculated *directly* from Table 5. While we cannot observe who has been offered partner benefits, we can observe the people who are likely or unlikely to take up a partner benefit offer. People whose partners already have their own employer-provided coverage are unlikely to take up partner benefits. In couples where at least one partner has employer coverage, 73.0%

of same-sex partners and 65.2% of different-sex partners have their own employment-based insurance.¹¹ To estimate the take-up rate, then, we add those who are already receiving partner benefits (the 5.4% of people in same-sex couples and 3.0% of different-sex couples) to the partners who are likely to take up new offers of partner coverage from an employer. If all other non-EBHI-covered partners would sign up, then the take-up rates would be 27.0% for same-sex partners and 34.8% for different-sex partners. If those with no insurance coverage are the only people to take up partner coverage, then an alternative estimated take-up rate is 19.0% and 26.1% for covered employees with same-sex or different-sex partners, respectively.

The higher indirect PTR estimates for same-sex couples would be consistent with the direct rate estimates if some partners with their own EBHI also take up partner coverage. Table 5 shows that roughly 16% of spouses of employed-and-covered married people double up on coverage. Even a smaller rate for partners would reconcile the direct and indirect estimates. The much lower indirect PTR estimates for different-sex unmarried couples suggest that the financial disincentives (employee copayments and higher income taxes) may discourage different-sex couples more than same-sex couples.

In the medium to long run, other decisions might increase the likelihood of taking up an employer's offer of partner coverage. The availability of health-care coverage through a partner's job might influence labor supply decisions. Partners who once needed their own employer-provided coverage might choose to retire, to return to school, or to stay home to care for children, for instance (see Gruber and Madrian, 2002, for a review of the evidence on retirement and on women's labor force and employment decisions). At the extreme, unmarried partner couples might eventually look like married couples in their decision-making based on health insurance if the differences

11. Some have wondered why observed enrollment numbers have been so low for same-sex partners when employers offer coverage to partners. The CPS findings in Table 5 explain that often both partners work and are covered by their own employment-based coverage in most same-sex couples, making partner coverage presumably less desirable for many employees with same-sex partners.

TABLE 6
PTR Estimates

	Low Direct (current dependents plus uninsured only)	High Direct (current dependents plus all other kinds of coverage)	Indirect (short-run; CPS plus firm data)	Highest Long-Run Estimate (indirect + induced)
Same sex (%)	19.0	27.0	30.9	44.9
Different sex (%)	26.1	34.7	19.5	33.5

in labor force participation, etc., are strongly influenced by health insurance availability. Table 5 allows us to estimate the take-up rate of married spouses, conditional on the other spouse having coverage through his or her employer. In the CPS sample, 69.1% of spouses of a partner with EBHI sign up as a dependent (sometimes in combination with the spouse's own EBHI). In other words, the PTR of married couples is likely to be much higher than the PTR of either type of unmarried couple.

Of course, unmarried partner couples are unlike married couples in other ways that might also influence these labor supply decisions. For example, Table 1 shows that unmarried couples have fewer children. Furthermore, other legal and social aspects of marriage besides health insurance are likely to influence labor market behavior. We can estimate a longer run PTR that isolates the health insurance effect by using the findings from several studies of the impact of spousal health insurance coverage on full-time employment, holding other factors constant. Gruber and Madrian report that the measured impact of spousal health insurance on full-time employment ranges from a drop of 8.5 to 14 percentage points. If unmarried partner couples react in the same way, their take-up rates will rise by 8.5–14 percentage points as family labor supply decisions change. If we use the highest impact mentioned by Gruber and Madrian, the 14 percentage point drop, then the take-up rate for same-sex partners rises to 44.9% and for different-sex partners to 33.5%.

We present the range of PTR estimates in Table 6: from 19% to 45% for same-sex couples and from 20% to 35% for different-sex couples.

Employer Take-up Rate. To get the ETR, we want to know how many employees will sign up a partner, as before, but this time

we will divide that by the total number of employees, regardless of partner status. Employers who are considering an offer of domestic partner benefits can then make a simple estimate of the total number of new enrollees. The ETR is defined as E^{newP}/E_T , where E^{newP} is the number of partners enrolled by employees and E_T is the total number of employees.

The relationship of PTR to ETR is simple to establish by expanding the definition of ETR, $ETR = (E^{\text{newP}}/E_p) \times (E_p/E_T)$, where E_p is the number of employees with partners. The first term, E^{newP}/E_p , is just the PTR, since E_p is now the people with partners who are newly offered partner coverage. Thus, $ETR = \text{PTR} \times (E_p/E_T)$.

The second term is the proportion of employees with partners, which we can calculate as an average for the whole workforce in the United States. Because same-sex and different-sex couples may have been undercounted in the CPS and because any given year of CPS data contains a relatively small number of people in unmarried couples, we use the data on unmarried partners from Census 2000 to calculate the ETR. We calculate the second term of the ETR by multiplying the number of people with partners from Census 2000 by the proportion of those employed full time in the CPS (from Table 1): 75.0% of people in same-sex couples and 70.6% of people in unmarried different-sex couples. Then we divide that estimate of employed partners by total employment in 2002 to get an economy-wide average for the second term above, 0.6% for same-sex partners and 4.9% for different-sex partners.

Finally, we multiply the proportion of partners by the various estimates of PTR from Table 6. The resulting figure is the economy-wide average ETR, which ranges from 0.1% to 0.3% for same-sex partners and from 1.3% to 1.8% for different-sex partners. The high end

of the range takes into account the possible labor supply adaptation of couples (going to part-time employment without health insurance or leaving the labor force altogether). Note the similarity of this range to the reported experience of employers mentioned earlier (Badgett, 2000; Gates, 2001).

Impact on Employer Costs. With an estimate of ETR, employers can then calculate the likely increase in health-care benefit costs from adding domestic partners. An employer offering benefits to same-sex and different-sex partners is likely to see an increase in enrollment of 1.4%–2.1% of current firm employment. Since employers pay a larger share of coverage for a single employee than for two-person or family coverage, the employer's costs will rise by less than the percentage change in enrollment if the new partner subsidy is less than the subsidy for a single employee.¹² Thus, we expect cost increases to track enrollment increases closely, that is, in the 1.4%–2.1% range.

Impact of a Benefits Nondiscrimination Policy on the Uninsured. If the federal government were to require employers to provide the same coverage for domestic partners that is offered to spouses, then some currently uninsured people are likely to become insured. While the impact on the overall rate of insurance would be small since the affected groups are relatively small, the rate of insurance could rise dramatically within the groups of people with unmarried partners. Universal domestic partner coverage (in contrast now to partial coverage, in which roughly 18% have access to partner benefits) would only affect those uninsured people whose partners have employer-provided coverage. To estimate the impact on the (unadjusted) overall rate of uninsured partners, calculated from Table 2 as an average of 20.1% for male and female same-sex couples and 32.4% of different-sex

partners, we first assume that *all* uninsured people whose employed partners are offered insurance take up the insurance. In that case, the uninsured rates fall to 11.4% and 19.4% for same- and different-sex partners, respectively, which represents substantial increases in coverage for people in these categories although a small fraction of all uninsured people.¹³ If, alternatively, partners remain uninsured at the same rate as married couples where one has EBHI, or 4.0%, then the rates of uninsured partners fall less dramatically to 14.0% and 21.7% for same-sex and different-sex couples, respectively.

Depending on the assumption about take-up by uninsured partners, then, the drop in the number of unmarried people who are uninsured ranges from 30% to 43%. Another way to think about this is to note that employers' failure to provide domestic partner coverage accounts for over one-third of the uninsured people who have an unmarried partner.

Since federal, state, and local governments incur costs of covering health-care expenses for uninsured people (Hadley and Holahan, 2003), the increased costs to businesses are at least partly offset by a decrease in social costs. We can estimate these savings by multiplying the change in rates of uninsured people by the number of partners (from the Census) to get the number of newly insured people. Then we multiply that number by \$485, the average cost to the federal government of care for an uninsured person (Hadley and Holahan, 2003). The total savings to the federal government alone ranges from \$0.5–\$1.8 billion.¹⁴

13. Here we multiply the proportions uninsured in Table 5 by the proportion of partners who have EBHI from Table 2 and then subtract that amount from the percentage uninsured in Table 2.

14. If the Internal Revenue Service continued to treat domestic partners differently from spouses in this scenario, tax revenues would also rise, since employer contributions for all—not just uninsured—domestic partners are considered taxable income (both for income taxes and employer and employee payroll taxes). At the average increased employer contribution of \$3,781 per year, marginal tax rate of 15%, and payroll tax rate of 15.3% (both employer and employee contributions), the increase in tax receipts would be \$1.3–\$4.5 billion per year. Overall, including savings from fewer uninsured people, the fiscal impact on the federal budget would then be a net gain of \$1.8–\$6.5 billion per year.

12. Recent figures suggest that employer costs for family coverage are 88% of costs for single coverage. In 2003 employers paid 85% of the cost of single coverage but only 75% of family coverage costs, and $75/85 = 0.88$. Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits Survey, 2003 Annual Survey."

V. CONCLUSION

Employment-based health insurance remains the most important source of health-care coverage for nonelderly Americans. But such coverage receives academic and policy scrutiny as a form of compensation, as well. Employers' practice of providing subsidized coverage for spouses but not unmarried partners has been accused of being discriminatory by GLB activists, in particular. Unmarried employees with long-term committed partners—whether of the same or different sex—are similarly situated but receive less in compensation than their married colleagues. This study shows that the difference in treatment is not simply theoretical: it is real and has financial and, perhaps, even health consequences. Data from the CPS show that people with partners are two to three times more likely to lack health insurance than are married couples, even after controlling for factors that influence coverage. A requirement to provide the same benefits for partners as are provided to spouses would reduce the proportion of uninsured people in same-sex couples and different-sex couples by as much as 43%. Such a requirement might improve the health of people in unmarried couples and would likely reduce the government share of the cost of health care for uninsured people.

However, businesses would see an increase in enrollment and, therefore, higher health insurance costs if they offered domestic partner benefits. This study demonstrates that roughly

half of the people with partners are likely to take up an offer of coverage over the long run. Although employers' health-care costs would rise, that increase will be small for several reasons. First, out of every thousand employees, on average only one to four would sign up a same-sex partner, and another 13–21 would sign up a different-sex partner. Second, the experience of many employers and the CPS data on self-reported health status both suggest that adverse selection would not occur.

Finally, we note that these findings for same-sex couples, in particular, allow us to predict one consequence of a widespread provision of a civil union status or marriage for same-sex partners. If this new status requires employers to treat legally united same-sex couples in the same way as married couples, then businesses on average would see somewhat less than (since some already provide domestic partner coverage) a 0.1%–0.3% rise in enrollment since not all couples will marry or enter that legal status. Experience with civil unions in Vermont and domestic partnership in California suggests that roughly 30%–50% of same-sex couples will register their relationships (Badgett and Sears, 2005). In fact, most small businesses would have no new additional enrollees. The small added costs for businesses result in important positive consequences for the relatively small number of same-sex couples, however: a large decline in the number of uninsured people and a likely increase in their health and well-being.

APPENDIX TABLE A-1
Comparison of CPS and Census Data

	Same-Sex Male		Same-Sex Female		Different-Sex Unmarried		Different-Sex Married	
	CPS	Census	CPS	Census	CPS	Census	CPS	Census
Mean age	39.2	40.0	39.2	39.4	34.1	34.5	42.8	43.0
Region of residence (%)								
Northeast	21	19	25	20	18	19	19	18
Midwest	17	18	15	18	24	24	25	24
South	27	35	22	35	32	32	36	36
West	35	28	38	27	26	25	20	22
Percent nonwhite	9	20	11	21	18	25	12	17
Percent with children	8	29	19	43	40	46	53	57
Years of education	14.9	13.6	14.8	13.8	12.8	12.8	13.5	13.5
Median income of couple (\$)	70,160	63,740	56,565	56,420	39,278	44,000	54,143	60,500
Working full time (men) (%)	78.4	70.5			78.4	77.1	84.2	81.6
Working full time (women) (%)			71.7	68.1	62.8	61.3	53.3	48.8

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