

# DEPARTMENT OF ECONOMICS

## Working Paper

**Separate and Unequal: The Effect of Unequal  
Access to Employment-Based  
Health Insurance on Gay, Lesbian, and  
Bisexual People**

by

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Health Insurance on Gay, Lesbian, and Bisexual People

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ABSTRACT

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ABSTRACT

Employers' standard practice of including legal spouses in health insurance is likely to place people in unmarried couples at a significant disadvantage for obtaining coverage. Data from married and unmarried couples in the Current Population Survey confirm that people with unmarried partners are two to three times more likely to lack health insurance than are people in 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 50%. We find no evidence of adverse selection. We predict that a typical employer offering domestic partner coverage will see a small increase in enrollment, ranging from 0.1% to 0.3% for same-sex partners and 1.3% to 2.1% for different-sex unmarried partners.

For most non-elderly 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, and 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. This paper assesses the consequences of compensation inequality for GLB people's insurance status as well as the impact of more equitable policies on GLB people and their employers.

Because 80 percent of non-elderly 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 same-sex domestic partners makes GLB people and their children likely to lack insurance at a rate higher than the 14-percent U.S. average for the non-elderly (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. One study pooled data from seven nonrandom surveys of lesbian and bisexual women, and 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 percent of heterosexual but 46 percent of GLB voters said that they "presently do not have health insurance" (Badgett, 1994). Finally, a study of women in 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). Our study starts by measuring insurance disparities across sexual orientation but goes beyond the existing literature to assess the contribution of employer compensation practices to the insurance disparity.

In addition to health policy concerns raised by the lack of insurance for gay, lesbian, and bisexual people, policymakers and many employers have most commonly addressed sexual orientation disparities from a civil rights perspective. 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' partners, as well (Badgett, 2001). A 2001 survey found that 16% of employees work for firms offering health care coverage to same-sex domestic partners, and 11% work for firms offering coverage to different-sex partners (Kaiser Family Foundation, 2001). Second, as purchasers of goods and services, the cities of Los Angeles, San Francisco, Seattle, and New York, 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 partnerships between two people of the same sex (Vermont, California, New Jersey, and Hawaii), creating situations that may 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 percent 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, 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.

## **Methods**

### *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, and Carpenter, 2004, for evidence that same-sex partners are

likely to be gay, lesbian, or bisexual) and that people with a different-sex partner or spouse are heterosexual.

The Annual Social and Economic (ASEC) Supplement, formerly the Annual Demographic Survey, a supplement to the Current Population Survey (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 age 65 or older 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 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 470 same-sex couples, or 476 men and 464 women in same-sex couples, and over the nine-year period, same-sex couples compose 0.26 percent of all couples. The rate in the CPS grows steadily over time, from 0.13 percent in 1996 to 0.36 percent 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 percent rate in the 1990 Census (Gary Gates, personal communication, 10/24/04) or the 1.0 percent rate in the 2000 Census (U.S. Bureau of the Census 2003). The difference between the Census and the CPS may reflect differences in willingness to report same-sex couple status on a self-administered Census questionnaire and on the CPS interview.

The partial panel structure of the CPS means that we observe most people in two adjacent years. We use the panel structure to check the assignment of couple status with the concern that misclassification of sex, for example, due to key-punch 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 mis-classification rate for same-sex couples of 3 percent.<sup>1</sup> The error checking enabled by the panel structure of the CPS is not possible in the purely cross-sectional Census, but the low mis-classification rate in the CPS data may help to validate Census-based research on same-sex couples. Almost all couples that 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 non-independence 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.

#### *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.

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<sup>1</sup> This rate is comparable to the error rate for same-sex couples in the 1990 Census inferred by Black et al., 2000.

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 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.

## **Results**

### *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 of 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 unmarried couples. Unmarried couples are slightly more likely to live in the northeast or west than are married couples (For all couple types, the chi-square (df=9) test

statistics is 482 (p-val=0.000); for same-sex couples compared only to married couples, the chi-square (df=6) test statistic is 75 (p-val=0.000)). Because of the differences in age structure and in region of residence among couple types, we present adjusted results 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 ten-year age categories. We note any case in which the non-adjusted 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 that are more likely to be employed full-time (U.S. Bureau of Labor Statistics, 2003). About 90 percent 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 rate of both partners working and potentially combine two 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.<sup>2</sup>

*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, which will influence the likelihood of coverage, Table 2 shows percentages adjusted for age and region differences. The characteristics of people in couples imply that people in unmarried couples should be more likely to have their own employer-provided coverage than to have coverage through a partner, a prediction confirmed by Table 2. About 63-65 percent of both gay men and lesbians receive health coverage through their own employer while 56 percent of different-sex unmarried partners get such coverage, but only 52 percent of married individuals report their own employer as the source of coverage.<sup>3</sup>

Given employers' benefits practices, however, fewer people in unmarried couples will receive employer-provided coverage as dependents, as Table 2 shows. Less than 7 percent of

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<sup>2</sup> Prior research on incomes by sexual orientation indicates that gay men and men in same-sex couples tend to earn less than heterosexual men or married men with controls for education, location, race, etc. See Badgett, 1995; Klawitter and Flatt, 1998; Allegretto and Arthur, 2001; Black, et al., 2003.

<sup>3</sup> These figures combine individuals with "own-EBHI" and "both own and dependent" coverage.

any category of unmarried partner has dependent coverage, but 39 percent 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).

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. Among the options facing policy-makers would be to limit a tax exemption or a requirement of partner benefits just to same-sex couples, with the rationale that marriage is not now an available option.

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 only a bit higher for gay male couples but are similar for married couples, lesbian couples, and unmarried different-sex couples. Instead, employers' practices result in less overall insurance coverage for people in unmarried couples. The last row of Table 2 shows that 10.7 percent of married individuals lack any form of health insurance

coverage. People in same-sex couples, however, are almost twice as likely to lack coverage: 18 percent have no health insurance. Unmarried heterosexuals are almost three times as likely as married couples to lack coverage.

Overall, Table 2 demonstrates that employer benefits practices do not simply rearrange the kind of coverage that unmarried individuals obtain. Those practices appear to 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 unmarried heterosexuals are the least likely to be insured.

One possible alternative explanation of the relatively low rates of uninsured people among married people is that they might have a greater demand for insurance coverage. The causes of greater demand by married people might include the 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.) 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 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. Table 3 also shows 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 10-11 percentage points less likely than married individuals to have health insurance. Different-sex unmarried couples are still 15-17 percentage points more likely than married couples to be uninsured, 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 two to three times 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 (s.e.=0.2)

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 (s.e.=0.8) 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.

### **Public and Private Policy Implications**

#### *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 (Spencer's Research Reports, 1992; Blanton, 1993). 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. Diamant, et al., 2000; Dean, et al., 2000; Cochran,

2001; Mays and Cochran, 2001; Cochran, Sullivan, and Mays, 2003). Such studies are not strictly comparable to the current investigation, since we are focusing on a subset of the gay community, i.e. 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. First, we compare the self-reported health status of all individuals by couple type to see if there are differences by broad group status. After controlling for age and region but no other characteristics, the rate of reported bad health is 8.4 percent for men in married couples and 10.0 percent for men in same-sex couples; the t-value for the significance of the difference is 1.36. Men in different sex unmarried couples are significantly more likely to report worse health; their rate of poor health is 12 percent and the difference is strongly significant. The rate of reporting fair or poor health for women differs slightly by couple type: 8.3 percent of women in married couples; 11.3 percent of women in same-sex couples; and 12.1 percent of women in unmarried different-sex couples, with lesbians statistically indistinguishable from women in unmarried different-sex couples.

Table 4, which introduces years of education as a proxy for human capital and other forms of opportunity, shows that 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 percent of men in married couples report fair or poor health while 12.6 percent of gay men report fair or poor health. However, the bad-health rate of gay men remains statistically indistinguishable from the health of men in unmarried different-sex couples, of whom 11.3 percent report poor or fair

health. For women in same sex couples, the worse-health disparity grows slightly with the introduction of the control for education.

Finally, we control directly for employment-based health insurance, either own or dependent coverage, and find that the lack of health insurance is 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 4.0 to 2.6 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 health of people in same-sex couples is not substantially worse than the health of people in married couples. The disparity is small, even after controlling for education, and lack of health insurance explains some of the disparity. 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.

Second, 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 if 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 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.

*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 policymaker, 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 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 (that is, 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 employed-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 non-employer

source considered more desirable than the employer.<sup>4</sup> Furthermore, as noted earlier, the IRS 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 partner will expose an employee as being gay, lesbian, bisexual, or nontraditional, making the employee more vulnerable to stigma. All of these influences will dampen the take-up of partner benefit offers.

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 offer take-up rate. 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.<sup>5</sup>

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

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<sup>4</sup> Some married people sign up for double coverage from their own employer and a spouse's employer, a possibility that we incorporate below.

<sup>5</sup> 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 partner take-up rates we estimate below will be biased upwards.

from 1996-1998 and probably 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 partner take-up rate by dividing the proportion of partnered people receiving employer-provided benefits as a dependent from 1996-2003 by the offer rate of partner benefits from 1999-2001. Table 5 shows that 5.8% of people with an EBHI-receiving partner had dependent coverage. Dividing 5.8% by the 14% offer rate gives us a PTR of 41%. The PTR for different-sex couples (3.6/12.3) is 29%. In other words, fewer than half of partners have signed up for benefits when offered them by a partner's employer.

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 likely to take-up a partner benefit offer. One group of workers is unlikely to take up the benefit: In couples where at least one partner has employer coverage, 70.8% of same-sex partners and 63.3% of different-sex partners have their own employment-based insurance.<sup>6</sup> To estimate the take-up rate, we add together those receiving partner benefits (the 5.8% of people in same-sex couples and 3.6% of different-sex couples) to the partners who might also 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 29.2% for same-sex partners and 36.6% for different sex partners. If those with no insurance

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<sup>6</sup> 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.

coverage are the only people to take-up partner coverage, then an alternative estimated take-up rate is 20.3% and 27.6% 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.

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, 2001, 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 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, 70.5% of spouses of a partner with EBHI also sign-up as a dependent (sometimes in combination with the spouse's own EBHI). In other words, the PTR of married couples is 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 an 8.5 to 14 percentage point drop. 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 56% and for different-sex partners to 43%.

We summarize the range of take-up rate estimates in Table 6: from 20% to 56% for same-sex couples and 27% to 43% for different-sex couples.

*Employer take-up rate (ETR):* To get the employer take-up rate, 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  $E^{\text{newP}}/E_T$ , where  $E^{\text{newP}}$  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,  $ETR = (E^{\text{newP}}/E_p) \cdot (E_p/E_T)$ , where  $E_p$  is the number of employees with partners. The first term,  $E^{\text{newP}}/E_p$ , is just the partner take-up rate, since  $E_p$  is now the people with partners who are newly offered partner coverage. Thus,

The second term is the proportion of employees with partners, which we can calculate as an average for the whole workforce in the U.S. To simplify matters, we calculate this for 2002 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): 73% of people in same-sex couples and 69% of people in different-sex couples. Then we divide that estimate of employed partners by total employment 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 0.4% for same-sex partners and 1.3% to 2.1% 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 1.5% to 2.5% of current firm employment. Since employers pay a larger share of coverage for a single employee than for family coverage, the employer's costs will often rise by less than the percentage change in enrollment. Recent figures suggest that employer costs for family coverage are 88% of costs for single coverage.<sup>7</sup> Thus the high-end estimate of a 2.5% increase in

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<sup>7</sup> 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,"

enrollment would increase an employer's health insurance costs by roughly 2.2%. Providing domestic partner coverage for same-sex partners only would result in a lower estimated health insurance cost increase of 0.1% to 0.3%.

*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. 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 overall rate of uninsured partners, calculated from Table 2 as an average of 18.2% for male and female same-sex couples and 27.7% 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 8.9% and 14.2% for same- and different-sex partners, respectively.<sup>8</sup> 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 11.5% and 16.5% 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 about one-third to one-half.

Another way to think about this is to note that employers' failure to provide domestic partner coverage accounts for up to one-half of the uninsured people who have an unmarried partner.

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<sup>8</sup> Here we multiply the proportions uninsured (as measured 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.

Since federal, state, and local governments incur costs of covering health care expenses for uninsured people (Hadley and Holahan, 2003), then the increased costs to businesses are at least partly balanced out 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 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 insured person (Hadley and Holahan, 2003). The total savings to the federal government alone ranges from \$ 0.6 – 1.9 billion.<sup>9</sup>

## **Conclusion**

Employment based health insurance remains the most important source of health care coverage for non-elderly 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 gay, lesbian, and bisexual activists, in particular. Unmarried employees with long-term committed partners 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 Current Population Survey 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

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<sup>9</sup> If IRS 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 \$3781 per year, marginal tax rate of 15%, and payroll tax rate of 15.3%, the increase in tax receipts would be \$1.3 to 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 to 6.5 billion per year.

people in same-sex couples and different-sex couples by as much as 50%. 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, health care costs if they offered domestic partner benefits. This study demonstrates that roughly half of 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 thirteen to twenty-one 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 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% to 0.3% rise in enrollment. 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.

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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 Non-white	8.8	11.0%	12.4%	18%
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	51,682	38,685	53,007
Percent working full-time (men)*	72.2		72.2	90.8
Percent working full-time (women)*		74.3	66.1	55.0
Percent with at least one full-time worker in household	94.9	92.0	91.8	95.3

Source: Authors' tabulation of Current Population Survey Annual Social and Economic (ASEC) Supplement, pooled 1996-2003.

\*Adjusted for age and region.

Table 2. Health insurance status, by couple type.

	Same-sex male	Same-sex female	Unmarried different-sex	Married different-sex
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

Source: Authors' tabulation of Current Population Survey Annual Social and Economic (ASEC) Supplement, pooled 1996-2003.

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.

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)	0.117 (0.005)	0.110 (0.011)
25 to 34 years	0.036 (0.002)	0.029 (0.002)	0.070 (0.040)	0.030 (0.002)	0.012 (0.009)
45 to 54 years	-0.018 (0.002)	-0.021 (0.002)	-0.057 (0.034)	-0.020 (0.002)	-0.067 (0.011)
55 to 64 years	-0.004 (0.002)	-0.051 (0.002)	-0.074 (0.047)	-0.047 (0.002)	-0.150 (0.016)
Self full-time worker		-0.059 (0.002)	-0.172 (0.044)	-0.051 (0.002)	-0.145 (0.008)
Partner full-time worker		-0.049 (0.002)	0.016 (0.034)	-0.048 (0.002)	-0.026 (0.008)
Education		-0.0182 (0.0003)	-0.018 (0.006)	-0.0177 (0.0003)	-0.0269 (0.0079)
Any Children		-0.015 (0.002)	0.011 (0.048)	-0.0174 (0.0016)	-0.0139 (0.0073)
Income (thousands)		-0.000544 (0.0000112)	-0.000492 (0.000114)	-0.000513 (0.0000111)	-0.00139 (0.0000967)
Constant	0.107 (0.001)	0.237 (0.003)	0.371 (0.054)	0.230 (0.003)	0.489 (0.012)
Sample Size		365,400	964	337,574	26,862

Source: Authors' tabulation of Current Population Survey Annual Social and Economic (ASEC) Supplement, pooled 1996-2003.

Notes: Dependent variable is a 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 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 composite region of residence.

Table 4. LPM estimation of fair or poor health status.

	Men only	Men only	Women only	Women only
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 to 34 years	-0.028 (0.002)	-0.030 (0.002)	-0.021 (0.002)	-0.023 (0.002)
45 to 54 years	0.052 (0.002)	0.052 (0.002)	0.046 (0.002)	0.046 (0.002)
55 to 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		-0.097 (0.003)		-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	

Source: Authors' tabulation of Current Population Survey Annual Social and Economic (ASEC) Supplement, pooled 1996-2003.

Notes: Dependent variable is a 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.

Table 5. Coverage of partners of people with own-EBHI, by couple type.

	Same-sex	Married different-sex	Unmarried different-sex
Own-EBHI	70.8	23.8	63.3
Dependent-EBHI	5.8	54.8	3.6
Both Own and Dependent	0	15.7	0
Medicaid	2.8	0.5	4.6
Other Government Coverage	1.6	0.7	1.2
Private or other	4.5	0.7	3.2
None	14.5	4.0	24.0

Source: Authors' tabulation of Current Population Survey Annual Social and Economic (ASEC) Supplement, pooled 1996-2003.

Table 6: Partner take-up rate 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	20%	29%	41%	56%
Different-sex	27%	37%	29%	43%