Self-Rated Health at the Intersection of Sexual Identity and Union Status

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ABSTRACT

We examined self-rated health at the intersection of sexual identity and union status, further testing the role of socioeconomic status in explaining any health disparities. To do so, we used logistic regression models on nationally representative population-based data from the 2013 National Health Interview Survey conducted in the United States (N = 23,772). Findings show that all groups, except for gay/lesbian previously-married, reported higher odds of poor/fair health than the straight married. Socioeconomic status variables fully explained the difference between the straight married and the straight and gay/lesbian never-married, reduced (but did not fully explain) the difference between the straight married and the straight cohabiting and previously-married, and increased the difference between the straight married and the gay/lesbian cohabiting—this was especially true among women. The gay/lesbian cohabiting experienced worse self-rated health than the straight never-married. Differences in self-rated health exist at the intersection of sexual identity and union status in the United States, with some gender variations and with socioeconomic status explaining some effects but contributing to others. Findings highlight the need for interventions with lesbian cohabiting women.

Keywords: Sexual Minorities, Self-rated Health, Gender, Union Status

A growing body of research shows that gay and lesbian identified individuals experience worse self-rated health and health behavior than heterosexuals in the United States (Institute of Medicine, 2011). Minority stress theory shows that these disparities are due, in part, to socioeconomic disadvantage, social stigma, and unequal access to legal and institutional benefits (e.g., marriage) that contribute to increased stress and psychological distress (Hatzenbuelher et al., 2010; Meyer, 2003a,b). A separate body of research demonstrates significant union status gradients in health, wherein the married experience advantaged health over the cohabiting, previously-married, and to some extent never-married at the population level (Liu & Reczek, 2011; Waite & Gallagher, 2000), in part due to socioeconomic differentials across union status. Union status may similarly structure health across gay and lesbian identified groups, protecting some gay and lesbian adults and further disadvantaging others. Yet, we know of no studies examining how the intersection of sexual identity and union status (i.e., "sexual partnership status") matters for self-rated health—a broad and inclusive measure of well-being—at the national level. Disparity in self-rated health at the intersection of sexual identity and union status is a critical question in understanding the health of sexual minorities, particularly given contemporary debates about the importance of marriage in the U.S.

A small but growing body of research has begun to examine the potential relationship between union status, sexual identity, and health. Recent national, population-based studies that examine self-rated health across individuals in same-sex and different-sex unions show that same-sex cohabitors experience similar self-rated health when compared to the different-sex cohabiting and disadvantaged health relative to the different-sex married (Boehmer, 2002). However, these studies do not identify whether sample respondents are gay, lesbian, or straight identified—a significant limitation that does not insure that same-sex households are in fact gay

and lesbian households. Moreover, previous research on the general population shows that the non-married are not homogenous, wherein the general population of cohabiting, never-married single, and previously-married single experience unique health outcomes (Liu & Reczek, 2011; Liu & Umberson, 2008; Urquia et al., 2013). For example, previous research shows that cohabitors report better self-rated health than the previously-married, but worse self-rated health than the never-married in the general population (Liu & Reczek, 2011; Wiliams & Umberson, 2013); differences appear to be partially driven by socioeconomic dissimilarities across groups (Waite & Gallagher, 2000). Yet, these studies do not differentiate gay, lesbian, and straight individuals within the unmarried. Recent research from state-level data in California shows that married and partnered gay, lesbian, and bisexual persons show less psychological distress than the unmarried gay, lesbian, and bisexual persons (Conron et al., 2010; Wight, LeBlanc, & Badgett, 2012; Wight, LeBlanc, De Vries, & Detels, 2012). Yet, these studies fail to differentiate gay, lesbian, and straight- identified never-married and previously-married individuals at the population level. Drawing on minority stress theory (Meyer, 2003a,b) gay and lesbian never-married, previously-married, and cohabiting likely experience increased stress due to discrimination and homophobia, and thus a self-rated health disadvantage relative to the straight cohabiting, never-married, and previously-married.

The purpose of the present study was to examine the self-rated health differences at the intersection of sexual identity and union status at the national level. To do so, we explore whether the union status gradient for self-rated health holds true across gay, lesbian, and straight-identified people. The 2013 population-based nationally representative National Health Interview Survey (NHIS) is among the first datasets in the United States that allows for the comparison of self-rated health across sexual partnership status at the population-based level (Ward et al.,

2013). Moreover, research posits that socioeconomic status is a key factor that links union status and health (Link & Phelan, 1995; Light, 2004), and socioeconomic status appears to explain some differences between same-sex cohabiting couples and their different-sex married and cohabiting counterparts on self-rated health and health behavior (Denney et al., 2013; Liu et al., 2013; Reczek, Liu, & Brown, 2014; Reczek, Liu, & Spiker, 2014). Therefore, our second objective is to assess how socioeconomic status contributes to self-rated health differences across sexual partnership status. Third, due to research that suggests the relationship between union status and health is gendered (Liu et al., 2013; Light, 2004), and that lesbians appear to experience greater health disadvantage relative to their heterosexual counterparts relative to gay men (Liu et al., 2014; Light, 2004), we examine gender differences in health disparities across sexual partnership status.

METHODS

We used newly released data from the 2013 Integrated NHIS (Minnesota Population Center 2013). This data set presents a unique opportunity to explore the intersection of sexual identity and union status (i.e., "sexual partnership status") at the population level. The NHIS is a cross-sectional household survey conducted annually in the United States by the National Center for Health Statistics (NCHS); it is representative of the United States civilian non-institutionalized population (NHIS, 2012). We limited our analyses to respondents between the ages of 18 and 65. We also excluded about 9.2% of respondents because of missing values on key variables included in the analysis. Our final analytic sample (N = 23,772) contained 165 individuals identified as gay/lesbian cohabitors, 285 individuals identified as gay/lesbian never-married, and 49 individuals identified as gay/lesbian previously-married. The gay/lesbian cohabiting group also included individuals who identify as married. We combined gay/lesbian

married individuals (n = 58) with the gay/lesbian cohabiting (n = 107) as one group to achieve a sufficient sample size for analysis and because of the unclear meaning of marriage among gays and lesbians in our sample. For example, it is unclear whether respondents are legally married in the state that they currently reside, if they call themselves married because they have had a commitment ceremony but not legal marriage, or if they identify as married because they are in a long-term committed relationship with no legal standing (Reczek et al., 2009). However, we ran supplementary analyses with the gay/lesbian married and gay/lesbian cohabiting as separate groups (available upon request), and those results show similar patterns as those we report in the paper.

Measures

Sexual Partnership Status. The 2013 wave of the NHIS is the first wave of data to provide information on the sexual identity of respondents. All adults in the NHIS were asked, "Which of the following best represents how you think of yourself?" Five response options were provided. For male respondents, they were: (1) Gay, (2) Straight, that is, not gay, (3) Bisexual, (4) Something else, and (5) I don't know the answer. For female respondents, response option (1) was worded "Lesbian or gay," and response option (2) was worded "Straight, that is, not lesbian or gay." Our analysis was restricted to respondents who identify as either "gay/lesbian" or "straight, that is, not gay/lesbian." We did not include bisexual, something else, and I don't know answer categories in our analysis due to small numbers in these categories across some union status categories. In terms of union status, NHIS included: *currently married*, *previously-married* (includes both widowed, separated, and divorced individuals), *never-married*, and *currently cohabiting*. We considered the intersection of union status and sexual identity and categorized them into six sexual partnership status categories: straight married (the reference), straight

cohabiting, straight never-married single, straight previously-married, gay/lesbian cohabiting, gay/lesbian never-married single, and gay/lesbian previously-married.

Self-rated health. Our dependent variable was self-rated health. Respondents rated their overall health as excellent, very good, good, fair, or poor. We recoded self-rated health into a dichotomous variable (1 = poor or fair health; 0 = excellent, very good, or good health). Prior research indicates that self-rated health is an irreplaceable dimension of health status and it is a robust predictor of subsequent disability and mortality (Idler & Benyamini, 1997).

Socioeconomic Status. We examined three measures of socioeconomic status (SES) as potential mediators: income-to-needs (0 = less than 100% of federal poverty level, 1 = 100% to 199%, 2 = 200% to 399%, 4 = 400% and greater), insurance status (0 = no health insurance coverage during the past 12 months (reference), 1 = covered by at least one public or private health care insurance program during the past 12 months), and employment status (employed (reference), employed but not in work, unemployed, not in labor force).

Other demographic covariates. Models also controlled for several demographic characteristics as potential confounders (Rosenfeld, 2007) including: race-ethnicity (non-Hispanic white, non-Hispanic black, Hispanic white, Hispanic black, and other with white as the reference), age in years, nativity status (0 = Born in US or US territory, 1 = Born outside US or US territory), and region of residence (Northeast (reference), Midwest/north central, south, west). We also included education (0 = less than high school, 1 = high school or equivalent, 2 = some college, 3 = Associate's degree, 4 = Bachelor's degree, and 5 = graduate/professional degree) as a control covariate, treated continuously in our model (we ran it both as a continuous and categorical variable with similar results). We include education as a demographic covariate instead of an SES measure because of concerns of endogeneity. That is, people with higher

levels of education may be more likely to self-identify as gay/lesbian and enter in a marriage than people with lower levels of education.

Analytic Strategy

We estimated three nested binary logistic regression models. The first model regresses poor or fair self-rated health across sexual partnership status, age, race-ethnicity, nativity status, region, and education. This model establishes whether differences across sexual partnership status groups net of basic demographic controls. In the second model, we added additional controls for poverty status, employment status, and health insurance coverage to examine the extent to which of these SES factors contributes to differences in self-rated health between same-sex cohabitors and other union status groups. We conducted post-hoc tests (Wald *F*-tests) to compare coefficients from Models 1 and 2 to evaluate whether controlling for SES significantly altered the association between sexual partnership status and self-rated health. These analyses indicated that all of the changes observed in the union status coefficients between Models 1 and 2 were statistically significant ($p \leq .001$). Finally, our third model introduces a series of interaction terms for gender by sexual partnership status in order to explore whether significant gender variations exist in the association between sexual partnership status and self-rated health. The heterosexual married are the reference group for the primary analysis; however, we rotated reference groups across all categories to test differences across all sexual partnership status groups. All analyses were weighted to account for the inverse probability of selection into the sample and post-stratification based on age, race-ethnicity, and gender. The "svy" commands in Stata were used to account for the complex nature of the NHIS sample design (StatCorp, 2013).

RESULTS

Descriptive Results

Descriptive results in Table 1 suggest that the straight never-married (8.7%) are the group least likely to report poor/fair health, followed by straight married (9.8%), gay/lesbian never-married (11.3%), straight cohabiting (11.4%), gay/lesbian cohabiting (12.9%), and gay/lesbian previously-married (15.1%). Straight previously-married (21.5%) are most likely to report poor/fair health among all union groups.

Regression Results

Table 2 shows estimated regression coefficients from logistic regression models to predict poor/fair health. As presented in Model 1 (Table 2), straight cohabiting (OR = 1.57, 95% CI=1.28 – 1.94), straight never-married (OR = 1.50, 95% CI= 1.28 – 1.77), straight previously-married (OR = 1.80, 95% CI = 1.59 – 2.03), gay/lesbian cohabiting (OR = 2.03, 95% CI= 1.03 – 3.98), and gay/lesbian never-married (OR = 1.94, 95% CI = 1.14 – 3.29) all had higher odds of reporting poor/fair health than the straight married after controlling for demographic covariates. The gay/lesbian previously-married (OR=1.50, 95% CI= 0.60 – 3.75) were the only group not significantly different from the straight married in reporting health. In additional analyses using the straight never-married as the reference group (not shown), the straight previously-married had higher odds of reporting poor/fair health than the straight never-married (OR = 1.19, 95% CI = 1.00 – 1.42).

As presented in Model 2 of (Table 2), after controlling for SES, the differences of straight never-married and gay/lesbian never-married in comparison to the straight married both became insignificant. This suggests that SES explains these differences. Again as shown in Model 2 (Table 2), after controlling for SES the differences of straight cohabiting and straight previously-married in comparison to the straight married were both reduced in magnitude by about 43% and 44% respectively, but remained statistically significant at the levels of $p < 0.05$ and $p < 0.001$

respectively. In contrast, in Model 2, adding controls of SES actually increased the difference between the gay/lesbian cohabiting and straight married. Thus, SES did not explain this difference. Note, our additional analysis by using the gay/lesbian cohabiting as the reference group (not shown) also suggested that the straight never-married were even less likely to report poor/fair health than the gay/lesbian cohabiting after controlling SES (OR = 0.40, 95% CI = 0.20 – 0.83). Additional analyses using the straight never-married as the reference group (not shown) show that when controlling for SES, the straight cohabiting (OR = 1.26, 95% CI = 1.02 – 1.56), straight previously-married (OR = 1.34, 95% CI = 1.11 – 1.61), and gay/lesbian cohabiting (OR = 2.48, 95% CI = 1.21 – 5.08) all experienced higher odds of poor/fair health than the straight never-married.

As presented in Model 3 (Table 2) we added gender interactions with sexual partnership status. The significant interaction of gender with gay/lesbian cohabiting status suggests that gay cohabiting men did not differ significantly from straight married men in odds of reporting poor health (OR = 0.83, 95% CI = 0.23 – 2.95), while lesbian cohabitors tended to have higher odds of reporting poor health compared to straight married women (OR = 0.83 * 5.34 = 4.43, 95% CI= 1.88 – 10.60); this gender difference was statistically significant ($p < 0.05$). This suggests that the significant differences between gay/lesbian cohabiting and straight married people in Models 1 and 2 were driven primarily by lesbians' health disadvantage.

DISCUSSION

There are clear sexual identity gradients in health, wherein gays and lesbians experience worse health than straight individuals (IOM, 2013; Cochran & Mays, 2007), and robust union status gradients in health wherein the married experience advantaged health over unmarried (Liu & Reczek, 2012). We merge these two research areas to explore self-rated health disparity at the

intersection of sexual identity and union status (i.e., sexual partnership status)—an unexplored research question at the population level. Our analysis of newly-released population-based nationally representative data show that the lesbian/gay cohabiting are disadvantaged relative to the straight married and straight never-married, and that this difference is driven at least partially by disparities among women. No disadvantages are found among the lesbian/gay never-married and previously-married once controlling for socioeconomic status. Findings point to the need for attention to diversity of health risk within the category of sexual minorities (IOM, 2013); in this case, policy and intervention attention is needed towards lesbian women in cohabiting relationships who are disadvantaged relative to other groups even after controlling for SES.

We first compared the straight married to all other sexual partnership status groups. Before controlling for SES, we find the straight married report better self-rated health than the straight and gay/lesbian cohabiting, straight and gay/lesbian never-married single, and the straight previously-married; gay/lesbian previously-married report similar health to the straight married groups, although this is possibly due to the small sample size of the gay/lesbian never-married. Controls for SES (i.e., employment, poverty status, and health insurance coverage) explain the difference between the straight married and both straight and gay/lesbian never-married, and reduce (but do not fully explain) the difference between the straight married and the straight cohabiting and previously-married. These findings are in line with previous research suggesting that there is a marital advantage in self-rated health that is attributable, at least in part, to SES (Drefahl, 2012). That is, it is higher levels of employment and health insurance and lower poverty status are associated with sexual partnership status, and it is these factors that underlie the health disparity found for disadvantaged groups. However, adding our controls for SES *increases* the difference between the straight married and the gay/lesbian cohabiting. It appears,

then, that lesbian and gay cohabitors' relatively high SES actually protects this group to some degree; without their current levels of SES, gay and lesbian cohabitors would experience even greater self-rated health disadvantage relative to the straight married (Denney et al., 2013; Liu et al., 2013). This disadvantage, protected but not erased by higher levels of SES, is likely a result of minority stress factors, including lack of access to same-sex marriage and increased discrimination and stigma due to a sexually stigmatized status (Meyer, 2003ab). With this finding in mind, future research and public policy should work to identify the factors that disadvantage gay and lesbian cohabitors—especially those with low SES— to attempt to ameliorate these negative effects.

Next, we compared all other sexual partnership status groups to one another. Results show that the lesbian/gay cohabiting report worse self-rated health than the straight never-married group both before and after controlling for SES. This suggests that the gay and lesbian cohabiting are disadvantaged relative to the straight never-married, but not different than other non-married groups. Notably, the straight never-married also report better self-rated health than the straight previously-married and straight cohabiting. These findings adds the recent body of research showing the straight never-married experience a health benefit relative to not only straight non-marrieds but also some gay and lesbian non-married groups (Liu & Reczek, 2012). This finding further demonstrates the potential disadvantages faced by lesbian/gay cohabitors relative not only to the straight married but also the straight never-married. Policy should take this into account with envisioning programs to ameliorate disadvantages in gay and lesbian health outcomes. Comparisons of the self-rated health across other non-married union statuses show no differences.

Finally, because men and women have distinct socioeconomic, sexual partnership status, and self-rated health patterns, we further suspected that these patterns would differ for men and women. Indeed, we find that the effects of sexual partnership status across gay/lesbian and straight identified individuals are stronger among women than men. Results show that gay cohabiting men do not differ significantly from straight married men in odds of reporting poor health, while lesbian cohabitors tend to have higher odds of reporting poor health compared to straight married women. This suggests that the significant differences between gay/lesbian cohabiting and straight married people are driven primarily by lesbian women's relative health disadvantage. This finding adds to a growing body of work suggesting that not all sexual minorities experience health disadvantage; rather, there are important points of variation—in this case, gender—that drive sexual minority disadvantages across union status. For example, women in same-sex relationships are far less likely than women in different-sex relationships to have health insurance, a checkup in the past year, and have unmet medical needs (Buchmueller & Carpenter, 2010; Heck, Sell, & Sheinfeld-Gorin, 2005). Thus, being in a cohabiting relationship may not protect lesbian women from health disadvantage relative to their married counterparts. We suggest that future research and policy should take into account the intersection of not only sexual identity and union status but also gender in attempts to uncover and most effectively ameliorate health disparities.

Limitations and Conclusion

This study is among the first to explore whether the union status gradient holds true across gay, lesbian, and straight identified people at the population level, finding that there are some important sexual partnership status differences that vary by gender. However, limitations exist. First, we did not include measures of bisexual men and women because of too few cases in

our sample. We expect that with additional forthcoming waves of data we will be able to report the effects of union status on self-rated health among bisexual women; this is an important endeavor as research shows that bisexual women are disadvantaged relative to lesbian and straight women (Fredriksen-Goldsen, 2010; Przedworski et al., 2014). Second, we did not separate out lesbian/gay married individuals due to sample size issues and a lack of clarity as to whom the lesbian/gay married group are in relation to the myriad of same-sex marriage laws in the U.S. today. We do conduct analysis with lesbian/gay cohabitors and lesbian/gay married people in separate groups, and findings are consistent with the presented findings (available upon request). There is also likely race and age variation in the relationship between union status and self-rated health across sexual identity; however, sample size prohibits us from testing race and age interactions. We were also unable to address issues of causality with our cross-sectional data.

The present study, in spite of limitations, provides the first population-based study of how union status matters for self-rated health by sexual identity and gender. We believe this study opens new research questions to be addressed on this topic by providing novel and robust evidence on the importance of one's sexual partnership status; union status appears to be an important marker of inequality in the gay/lesbian population, protecting some gay and lesbian adults and disadvantaging others. It may be that new access to same-sex marriage will shape the nature of self-rated health across the gay and lesbian population, possibly ameliorating some of the negative consequences of the gay/lesbian cohabiting—particularly lesbian cohabiting—relative to the straight married and straight never-married in the US (Mays & Cochran, 2001). Future efforts to increase access to socioeconomic resources that boost well-being among disadvantaged gay/lesbian union status groups is critical, especially as we show that SES protects gay/lesbian cohabitors from having even worse relative health (Buffie, 2011; Mayer, 2008). It

will also be important to target other modifiable factors, such as increased discrimination and victimization, which are strongly correlated with poorer health among gay/lesbian populations in past research (Meyer, 2003ab).

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Table 1

Descriptive Statistics by Sexual Partner Status

Variable	Straight Married	Straight Cohabiting	Straight Never-Mar	Straight Prev-Mar	Gay/Lesb Cohabiting	Gay/Lesb Never-Mar	Gay/Lesb Prev-Mar	Total
Health (Percent)								
Excellent/Very Good/Good	90.2	88.6	91.3	78.5	87.1	88.7	84.9	88.8
Poor/Fair	9.8	11.4	8.7	21.5	12.9	11.3	15.1	11.2
Sex (Percent)								
Male	49.7	50.7	53.0	40.4	42.9	63.2	44.6	49.4
Female	50.3	49.3	47.0	59.6	57.1	36.8	55.4	50.6
Race (Percent)								
NH White	67.9	60.7	55.5	64.5	76.9	61.7	75.1	63.9
NH Black	7.5	13	19.7	15.8	6.0	15.3	11.0	12.0
Hispanic White	15.1	18.7	15.2	12.5	13.6	10	9.0	15.0
Hispanic Black	0.4	1.0	0.7	0.4	0.4	1.3	1.3	0.5
Other	9.2	6.6	8.9	6.8	3.0	11.6	3.5	8.6
Foreign Born (Percent)								
No	77.0	86.0	86.2.0	85.0	88.5	90.2	96.0	81.2
Yes	23.0	14.0	13.8	15.0	11.5	9.8	4.0	18.8
Region (Percent)								
Northeast	17.1	15.8	18.5	15.0	21.9	15.7	13.9	17.1
North Central/Midwest	22.7	25.1	22.6	21.2	17.9	18.8	12.4	22.6
South	36.9	33.5	34.8	42.8	30.1	37.7	54.6	36.9
West	23.2	25.7	24.1	21.0	30.1	27.8	19.0	23.4
Insured (Percent)								
No	14.6	30.6	25.3	23.3	14.2	19.9	12.9	19.6
Yes	85.4	69.4	74.7	76.7	85.8	80.1	87.1	80.4
Employment Status (Percent)								
Employed	70.5	70.2	63.2	63.7	77.8	70.7	56.3	67.9

Employed, but not at work	3.2	2.2	1.6	2.8	5.3	1.3	0.0	2.7
Unemployed	3.9	7.2	11.0	6.1	5.7	9.1	10.0	6.2
NILF	22.4	20.4	24.1	27.4	11.2	18.9	33.8	23.2
Income-to-Needs (Mean)	2.2	1.7	1.6	1.6	2.4	1.8	1.6	1.9
Age (Mean)	45.1	35.1	29.8	49.6	42.9	35.7	47.8	41.1
Education (Mean)	2.6	2.0	2.1	2.1	3.0	2.5	2.6	2.3
N	10,407	1,656	6,521	4,689	165	285	49	23,772

Table 2.

Estimated Coefficients from Logistic Regression Models to Predict Poor/Fair Health (N = 23,772)

Variables	Model 1			Model 2			Model 3		
	OR	95% CI		OR	95% CI		OR	95% CI	
Union Status									
Straight Cohabiting	1.57***	1.28	1.94	1.30[b]	1.05	1.60	1.29[b]	0.95	1.74
Straight Never-married	1.50***[c]	1.28	1.77	1.03[acd]	0.86	1.23	0.90[ac]	0.71	1.14
Straight Previously-married	1.80***[b]	1.59	2.03	1.38***[b]	1.19	1.60	1.31*[b]	1.06	1.63
L/G Partnered	2.03*	1.03	3.98	2.56*[b]	1.26	5.20	0.83	0.23	2.95
L/G Never-married	1.94*	1.14	3.29	1.46	0.80	2.66	1.51	0.68	3.35
L/G Previously-married	1.50	0.60	3.75	0.80	0.30	2.08	1.26	0.31	5.11
Sex									
Female	1.08	0.97	1.20	0.86*	0.76	0.97	0.79**	0.66	0.93
Race/ethnicity									
Non-Hispanic Black	1.61***	1.40	1.86	1.37***	1.17	1.60	1.35***	1.16	1.58
Hispanic White	1.27*	1.04	1.55	1.16	0.94	1.44	1.16	0.93	1.44
Hispanic Black	1.14	0.57	2.27	1.15	0.55	2.40	1.14	0.54	2.38
Other	1.46***	1.18	1.79	1.23	1.00	1.53	1.23	0.99	1.52
Education (6 Category)									
Education	0.68***	0.65	0.71	0.83***	0.80	0.86	0.83***	0.79	0.86
Foreign Born									
Foreign Born	0.78*	0.64	0.95	0.76**	0.63	0.93	0.76	0.63	0.93
Region									
Midwest/North Central	1.01	0.82	1.25	0.93	0.74	1.16	0.93	0.74	1.16
South	1.14	0.95	1.37	1.09	0.90	1.33	1.10	0.90	1.34
West	1.01	0.82	1.23	0.95	0.76	1.17	0.95	0.77	1.18
Age (Single Years)									
Age	1.05***	1.04	1.05	1.05***	1.04	1.05	1.05	1.04	1.05
Income-to-Needs (4 Category)									
Income-to-Needs				0.59***	0.56	0.63	0.60***	0.56	0.64

Insurance Status						
Insured	1.07	0.91	1.25	1.06	0.91	1.24
Employment Status						
Employed, but Not at Work	2.76***	1.98	3.85	2.78***	1.99	3.89
Unemployed	1.91***	1.52	2.41	1.92***	1.52	2.42
Not in Labor Force	3.91***	3.44	4.44	3.97***	3.48	4.53
Interactions						
Straight Cohabiting * Female				1.00[d]	0.65	1.54
Straight Never-married * Female				1.30	0.97	1.75
Straight Previously-married * Female				1.10[d]	0.84	1.44
L/G Cohabiting * Female				5.34*[ac]	1.13	25.16
L/G Never-married * Female				0.87	0.28	2.71
L/G Previously-married * Female				0.35[d]	0.05	2.27
F	90.32***		187.45***		1.51	

Note: 95% confidence intervals shown in parentheses. Total sample size was N = 23,772.

* differs from Straight Married ($p < 0.05$), two-tailed. ** differs from Straight Married ($p < 0.01$), two-tailed. *** differs from Straight Married ($p < 0.001$), two-tailed. [a] differs from Straight Cohabiting ($p < 0.05$), two-tailed. [b] differs from Straight Never-married ($p < 0.05$), two-tailed. [c] differs from Straight Previously-married ($p < 0.05$), two-tailed. [d] differs from Lesbian/Gay Partnered ($p < 0.05$), two-tailed. [e] differs from Lesbian/Gay Never-married ($p < 0.05$), two-tailed.