

Same-Sex Cohabitors and Health: The Role of Race-Ethnicity, Gender, and Socioeconomic Status

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Hui Liu¹, Corinne Reczek², and Dustin Brown³

Abstract

A legacy of research finds that marriage is associated with good health. Yet same-sex cohabitators cannot marry in most states in the United States and therefore may not receive the health benefits associated with marriage. We use pooled data from the 1997 to 2009 National Health Interview Surveys to compare the self-rated health of same-sex cohabiting men ($n = 1,659$) and same-sex cohabiting women ($n = 1,634$) with that of their different-sex married, different-sex cohabiting, and unpartnered divorced, widowed, and never-married counterparts. Results from logistic regression models show that same-sex cohabitators report poorer health than their different-sex married counterparts at the same levels of socioeconomic status. Additionally, same-sex cohabitators report better health than their different-sex cohabiting and single counterparts, but these differences are fully explained by socioeconomic status. Without their socioeconomic advantages, same-sex cohabitators would report similar health to nonmarried groups. Analyses further reveal important racial-ethnic and gender variations.

Keywords

gender, race-ethnicity, same-sex cohabitation, self-rated health, socioeconomic status

Marriage has long been shown to promote mental and physical well-being (Waite and Gallagher 2000). Yet most of the roughly 646,000 same-sex cohabitators in the United States do not have the option of legally marrying their partners (U.S. Census Bureau 2011). A recent report from the Institute of Medicine (2011) suggests that a lack of access to legal marriage may facilitate poorer health among same-sex cohabitators compared with their different-sex married counterparts because of reduced socioeconomic, psychosocial, and institutional resources.¹ Despite the plausibility of this claim, little empirical research has examined whether same-sex cohabitators have worse health relative to different-sex married people. Moreover, if same-sex cohabitators have worse health than different-sex married individuals, it is unclear whether same-sex cohabitators experience diminished health outcomes analogous to different-sex cohabitators whose relationships also lack the

socioeconomic, psychosocial, and institutional benefits that coincide with marriage (Carr and Springer 2010). Alternatively, same-sex cohabitators may report health that is more similar to other single groups, such as the divorced, widowed, and never married, who each have relatively worse health than the married as a result of greater stress and fewer resources (Waite and Gallagher 2000).

The main objective of the present study is to comprehensively compare the self-rated health of

¹Michigan State University, East Lansing, MI, USA

²University of Cincinnati, Cincinnati, OH, USA

³The University of Texas at Austin, Austin, TX, USA

Corresponding Author:

Hui Liu, Michigan State University, Department of Sociology, Berkey Hall, 509 E. Circle Drive 316, East Lansing, MI 48824-1111, USA.

E-mail: liuhu@msu.edu

same-sex cohabitators with that of individuals in other union statuses, including the different-sex married, different-sex cohabiting, and the unpartnered divorced, widowed, and never-married single.² Because research posits that socioeconomic status (SES) is a key factor that links union status and health (Waite and Gallagher 2000), our second objective is to assess how SES contributes to self-rated health differences between same-sex cohabitators and those in other union statuses. Finally, given substantial racial-ethnic and gender differences in family processes and health (Brown, Van Hook, and Glick 2008), our third objective is to explore gender and racial-ethnic variations in these associations.

BACKGROUND

Previous research on same-sex cohabitation and well-being has been predominantly qualitative in nature or based on small, community-based, non-representative surveys with primarily white and high-SES samples; thus, it is difficult to generalize conclusions from this body of research to the population as a whole (Patterson 2000). A number of these studies have found no discernible differences when comparing gay, lesbian, and heterosexual populations (typically defined by sexual identity) on a variety of outcomes (e.g., relationship quality, psychological adjustment, child well-being) (Kurdek 2004; Patterson 2000). Although data limitations remain a major obstacle to population-based research in this area, recent developments provide an opportunity to identify same-sex cohabitators in large survey data sets. For example, by merging three data sets, Wienke and Hill (2009) found that same-sex cohabitators, different-sex married persons, and different-sex cohabitators reported similar levels of self-rated health. Although informative, this work is limited by inconsistencies in measurements and ambiguity of representative populations because of the combination of three different surveys, each with its own survey design and sampling method. In contrast to Wienke and Hill's research, other population-based studies have revealed that in comparison with their different-sex married counterparts, individuals in same-sex cohabiting relationships tend to have more physical health problems, such as human immunodeficiency virus infection (Campsmith et al. 2010), asthma (Heck and Jacobson 2006), activity limitations, and cardiovascular diseases (Conron, Mimiaga, and Landers 2010). Taken together, previous research

provides few consistent population-based findings on the general health of same-sex cohabitators relative to their different-sex married or cohabiting counterparts.

Recent research emphasizes the need to incorporate the complete range of nonmarried individuals, including the divorced, widowed, and never-married single, to fully understand the relationship between union status and health (Liu and Reczek 2012; Liu and Umberson 2008), yet few studies have compared the health of same-sex cohabitators with that of individuals in these single groups. Additionally, previous empirical research on same-sex cohabitation and health has tended to either ignore socioeconomic, racial-ethnic, and gender dynamics or has simply included these factors as control covariates (Institute of Medicine 2011). Consequently, previous research has not fully addressed how these factors work together to influence health differences between same-sex cohabitators and other union status groups. To address these issues, we draw on theoretical and empirical research concerning SES, racial-ethnic, and gender differences in health to compare the health status of same-sex cohabitators with that of other union status groups.

Same-Sex Cohabiting versus Different-Sex Married: SES, Gender, and Race-Ethnicity Hypotheses

SES is a "fundamental cause" of health disparities; higher levels of SES, most often measured by income and education, uniquely promote access to valued material (e.g., economic goods) and non-material (e.g., sense of control) resources that enhance mental and physical well-being (Link and Phelan 1995). Previous population-based research suggests that same-sex cohabitators are more educated than their different-sex married counterparts (Black et al. 2000; Gates and Ost 2004), possibly because of selection processes in which only the most educated gays and lesbians are able or willing to cross social boundaries and publically enter into same-sex cohabiting relationships (Ohlander, Batalova, and Treas 2005; Rosenfeld 2007). However, same-sex cohabitators earn less than different-sex married persons, possibly because of workforce discrimination (Badgett 2001). Income differentials between same-sex cohabitators and different-sex married persons are further exacerbated because same-sex cohabitators are restricted from marrying and are thus unable to access financial benefits accrued with marriage (e.g., state and

federal tax breaks). Therefore, even same-sex cohabitators whose gross incomes are identical to those of different-sex married persons may have less disposable income (Institute of Medicine 2011). Additionally, because of their inability to legally marry, same-sex cohabitators may experience barriers to obtaining insurance benefits via an employed spouse (Heck, Sell, and Gorin 2006). This in turn increases out-of-pocket costs associated with the receipt of health care services, creating a financial barrier to timely, high-quality health care (Heck et al. 2006). Taken together, we propose the following hypotheses:

Hypothesis 1: Same-sex cohabitators will have worse health than their different-sex married counterparts.

Hypothesis 1a: These differences are due partially to same-sex cohabitators' lower levels of SES.

Importantly, however, the mechanisms linking different-sex marriage and health are gendered. Women are more likely than men to experience health benefits from increased economic resources via their spouses' earnings in different-sex marriage (Waite and Gallagher 2000). Because men on average earn more than women, it may be that two men in a same-sex relationship experience even greater economic resources, and thus better health, than different-sex married men, whereas two women in a same-sex relationship experience relatively fewer economic resources, and thus worse health, than women in different-sex marriages. However, studies have shown that men in same-sex relationships earn significantly less than men in different-sex marriages with the same levels of education, whereas women in same-sex relationships are not significantly disadvantaged in terms of income compared with women in different-sex marriages (Black, Sanders, and Taylor 2007; for contrary evidence, see Badgett 2001). Moreover, married men receive psychosocial benefits from marriage because their wives tend to maintain social networks, provide emotional support, and regulate health behaviors, while men provide fewer such resources to their spouse (Reczek and Umberson 2012). The gendered norms found in different-sex marriages suggest that men in same-sex cohabiting relationships would obtain relatively fewer, and women in same-sex relationships relatively more, psychosocial resources from their partner. Thus, we hypothesize that:

Hypothesis 1b: If same-sex cohabitators report worse health than different-sex married persons, the gap will be larger among men than women.

Race-ethnicity may further complicate these dynamics. Because married non-Hispanic black (hereafter "black") or Hispanic men earn less than married non-Hispanic white (hereafter "white") men, black and Hispanic women in racially homogenous marriages may not receive the same financial boost from marriage as their white female counterparts (Cohen 1999; Edin and Kefalas 2005). Therefore, the socioeconomic, and thus health, dividends of marriage may be less pronounced among blacks and Hispanics than whites, perhaps especially among women (Liu and Reczek 2012). Moreover, recent research suggests that black and Hispanic men and women are less likely than white men and women to participate in a same-sex cohabiting relationship (e.g., Herek et al. 2010), possibly because of higher levels of homophobia in the black and Hispanic communities (Bonilla and Porter 1990; Herek et al. 2010; Institute of Medicine 2011; Lewis 2003; Loftus 2001; Ramirez-Valles et al. 2010). This suggests that only the most socioeconomically advantaged black and Hispanic individuals are able to openly live in same-sex relationships. Thus, the selection process of individuals with higher SES into same-sex cohabitation may be more pronounced among blacks and Hispanics than whites, which could reduce the potential health disadvantage of black and Hispanic same-sex cohabitators in comparison with their different-sex married counterparts. Taken together, we expect that:

Hypothesis 1c: If same-sex cohabitators report worse health than different-sex married persons, the gap will be more pronounced among whites and less pronounced among blacks and Hispanics.

Same-Sex versus Different-Sex Cohabiting: SES, Gender, and Race-Ethnicity Hypotheses

Same-sex and different-sex cohabitators alike lack the socioeconomic, psychosocial, and institutional protections for their relationships reportedly found in marriage—these protections are argued to be a key factor explaining the health benefits of marriage (Waite and Gallagher 2000). Such analogous contexts suggest that same-sex and different-sex

cohabitators may in turn have similar health outcomes. Yet despite this commonality, same-sex cohabitators are distinguished from different-sex cohabitators in significant ways. Different-sex cohabitators are more likely to be in short-term relationships with less commitment (Waite and Gallagher 2000), whereas same-sex cohabitators as a group are more likely to include longer term cohabitators with higher levels of commitment because of the illegality of same-sex marriage (Reczek, Elliott, and Umberson 2009; but also see Lau 2012). Therefore, same-sex cohabitators as a whole may be more likely to share socioeconomic and psychosocial resources than different-sex cohabitators (Reczek and Umberson 2012). Resource pooling and relationship commitment are important because they increase relationship stability; persons in stable, high-quality relationships have better mental and physical health than those in unstable, lower quality relationships (Umberson and Montez 2010). Moreover, same-sex cohabitators generally have higher SES than different-sex cohabitators (Black et al. 2007), possibly because of the considerable socioeconomic, psychosocial, and institutional resources that may be necessary to transverse social boundaries to publically enter into a same-sex cohabiting relationship (Meyer 2003; Rosenfeld 2007). Taken together, we propose the following hypotheses:

Hypothesis 2: Same-sex cohabitators will have better health than different-sex cohabitators.

Hypothesis 2a: These differences are due partially to same-sex cohabitators' higher levels of SES.

Once again, these dynamics likely vary by gender and race-ethnicity. In comparison with same-sex cohabiting women, same-sex cohabiting men tend to have longer relationship durations (Andersson et al. 2006; but also see Lau 2012). This could indicate that same-sex cohabiting men on average may be more committed to their partners and more likely to share socioeconomic and psychosocial resources that promote health than same-sex cohabiting women. Moreover, studies suggest that men's economic circumstances are more influential than women's in union formation decisions (Oppenheimer 1988; also see Sweeney 2002). Cohabitation is more common among lower SES heterosexual men (Smock 2000),

whereas gay men with higher SES are more likely to cohabit rather than remain single (Rosenfeld 2007). These socioeconomic differentials may contribute to health differences between same-sex and different-sex cohabiting men. Both lesbian and heterosexual women's SES appears to be less important for union formation (Oppenheimer 1988; also see Sweeney 2002), which may level off health differences between same-sex and different-sex cohabiting women. Taken together, we expect that:

Hypothesis 2b: If same-sex cohabitators report better health than different-sex cohabitators, the gap will be larger among men than women.

Additionally, blacks and Hispanics are more likely than whites to live in different-sex cohabiting unions (Brown et al. 2008), suggesting that cohabitation (either same-sex or different-sex) may have different meanings and dynamics that are linked to health across racial-ethnic groups. Whites are the most likely to marry their different-sex cohabiting partners, and therefore different-sex cohabitation for this group may be more of a trial marriage (Thornton, Axinn, and Xie 2007). In contrast, different-sex cohabitations, and perhaps also same-sex cohabitations, tend to be an alternative to marriage and perhaps more "marriage-like" for blacks and Hispanics (Brown et al. 2008; Thornton et al. 2007). Therefore, same-sex and different-sex cohabitation may be more similar to different-sex marriage for blacks and Hispanics and thus mirror the process of different-sex marriage in promoting health. This suggests that:

Hypothesis 2c: If same-sex cohabitators report better health than different-sex cohabitators, the gap will be more pronounced among whites and less pronounced among blacks and Hispanics.

Same-Sex Cohabiting versus Unpartnered Single³: SES, Gender, and Race-Ethnicity Hypotheses

Researchers have yet to investigate how the health status of same-sex cohabitators compares with that of other unpartnered singles, including the never married, divorced, and widowed. The transition out of marriage via divorce or widowhood is a stressful life

event, and stress is a risk factor for unhealthy behaviors, depression, poor physical health, and mortality (Liu 2012; Williams and Umberson 2004). The emotional strain that divorced and widowed individuals experience often is compounded by a significant loss in socioeconomic resources with the dissolution of a marriage, especially among women (Williams and Umberson 2004). Although the never married do not experience the stress that accompanies divorce or widowhood, they have only partial access to socioeconomic resources because they do not share resources (e.g., rent) with a partner. Although same-sex cohabitators experience high levels of stress due to discrimination and homophobia, which may in turn promote poor health (Meyer 2003), same-sex cohabitators are hypothesized to accumulate at least some socioeconomic and psychosocial benefits by virtue of sharing resources and having a close companion. Indeed, recent studies with nationally representative data have found that same-sex cohabitators have higher levels of SES than unpartnered single individuals (Black et al. 2007). Taken together, we propose the following hypotheses:

Hypothesis 3: Same-sex cohabitators will have better health than unpartnered divorced, widowed, and never-married singles.

Hypothesis 3a: These differences are due partially to same-sex cohabitators' higher levels of SES.

Previous research on gender and race-ethnicity shapes expectations of comparisons between same-sex cohabitators and single groups. In terms of gender, research suggests that although divorce, widowhood, and never marrying are more likely to lead to economic hardship for women, these union statuses more significantly diminish the health of men (Williams and Umberson 2004). This is in part because divorced, widowed, and never-married women are more likely to maintain social network connections, whereas men in similar union statuses are more likely to be socially isolated (Liu and Umberson 2008). Additionally, because the socioeconomic characteristics of men, but not women, drive union status transitions (Oppenheimer 1988; also see Sweeney 2002), it may be that heterosexual men with the lowest levels of SES are more likely to experience marital dissolution

and remain single. Yet gay men with the highest levels of SES are more likely to cohabit with their partners (Rosenfeld 2007). Such SES differences are likely associated with significant health disparities between same-sex cohabiting and unpartnered single men. In contrast, women's SES may be less important when entering or dissolving a relationship, and therefore the health differences between same-sex cohabiting and unpartnered single women may be diminished. Thus, we expect that:

Hypothesis 3b: If same-sex cohabitators report better health than divorced, widowed, and never-married singles, the gap will be larger among men than women.

Moreover, in comparison with whites, blacks have a higher risk for divorce, widowhood, and never marrying (Bulanda and Brown 2007), suggesting that such unpartnered statuses may be more normative in black communities and thus carry less stress and negative health consequences (Liu and Umberson 2008). Research also suggests that blacks in different-sex married and cohabiting unions, and perhaps also in same-sex unions, report higher levels of relationship strain than whites (Bulanda and Brown 2007); such strain is shown to reduce the benefit of intimate relationships for health (Umberson and Montez 2010). Although behaviors surrounding different-sex union transitions appear to be more similar for Hispanics and whites, divorced, widowed, and never-married Hispanics are more likely to receive support from family and friends than whites (Bulanda and Brown 2007), which may alleviate some of the negative consequences of an unpartnered status for Hispanics. Additionally, both Hispanic and black same-sex cohabitators are more likely to suffer higher levels of homophobia than white same-sex cohabitators (Herek et al. 2010; Lewis 2003; Loftus 2001; Ramirez-Valles et al. 2010), which may reduce the health benefits of blacks and Hispanics in a same-sex intimate relationship relative to singlehood. Taken together, this body of work suggests that:

Hypothesis 3c: If same-sex cohabitators report better health than divorced, widowed, and never-married singles, the gap will be more pronounced among whites and less pronounced among blacks and Hispanics.

DATA AND METHODS

Data

We use pooled data from the 1997 to 2009 Integrated National Health Interview Surveys (NHIS) (Minnesota Population Center and State Health Access Data Assistance Center 2010).⁴ The NHIS is a cross-sectional household survey conducted annually by the National Center for Health Statistics. The NHIS is representative of the U.S. civilian noninstitutionalized population (National Center for Health Statistics 2000). We limit our analyses to respondents aged 18 to 65 years identified as non-Hispanic whites, non-Hispanic blacks, and Hispanics. We exclude respondents aged 66 and older because research suggests that both cohabitation and same-sex relationships have very different meanings among older adults (Chevan 1996). We also exclude a minority (<2 percent) of observations with missing values on union status or self-rated health. Our final analytic sample ($N = 686,846$) contains 1,659 men and 1,634 women identified as same-sex cohabitators. All analyses are weighted to account for the inverse probability of selection into the sample and post-stratification on the basis of age, race-ethnicity, and gender. The “svy” commands in Stata were used to account for the complex nature of the NHIS sample design (StataCorp LP 2007).

Measures

Same-sex cohabitators and other union statuses. We use the household survey nature of the NHIS data that provide sociodemographic information of each household member. Within each household, one person was identified as the reference person, and interviewers recorded the relationship of each household member to the reference person. We identify individuals in a same-sex cohabiting relationship if a household member with the same gender as the reference person is listed as a “spouse” or “unmarried partner” of the reference person. Notably, this approach increases the potential risk for misclassification bias because of miscoded gender. However, because the NHIS is collected via face-to-face interviews, the potential for gender miscodes should be lower in the NHIS than in other national data sources that identify same-sex cohabitators (e.g., the U.S. Census).

Union status is categorized into six categories: same-sex cohabiting (the reference), different-sex married, different-sex cohabiting, divorced, widowed, and never married. Although we are able to identify respondents in same-sex marriages, our analyses combine same-sex married and cohabiting respondents for two primary reasons. First, the number of same-sex married individuals in the sample is relatively small. Second, the social and legal meanings, and therefore the health implications, of marriage for these individuals are unclear because same-sex marriage is allowed only in a minority of states and is not legally recognized at the federal level. For example, it may be that cohabitators in this sample define themselves as married as a symbolic act (Reczek et al. 2009) or were legally married in a state that allows same-sex marriage (e.g., Massachusetts) but live in another state and receive no institutional benefits from this marriage (Rosenfeld 2007). Notably, the NHIS did not collect data on sexual orientation during the study period, so we are unable to identify gay and lesbian respondents who are not in cohabiting relationships.

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

SES. We examine three measures of SES⁵: education, poverty status, and insurance coverage. Education is measured as a categorical variable: no high school diploma (the reference), high school graduate or General Educational Development certificate, some college education, college graduate, or missing report (2.34 percent). Poverty status is based on poverty thresholds published annually by the U.S. Census Bureau. The measure takes into account self-reported total family income, family size, and the ages and number of children present. Persons who have a total family income below the poverty threshold for families of a given size and age composition are considered “in poverty.” Poverty status is missing for almost a quarter (23.21

percent) of the respondents in the total analyzed sample. We flag respondents with missing values for poverty status in the analyses; the reference category contains persons deemed “not in poverty.” The variable representing health insurance coverage has three categories: covered by at least one public or private health care insurance program during the past 12 months (the reference), no health insurance coverage during the past 12 months, and a flag for respondents with missing health insurance information (0.91 percent of the total sample).

Other demographic covariates include race-ethnicity (white, black, and Hispanic, with white as the reference), age in years, nativity status (native born, foreign born, and unknown, with native born as the reference), and survey year (centered at 1997).⁶ These covariates are related to both self-rated health and union status and are controlled as potential confounders in the models (Liu and Umberson 2008; Rosenfeld 2007).

Analytic Strategy

To evaluate our hypotheses, we estimate three nested binary logistic regression models separately for men and women. The first model regresses poor or fair self-rated health on union status, age, race-ethnicity, nativity status, and survey year. This model establishes whether differences in self-rated health exist between same-sex cohabitators and other union status groups net of the effects of basic demographic controls. In the second model, we add additional controls for education, poverty status, and health insurance coverage to examine the extent to which SES contributes to differences in self-rated health between same-sex cohabitators and other union status groups. We conduct post hoc tests (Wald F tests) to compare coefficients from Models 1 and 2 to evaluate whether controlling for SES significantly alters the association between union 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 race-ethnicity by union status to explore whether significant racial-ethnic variations exist in the association between union status and self-rated health.

RESULTS

Tables 1 (men) and 2 (women) present descriptive statistics for our analytic sample stratified by gender and union status. To conserve space, we limit our discussion of Tables 1 and 2 to our results concerning union status differentials in self-rated health. Table 1 shows that the proportion reporting poor or fair health is not significantly different for different-sex married men, different-sex cohabiting men, and single men in comparison with same-sex cohabiting men. Table 2 shows that in comparison with same-sex cohabiting women, the proportion of reporting poor or fair health is significantly higher for single women, although it is not different for different-sex married or different-sex cohabiting women.

Estimated Health Differences between Same-Sex Cohabitators and Other Union Statuses without Controlling for SES

Tables 3 and 4 show the estimated odds ratios of reporting poor or fair health by union status for men and women respectively from logistic regression models. Results from Model 1 in Tables 3 and 4 suggest that, after controlling for basic demographic covariates, for both men and women the odds of reporting poor or fair health are not significantly different between different-sex married persons and same-sex cohabitators, whereas the different-sex cohabiting, divorced, widowed, and never married have significantly higher odds of reporting poor or fair health than same-sex cohabitators.

The Role of SES

To assess how SES contributes to the general differences in self-rated health between same-sex cohabitators and other union status groups, we add education, poverty status, and insurance coverage in Model 2 in Tables 3 and 4 as additional covariates. A comparison of results from Models 1 and 2 suggests that, after controlling for SES in Model 2, different-sex married men and women tend to have lower odds of reporting poor or fair health in comparison with their same-sex cohabiting counterparts. Moreover, after controlling for SES, the higher odds of reporting poor or fair health of different-sex cohabitators, the divorced, widowed, and never married in

Table 1. Weighted Descriptive Statistics by Union Status for Men ($n = 330,280$), National Health Interview Surveys, 1997 to 2009.

| Variable | Same-Sex Cohabiting ($n = 1,659$) | Different-Sex Married ($n = 197,581$) | Different-Sex Cohabiting ($n = 20,269$) | Single ($n = 110,771$) |
|--------------------------|--|--|--|-----------------------------|
| Self-rated health (%) | | | | |
| Fair/poor | 8.22 (.007) | 8.24 (.001) | 9.39 (.002) | 9.30 (.001) |
| Excellent/very good/good | 91.78 (.007) | 91.76 (.001) | 90.61 (.002) | 90.70 (.001) |
| Race-ethnicity (%) | | | | |
| White | 81.66 (.010) | 77.33* (.001) | 69.34* (.003) | 69.42* (.001) |
| Black | 8.07 (.007) | 8.51 (.001) | 15.77* (.003) | 16.02* (.001) |
| Hispanic | 10.27 (.007) | 14.15* (.001) | 14.89* (.003) | 14.55* (.001) |
| Nativity (%) | | | | |
| U.S. born | 88.99 (.008) | 84.54* (.001) | 88.04 (.002) | 88.13 (.001) |
| Foreign born | 10.13 (.007) | 15.03* (.001) | 11.73 (.002) | 11.58 (.001) |
| Unknown | 0.88 (.002) | .43* (.000) | .23* (.000) | .29* (.000) |
| Education (%) | | | | |
| No high school diploma | 6.59 (.006) | 13.66* (.001) | 19.09* (.003) | 18.1* (.001) |
| High school graduate | 19.70 (.010) | 28.43* (.001) | 36.21* (.003) | 31.02* (.001) |
| Some college | 27.02 (.011) | 25.71 (.001) | 26.42 (.003) | 31.45* (.001) |
| College graduate | 43.92 (.012) | 29.48* (.001) | 15.80* (.003) | 17.30* (.001) |
| Unknown | 2.77 (.004) | 2.71 (.000) | 2.48 (.001) | 2.13 (.000) |
| Poverty status (%) | | | | |
| Not in poverty | 75.99 (.011) | 72.30* (.001) | 68.55* (.003) | 64.4* (.001) |
| In poverty | 5.17 (.005) | 4.79 (.000) | 10.39* (.002) | 11.54* (.001) |
| Unknown | 18.84 (.010) | 22.91* (.001) | 21.06* (.003) | 24.07* (.001) |
| Insurance coverage (%) | | | | |
| Any insurance | 80.10 (.010) | 85.71* (.001) | 62.5* (.003) | 69.55* (.001) |
| No insurance | 18.45 (.010) | 13.64* (.001) | 36.68* (.003) | 28.89* (.001) |
| Unknown | 1.45 (.003) | .65* (.000) | .82* (.001) | 1.56 (.000) |
| Mean age (years) | 40.41 (.278) | 44.21* (.025) | 35.32* (.079) | 33.35* (.040) |

Note. Values in parentheses are standard errors. All statistics are weighted except for the numbers of observations.

*Difference between same-sex cohabitators and the specific union status group is significant at $p < .05$.

comparison with same-sex cohabitators all become nonsignificant for both men and women.

Race-Ethnicity and Gender Variations

To further examine whether the relationship between union status and self-rated health varies by race-ethnicity and gender, we include race-ethnicity interactions by union status in Model 3 in Tables 3 (men) and 4 (women). The nonsignificant union status and race-ethnicity interaction terms for men displayed in Table 3 (Model 3) suggest that self-rated health differences documented in the previous model between same-sex cohabitators and other union status groups do not differ across race-ethnic groups. The results for

women (Model 3 of Table 4) suggest that although the difference in self-rated health between different-sex married women and same-sex cohabiting women is not significantly different across racial-ethnic groups, there are significant racial-ethnic variations when comparing same-sex cohabiting women with other nonmarried women. The significant interaction effects of the nonmarried statuses by race-ethnicity for women in Model 3 of Table 4 suggest that the health advantage of same-sex cohabitators relative to these nonmarried groups exists only among white women and does not exist among black or Hispanic women. To better illustrate these racial-ethnic interaction results for women, we calculate odds ratios of reporting poor or fair health by union status for white

Table 2. Weighted Descriptive Statistics by Union Status for Women ($n = 356,566$), National Health Interview Surveys, 1997 to 2009.

| Variable | Same-Sex Cohabiting ($n = 1,634$) | Different-Sex Married ($n = 204,660$) | Different-Sex Cohabiting ($n = 20,189$) | Single ($n = 130,83$) |
|--------------------------|--|--|--|----------------------------|
| Self-rated health (%) | | | | |
| Fair/poor | 8.77 (.007) | 8.52 (.001) | 10.23 (.002) | 12.40* (.001) |
| Excellent/very good/good | 91.23 (.007) | 91.48 (.001) | 89.77 (.002) | 87.60* (.001) |
| Race-ethnicity (%) | | | | |
| White | 81.74 (.010) | 79.36* (.001) | 74.15* (.003) | 63.63* (.001) |
| Black | 10.35 (.008) | 7.80* (.001) | 12.46* (.002) | 22.83* (.001) |
| Hispanic | 7.91 (.007) | 12.84* (.001) | 13.39* (.002) | 13.54* (.001) |
| Nativity (%) | | | | |
| U.S. born | 93.59 (.006) | 86.02* (.001) | 89.43* (.002) | 88.99* (.001) |
| Foreign born | 6.34 (.006) | 13.57* (.136) | 10.34* (.002) | 10.79* (.001) |
| Unknown | .08 (.001) | .41* (.000) | .24 (.000) | .22 (.000) |
| Education (%) | | | | |
| No high school diploma | 6.62 (.006) | 11.65* (.001) | 16.32* (.003) | 16.03* (.001) |
| High school graduate | 21.10 (.010) | 29.24* (.001) | 32.91* (.003) | 27.38* (.001) |
| Some college | 29.01 (.011) | 28.98 (.001) | 31.91* (.003) | 35.10* (.001) |
| College graduate | 41.89 (.012) | 27.64* (.001) | 17.23* (.003) | 19.71* (.001) |
| Unknown | 1.38 (.003) | 2.49* (.000) | 1.63 (.001) | 1.78 (.000) |
| Poverty status (%) | | | | |
| Not in poverty | 76.87 (.010) | 72.02* (.001) | 68.77* (.003) | 58.83* (.001) |
| In poverty | 4.49 (.005) | 4.73 (.000) | 10.06* (.002) | 17.49* (.001) |
| Unknown | 18.64 (.010) | 23.25* (.001) | 21.17* (.003) | 23.67* (.001) |
| Insurance coverage (%) | | | | |
| Any insurance | 83.21 (.009) | 86.79* (.001) | 70.23* (.003) | 78.10* (.001) |
| No insurance | 16.51 (.009) | 12.56* (.001) | 28.83* (.003) | 20.75* (.001) |
| Unknown | .29 (.001) | .65 (.000) | .95* (.001) | 1.15* (.000) |
| Mean age (years) | 39.87 (.284) | 43.03* (.025) | 33.73* (.080) | 36.85* (.040) |

Note. Values in parentheses are standard errors. All statistics are weighted except for the numbers of observations.

*Difference between same-sex cohabitators and the specific union status group is significant at $p < .05$.

women, black women, and Hispanic women on the basis of results from Model 3 in Table 4. We report these calculated odds ratios in Table 5. These results suggest that different-sex cohabiting and divorced white women have higher odds of reporting poor or fair health than same-sex cohabiting white women, although widowed and never-married white women have similar odds of reporting poor or fair health as same-sex cohabiting white women. In contrast, the odds of reporting poor or fair health are significantly lower for different-sex cohabiting, divorced, widowed, and never-married black women, respectively, in comparison with same-sex cohabiting black women. Never-married Hispanic women also have lower odds of reporting poor or fair health than their

same-sex cohabiting Hispanic women counterparts, although different-sex cohabiting, divorced, or widowed Hispanic women are not significantly different from same-sex cohabiting Hispanic women in terms of self-rated health.

Finally, all of the other estimated covariates are in the expected directions. Specifically, results in Tables 3 and 4 suggest that for both men and women, blacks and Hispanics have higher odds of reporting poor or fair health than whites, age is positively related to the odds of reporting poor or fair health, the foreign born are less likely to report poor or fair health than the native born, higher education is associated with lower odds of reporting poor or fair health, and living in poverty is related to higher odds of reporting poor or

Table 3. Estimated Odds Ratios of Reporting Poor or Fair Health for Men (n = 330,280).

| Variable | Model 1 | | | Model 2 | | | Model 3 | | |
|--|------------|---------------|------------|---------------|------------|---------------|------------|--------|--|
| | Odds Ratio | 95% CI | Odds Ratio | 95% CI | Odds Ratio | 95% CI | Odds Ratio | 95% CI | |
| Union status (0 = same-sex cohabitators) | | | | | | | | | |
| Different-sex married | .7901 | (.622–1.004) | .6201*** | (.485–.794) | .6303** | (.475–.836) | | | |
| Different-sex cohabiting | 1.4554** | (1.138–1.861) | .9255 | (.718–1.193) | .9980 | (.745–1.337) | | | |
| Divorced | 1.5352*** | (1.205–1.956) | 1.0302 | (.802–1.323) | 1.1098 | (.833–1.478) | | | |
| Widowed | 1.5118** | (1.163–1.965) | .8967 | (.684–1.176) | .9181 | (.669–1.260) | | | |
| Never married | 1.4865** | (1.169–1.891) | .9769 | (.762–1.253) | 1.0509 | (.789–1.399) | | | |
| Union status x race-ethnicity | | | | | | | | | |
| Different-sex married x black | | | | | .7987 | (.438–1.458) | | | |
| Different-sex married x Hispanic | | | | | 1.0620 | (.550–2.051) | | | |
| Different-sex cohabiting x black | | | | | .6678 | (.367–1.217) | | | |
| Different-sex cohabiting x Hispanic | | | | | .8761 | (.442–1.736) | | | |
| Divorced x black | | | | | .6491 | (.356–1.185) | | | |
| Divorced x Hispanic | | | | | .8447 | (.436–1.637) | | | |
| Widowed x black | | | | | .8405 | (.433–1.633) | | | |
| Widowed x Hispanic | | | | | .8222 | (.405–1.669) | | | |
| Never married x black | | | | | .6446 | (.356–1.168) | | | |
| Never married x Hispanic | | | | | .9536 | (.491–1.852) | | | |
| Basic demographic covariates | | | | | | | | | |
| Age | 1.0646*** | (1.063–1.066) | 1.0669*** | (1.066–1.068) | 1.0671*** | (1.066–1.068) | | | |
| Race-ethnicity (0 = white) | | | | | | | | | |
| Black | 1.8237*** | (1.731–1.922) | 1.4196*** | (1.353–1.489) | 1.9683* | (1.089–3.558) | | | |
| Hispanic | 1.8844*** | (1.792–1.981) | 1.2063*** | (1.139–1.278) | 1.2163 | (.630–2.348) | | | |
| Nativity (0 = U.S born) | | | | | | | | | |
| Foreign born | .7822*** | (.742–.824) | .6535*** | (.615–.694) | .6466*** | (.608–.687) | | | |
| Unknown | .4531*** | (.338–.608) | .4833*** | (.356–.656) | .4798*** | (.353–.652) | | | |
| Survey year | 1.0080** | (1.003–1.013) | 1.0160*** | (1.011–1.021) | 1.0159*** | (1.011–1.021) | | | |
| SES | | | | | | | | | |
| Education (0 = no high school diploma) | | | | | .4948*** | (.476–0.515) | | | |
| High school graduate | | | | | | (.476–0.515) | | | |

(continued)

Table 3 (continued)

| Variable | Model 1 | | Model 2 | | Model 3 | |
|--|------------|-------------|------------|---------------|------------|---------------|
| | Odds Ratio | 95% CI | Odds Ratio | 95% CI | Odds Ratio | 95% CI |
| Some college | | | .3598*** | (.343–.377) | .3599*** | (.343–.377) |
| College graduate | | | .1505*** | (.142–.160) | .1510*** | (.142–.160) |
| Unknown | | | .4379*** | (.398–.482) | .4387*** | (.399–.483) |
| Poverty status (0 = not in poverty) | | | | | | |
| In poverty | | | 3.0574*** | (2.909–3.213) | 3.0606*** | (2.912–3.217) |
| Unknown | | | 1.1088*** | (1.069–1.150) | 1.1087*** | (1.069–1.150) |
| Insurance coverage (0 = any insurance) | | | | | | |
| No insurance | | | .9707 | (.933–1.010) | .9697 | (.932–1.009) |
| Unknown | | | .8613 | (.741–1.001) | .8624 | (.742–1.002) |
| Intercept | .0050*** | (.004–.006) | .0136*** | (.010–.018) | .0130*** | (.010–.017) |
| AIC | 185,356 | | 174,127 | | 174,095 | |
| BIC | 185,484 | | 174,341 | | 174,416 | |

Note. AIC = Akaike information criterion; BIC = Bayesian information criterion; CI = confidence interval.
 * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4. Estimated Odds Ratios of Reporting Poor or Fair Health for Women (n = 356,566).

| Variable | Model 1 | | Model 2 | | Model 3 | |
|--|------------|---------------|------------|---------------|------------|---------------|
| | Odds Ratio | 95% CI | Odds Ratio | 95% CI | Odds Ratio | 95% CI |
| Union status (0 = same-sex cohabitators) | | | | | | |
| Different-sex married | .8280 | (.679–1.010) | .6863*** | (.564–.835) | .7865 | (.598–1.035) |
| Different-sex cohabiting | 1.5284*** | (1.248–1.871) | 1.0674 | (.874–1.303) | 1.3653* | (1.032–1.806) |
| Divorced | 1.5309*** | (1.253–1.871) | 1.0700 | (.879–1.303) | 1.3475* | (1.023–1.776) |
| Widowed | 1.5332*** | (1.247–1.886) | .9365 | (.763–1.149) | 1.1038 | (.832–1.464) |
| Never married | 1.2956* | (1.059–1.585) | .8945 | (.733–1.091) | 1.1187 | (.846–1.479) |
| Union status x race-ethnicity | | | | | | |
| Different-sex married x black | | | | | .6572 | (.403–1.072) |
| Different-sex married x Hispanic | | | | | .6242 | (.364–1.070) |
| Different-sex cohabiting x black | | | | | .4233*** | (.256–.700) |
| Different-sex cohabiting x Hispanic | | | | | .4592** | (.264–.799) |
| Divorced x black | | | | | .4360*** | (.267–.712) |
| Divorced x Hispanic | | | | | .5222* | (.302–.903) |
| Widowed x black | | | | | .5134** | (.309–.852) |
| Widowed x Hispanic | | | | | .6316 | (.357–1.116) |
| Never married x black | | | | | .4817** | (.293–.793) |
| Never married x Hispanic | | | | | .5314* | (.306–.922) |
| Basic demographic covariates | | | | | | |
| Age | 1.0516*** | (1.050–1.053) | 1.0529*** | (1.052–1.054) | 1.0531*** | (1.052–1.054) |
| Race-ethnicity (0 = white) | | | | | | |
| Black | 1.9230*** | (1.841–2.009) | 1.5061*** | (1.447–1.568) | 2.8469*** | (1.742–4.653) |
| Hispanic | 1.9815*** | (1.901–2.065) | 1.2677*** | (1.210–1.329) | 2.1992** | (1.280–3.779) |
| Nativity (0 = U.S born) | | | | | | |
| Foreign born | .8574*** | (.822–.895) | .7192*** | (.685–.755) | .7117*** | (.678–.747) |
| Unknown | .4498*** | (.335–.605) | .5051*** | (.373–.683) | .5014*** | (.371–.678) |
| Survey year | 1.0088*** | (1.004–1.013) | 1.0191*** | (1.015–1.023) | 1.0189*** | (1.015–1.023) |
| SES | | | | | | |
| Education (0 = no high school diploma) | | | | | | |
| High school graduate | | | .5005*** | (.482–.519) | .5010*** | (.483–.520) |

(continued)

Table 4 (continued)

| Variable | Model 1 | | Model 2 | | Model 3 | |
|--|------------|-------------|------------|---------------|------------|---------------|
| | Odds Ratio | 95% CI | Odds Ratio | 95% CI | Odds Ratio | 95% CI |
| Some college | | | .3687*** | (.354–.384) | .3678*** | (.353–.383) |
| College graduate | | | .1665*** | (.158–.176) | .1663*** | (.158–.175) |
| Unknown | | | .4315*** | (.394–.473) | .4319*** | (.394–.473) |
| Poverty status (0 = not in poverty) | | | | | | |
| In poverty | | | 2.7024*** | (2.597–2.812) | 2.7135*** | (2.607–2.824) |
| Unknown | | | 1.0945*** | (1.061–1.129) | 1.0946*** | (1.061–1.129) |
| Insurance coverage (0 = any insurance) | | | | | | |
| No insurance | | | 1.0437* | (1.008–1.081) | 1.0411* | (1.005–1.078) |
| Unknown | | | .7381*** | (.631–.864) | .7389*** | (.631–.865) |
| Intercept | | | .2420*** | (.020–.030) | .0202*** | (.015–.027) |
| AIC | .0094*** | (.008–.012) | | | | |
| BIC | 225,990 | | 213,197 | | 213,042 | |
| | 226,120 | | 213,413 | | 213,365 | |

Note. AIC = Akaike information criterion; BIC = Bayesian information criterion; CI = confidence interval.

* $p < .05$. *** $p < .01$. **** $p < .001$.

Table 5. Adjusted Odds Ratios of Reporting Poor or Fair Health for Women by Race-Ethnicity.

| Variable | White Women | | Black Women | | Hispanic Women | |
|---|-------------|---------------|-----------------------|-------------|---------------------|--------------|
| | Odds Ratio | 95% CI | Odds Ratio | 95% CI | Odds Ratio | 95% CI |
| Union status (0 = same-sex cohabitators) | | | | | | |
| Different-sex married | .7865 | (.598–1.035) | .5169*** | (.351–.760) | .4909** | (.309–.780) |
| Different-sex cohabiting | 1.3653* | (1.032–1.806) | .5779*** ^a | (.390–.857) | .6269 ^a | (.390–1.008) |
| Divorced | 1.3475* | (1.023–1.776) | .5875*** ^a | (.399–.864) | .7037 ^a | (.440–1.126) |
| Widowed | 1.1038 | (.832–1.464) | .5667*** ^a | (.378–.850) | .6972 ^a | (.426–1.140) |
| Never married | 1.1187 | (.846–1.479) | .5389*** ^a | (.365–.796) | .5945* ^a | (.370–.955) |

Notes. Adjusted odds ratios are calculated on the basis of results from Model 3 in Table 4, with all sociodemographic and SES covariates controlled.

a. The difference in the estimated odds ratios between black or Hispanic women and white women is significant at $p < .05$.

* $p < .05$. ** $p < .01$. *** $p < .001$.

fair health. Having no health insurance is related to higher odds of reporting poor or fair health for women but not for men.

DISCUSSION

The implications of same-sex relationships for population well-being are a continued concern, as underscored by a recent report by the Institute of Medicine (2011). Despite theoretical development highlighting the potential importance of same-sex relationships for health, very little is known about the health of this population, because empirical evidence from population-based national data is rare. The present study is among the first to examine the association between same-sex cohabitation and self-rated health with a large nationally representative sample. On the basis of pooled data from the 1997 to 2009 NHIS, we find significant differences in self-rated health between same-sex cohabitators and other union status groups. We discuss these significant results in relation to the role of SES, gender, and race-ethnicity below.

Health Differences between Same-Sex Cohabitators and Other Union Statuses: General Findings and the Role of SES

Given previous research on union status and health (Liu and Reczek 2012), we hypothesized that same-sex cohabitators overall would have worse health than their different-sex married

counterparts (Hypothesis 1), and we indeed find this to be the case. This finding is inconsistent with a previous study that found no difference in self-reports of health status when comparing same-sex cohabitators with different-sex married persons (Wienke and Hill 2009). This inconsistency is perhaps due to the small number of identified same-sex cohabitators in the previous study, which reduced the statistical power to make inferences on group differences. It is noteworthy that socioeconomically disadvantaged gay and lesbian individuals may choose not to disclose their involvement in a same-sex cohabiting relationship because of fear of social and economic discrimination (Ohlander et al. 2005; Rosenfeld 2007). Therefore, our sample may be selective of individuals in same-sex cohabiting relationships who are the most advantaged and healthiest. If this were true, the estimated health disadvantages of same-sex cohabitators relative to different-sex married persons are conservative.

We also hypothesized that the poorer health of same-sex cohabitators in comparison with different-sex married persons would be due to their lower levels of SES (Hypothesis 1a), but this hypothesis was not supported. Indeed, without considering SES differences, we would have observed similar health between same-sex cohabitators and different-sex married individuals. However, at the same levels of SES, same-sex cohabitators report worse health than their different-sex married counterparts. The question

therefore remains: What factors other than SES might explain the poorer health of same-sex cohabitators relative to different-sex married persons? It may be that same-sex cohabitators experience higher levels of discrimination via homophobia than individuals who do not identify as sexual minorities by virtue of living together and disclosing their relationship status (Meyer 2003). Research consistently suggests that “out” sexual minorities experience heightened levels of stress and higher levels of discrimination (Institute of Medicine 2011), and these experiences may in turn significantly influence the health of this population (Institute of Medicine 2011). The additional stress associated with having disclosed a same-sex relationship, therefore, may contribute to their worse health compared with different-sex married persons.

It may also be that same-sex cohabitation does not provide the same psychosocial, socioeconomic, and institutional resources that come with legal marriage, factors that are theorized to be responsible for many of the health benefits of marriage (Waite and Gallagher 2000). Access to legal marriage may provide same-sex cohabitators health benefits similar to those found in different-sex married persons, reducing this health disparity (Lau and Strohm 2011). Because same-sex marriage is not legal at the federal level and is legal in only a minority of states in the United States, few same-sex cohabitators are able to self-select into legal marriage; thus, it is likely that same-sex cohabitators identified in this study are a particularly heterogeneous group (Rosenfeld 2007). In this vein, as feminist and queer theories suggest, marriage and cohabitation may have different symbolic and political meanings for same-sex and different-sex couples (Lannutti 2005; Reczek and Rothblum 2012; Rothblum 2005), further suggesting that our sample captures a wide range of same-sex cohabiting individuals. For example, it is likely that a portion of the same-sex cohabitators in our sample would marry if they could (Reczek et al. 2009), whereas others in similarly committed long-term cohabiting relationships would not marry, because they oppose the institution of marriage. These committed cohabitators, even without legal marriage, may receive the same health benefits as different-sex married individuals (Reczek and Umberson 2012). In this way, even if same-sex

couples were able to legally marry at the federal level, these individuals may not experience a marital health boost, because they have already experienced enhanced health via their cohabiting ties. Future research should consider the heterogeneity of same-sex cohabitators when studying health disparities among this population.

We also hypothesized that same-sex cohabitators would have better health than other nonmarried groups, including different-sex cohabitators (Hypothesis 2) as well as the divorced, widowed and never-married singles (Hypothesis 3). Consistent with these hypotheses, we find that same-sex cohabitators have lower odds of reporting poor or fair health than different-sex cohabiting, divorced, widowed, and never-married individuals. Moreover, consistent with Hypotheses 2a and 3a, our results further suggest that the better health of same-sex cohabitators in comparison with other nonmarried groups is fully explained by socioeconomic characteristics. Same-sex cohabitators have greater socioeconomic resources than both different-sex cohabitators and single individuals, which may contribute to better health by, for example, the purchasing of healthy food and residence in safer neighborhood with more access to exercise facilities (Mirowsky and Ross 2003). Yet without their socioeconomic premium, we find little health benefit accrued from being involved in a same-sex cohabiting relationship compared with other nonmarried statuses. As discussed above, it is possible that same-sex cohabitators are more likely on average to be in long-term, “marriage-like” committed relationships in which they accrue at least some health promoting socioeconomic resources, inaccessible for other nonmarried groups (Reczek et al. 2009). Yet with socioeconomic advantages held constant, same-sex cohabitators lose their health advantage, possibly because of experiences with higher levels of stress due to homophobic and heteronormative institutional, legal, and social contexts (Institute of Medicine 2011; Reczek 2012). Another possibility is that these health differences are a result of a selection process due to gay and lesbian individuals who have lower income and education and are also less likely to participate in or disclose their cohabiting status in the survey because of fear of homophobia (Gates and Ost 2004).

Race-Ethnicity and Gender Variations

Given the long-standing literature on the linkages between gender, race-ethnicity, and union status and health, we expected that the health differences between same-sex cohabitators and other union statuses would be more pronounced for men than women (Hypotheses 1b, 2b, and 3b) and for whites than blacks and Hispanics (Hypotheses 1c, 2c, and 3c). We find mixed evidence for these gender and racial-ethnic patterns. First, our results suggest that the pattern of poorer self-rated health of same-sex cohabitators in comparison with different-sex married persons is quite robust and does not vary by gender and race-ethnicity. This suggests that in comparison with different-sex married persons, the health disadvantage of same-sex cohabitators is prevalent in the general population and is not specific to one racial-ethnic or gender group. Although marriage provides a stronger health boost for men than women and for whites than racial-ethnic minorities, research consistently shows that men and women in all racial-ethnic groups benefit at least partially from marriage because of increased social, psychological, and economic resources (Carr and Springer 2010). Therefore, it is likely that an inability to participate in marriage, regardless of gender or race-ethnicity, reduces access to resources and in turn diminishes the health of same-sex cohabitators.

In contrast, our results comparing same-sex cohabitators with different-sex cohabiting and single women, but not men, revealed important racial-ethnic patterns. We find that same-sex cohabiting white women report better health than both different-sex cohabiting white women and divorced white women net of the effects of SES, while same-sex cohabiting black women report worse health than their different-sex cohabiting, divorced, widowed and never-married black female counterparts. Still, same-sex cohabiting Hispanic women report similar health as their different-sex cohabiting, divorced, and widowed Hispanic female counterparts but worse health than their never-married Hispanic female counterparts. Several explanations may account for this racial-ethnic difference among women. White women in same-sex relationships are more likely than their black and Hispanic counterparts to define themselves as feminists, have

egalitarian household divisions of labor, have both partners in full-time employment, and adhere to general ideals of equality (Moore 2011), factors that may in turn boost same-sex cohabiting white women's health status. Moreover, previous studies suggest that gays and lesbians are more likely to experience stress due to social discrimination and public malice compared with the general heterosexual population (Meyer 2003). This social stress may particularly shape the social context of racial-ethnic minorities, who may experience more stigma, discrimination, and economic disadvantages than their white counterparts (Herek et al. 2010; Institute of Medicine 2011). For example, black and Hispanic women may face more overt employment discrimination or may have less social support outlets to help cope with discrimination, compared with white women (Black et al. 2007). Together, these factors may produce a type of "triple jeopardy" wherein socioeconomically disadvantaged racial-ethnic and sexual minorities—especially black women and to a lesser degree Hispanic women in same-sex relationships—face multiple stressors that undermine health (Institute of Medicine 2011). This could lead to lower levels of psychological well-being and promote unhealthy behaviors, which may be in turn detrimental to the physical health of black and Hispanic women in same-sex relationships. Future research should examine the extent to which psychological and behavioral mechanisms explain the self-rated health disadvantage of racial-ethnic minority women, especially black women, in same-sex relationships.

We emphasize that our results concerning racial-ethnic variations in the association between same-sex cohabitation and self-rated health are tentative in many respects given that our sample contains relatively small numbers of black and Hispanic same-sex cohabitators. This limitation is compounded when one considers that the models we present are gender specific and that reports of poor or fair self-rated health are relatively uncommon. Moreover, given research suggesting that blacks and Hispanics express higher levels of disapproval toward homosexuality than their white counterparts (Bonilla and Porter 1990; Herek et al. 2010; Lewis 2003; Loftus 2001; Ramirez-Valles et al. 2010), it is possible that our sample is more selective of black and Hispanic same-sex cohab-

itors with higher levels of education who are able or willing to cross social boundaries and publically enter into same-sex cohabiting relationships. If this scenario holds, the health disadvantages we document among black and Hispanic same-sex cohabitators, especially black women, are conservative.

CONCLUSIONS

This study is among the first to use nationally representative data to compare the self-rated health of same-sex cohabitators with that of different-sex married, different-sex cohabiting, divorced, widowed, and never-married individuals. Our results suggest that same-sex cohabitators report poorer health than different-sex married individuals if they have similar levels of SES. However, SES protects same-sex cohabitators from reporting poorer health in comparison with other nonmarried groups. Without their SES advantages, same-sex cohabitators would generally report similar levels of health as their different-sex cohabiting, divorced, widowed, and never-married counterparts. We also note that some individuals in same-sex cohabiting relationships, particularly black women, may experience significant social discrimination and homophobia, and such stressors may shape their health in especially detrimental ways (Institute of Medicine 2011).

Although our analyses provide compelling evidence that same-sex cohabitators report poorer health than individuals in different-sex marriages, we do not and cannot directly assess the potential health consequences of legalizing same-sex marriage. Yet it is plausible that legalizing same-sex marriage would provide a viable alternative to cohabitation for same-sex couples and increase public support for same-sex relationships. Therefore, it may be that providing same-sex cohabitators the option to marry at the state and/or federal level will boost measures of self-rated health across sexual minority populations because of higher levels of acceptance and lower levels of stigma in general (Lau and Stroh 2011). Moreover, legalizing same-sex marriage could provide other important socioeconomic and psychological benefits often associated with different-sex marriage—such as partner health insurance benefits, joint tax returns, and increased relationship support—that may directly and indirectly influence the health of individuals in same-sex unions. In this

sense, with such legalization, individuals who choose to enter into same-sex marriages may experience a “marriage benefit” in self-rated health similar to their different-sex married counterparts. However, recent research suggests that married and cohabiting individuals are becoming more similar in their benefit for health (Musick and Bumpass 2012), so it may be that even if provided access to legal marriage, same-sex married individuals may not experience a marital boost in self-rated health relative to their same-sex cohabiting counterparts. Although only a minority of states have legalized same-sex marriage, a critical next step in research in this area is to move beyond our descriptive examination of same-sex cohabitators to explore how the health of individuals in same-sex marriages and cohabiting unions, as well as single gays and lesbians, is shaped by the legalization of same-sex marriage.

Additionally, a growing body of evidence suggests that the relationship between union status and health varies across racial-ethnic groups, wherein black and Hispanic individuals do not receive as high a “marital boost” as their white counterparts (Liu and Reczek 2012). Therefore, access to legalized same-sex marriage at the state and/or federal level may have different health consequences across racial-ethnic groups. This possibility should be explored in future research to fully parse the relationship between union status and health disparities in same-sex populations. The present study suggests that some racial-ethnic sexual minorities may be at an increased risk for poor health; determining why these groups are at risk for health should be the focus of increased research attention. Future research should also pay particular attention to developing new approaches and policy recommendations to alleviate health disparities among same-sex racial-ethnic minority populations who may be at a particular disadvantage.

This study reveals additional novel and exciting areas for future research. First, because of our cross-sectional data, we are unable to determine whether our findings regarding SES are a result of selection into union status groups or if SES is acting as a mediator in this association. Future research should use longitudinal data to address this limitation. Moreover, we do not examine individuals in same-sex relationships who are over the

age of 65 years. It is likely that there are critical cohort and age differences in the relationship between same-sex relationships and self-rated health, perhaps strongly related to minority stress experiences (Meyer 2003; Reczek et al. 2009). Future research should work toward elucidating the health outcomes of older adults in same-sex relationships and examining age and cohort differences in these measures. Finally, although this study is among the first to examine general health from a population-based sample, future research should look beyond self-rated health to examine how other more specific health measures—such as substance use, body weight, and mental health (e.g., psychological distress)—relate to union status for same-sex populations. This line of research, building on the present study, will broaden our understanding of the relationship between same-sex union status and health so that we can more completely address disadvantage and disparities found among this minority population.

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NOTES

1. Alternatively, some feminists and queer scholars suggest that marriage may have different meanings and consequences for same-sex couples, and thus the lack of access to legal marriage may have little effect on the health of same-sex cohabitators.
2. Because of data limitations, we are unable to identify the sexual orientations of the divorced, widowed, and never-married single individuals. Thus, we are unable to differentiate heterosexual-, gay-, and lesbian-identified individuals in these union status groups.
3. We have named the divorced, widowed, and never married as “single” for ease of reading. We combine these single groups as one in the descriptive results to keep the comparison parsimonious. However, we note that because individuals in each of these single groups

exist in extremely varying contexts, our regression analysis distinguishes the divorced, widowed, and never-married singles as separate union statuses.

4. The NHIS first collected data on cohabitation status in 1997. To increase the number of same-sex cohabitators in our sample, we pool NHIS survey data from 1997 to 2009.
5. Previous literature is mixed concerning the role SES plays in the relationship between union status and health. Given that persons who are healthier and have higher levels of education and family income (and thus greater likelihood of having insurance) are also more likely to select into marriage and remain married (Sweeney 2002), it is possible that SES would operate as a precursor or confounder in the relationship between union status and health. In contrast, some scholars regard SES as a potential mediator linking union status and health, as they argue that marriage (and to a less extent cohabitation) may promote socioeconomic resources (especially higher levels of family income and insurance coverage) that in turn lead to better health (Waite and Gallagher 2000). In this study, we examine SES as one potential factor that may explain the association between union status and health. Our analyses are descriptive, and the cross-sectional data limit our ability to tease out the causal or selection processes related to SES that links union status and health. However, this issue warrants further examination in future research.
6. In additional analyses (not shown but available on request), we estimated models with interaction terms of union status by survey year. The results suggested that the self-rated health gap between same-sex cohabitators and any other union status group examined remained relatively stable over the study period. It may be that our same-sex cohabiting sample within individual survey year is relatively small, which may reduce the statistical power of detecting significant trends over time. Future research should explore these trends using other data sets.

REFERENCES

- Andersson, Gunnar, Turid Noack, Ane Seierstad, and Harald Weedon-Fekjær. 2006. “The Demographics of Same-Sex Marriages in Norway and Sweden.” *Demography* 43(1):79–98.
- Badgett, M. V. Lee. 2001. *Money, Myths, and Change: The Economic Lives of Lesbians and Gay Men*. Chicago: University of Chicago Press.

- Black, Dan, Gary Gates, Seth Sanders, and Lowell Taylor. 2000. "Demographics of the Gay and Lesbian Population in the United States: Evidence from Available Systematic Data Sources." *Demography* 37(2):139–54.
- Black, Dan A., Seth G. Sanders, and Lowell J. Taylor. 2007. "The Economics of Lesbian and Gay Families." *Journal of Economic Perspectives* 21(2): 53–70.
- Bonilla, Louis and Judith Porter. 1990. "A Comparison of Latino, Black, and Non-Hispanic White Attitudes toward Homosexuality." *Hispanic Journal of Behavioral Sciences* 12(4):437–52.
- Brown, Susan L., Jennifer Van Hook, and Jennifer E. Glick. 2008. "Generational Differences in Cohabitation and Marriage in the U.S." *Population Research and Policy Review* 27(5):531–50.
- Bulanda, Jennifer Roebuck and Susan L. Brown. 2007. "Race-Ethnic Differences in Marital Quality and Divorce." *Social Science Research* 36(3):945–67.
- Campsmith, Michael L., Philip Rhodes, Irene H. Hall, and Timothy A. Green. 2010. "Undiagnosed HIV Prevalence among Adults and Adolescents in the United States at the End of 2006." *Journal of Acquired Immune Deficiency Syndromes* 53(5):619–24.
- Carr, Deborah and Kristen W. Springer. 2010. "Advances in Families and Health Research in the 21st Century." *Journal of Marriage and Family* 72(3):743–61.
- Chevan, Albert. 1996. "As Cheaply as One: Cohabitation in the Older Population." *Journal of Marriage and the Family* 58(3):656–67.
- Cohen, Philip N. 1999. "Racial-Ethnic and Gender Differences in Returns to Cohabitation and Marriage: Evidence from the Current Population Survey." *Population Division Working Paper No. 35*. Washington, DC: U.S. Census Bureau.
- Conron, Kerith J., Matthew J. Mimiaga, and Stewart J. Landers. 2010. "A Population-Based Study of Sexual Orientation Identity and Gender Differences in Adult Health." *American Journal of Public Health* 100(10):1953–60.
- Edin, Kathryn and Maria Kefalas. 2005. *Promises I Can Keep: Why Poor Women Put Motherhood before Marriage*. Berkeley, CA: University of California Press.
- Gates, Gary J., Jason Ost, and Elizabeth Birch. 2004. *Gay and Lesbian Atlas*. Washington, DC: The Urban Institute Press.
- Heck, Julia E. and Judith S. Jacobson. 2006. "Asthma Diagnosis among Individuals in Same-Sex Relationships." *Journal of Asthma* 43(8):579–84.
- Heck, Julia E., Randall L. Sell, and Sherri Sheinfeld Gorin. 2006. "Health Care Access among Individuals Involved in Same-Sex Relationships." *American Journal of Public Health* 96(6):1111–18.
- Herek, Gregory M., Aaron T. Norton, Thomas J. Allen, and Charles L. Sims. 2010. "Demographic, Psychological, and Social Characteristics of Self-Identified Lesbian, Gay, and Bisexual Adults in a U.S. Probability Sample." *Sexuality Research and Social Policy* 7(3):176–200.
- Idler, Ellen L. and Yael Benyamini. 1997. "Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies." *Journal of Health and Social Behavior* 38(1):21–37.
- Institute of Medicine. 2011. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press.
- Kurdek, Lawrence A. 2004. "Are Gay and Lesbian Cohabiting Couples Really Different from Heterosexual Married Couples?" *Journal of Marriage and Family* 66(4):880–900.
- Lannutti, Pamela J. 2005. "For Better or Worse: Exploring The Meanings of Same-Sex Marriage within The Lesbian, Gay, Bisexual and Transgendered Community." *Journal of Social and Personal Relationships* 22(1):5–18.
- Lau, Charles Q. 2012. "The Stability of Same-Sex Cohabitation, Different-Sex Cohabitation, and Marriage." *Journal of Marriage and Family* 74(5):973–88.
- Lau, Holning and Charles Q. Strohm. 2011. "The Effects of Legally Recognizing Same-Sex Unions on Health and Well-Being." *Law and Inequality: A Journal of Theory and Practice* 29:107–48.
- Lewis, Gregory B. 2003. "Black-White Differences in Attitudes toward Homosexuality and Gay Rights." *Public Opinion Quarterly* 67(1):59–78.
- Link, Bruce G. and Jo Phelan. 1995. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* 35(Spec. No.):80–94.
- Liu, Hui. 2012. "Marital Dissolution and Self-Rated Health: Age Trajectories and Birth Cohort Variations." *Social Science and Medicine* 74(7): 1107–16.
- Liu, Hui and Corinne Reczek. 2012. "Cohabitation and U.S. Adult Mortality: An Examination by Gender and Race." *Journal of Marriage and Family* 74(4):794–811.
- Liu, Hui and Debra Umberson. 2008. "The Times They Are A Changin': Marital Status and Health

- Differentials from 1972 to 2003." *Journal of Health and Social Behavior* 49(3):239–53.
- Loftus, Jeni. 2001. "America's Liberalization in Attitudes toward Homosexuality, 1973 to 1998." *American Sociological Review* 66(5):762–82.
- Meyer, I. H. 2003. "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence." *Psychological Bulletin* 129(5):674–97.
- Minnesota Population Center and State Health Access Data Assistance Center. 2010. "Integrated Health Interview Series: Version 3.0." Minneapolis, MN: University of Minnesota.
- Mirowsky, John and Catherine Ross. 2003. *Education, Social Status, and Health*. New York: Aldine de Gruyter.
- Moore, Mignon. 2011. *Invisible Families: Gay Identities, Relationships and Motherhood among Black Women*. Berkeley, CA: University of California Press.
- Musick, Kelly and Larry Bumpass. 2012. "Reexamining the Case for Marriage: Union Formation and Changes in Well-Being." *Journal of Marriage and Family* 74(1):1–18.
- National Center for Health Statistics. 2000. National Health Interview Survey [Computer file]. 2nd ICPSR version. Hyattsville, MD: U.S. Department of Health and Human Services, National Center for Health Statistics.
- Ohlander, Julianne, Jeanne Batalova, and Judith Treas. 2005. "Explaining Educational Influences on Attitudes toward Homosexual Relations." *Social Science Research* 34(4):781–99.
- Oppenheimer, Valerie K. 1988. "A Theory of Marriage Timing." *American Journal of Sociology* 94(3): 563–91.
- Patterson, Charlotte J. 2000. "Family Relationships of Lesbians and Gay Men." *Journal of Marriage and the Family* 62:1052–69.
- Ramirez-Valles, Jesus, Lisa M. Kuhns, Richard T. Campbell, and Rafael M. Diaz. 2010. "Social Integration and Health: Community Involvement, Stigmatized Identities, and Sexual Risk in Latino Sexual Minorities." *Journal of Health and Social Behavior* 51(1):30–47.
- Reczek, Corinne. 2012. "The Promotion of Unhealthy Habits in Gay, Lesbian, and Straight Intimate Partnerships." *Social Science and Medicine* 75(6):1114–21.
- Reczek, Corinne, Sinikka Elliott, and Debra Umberson. 2009. "Commitment without Marriage: Union Formation among Long-Term Same-Sex Couples." *Journal of Family Issues* 30(6):738–56.
- Reczek, Corinne and Esther Rothblum. 2012. "A Little Bit Pregnant? The Ethics of Same-Sex Marriage." Pp. 459–74 in *Handbook of LGBT Affirmative Couple and Family Therapy*, edited by J. J. Bigner and J. Wetchler. New York: Routledge.
- Reczek, Corinne and Debra Umberson. D. 2012. "Gender, Health Behavior, and Intimate Relationships: Lesbian, Gay, and Straight Contexts." *Social Science and Medicine* 74(11):1783–90.
- Rosenfeld, Michael. 2007. *The Age of Independence: Interracial Unions, Same-Sex Unions and the Changing American Family*. Cambridge, MA: Harvard University Press.
- Rothblum, Esther D. 2005. "Same-Sex Marriage and Legalized Relationships: I Do, or Do I?" *Journal of GLBT Family Studies* 1(1):21–31.
- Smock, Pamela. 2000. "Cohabitation in the United States: An Appraisal of Research Themes, Findings, and Implications." *Annual Review of Sociology* 26:1–20.
- Sweeney, Megan M. 2002. "Two Decades of Family Change: The Shifting Economic Foundations of Marriage." *American Sociological Review* 67(1):132–47.
- StataCorp LP. 2007. *Stata 10 User's Guide*. College Station, TX: StataCorp LP.
- Thornton, Arland, William Axinn, and Yu Xie. 2007. *Marriage and Cohabitation*. Chicago: University of Chicago Press.
- Umberson, Debra and Jennifer Karas Montez. 2010. "Social Relationships and Health." *Journal of Health and Social Behavior* 51(Suppl. 1):S54–S66.
- U.S. Census Bureau. 2011. "Census Bureau Releases Estimates of Same-Sex Married Couples." Retrieved November 7, 2012 (http://www.census.gov/newsroom/releases/archives/2010_census/cb11-cn181.html).
- Waite, Linda J. and Maggie Gallagher. 2000. *The Case for Marriage: Why Married People Are Happier, Healthier, and Better Off Financially*. New York: Doubleday.
- Wienke, Chris and Gretchen J. Hill. 2009. "Does the 'Marriage Benefit' Extend to Partners in Gay and Lesbian Relationships?" *Journal of Family Issues* 30(2):259–89.
- Williams, Kristi and Debra Umberson. 2004. "Marital Status, Marital Transitions, and Health: A Gendered Life Course Perspective." *Journal of Health and Social Behavior* 45(1):81–98.

Author Biographies

Hui Liu is an assistant professor of sociology at Michigan State University. Her research focuses on developing, testing, and promoting scientific understanding about marriage and family processes related to population health and well-being using innovative quantitative methods. Her recent research also extends to other “marriage-like” intimate relationships, such as different-sex and same-sex cohabiting relationships, and how they are related to individuals’ health and well-being. Her research has been published in the *Journal of Health and Social Behavior*, *Social Science and Medicine*, the *Journal of Marriage and Family*, *Social Science Research*, *Structural Equation Modeling*, and other journals.

Corinne Reczek is an assistant professor in the Department of Sociology at the University of Cincinnati. Her research focuses on the relationship between family ties and health,

specifically examining how gender, sexuality, and aging dynamics in family ties intersect to promote or deter health and health behavior. Her current research uses quantitative and qualitative methods to explore the dynamics and consequences of same-sex intimate relationships and inter-generational relationships on health and well-being. Her recent research has been published in the *Journal of Marriage and Family*, *Social Science and Medicine*, and the *Journal of Family Issues*, among other journals.

Dustin Brown is a doctoral candidate in the Department of Sociology and the Population Research Center at the University of Texas at Austin. His research broadly examines how socioeconomic inequality and social relationships influence health over the life course. His dissertation examines how education, marriage, and gender combine to influence adult health and mortality. His recent research has been published in *Demography* and the *Journal of Gerontology: Psychological Sciences and Social Sciences*.