REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - I-98

Subject: Health Insurance for Domestic Partners

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INTRODUCTION

At the 1997 Interim Meeting, the House of Delegates adopted Substitute Resolution 101, which calls for the AMA to study the experience of employers that have extended health insurance coverage to domestic partners and the effects of such programs on costs and access by otherwise uninsured individuals. Substitute Resolution 101 also reaffirmed Policy H-180.980 (AMA Policy Compendium), which opposes the denial of health insurance on the basis of sexual orientation.

The following report, which is presented for the information of the House, reviews available literature on the number of employers offering domestic partner health benefits, the criteria employers use to establish eligibility for such benefits, the extent to which employees take advantage of such benefits, the number of individuals covered by such benefits, and the costs of such benefits.

Much of the information contained in this report comes from surveys of firms conducted by Hewitt Associates (1994), the International Society of Certified Employee Benefit Specialists (1995), the International Foundation of Employee Benefit Plans (IFEBP, 1994) the Society for Human Resource Management (SHRM, 1997), and KPMG Peat Marwick (1998). Additional information was drawn from studies conducted by academic institutions or municipalities prior to extending benefits to employees' domestic partners (Ohio State University, the University of Iowa, Harvard University, City University of New York, the City of San Francisco). While low response rates and the small number of survey respondents offering domestic partner benefits make it difficult to quantify precisely the extent and cost of such benefits, the various sources provide generally consistent information.

DEFINING DOMESTIC PARTNERSHIP

Since 1970, there has been a 400% increase in the number of unmarried-couple households to 4.1 million or 7.5% of the adult population (1997 U.S. Census Bureau). More than one-third of these households include children under the age of 15. Estimates of the number of unmarried-couple households made up of same-sex couples range from 2% to 33%. Although definitions of domestic partnership vary, such a partnership is generally understood to be a committed, exclusive relationship between two people of legal age who are not related by blood, share the same residence, and are financially and emotionally interdependent. Domestic partnerships include both opposite-sex and same-sex relationships.

Employers offering domestic partner benefits must formulate working definitions of domestic partnership. Some employers require a relationship to be of a minimum duration to be considered a domestic partnership, e.g., six or twelve months. Similarly, some employers require a "cooling

off" period of six to twelve months between the end of one domestic partnership and eligibility for benefits under another. Such "cooling off" periods are not required of heterosexual employees who divorce and remarry.

The official status of a relationship as a domestic partnership or a marriage depends on location, sexual orientation, and the couple's actions (i.e., participating in a marriage ceremony or registering with a domestic partner registry). While a growing number of states, counties, and cities maintain registries for both same- and opposite-sex partnerships, no state recognizes same-sex marriages. Domestic partner registration confers a degree of recognition but not the full legal status of marriage. Common law marriage between heterosexuals is granted or recognized by a majority of states and entails the same legal rights and responsibilities as traditional marriage.

It is not known the extent to which heterosexual couples fail to take advantage of family employment benefits because they are unaware that they qualify for common law marriage or that common law spouses are legally equivalent to traditionally married spouses. Employers generally do not publicize, or are unaware of, the benefits implications of common law marriage. Thus, although common law marriage is legally distinct from domestic partnership, couples who unwittingly forgo common law spouse benefits would be affected by domestic partner policies. For purposes of this report, such couples can be considered domestic partners.

TAX AND LEGAL STATUS OF DOMESTIC PARTNER BENEFITS

Under current law, domestic partner health insurance expenditures are tax deductible for the employer, but generally taxable to the employee. According to rulings issued by the Internal Revenue Service, employer-provided health benefits for cohabitants are excludable from taxable income only if the recipients are legal spouses under state law or legal dependents under section 152 of the tax code. Flexible benefits provided under Section 125 of the tax code are nontaxable and, thus, cannot be offered to non-common law spouse, non-dependent domestic partners. Flexible benefits may be provided to domestic partners, but the value of such benefits must be declared as taxable income.

In the last decade, numerous initiatives to mandate domestic partner benefits have met legislative and judicial opposition. For example, a law granting benefits to same-sex partners of City of Philadelphia employees is currently being contested in court on the grounds that by passing the law, the City has redefined marriage, which can only be done at the state level. A 1996 San Francisco ordinance requires city contractors to provide domestic partner benefits equivalent to spousal benefits. In a legal suit filed by the airline industry, a federal district court ruled that employers with self-funded ERISA plans are exempt from the San Francisco ordinance. A bill has also been introduced in the U.S. House of Representatives that would reduce federal funding to San Francisco if the ordinance remains in effect, although no corresponding bill has been introduced in the Senate. In a 1993 case, a Labor Relations Board ordered the University of Vermont to conform to its own policy prohibiting discrimination based on sexual orientation by providing health benefits for same-sex domestic partners.

PREVALENCE AND SCOPE OF DOMESTIC PARTNER BENEFITS

In response to demographic changes and to pressure from employees, employers started extending benefits to employees' domestic partners over 15 years ago. The main reasons employers cite for offering domestic partner benefits are to meet the needs of their employees, to recruit and retain

talented workers, and to align their employment practices with their anti-discrimination policies. The major reasons cited for not offering domestic partner benefits are concern about health care costs and, in the past, insurance company refusal to cover domestic partners. Employers that have considered and rejected the idea of offering domestic partner benefits often cite concerns about public reaction or that recognition of domestic partnerships would undermine the institution of marriage.

Surveys show that 7% to 13% of U.S. employers currently offer benefits to employees' domestic partners and that more employers are considering doing so. According to the 1998 KPMG survey, employers least likely to offer domestic partner benefits are located in the South, whereas employers offering domestic partner benefits are concentrated on the East and West coasts. Such benefits are most likely to be offered in competitive industries with relatively young workforces such as high technology, telecommunications, and entertainment. The most comprehensive list of U.S. employers offering domestic partner benefits is maintained by the Human Rights Campaign (http://www.hrc.org/issues/workplac/dp/dplist. html) and contains approximately 600 municipalities, academic institutions, and private employers. The list includes Kaiser-Permanente, Time Warner, Tropicana Beverages, the University of Chicago, and Walt Disney.

Among employers offering domestic partner benefits, health insurance is the most frequently offered benefit. About half the time, domestic partner benefits are less comprehensive than those offered to employees' spouses (e.g., they include only health or only non-health benefits, or they do not include dental or vision coverage). Employers cannot always offer the usual range of health plans to employees seeking domestic partner coverage because some insurance carriers do not insure domestic partners. This situation has occurred less frequently as insurers have accumulated a body of actuarial data upon which to project claims costs. Approximately two-thirds of employers offering domestic partner benefits extend COBRA coverage to domestic partners of employees. Occasionally, employers require employees to pay the full cost of adding domestic partners to health plans.

Among employers offering domestic partner benefits, one-third to one-half offer benefits to both opposite-sex and same-sex partners, with the remainder being roughly split between those offering benefits to opposite-sex partners only and those offering benefits to same-sex partners only. Academic institutions generally offer benefits to same-sex partners only, whereas public employers are more likely to offer them to both opposite-sex and same-sex partners.

Employers offering benefits to opposite-sex partners only may do so out of moral objections or fears of negative public reaction. Some employers offering benefits to same-sex partners only, including IBM and Lotus, reason that heterosexuals have the option of legal marriage whereas same-sex couples do not. The Stanford University subcommittee that studied domestic partner benefits recommended that, if the cost of covering both groups was prohibitive, benefits should be extended to same-sex couples only because they had a stronger equity claim. A New York State court recently dismissed a case brought against Bell Atlantic by an unmarried heterosexual employee seeking health benefits for his domestic partner; the case is currently in Federal court.

There is little information on children of domestic partners. Domestic partnerships average fewer children than traditional marriages. Available information indicates that employee benefits are usually not extended to dependents of domestic partners.

VERIFICATION OF DOMESTIC PARTNERSHIP

Of employers offering domestic partner benefits, 75% to 90% require a signed affirmation or notarized affidavit of partnership status. In municipalities with domestic partner registries, employers may accept or require registration to qualify for domestic partner benefits. Affirmations or affidavits written by the employer typically include a statement of requirements for domestic partner benefits and a statement that the employee will promptly notify the employer if the relationship ends. The document might also include a statement that the employee recognizes possible legal ramifications of domestic partnership. For example, the relationship could be considered equivalent to marriage for purposes of allocating community property or being responsible for a partner's debts. Among employers requiring signed statements of domestic partnership, about half require additional documentation, such as a statement from a joint bank account, a mortgage, or a lease. A minority of employers who require proof of domestic partnership also require married couples to furnish proof of marriage.

Despite early concerns about fraud and abuse, employers have consistently reported having no problems with false claims of domestic partnership in order to obtain health or other benefits. Documentation requirements, social stigma associated with domestic partnership, and limits on pre-existing conditions serve as deterrents to fraudulent claims.

EFFECT ON INSURANCE COVERAGE AND COSTS

Enrollment rates for domestic partner health insurance have been much lower than anticipated by employers, representing only 1% to 4% of employees. Organizations that offer coverage to both opposite- and same-sex couples experience higher enrollment rates than those covering only same-sex domestic partners. About two-thirds of couples electing domestic partner benefits are opposite-sex couples. Possible reasons for low enrollment rates, particularly among same-sex couples, include reluctance to disclose domestic arrangements for fear of social stigma, the fact that many domestic partners have access to health insurance through their own employers, and unfavorable tax treatment of domestic partner benefits. Although the total number of individuals who obtain health insurance through domestic partner benefits is unknown and probably relatively small, domestic partner benefits are an important source of access to those with no other source of health insurance.

Costs are affected by the total number of enrollees and by average cost per enrollee. Limited available data indicate that most employers have not experienced a significant change in costs after offering domestic partner benefits, and that adverse selection has not been a problem. Eighty-five percent of respondents to the 1997 SHRM employer survey reported that their firms' health care costs "stayed about the same" rather than "increased" or "decreased." CCH Employee Benefits Management Directions (1994) reports that plans offering coverage only to same-sex couples experience about a 1% total increase in health care costs, whereas plans offering coverage to all domestic partners experience about a 3% increase in costs.

Evidence from employer surveys suggests that adding domestic partner coverage has little effect on costs per enrollee, with more employers reporting slightly reduced average costs than slightly higher average costs (IFEBP, 1994 and Report of the CUNY Study Group on Domestic Partnerships, 1993). Fears about catastrophic HIV-related costs have not been realized (Hewitt, 1994 and IFEBP, 1994). Within employment groups, increased risk of HIV-related claims from male couples is offset by reduced risk of HIV-related claims from female couples. Lifetime costs

associated with HIV infection and AIDS are on par with costs of other serious illnesses such as cancer, kidney failure, heart disease, and premature birth (Hewitt, 1994 and IFEBP, 1994). Compared to married couples, same- and opposite-sex domestic partner couples present reduced risk of pregnancy – one of the largest components of inpatient costs – and fewer children. In addition, those in domestic partnerships tend to be younger than those who are not (Hewitt, 1994).

In the past, employers had to accept premium increases in order to add domestic partner coverage. Surcharges were sometimes dropped once subsequent experience proved them to be unwarranted. Today, employers are less likely to be subject to such increases and when they are, the increases are usually eventually eliminated based on experience.

RELEVANT AMA POLICY

The AMA has established a number of policies that are relevant to the issues raised in Substitute Resolution 101 (I-97). Policy H-180.980 opposes the denial of health insurance on the basis of sexual orientation. Policies H-160.991, H-65.992, and H-65.990 support equal rights regardless of sexual orientation. Numerous AMA policies support universal health insurance coverage (Policies H-165.904, H-165.882, H-165.877, H-165.919, H-165.960). Policy H-165.978 supports exploring ways of expanding health insurance coverage to uninsured dependents of insureds. In addition, Policy H-180.978 supports expanding access to health insurance through market mechanisms rather than through government mandates and regulations.

CONCLUSION

AMA policy favors the expansion of access to health insurance through market mechanisms rather than legislative mandates. AMA policy also opposes the denial of health insurance or other discrimination on the basis of sexual orientation. Accordingly, the trend toward domestic partner benefits is consistent with AMA policy. Market forces and changing social norms have led an increasing number of employers to extend employee health benefits to domestic partners, bringing such benefits into the mainstream. Although there are limited data on the extent and cost of domestic partner benefits, several conclusions clearly emerge from existing reports. First, employers have found workable ways of defining and verifying domestic partnership. Second, a relatively small but growing number of people obtain health coverage as domestic partners or as dependents of domestic partners, most being opposite-sex partners. Third, adding domestic partner coverage appears to have little effect on average costs per enrollee or on premiums. Finally, employers who offer domestic partner benefits have experienced increases in total health benefits costs of 1 to 3%. Total costs increase more when coverage is offered to both opposite-sex and same-sex partners.

This report is intended to provide information on the current status of domestic partner health insurance benefits. The Council on Medical Service will continue to monitor trends in domestic partner benefits.