Marriage-Lock: Staying Together for the Sake of Health Insurance

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Abstract

Most American adults under 65 obtain health insurance through their employer or their spouse. The absence of a universal healthcare system in the United States put Americans at considerable risk for losing their coverage when transitioning out of jobs or marriages. Scholars have found evidence of 'job-lock' that reduces job mobility among individuals who are dependent on their employers for healthcare coverage. In this paper, I present evidence of 'marriage-lock' among those who are dependent on their spouse for health insurance. I apply the hazards model to married individuals in the longitudinal 2004 wave of the Survey of Income Program Participation (N=17,137) and find lower divorce rates among people who are insured through another's plan. These effects are magnified for individuals who have a greater need for health insurance. Furthermore, I find gender differences in the relationship between healthcare coverage and divorce rates: insurance dependent women have lower rates of divorce than men in similar situations.

We hear anecdotes of couples staying together in an otherwise undesirable relationship to share health insurance benefits. My paper uses a national representative longitudinal survey to present empirical evidence showing that these stories are not isolated incidents. Health insurance is a significant factor when making divorce decisions for some Americans.

The United States is the only developed country whose government does not provide universal healthcare to its residents (Jost 2003). While Medicare came about under Title XVIII of the Social Security Act of 1965 ensuring coverage to seniors over 65 years of age, the majority of non-elderly adult men and women are left responsible for securing their own health insurance. The US Census Bureau reports that 55.3 percent of the American adult population gains health insurance through employment (US Census 2011). The second biggest source of insurance is through a family member. Twenty-four percent of non-elderly adult women and 14 percent of men are covered as a dependent (Kaiser Family Foundation 2011).

As American adults transition into and out of jobs and marriages, they risk losing coverage (Harrington, Meyer, and Pavalko 1996). To help people through these life events the Consolidated Omnibus Budget Reconciliation Act (COBRA) gives people the option to continue purchasing insurance at the lower group rate. However, this option is only available for limited periods of time and its costs can be prohibitive for recently unemployed or divorced individuals. Many experience a break in insurance coverage as when they change jobs or experience divorce (Swartz and McBride 1990). Prior to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), individuals who experienced a break in insurance coverage faced difficulty in enrolling in another plan if they had pre-existing conditions. While the enforcement of HIPAA alleviated the issue of insurance companies denying coverage to previously sick people, it does not prohibit insurers from increasing premiums or lowering maximum payouts. A break in

insurance coverage may have significant financial consequences for those who have the greatest need for healthcare. The reality is that the current American healthcare system lacks an adequate safety net for its denizens to rely on when unexpectedly faced with life events and crises.

Being uninsured is associated with lower healthcare utilization, increased morbidity, and higher mortality (Institute of Medicine 2004). Not having insurance creates a barrier to adequate access to healthcare (Fairbrother et al. 2002). Uninsured individuals are more likely to be diagnosed with late stage cancer—diseases that are often detected at early states during routine doctor visits (Halpern et al. 2008)—and are less likely to have an ongoing relationship with a healthcare provider (IOM 2001; Holahan and Spillman 2002). Scholars and policy makers do not contend the fact that being uninsured is associated with negative consequences.

Considering these known risks of being uninsured, it is not surprising that Americans treat health insurance as a valuable commodity. In the absence of a universally guaranteed health care system employer-provided health insurance is a significant motivator for people to seek and retain employment. When the current employer-provided health benefit becomes a deterrent in moving to another job—for advancement, greater satisfaction, and other reasons—health insurance is now considered what scholars call a 'job-lock'. Employees who receive healthcare coverage through their current employer are said to forgo better opportunities and higher paying positions in fear of losing their insurance benefits; they are essentially 'locked' into their jobs. Such 'job-lock' threatens the concept of a free labor market where workers obtain employment to maximize their productivity and income (Monheit and Cooper 1994). The literature on this topic debates the magnitude and significance of 'job-lock' in the United States showing varying levels depending on the study design and the demographic composition of the sample. The results depend on how a study measures 'job-lock' and the gender of the workers in the sample.

Cooper and Monheit (1993) and Madrian (1994) drew attention to the significantly large effects of employer-provided health insurance on job mobility. These two studies used the 1987 National Medical Expenditure Survey examining male and female wage earners aged 25-54 and married men aged 20-55 respectively. The first study found a 23% reduction in mobility among single men and 39% reduction among single women. The effects were slightly higher for married men and lower for married women. The second study built upon the first and added variables measuring the *need* for healthcare coverage. Having a large family or a pregnant wife served as proxies among married men. Here, Madrian (1994) found that the overall reduction in job-mobility was 30% which increased to 37% among married men with large families and 67% among men with pregnant wives. Four years after Madrian (1994) published these numbers, Kapur (1998) revisited the 1987 panel of the National Medical Expenditure Survey and refuted prior results by pointing out that when she used different variables (medical conditions, health services utilization, and medical expenses) as proxies for family sickness, the effects that Madrian found becomes nonexistent. Holtz-Eakin (1994) would agree with Kapur (1998) as he also found insignificant evidence of job-lock among his sample of full-time workers aged 25 to 55 in the 1984 Panel Study of Income Dynamics. The debate continues as researchers use different sources of data and model specifications to argue for or against the existence of 'job-lock' in the US labor market. More recent studies exploit richer datasets to account for possible spurious relationships between generally higher quality jobs and the option of employer-provided healthcare. The results are still mixed (Gilleskie and Lutz 2002, Berger, Black, Scott 2004).

A couple of studies in addition to Cooper and Monheit (1993) find gender differences in how employees react to potential health-insurance driven 'job-lock'. Buchmueller and Valletta

(1996) stronger evidence of decreased job-mobility among women—married and single—than in men in their 1984 Panel of Survey of Income Program Participation. A detailed Indiana study by Stroupe, Kinney, and Kniesner showed that while the effect of 'job-lock' among workers facing chronic illness were similar between men and women, men's reduced mobility was mainly driven by their own illness whereas the illness of a family member was the larger cause of 'job-lock' among women. Empirically, women tend to be more sensitive to the prospect of being uninsured than men when faced with job or career change.

Studies that focus on the availability of healthcare coverage after the termination of the current job (Cooper and Monheit 1993, Buchmueller and Valletta 1996) through a spouse or a new employer show a more consistent evidence for 'job-lock' than studies that use family health status or health service utilization as proxy measurements (Gruber and Madrian 2002). Apart from a very early paper by Mitchell (1982), women workers appear to demonstrate greater effects of 'job-lock' than men. Buchmueller and Valletta (1996) relate this trend to higher healthcare utilization among women.

A study has yet to examine if a similar phenomenon exists within a marriage—the second most common source of health insurance. After all, approximately 36 million American adults under 65 gain access to healthcare through a spouse or a family member. In this paper, I seek and find evidence for health insurance as a form of 'marriage-lock'. I make the argument that individuals consider their sources of health insurance when making marital decisions. More specifically, I find that married individuals in the United States have lower rates of divorce if they are dependent on their spouses for health insurance. I test my research questions using the 2004 panel of the longitudinal survey dataset, Survey of Income Program Participation (SIPP). The 2004 SIPP panel tracks a nationally representative sample of 46,500 households and records

each member's marital and healthcare status every month between November 2003 through October 2007—a period of 48 months. The longitudinal SIPP allows me to suggest a causal relation between healthcare and divorce decisions as the data tracks my two key variables—marital status and source of health insurance—each month. One significant advantage of the SIPP is its frequent, monthly measurements. I use discrete event analysis to estimate the relative risk of divorce between the insurance-dependent and non-dependent.

Theory: Family Bargaining and Exchange

The concept of health insurance as a form of 'marriage-lock' speaks to the marital exchange theory or family bargaining theory. He posits that a marriage occurs and remains intact when the resources of a couple exceed the combined resources of the two individuals. Couples who believe that their lives would be better outside the relationship would divorce. Theorists in this field (Heer 1963, Brines 1994, Molm and Cook 1995, Cherlin 2000, and Bittman et al. 2003) further expands the relationship between resources and marital stability saying that the more resources an individual brings to a marriage, the more bargaining power that person has and thus, he or she is more likely to initiate divorce when the marriage becomes less than ideal. Resources that can create this dynamic within a marriage would be something that is attributable to either the husband or wife, becomes a common good within the marriage, and leaves the marriage with the person who brought it in the first place. Access to a group healthcare plan is one instance of such resource. An individual gains access to a health insurance plan through employment or the government. On marriage he or she may add the spouse onto the plan as a dependent and if they divorce, the dependent spouse would no longer be able to benefit from the group healthcare plan. Access to the family health insurance is more valuable to dependents that do not have an

alternative source for healthcare other than from their spouses. The family health insurance then becomes a form of 'marriage-lock' that binds these men and women to marriages that may be unappealing to individuals who have healthcare of their own. If a married person has healthcare coverage under their own name (rather than enrolled as a dependent of their spouse), his or her expected life quality after divorce would be higher than those who would lose health insurance along with their spouse. According to the family bargaining model, a higher expected quality of life after divorce will lower the tolerance to remain in an otherwise unsatisfactory marriage.

While no one has directly examined the role of health insurance on marriage and divorce, many researchers have empirically studied the influence of various resources on marital dissolution. Nock (1995) empirically tests Blood and Wolfe (1960)'s "resource theory of power" within American marriages and finds that women's dependency on their spouses' income, occupational prestige, and amount of labor has positive influence on their self-reported level of marital commitment. Financial assets such as homeownership have been repeatedly associated with lower rates of divorce (Becker et al. 1977, Levinger 1979, Moore and Waite 1981, South and Spitze 1986).

Theory: Marriage as a Gendered Institution

The traditional economic household model does not distinguish how women evaluate their marital utility from men. Becker (1991) theorized that married couples achieve the greatest efficiency gains when the husband and wife contribute different or 'specialized' labor and resources to the marriage. The institutional view on marriage argues that 'specialized' labor husbands and wives are expected to deliver is governed by social norms and generally accepted cultural understandings (Nock 1998; Amato et al. 2007; Wilcox and Dew 2009). Marital

instability is more likely to occur when these norms are violated and social support for the marriage diminishes as a result. To put it differently, marriages are the most stable when it conforms to the illustrative image of the 'perfect family'. In the United States, the husband have been traditionally considered the breadwinner, providing financial support to the family while the wife manages activity within the home and takes responsibility of daily child-rearing duties. While his rigid gendered perspective on marriages has diminished over the past few decades (Andrew Cherlin (2004) terms this shift the 'deinstitutionalization' of marriage), gender-specific roles are still expected of husbands and wives. Increasing women's workforce participation and educational attainment has made household roles and duties more flexible and negotiable but, women still do more than their share of household work and childrearing (Nock 1995, Cherlin 2004). Kalmijn and his coauthors (2007) observe that the traditional specialization of labor contributes to marital stability and the risk of divorce increases as the wife's income begin to exceed that of her husband's. Considering that the contribution to marriage differs by gender, we can expect husbands and wives to value marital resources differently. Studies show that women put more importance on the earning potential of their spouses than men. A husband's unemployment is a reason for divorce whereas the same standards are not expected from wives (Sayer et al 2011).

Direct access to a health insurance plan is closely related to one's employment status. It is often considered a salient component of a job's total compensation package in addition to the regular paychecks. If the social norm puts greater pressure on husbands to contribute via economic activity in the labor market, it is likely that they have a greater burden than their wives to provide the family health insurance. Women would derive greater marital value from their husband's access to healthcare as it validates the normative structure of a good and proper

marriage—more so than when the situation is reversed. Men may not put as much importance to losing health coverage after divorce as men generally expect to secure insurance through means other than their wives. Despite recent changes in America's perception of gender roles, I argue that people still perceive marriage as a more socially accepted source of health insurance for women than for men and thus, women are more likely consider their level of dependency on the family insurance when contemplating divorce. Therefore, I expect my analysis to show women exhibiting a greater degree of health insurance driven marriage-lock.

Based on these theoretical grounds and prior empirical findings, I form and test two hypotheses in my paper. Firstly, married adults who are covered under their spouses' healthcare plans are less likely to divorce than married individuals who are insured under their own names. I strengthen my argument by showing that people who have a greater need for their spouses' insurance plans are even less likely to divorce. The men and women who are more dependent on the family healthcare plan would place greater value on it and its contribution to marriage. Following the tradition of researchers of 'job-lock' I measure the dependency on the family plan using two different methods: health status and the availability of an alternative source of insurance. My second research aim examines and compares the effects of 'marriage-lock' separately for men and women. I expect to find larger effects among women.

Data

I use the 2004 Panel of the Survey of Income and Program Participation (SIPP) to examine the relationship between health insurance status and divorce. SIPP is a large longitudinal dataset that follows its respondents for 48 months. The strength of this data lies in its large size, its wide range of household insurance and demographic variables, and its

longitudinal structure. The SIPP also follows individuals who depart the original household and incorporates new members. This allows the researcher to get a good picture of how family situation and sources of health insurance for a particular respondent changes over time. Since the SIPP records data every month throughout the study period, I can get relatively good estimates of when changes in marital and healthcare statuses occurred; these life events rarely occur multiple times within a single month.

The 2004 panel began its first wave of interviews in February 2004 and consists of 46,500 nationally representative households. The panel continued for 12 waves interviewed every 4 months. The survey records data separately for each reference month and thus I am able to observe and follow each individual every month for a period of 2 years between November 2003 and November 2007. The SIPP questionnaires are divided into core questionnaires and topical modules. The core questionnaire is administered every wave while topical modules are only administered at select waves. Most of the variables that I use in my analyses are from the core questionnaires whose variables are recorded each month. The only variable that is measured at two waves (wave 3 between October 2003 and January 2005 and wave 6 at October 2005 and January 2006) is the respondent's self-rated health.

Because the SIPP interviews every person in each household, I chose to track the household's primary respondent—a randomly assigned individual when the panel was initially set. In this manner, I created a dataset of 46,500 individuals with both individual and household-level information. I also limit my analysis sample to adults between the ages of 18 and 64. Those over 65 are almost universally insured through Medicare and marriage and divorce decisions are less likely to be influenced (or at least differently) than the rest of the population. After applying list-wise deletion to observations with missing values, my analysis sample consisted of 17,137

individuals who were ever at risk for divorce during the observation period. They collectively experienced 539 divorces between 2003 and 2007. I add people who marry during the observation period to the risk population.

Measures

Marital Status

I assign everyone who responded as being married (whether their spouses are present in the household or not) as married and those who are widowed, divorced, separated, and never married as unmarried at the beginning survey period. When the panel of interviews began in November 2003, XX% of my sample was married. I update this marital status variable every month and a change reflects an event of marriage or divorce sometime during the previous 30 days. Only the respondents who are married are at risk of divorce at any point in time. The analysis focuses on the change in legal marital status rather than the change in residence (separation) as eligibility for healthcare as a dependent is defined by the legal relationship between two people.

Health Insurance Status

I combine two SIPP variables asking health insurance type and coverage source, to create a nominal scale to differentiate individuals who are covered by their own plan from those covered under someone else's, government sponsored need based insurance (Medicare or Medicaid) or none at all. I lag insurance status by one month to associate the insurance status *prior* to the divorce as this marital event is often simultaneously accompanied by a change in healthcare status.

Following the job-lock literature I operationalize the need or dependence on health insurance in two ways: self-rated health and alternative source of insurance through full-time employment. The survey asks respondents their self-rated health on a Likert scale (1 excellent to 5 poor). I use this variable to operationalize individual's need for healthcare. Health researchers use self-reported health as a reliable measurement of general health (Lundberg and Manderbacka 1996, Idler et al. 2004). I create a dichotomous variable, poor health (0/1), to identify individuals who reported having poor health on their questionnaire. Respondents' health status remains quite stable throughout the 48-month study period; only 4 % change their health between poor and non-poor health between Waves 3 and 6. I use answers from Wave 3 to record respondents' health and update their status during Wave 6.

I determine an individual's employment status from SIPP's 'Worked less than 35 hours some weeks during reference month' and 'usual number of hours worked in a week'. I assigned individuals who indicated that they usually work 35 hours a week as a full time employee to account for temporary leave and vacation time in during the immediate reference month.

Control Variables

I incorporate demographic and socioeconomic variables that prior research identified as determinants or predictors of divorce—education, race and ethnic origin, number of children, age and income (Martin 2004, Cherlin 1992, Casper and Bianchi 2001, Amato 2010). These variables may have spurious effects on both the dependent and independent variables. My model includes age, gender, race/ethnicity, educational attainment, logged monthly income, and the number of children as controlling covariates. I also include a polynomial age term to account for the non-linear age-pattern of divorce. I expect higher educational attainment, higher income, and

having more children to be associated with lower rates of divorce (Martin 2004, Cherlin 1992, Casper and Bianchi 2001, Amato 2010). All covariates with the exception of gender are time-varying. Table 1 shows the demographic and socioeconomic composition of the 17,122 people who were married when the panel started in November 2003.

[Table 1 – Descriptive Statistics of Population at Risk of Divorce]

Model

I use Cox's proportional hazards model (Cox 1972) to measure the effect of health insurance on marriage. I use a semi-parametric model to determine the incremental risk of an event happening to one group relative to another without having to estimate the baseline hazard and succumb to the restrictive assumptions of a fully-parametric model. Researchers consider the Cox proportional hazard model as the standard when examining marital transitions (Bumpass 1991, South and Lloyd 1995).

$$h_i(t) = h_0(t) \exp(\beta Z_i + \gamma X_i) \quad (1)$$

$$\eta_i = \beta Z_i + \gamma X_i \quad (2)$$

Equation (1) specifies the hazard of divorce for the i^{th} individual as a function of the vector of explanatory variables, Z and the vector of controls, X. Equation (2) states that the covariates, Z and X influences the hazard in a linear fashion. This model determines the proportionate hazard of one group or individual relative to another by taking the ratio of the two

exponents ($e^{\eta 1}/e^{\eta 2}$). Ratios greater than 1.0 indicates that the person or group that we are studying is experiencing divorce at a faster rate than the reference. Conversely, ratios between 0 and 1 signify that the study person or group is slower to experience the event than the reference. Mathematically, Cox's model cannot produce hazard ratios less than 0. I use STATA's stcox package to estimate all hazard coefficients.

Results

My first research question asks the differential rates of divorce based on health insurance status. The dependent variable or the 'failure event' is divorce. I estimate the hazard as a function of the individual's source of health insurance during the prior month controlling for demographic and socioeconomic covariates.

[Table 2. Hazard Ratios]

Divorce and health insurance

The hazard ratio from Model 1 clearly shows that individuals who are dependent on someone else for their health insurance are significantly less likely to divorce than those who are covered under their own name. Their hazard for divorce is approximately a third of the reference category whose coefficient is significant at the alpha 1% level. Figure 1 graphically compares the average cumulative risk of divorce between those who have their own insurance and individuals who are enrolled as dependents.

The estimated coefficients on the control covariates are consistent with prior findings on divorce. People with higher educational attainment have lower rates of divorce (Martin 2006,

Orbuch et al. 2002, Amato 2010). Income is negatively associated with divorce (Bumpass et al. 1991, Presser 2000). The relationship between race and marriage however, is statistically insignificant. The decrease in divorce odds for those who are insured under their spouse's health insurance plan is comparable to individuals who have two children in the marriage. This is a significant finding. The barriers against divorce created by health insurance dependency is equivalent to the largest factor in this model associated with lowered divorce rates—children (Koo et al. 1984, Waite and Lillard 1991).

Divorce, health insurance, and poor health

Model 2 interacts insurance status with whether the individual has poor health to observe any marginal effect of health among those with different sources of insurance. Having poor health further lowers the propensity for divorce across all types of insurance statuses. However, these coefficients lack significance. These findings mirror the conclusions Gruber and Madrian (2002) make in their review: using individual health does not yield significant evidence for the existence of job-lock. Self-reported health may not properly capture the need for healthcare and insurance. Similarly to the insignificant findings in the job-lock literature, health status does not appear to adequately capture the degree of need for healthcare. Instead, in this context of marital unions, poor health appears to reflect the quality of an individual as a mate. Teachman (2010) also found negative effects of health on marriage duration. In my sensitivity analyses (not shown), I divide self-reported health into excellent health (reported heath = 1) and non-excellent heath (reported health = 2 to 5). Hazard estimates on marriage and divorce remained insignificant.

Divorce, health insurance, and full-time employment

Model 3 interacts insurance status with employment status. Full time employment is associated with the availability of employer-provided health insurance even if the individual decides to forgo it in favor of his or her spouse's family plan. In this model, I am making the assumption that individuals who are not employed full-time do not have an alternative source of healthcare other than the one provided through their spouse. The reference category in this model contains individuals who are employed full time and are insured under their own name. Full time employees who are still insured through someone else's plan have a lower risk of divorce (54.3% of reference group). Not having full-time employment further decreases the risk of divorce to 23.2% of the risk of the reference group. These coefficient estimates are both significant at the 0.01 level. Being insured through a public health care system (Medicare or Medicaid) or being uninsured while not having full-time employment is significantly associated with higher risk for divorce. These characteristics most likely reflect the quality of the spouse. Again, educational attainment and the number of children are significantly associated with lowered divorce hazards.

Divorce, health insurance, and gender

Models 4 to 7 estimate the effects of insurance status separately by gender. We can draw two conclusions from these gender-stratified models: while both men and women's risk for divorce is influenced by insurance status, the evidence of a 'marriage-lock' is more apparent among women.

Models 4 and 5 estimate the overall effect of insurance on men and women separately. These models are equivalent to model 1. They show that both men and women are less likely to divorce if dependent on someone else for health insurance. The effect on women is much

stronger with a hazard ratio of 0.27 compared to men's ratio of 0.46. Both are statistically significant at the 0.01 level. The negative association between education, children, and divorce still holds for both men and women. Figures 2 and 3 compares the cumulative hazards of divorce between individuals who are the primary subscribers and those who are insured as dependents. These figures illuminate the different responses that men and women have towards health insurance.

Models 6 and 7 are gender-stratified versions of model 3 that examines the effect of insurance source by full time employment status. The difference between the two sexes becomes even more prominent in these models. The hazard ratios are in reference to men and women who are employed full-time and have their own health insurance. Men who are insurance-dependent and do not have a full-time job are no more significantly to divorce than those who have a full-time job and have healthcare coverage under their own name. The situation for women is starkly different. Women who are covered under someone else's healthcare plan and do not have full-time employment have a divorce risk that is 14% of women who are employed full-time and are insured under their own name. Again, the coefficient estimates for other covariates are consistent with existing research in marital disruption. Individuals with higher education and with more children are less likely to divorce.

Discussion

The first set of results (Model 1) affirms my first hypothesis: married individuals who are enrolled as dependents are less likely to divorce than those who are the primary subscribers of their health insurance plans. In concordance with the findings from researchers of 'job-lock', poor health does not appear to increase the degree of 'marriage-lock'. Not having an alternative

source for healthcare (full-time employment in this case) however, makes individuals less likely to divorce. It is the prospect of becoming uninsured rather than current utilization of health services that motivate people to exhibit behaviors of 'marriage-lock'. In other words, it is not just the sick that worry about continued healthcare coverage; this also concerns the healthy that may not currently have high healthcare expenditures.

My second set of gender-stratified models 4 through 7 supports the institutional view on marriage. Men and women react differently to the family healthcare plan that their spouses bring to the marriage. The gendered relationship between health insurance and divorce mirrors the dynamics of income and marital stability. Risk of divorce rises along with wives' contribution to the family income with the most stable marriages being those where the husband is the primary earner (Heckert et al. 1998; Ono 1998; Kalmijn, Loeve, and Manting 2007). Likewise, I find divorce rates are the highest among women who have access to health insurance independent of their husbands. While women's employment has transitioned from being a marital destabilizer to a stabilizer (Parsons 1949, Oppenheimer 1997, Sayer et al. 2011), it appears that securing the family health insurance still remains within the male's domain.

I recognize that marital decisions may not always be unilateral and often times results from joint decision-making between the two spouses. A wife may be motivated to stay together in consideration for the husband's lack of health insurance. Whatever the mechanisms are at play, my results show the different divorce outcomes based on an individual's insurance situation. While the monthly health insurance and marital status measurements in the SIPP is a strength in determining the causal relationship between the two, I also note that couples often obtain legal divorce decrees months after they make their decision. The health insurance situation of the two individuals involved in the failing marriage may have changed since beginning divorce

proceedings. Research has shown increases in married women's labor force participation in the periods prior to divorce (Gray 1995). Similarly, the insurance-dependent partner may be motivated to secure other sources for health insurance in anticipation of the change in marital status. Applications for divorce specifically address the issue of healthcare coverage and divorcing individuals are fully aware of the termination of benefits through their soon-to-be former spouse. If this is the case, the magnitude of 'marriage-lock' that resulted from these analyses may be an upper-bound more relevant to couples who were not able to secure independent coverage the month immediately prior to the finalization of the divorce.

Conclusion

This paper has at least three implications. The first contributes to the literature that examines economic bargaining within families and couples. Access to health insurance is another resource that an individual can bring to a marriage. I argue that its role within an American marriage is comparable to other traditionally studied marital resources—education, income, and financial assets. It should be considered in analyses that examine spousal dynamics under the family exchange or bargaining framework.

The second reaffirms that American marriages are still remain a strongly gendered institution despite changes in recent decades. Men are expected to financially provide for the family through labor force participation outside the household. Resources that are generally associated with employment and income—health insurance being one of several—also fall within the responsibility of the male bread winner. Thus, this expands how sociologists of marriage and family form hypotheses on the economic dynamics between men and women within marriages. Researchers have reason to believe that wives have greater expectations on

their husbands to perform activities affiliated with the labor market such as managing retirement funds, enrolling in life insurance, and submitting tax returns.

Lastly, the findings indicate that an individual's sources of health insurance can influence marital longevity. This calls attention to considerable importance Americans place on securing access to healthcare. In an environment where affordable, dependable healthcare is not guaranteed, people look to various sources to secure coverage and to hedge themselves of potential lapses. Access to health insurance serving as motivators to seek and maintain employment may arguably be a positive outcome of such a system. The fear of becoming uninsured turning into a barrier against ending an otherwise unhappy and unproductive marriage is quite decidedly a negative outcome. It is important to understand how current healthcare policies can affect behavior and shape families. By understanding these relationships, we can incorporate the knowledge into future policies that works towards promoting a healthier and happier population.

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Table 1. Descriptive Statistics of Married Population

	Population at Risk[1]	17122
	Observations	**(%)**
Insurance Status		
Insured under own name	8,587	50.2
Insured under someone else's plan	5,510	32.2
Gov't Insurance (Medicaid, Medicaid)	1,030	6.0
Uninsured	1,995	11.7
Gender		
Female	7,922	46.3
Male	9,200	53.7
Race		
Non-Hispanic White	12,946	75.6
African American	1,338	7.8
Hispanic	1,652	9.6
Asian	666	3.9
Other	520	3.0
Educational Attainment		
High School Diploma or Equiv.	3,672	21.4
Less than High School	1,569	9.2
Associate degree or some college	6,487	37.9
Bachelors' degree	3,540	20.7
Advanced degree	1,854	10.8
Children		
Childless	6,088	35.6
One child	3,929	22.9
Two children	4,409	25.8
Three children	2,696	15.7
	Mean	**S.D.**
Age	42.05338	10.53837
Monthly Income	6385.263	6017.15
Insurance and Health		
	Good Health	Poor Health
Insured under own name	8,497	90
Insured under someone else's plan	5,382	128
Gov't Insurance (Medicaid, Medicaid)	843	187
Uninsured	1,914	81
Insurance and Full-time Employment		
	Employed Full-Time	Not Full-Time
Insured under own name	7,328	1,259
Insured under someone else's plan	2,467	3,043
Gov't Insurance (Medicaid, Medicaid)	192	838
Uninsured	936	1,059

Note: Population at risk at first reference month (November 2003)

Table 2. Cox Hazard Ratio Estimates

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
Insurance Status							
Insured under own name	*(reference)*			*(reference)*	*(reference)*		
Insured under someone else's plan	0.376			0.458	0.263		
	(0.132)**			(0.256)**	(0.158)**		
Gov't Insurance (Medicaid, Medicaid)	1.245			0.621	1.127		
	(0.148)			(0.369)	(0.174)		
Uninsured	0.989			1.034	0.839		
	(0.132)			(0.212)	(0.171)		
Insurance and Health							
Own Insurance x good health		*(reference)*					
Own Insurance x poor health		0.381					
		(1.003)					
Another's Insurance x good health		0.362					
		(0.135)**					
Another's Insurance x poor health		0.887					
		(0.506)					
Gov't Insurance x good health		1.309					
		(0.157)					
Gov't Insurance x poor health		0.908					
		(0.361)					
Uninsured x good health		1.011					
		(0.133)					
Uninsured x poor health		0.472					
		(0.717)					
Insurance and Full-time Employment							
Own insurance x Full-time employee			*(reference)*			*(reference)*	*(reference)*
Own insurance x not FT employee			0.993			1.096	0.723
			(0.164)			(0.256)	-0.214
Another's insurance x Full-time employee			0.543			0.425	0.447
			(0.157)**			(0.314)**	(0.187)**
Another's insurance x not FT employee			0.232			0.555	0.126
			(0.215)**			(0.422)	(0.254)**
Gov't insurance x Full-time employee			2.250			0.440	2.158
			(0.229)**			(1.007)	(0.248)**
Gov't insurance x not FT employee			0.959			0.666	0.725
			(0.179)			(0.397)	-0.212
Uninsured x Full-time employee			1.332			1.353	1.383
			(0.155)			(0.231)	-0.208
Uninsured x not FT employee			0.658			0.574	0.476
			(0.193)*			(0.391)	(0.229)**

Note: Numbers in parentheses are standard errors

*p < .05; ** p < .01

Table 2 Continued. Cox Hazard Ratio Estimates

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
Age	1.195	1.196	1.190	1.274	1.182	1.281	1.168
	(0.035)**	(0.035)**	(0.035)**	(0.059)**	(0.044)**	(0.059)**	(0.044)**
Age-squared	0.997	0.997	0.997	0.997	0.997	0.997	0.998
	(0.000)**	(0.000)**	(0.000)**	(0.001)**	(0.001)**	(0.001)**	(0.001)**
Race							
Non-Hispanic White	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*
African American	0.839	0.831	0.838	0.793	0.844	0.812	0.791
	(0.157)	(0.157)	(0.157)	(0.265)	(0.195)	(0.265)	-0.196
Hispanic	0.830	0.826	0.813	1.083	0.725	1.067	0.715
	(0.158)	(0.159)	(0.159)	(0.258)	(0.201)	(0.259)	-0.201
Asian	0.423	0.425	0.420	0.265	0.643	0.270	0.660
	(0.323)**	(0.323)**	(0.323)**	(0.588)*	(0.386)	(0.588)*	-0.386
Other	0.909	0.928	0.901	0.702	1.036	0.724	0.976
	(0.231)	(0.231)	(0.231)	(0.419)	(0.277)	(0.419)	-0.278
Educational Attainment							
High School Diploma or Equiv.	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*
Less than High School	0.527	0.532	0.538	0.371	0.624	0.373	0.660
	(0.196)**	(0.196)**	(0.196)**	(0.374)**	(0.233)*	(0.374)**	
Associate degree or some college	1.024	1.020	1.015	0.900	1.096	0.913	1.063
	(0.106)	(0.106)	(0.106)	(0.172)	(0.136)	(0.173)	-0.136
Bachelors' degree	0.721	0.720	0.717	0.760	0.666	0.773	0.652
	(0.141)*	(0.141)*	(0.140)*	(0.209)	(0.192)*	(0.210)	(0.192)*
Advanced degree	0.504	0.503	0.498	0.492	0.519	0.501	0.505
	(0.205)**	(0.205)**	(0.205)**	(0.312)*	(0.273)*	(0.313)*	(0.272)*
Children							
Childless	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*	*(reference)*
One child	0.566	0.563	0.563	0.298	0.884	0.293	0.899
	(0.113)**	(0.113)**	(0.113)**	(0.196)**		(0.196)**	
Two children	0.395	0.393	0.392	0.144	0.683	0.143	0.690
	(0.120)**	(0.120)**	(0.120)**	(0.239)**	(0.154)*	(0.239)**	(0.154)*
Three children	0.276	0.274	0.279	0.100	0.455	0.098	0.490
	(0.157)**	(0.157)**	(0.157)**	(0.349)**	(0.192)**	(0.350)**	(0.193)**
Log(Monthly Income)	0.790	0.791	0.777	0.798	0.790	0.791	0.767
	(0.018)**	(0.018)**	(0.018)**	(0.029)**	(0.023)**	(0.030)**	(0.023)**
Number of Observations	*540,574*	*540,574*	*540,574*	*247,466*	*293,108*	*247,466*	*293,108*

Note: Numbers in parentheses are standard errors

*p < .05; ** p < .01

Figure 1

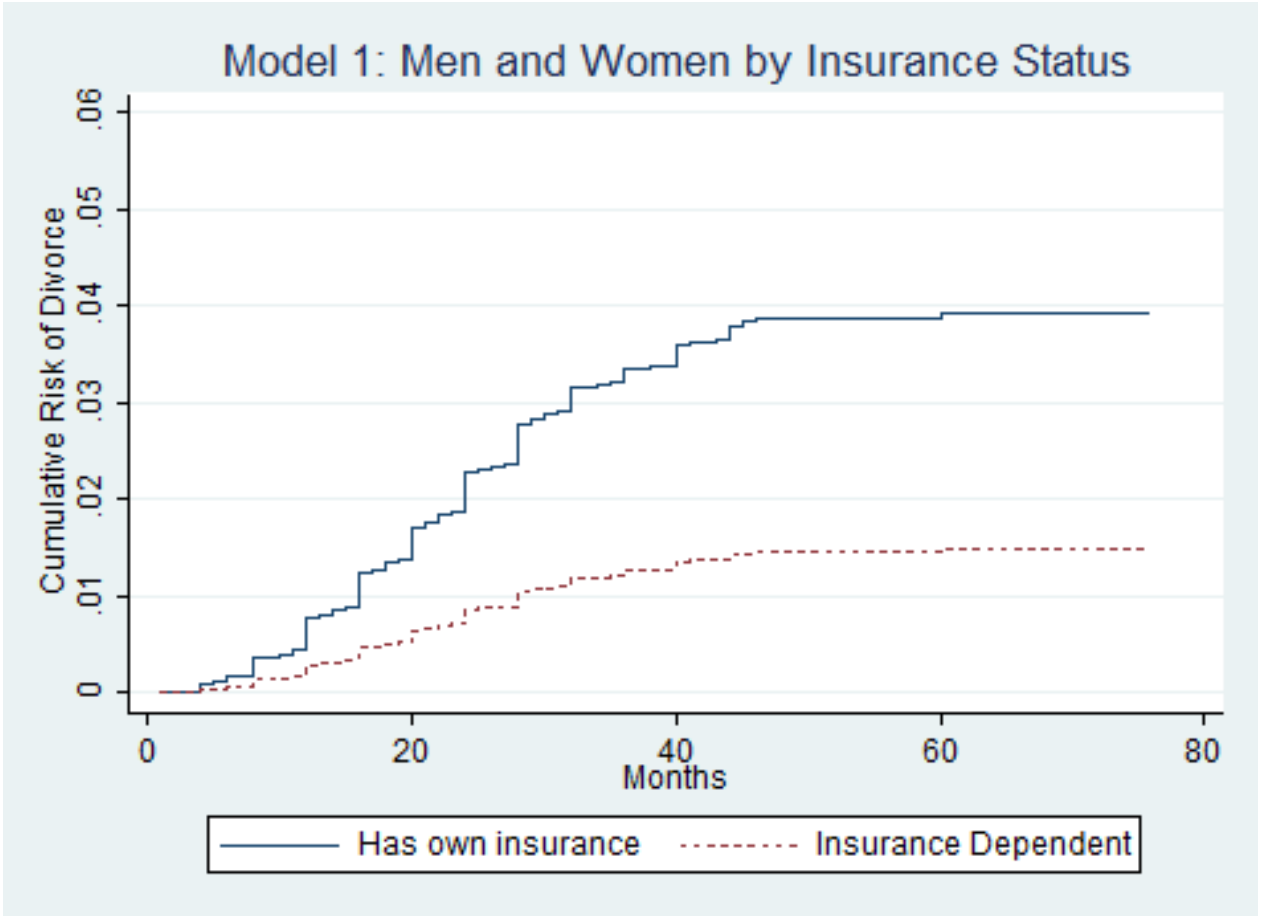

Model 1: Men and Women by Insurance Status
Cumulative Risk of Divorce
0
.01
.02
.03
.04
.05
.06
0
20
40
60
80
Months
Has own insurance
Insurance Dependent

Figure 2

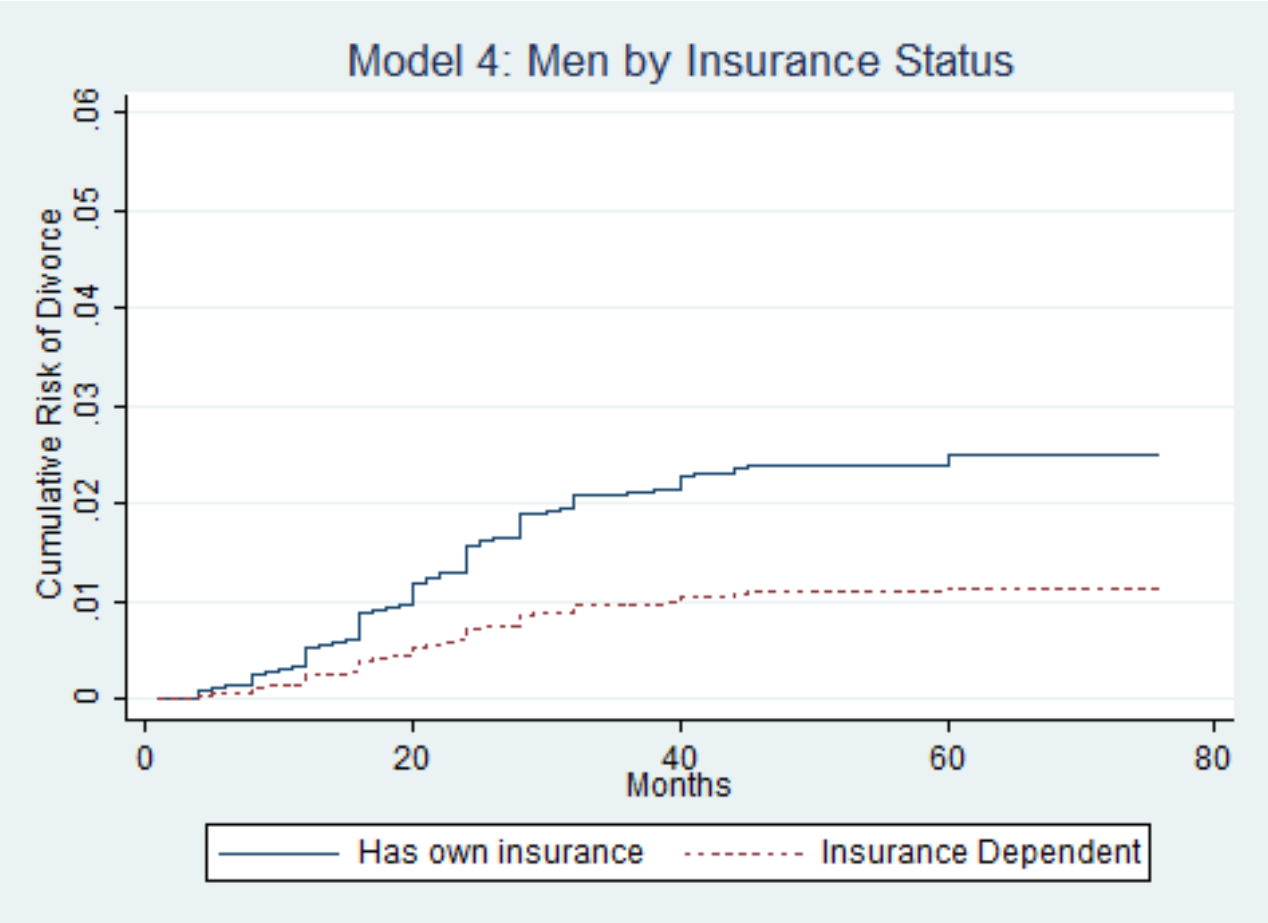
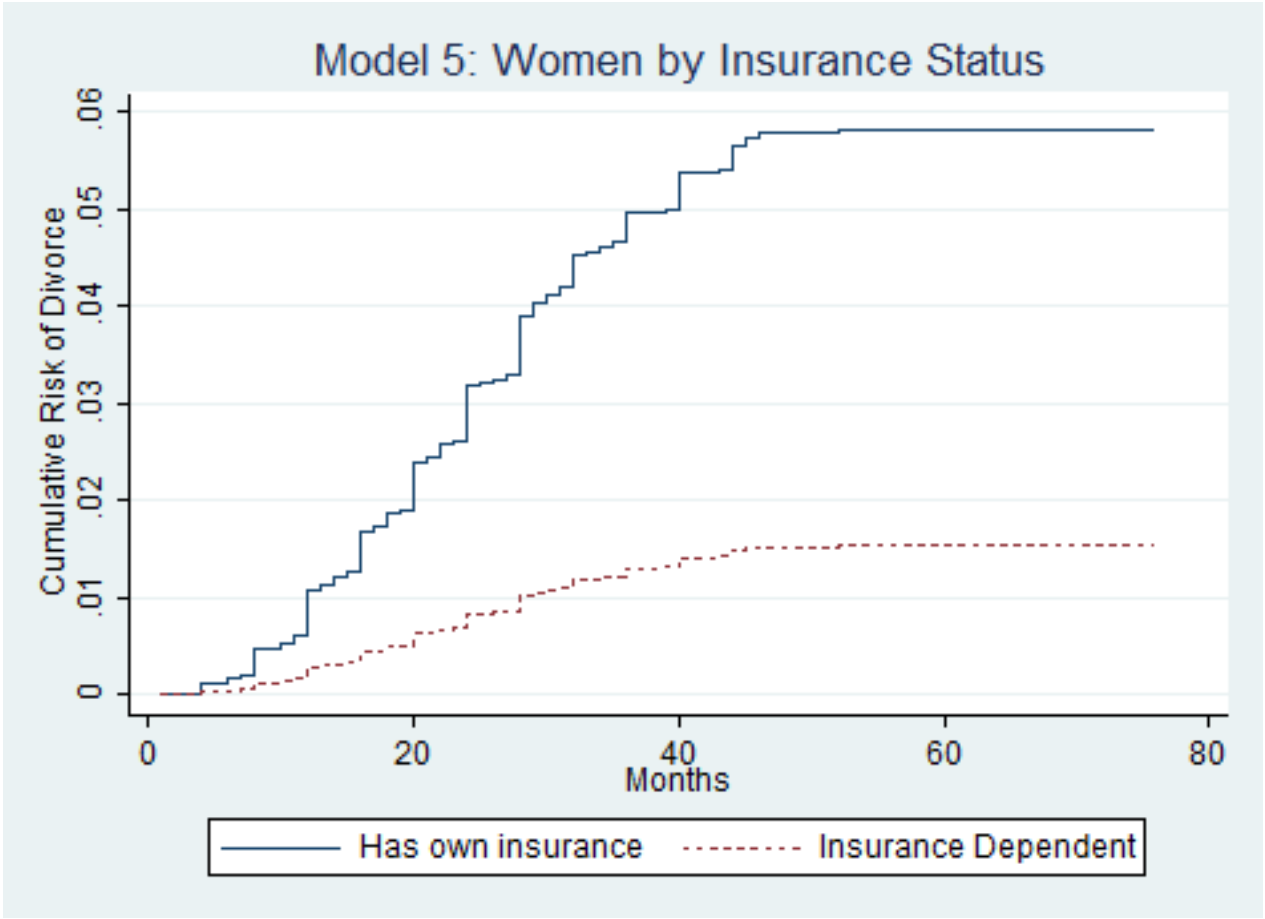

Model 4: Men by Insurance Status
Cumulative Risk of Divorce
0
.01
.02
.03
.04
.05
.06
0
20
40
60
80
Months
Has own insurance
Insurance Dependent

Figure 3


Model 5: Women by Insurance Status
Cumulative Risk of Divorce
0
.01
.02
.03
.04
.05
.06
0
20
40
60
80
Months
Has own insurance
Insurance Dependent