

The Challenge Of Providing Health Benefits For Domestic Partners

By Anne E. Moran

As the political and social climate in the United States has changed, and the growing economy has (at least until recently) increased competition among employers for skilled workers, there has been a dramatic increase in the number of “domestic partner” benefits offered by employers to unmarried heterosexual or homosexual couples since the first major reported benefits were offered by the *Village Voice* in 1982. One of the most frequently requested benefits is inclusion of domestic partners in an employer-provided health plan. According to the Human Rights Campaign Foundation, a gay rights organization, over 35,000 companies now offer health benefits for domestic partners. Employers offering such benefits have expanded from municipalities in San Francisco and Seattle, to the high-technology giants like Microsoft and Apple Computers, to the automobile industry, when in December 2000 it was reported in *USA Today* that the “big three” auto companies reported that they would offer health benefits for domestic partners.

Employers must deal with a number of special planning and tax issues when they provide domestic partner benefits. Three major issues they need to consider are (1) whether such benefits can be offered without jeopardizing the tax-advantaged status of the employer’s health plan, (2) whether such benefits can be excluded from income of the employee and dependent who receive them, and (3) how to structure the plan’s eligibility requirements to ensure it is

administrative and financially feasible. This article discusses these issues and how many employers can and do handle them.

Eligibility Criteria For Domestic Partner Coverage

Most employers have provided health benefits to employees and their “traditional” families—spouses and children. Employees with domestic partners (generally defined for purposes of this article as heterosexual or homosexual couples who share basic living arrangements but are not married either formally or by common-law marriage) have sought employer-provided health insurance because of its significant advantages. First, the cost to an employee of group coverage—even if not subsidized by the employer—is significantly less than individual coverage. In addition, the Internal Revenue Code (“Code”) provides major tax advantages for employees who receive such coverage. Any payments made by the employer for the provision of such coverage are tax-free to the recipient employee or dependent under section 106 of the Code. Further, any reimbursements by the employer to the employee for medical expenses are exempt from income under section 105(b) of the Code.

These tax advantages generally apply, however, to coverage of and payments with respect to employees and their "dependents." A dependent is defined in section 152 of the Code as the taxpayer's spouse or "who, for the taxable year of the taxpayer, has as his principal place of abode the home of the taxpayer and who is a member of the taxpayer's household." Code § 152(a)(9). In addition, the dependent must receive over half of his support from the employer/taxpayer. Code § 152(a). While domestic partners generally reside in each other's household, it is harder for many to meet the criterion that the dependent receive over half of his support from the employee/taxpayer. And even though some domestic partners might qualify as receiving half their support from another, the employer might feel that monitoring this

requirement is too difficult or intrusive. Another obstacle is section 152(b)(5) of the Code, which prohibits dependent status if the relationship *is in violation of local law*. The IRS has not defined the scope of this italicized phrase and will likely not do so. In a recent field service advice, however, the IRS made it clear that although the definition of “dependent” for purposes of determining the federal income tax consequences of providing health benefits to domestic partners was determined under section 152, local law, and not any principle under section 152, would govern in determining whether the relationship was in violation of local law for purposes of section 1529(b)(5). *See* Field Service Advice FSA 199911012 (Dec. 10, 1998). Thus, given this uncertainty and the fact that old antisodomy and similar laws still exist in many states, some employers have been reluctant to rely on the definition of "dependent" under section 152 to cover domestic partners.

As a practical matter, therefore, most employers try to design domestic partner policies assuming that most partners will not be "dependents" as defined in section 152. A clear definition of domestic partner in the employer's plan is necessary, however, because employers, insurance carriers, and any other service providers will want to avoid the adverse selection that would occur if all employees could sign up any “partners” they chose without established criteria. Criteria often used in health plans include requirements that the domestic partners (a) have been in a committed and exclusive relationship with one another, usually for a minimum period of time, such as a year or six months, (b) live together in the same principal residence, (c) are over 18, unmarried, legally competent to contract, and (d) are not related by blood. Some employers require that the domestic partners be jointly responsible for basic living expenses, such as food and shelter. This was one of the requirements under the San Francisco Domestic Partnership Ordinance, S.F. Admin. Code Chs. 62, Sections 62.2(a) and (b). Others require that

the employee provide the domestic partner with over half of the partner's financial support. Often these representations are made in an affidavit signed by the partners.

In some cases, employers will only cover domestic partners who are registered under state- or city-sponsored "registries" of domestic partners. However, this technique has problems because the registry may be more or less inclusive than the employer prefers, and because the criteria in the registry can change and is beyond the control of the employer.

Tax Treatment Of Domestic Partner Coverage

Once eligibility criteria have been established, the employer must deal with the tax consequences of these benefits. Here, the Internal Revenue Service ("IRS") has provided some limited guidance in the form of private-letter rulings.

The IRS first discussed the tax consequences of employer-provided domestic partner health benefits in a private-letter ruling issued to the city of Seattle.¹ Priv. Ltr. Rul. 9034048 (May 29, 1990). The Service pointed out that section 106 of the Code and its underlying regulations exclude from an employee's gross income any payments made by the employer for health coverage of the employee, his spouse, or dependents, as defined in section 152. *See* Treas. Reg. § 1.106-1. Further, all reimbursements for such medical expenses are excludable under section 105(b) of the Code. The Service went on to say that medical coverage or reimbursements for persons *other than* an employer, spouse, or dependents is *not* excludable from income, and would be taxed as compensation or other income under section 611 of the

¹ The holding of any private-letter ruling applies only to the recipient who receives it; however, such rulings are used by the taxpayers as indicators of how the IRS might rule in certain cases.

Code. Thus, in the Service's view, an income exclusion for domestic partners benefits appears to depend on whether such individual could be deemed a spouse or dependent.

The Service refused to rule on the question of whether the domestic partners covered under this plan were dependents as defined in section 152, relying on *Ensminger v. Commissioner*, 610 F.2d 189, 191 (4th Cir. 1979), for the principle that the status of a spouse or dependent was a factual issue to be determined under state law. However, the ruling (and subsequent rulings) did set forth the Service's position as to how nonspouse dependents should be taxed if they did not qualify as dependents. This ruling was followed by other rulings that expounded on this position.

Although the rulings were initially not specific on this point, the Service finally specifically ruled that an employer's health plan can add domestic partners who are not dependents as defined in section 152 without jeopardizing the tax-free receipt of income by employees or dependents. Priv. Ltr. Rul. 9603011 (Oct. 18, 1995). The prior rulings had consistently stated that employees and dependents are not taxed on the cost of coverage or benefits received, and never hinted that the results would change by the addition of domestic partners to the plan. *See* Priv. Ltr. Rul. 9109060 (Dec. 6, 1990).

The IRS has made it clear, however, that if domestic partners are not "dependents," the value of employer-provided health care *coverage* provided to them is not excluded from income under section 105 and 106. Therefore, if an employer offers such coverage to employees with domestic partners, the employer must have to impute income to those employees who enjoy such coverage. In addition, the amount includible in the employee's income will constitute "wages" under section 3401(a) and 3121(a) of the Code, and is therefore subject to income tax withholding under the Federal Insurance Contributions Act (FICA) and will constitute wages

under the Federal Unemployment Tax Act (FUTA). Finally, the employee would be subject to any withholding taxes on that income. *See, e.g.*, Priv. Ltr. Rul. 9850011 (September 10, 1998), Priv. Ltr. Rul. 9109060, and Priv. Ltr. Rul. 9717018, (January 22, 1997).

Priv. Ltr. Rul 9717018 also explicitly permitted coverage of a domestic partner's dependents, although the costs of that coverage would be taxable. The amount of imputed income will equal the amount of the fair-market value of the coverage minus the amount, if any, paid by the employee. Treas. Reg. § 1.61-2(b). The IRS will not issue rulings as to what constitutes the fair-market value of such coverage. However, the IRS has implied that such fair-market value will be measured by examining the value of group coverage, not the more expensive individual coverage. Priv. Ltr. Rul. 9603011. *But see* Priv. Ltr. Rul. 9034048 (where IRS originally stated that the value should be based on individual policy rates). *See also* Priv. Ltr. Rul. 9717018.

Commentators have suggested alternative ways to value domestic partner coverage. One method might be to assume the additional cost is equal to the cost of individual coverage. Another would be to value the marginal cost of coverage; for example, if an employee has individual coverage and adds his domestic partner, the additional cost of changing from individual coverage to "family coverage" or "employee plus one" (depending on how the plan is structured) might be the imputed income. Obviously if the employee with the domestic partner paid for this coverage there would be no imputed income. Employers sometimes *require* the employee to pay for the coverage to avoid imputed income requirements.

Furthermore, the IRS has made it clear that amounts received by or on behalf of domestic partners as a reimbursement or payment of medical benefits under the plan will not be included in the income of the employee or domestic partner, to the extent that either coverage was paid for

by employee contributions to the plan or if the fair-market value of the coverage was included in the employee's income. Priv. Ltr. Rul. 9603011; Code § 104(a)(3).

Finally, the Service has not ruled on the ability of the employer to deduct the costs of any domestic coverage that it provides. However, since there is no specific requirement that payment of health benefits other than to an employee be limited to spouses or dependents, presumably any employer contributions would be deductible under section 162 of the Code. *See* Treas. Reg. § 1.162. However, self-employed individuals likely cannot deduct the cost of domestic partner coverage, because such deduction is limited to 60% of the amount paid during the year for coverage of the employee, spouse, or dependents. *See* Code § 162(l).

Applying Related Laws To Domestic Partners

Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employees and their qualified beneficiaries can elect to continue coverage under the employer's health plan in certain circumstances under which coverage would normally end (e.g., termination of employment, death of the employee spouse). *See* Code § 4980B (2000) and ERISA § 601 *et seq.* However, the COBRA-continued health care coverage requirements do not apply to domestic partners, who would not be "a qualifier beneficiary," defined in the Code as a spouse or dependent child of the employee. *See* Code § 4980B(g)(1)(a) and ERISA § 607(3)(A). Plans could voluntarily provide COBRA coverage to these individuals, however. The requirements under the so-called HIPAA rules that plans extend preexisting coverage to plan participants do not apply to domestic partners, and there may be practical problems to determining the amount of a participant's "creditable coverage" if prior plans did not cover these individuals.

Often employers establish “cafeteria plans” under section 125 of the Code to permit employees to pay for health care and other employee benefits on a pre-tax basis. Although there have been no specific rulings on the issue, it would appear that domestic partners who are not considered "dependents" would result in imputed income with respect to the health care portion of any cafeteria plan. This is because the qualified benefits that may be excluded from income would not include any imputed coverage of domestic partners. Similarly, amounts paid from medical expense spending accounts for domestic partners would not be excludable from income, because such amounts are defined under the Code as expenses otherwise deductible under section 213 of the Code. Expenses for a non-dependent are not deductible under that section.

A more difficult issue for some employers involves the use of voluntary employee beneficiary associations (VEBAs), which very generally are tax-exempt trust funds that are often used to fund employee or retiree health benefits. *See* Code § 501(c)(9). VEBAs are permitted to provide health care coverage to members of the VEBA or their "designated beneficiaries." A domestic partner would not qualify as a beneficiary because that definition relies on the definition of "dependent" under section 152. *See* Treas. Reg. § 1.501(c)(9)-3(a). A domestic partner would also not qualify as a "member" of a VEBA, generally defined as the employee or dependent. *See* Treas. Reg. § 1.501(c)(9)-3(a).

The VEBA rules state that a VEBA is disqualified (and thus loses its tax-exempt status) unless 90% of its members are employees or dependents. The other 10% must share an "employment-related bond" with the VEBA's members. *See* Treas. Reg. §§1.501(c)(9)-2(a)(1) and 1.501(c)(9)-2(b). An example given in the regulations allows proprietors and owners of business to be VEBA members even if they are not employees, as long as they do not constitute more than 10% of the membership. Treas. Reg. § 1.501(c)(9)-2(a)(1). Similarly, a VEBA must

not fund more than a de minimis amount of *benefits* that are not permitted to be offered under a VEBA.

These limits make it clear that a VEBA's status could be jeopardized if domestic partners become covered under the underlying health plan. It is our understanding from informal discussions with IRS personnel that the IRS will likely not attack the qualification of a VEBA if de minimis benefits are paid to domestic partners from a VEBA. The Service has given no formal definition of what benefits are de minimis, however, and whether one measures the number of people covered or the benefits received. One private-letter ruling issued in 1998 held that in the particular circumstances cited therein, coverage of a non-dependent domestic partner would not affect the exemption of the VEBA as long as the benefits paid with respect to such individuals did not exceed three percent of the total benefits of the VEBA. Priv. Ltr. Rul. 9850011 (Sept. 10, 1998).

VEBAs are also subject to general non-discrimination requirements, but since VEBAs may contain eligibility classifications that are reasonable, one would assume that allowing a defined group of domestic partners would be reasonable, particularly if, as in some cases, the employer is accommodating a local ordinance. Some limited protection might also be provided if the existence of this classification is highlighted on the Form 1024 determination letter that is sent to the Service to obtain a ruling that the VEBA is tax-exempt.

If an employer prefers to provide domestic partners with these benefits outside the VEBA to avoid any risk to the employee VEBA, as many employers do, that fact should clearly be stated in the plan's summary plan description (SPD), which requires a description of funding. There may be some recordkeeping and administrative complications if this approach is taken.

If the employer's plan is self-funded and subject to the nondiscrimination rules of section 105(h), it should make sure that the class of individuals who use a domestic partner benefit is not disproportionately highly compensated (defined as top 5 officers, 10 percent shareholders and top ¼ of the work force). This is because section 105(h) of the Code, which applies to self-insured plans, provides that highly compensated individuals will not be able to exclude benefits payable to them under a discriminatory medical reimbursement plan. While the definition of "discriminatory" under section 105(h) is not precise, the regulations look to see if a plan benefit is available or otherwise discriminates in favor of the highly compensated. *See* Treas. Reg. § 1.105-11(e)(2) and (3). The penalty for having a discriminatory benefit is the loss of the exclusion for the reimbursement, which could be significant if the reimbursement is for a major medical expense. One might argue the benefit in this case is the "coverage" of the domestic partners on which income is imputed, but since the law is so unclear in this area and the regulations focus on the benefits received, it is risky to rely on that position.

Administrative Issues

Some employees have limited domestic partner benefits to cities where ordinances require such benefits. Both the VEBA rules and section 105(h) nondiscrimination rules would deem geographic areas to be reasonable classification, and it seems likely that selecting beneficiaries in cities with ordinances as a type of trial/demonstration program is also a reasonable classification of employees.

Similarly, some employers limit the eligible domestic partners to "same-sex" partners to control costs. In particular, employers with retiree health benefits are unwilling to shoulder the burden of adding domestic partners who could marry but do not do so because they would lose Social Security benefits. It also limits any potential liability for covering couples who could

otherwise marry but who choose to live together without marriage due to tax or other reasons. Finally, this restriction limits the number of potential domestic partners in the VEBA, helping to ensure that benefits to such partners remain de minimis.

The California state labor commissioner has opined informally that a state government plan's limitation of benefits to same-sex partners was unlawful discrimination. Also, the San Francisco ordinance applies to both opposite-sex and same-sex partners. The California courts have recently taken the position that such ordinances, to the extent that they relate to employee benefit plans subject to ERISA, they could be preempted in certain cases. *See Air Transport Ass'n. v. City and County of San Francisco*, 992 F. Supp. 1149 (N.D. Cal. 1998), and *S.D. Myers, Inc. v. City and County of San Francisco*, 1999 U.S. Dist. LEXIS 8748 (N.D. Cal. 1999). Note, however, that the courts have also found exceptions to this ERISA preemption, for example, if the issuer of the ordinance is acting as a consumer, and not as a regulator, which may be the case with respect to many employers. In the *Air Transport Ass'n* case, for example, the court made it clear that ERISA preemption applied in that instance because air transportation was so heavily regulated, but said that ERISA preemption might not apply in cases where the city was merely a consumer of services. Similarly, the court in *Myers* found that ERISA preemption did not apply because the plaintiffs in that case (who were challenging the San Francisco Domestic Partnership Ordinance) could not show irreparable harm and so had no standing to sue. (Moreover, ERISA preemption would not apply to non-ERISA benefits such as bereavement leave.)

Civil rights groups continue to challenge “same-sex” domestic partner plans, but although this issue has just begun to be litigated, at least two court cases have held that employee benefit plans covering spouses and unmarried homosexual partners, but not unmarried

heterosexual partners, do not violate Title VII of the Civil Rights Act. *See Foray v. Bell Atlantic a/k/a/ NYNEX Corp.*, 56 F. Supp. 2d 327 1999 U.S. Dist. LEXIS 8494 (S.D. N.Y. 1999), and *Cleaves v. City of Chicago*, 21 F. Supp. 2d 858, 861 (N.D. Ill. 1998). Nevertheless, employers could face a legal challenge if they limit such benefits to same-sex partners who "cannot otherwise be married."

There are other practical, non-tax issues to be considered by employers that cover domestic partners. If the employer has an insured plan, if it uses a reinsurer, HMO, or any other contractual provider of services, it should inform those providers of any proposed eligibility criteria so that everyone is clear as to whether such persons are covered under the service and insurance contracts.

Finally, while employers naturally want to protect their employees' privacy, an employer should also protect itself by informing participants that while it will consider any domestic partner application/affidavit to be confidential personnel information, it may be necessary to disclose an employee's domestic partner relationship to medical, dental, or other vendors, as well as to authorized personnel for purposes of calculating deductions and income inclusion. Some employers require a written acknowledgment of this fact.

Conclusion

Although covering domestic partners is not a simple matter, employers can do so with careful planning and up-front communication with employees and service providers about the scope and effect of such coverage.