July 2021 Employee Benefits Compliance

Domestic Partner Coverage Overview

Introduction

Trends towards extending or eliminating coverage or benefits eligibility for domestic partners have changed drastically over the last decade. While many plans initially covered domestic partners to allow employees to cover same sex partners, the landscape changed in 2014 when the Supreme Court legalized same sex marriage. In light of that new legal recognition, many employer plans eliminated domestic partner coverage because all or most employees now had access to tax favored benefits as married spouses.[1] In fact, most states with domestic partner registries converted existing registered domestic partnerships to marriages and ceased all new registrations. Although this simplified tax and benefits administration issues, some employers are revisiting whether to offer domestic partners again to increase inclusion. When deciding whether to extend coverage to domestic partners, employers should review the issues summarized below, including imputing income, account based plan reimbursements or restrictions, DCAP eligibility, COBRA and Medicare interactions. It is also important to consult with tax and other legal advisors on these issues due to their complexity as well as to address other non-health and welfare compliance concerns.

Overview of Tax Issues with Providing Benefits to Domestic Partners

In general (and with exceptions noted below), domestic partners cannot receive tax favored employer sponsored group health plan benefits under Federal or State law. Therefore, most employees covering domestic partners will have the Fair Market Value (FMV) of coverage imputed as income under Federal and State law. However, a domestic partner can be a federal tax dependent of an employee as a "qualifying relative," under Code § 152 as modified by § 105(b). Any individual that satisfies the "Qualifying Relative" criteria will not have the FMV of coverage imputed as income under federal or state law. For a Domestic Partner to qualify as an employee's Qualifying Relative and Code §152/105(b) tax dependent the domestic partner must:

1. have the same principal place of abode as the employee and be a member of the employee's household (must not violate local law);
2. receive over half of his or her support from the employee;
3. not be anyone's "Qualifying Child"; and
4. be a citizen or national of the U.S., a resident of the U.S., or a country contiguous to the U.S.

Similarly, the children of domestic partners (who are not otherwise children of the employee) are entitled to receive tax-free health coverage only if they qualify as Code § 152/105(b) tax dependents as a qualifying relative or as stepchildren under state law. Since one of the conditions of the qualifying relative test is that a qualifying relative cannot be the qualifying child of any other taxpayer, the child of a domestic partner will frequently fail to satisfy this test because they are generally the qualifying child of the Domestic Partner. Nonetheless, if an employee is a stepparent of his or her domestic partner's child as recognized by the laws of the state in which the partners reside, then the employee will also be the child's stepparent for federal income tax purposes and there will not be imputed income under federal or state law (e.g. children of CA Registered Domestic Partners are stepchildren). As discussed below, tax status should be confirmed by affidavit.

As noted above, coverage for non-tax dependent domestic partners requires imputing income under both Federal and State law. However, there is no need to impute income under state law in states with no personal income tax or that only tax interest or dividend income. California also remains an exception to imputing income under state law for domestic partners registered with the Secretary of State. While most states converted existing registered domestic partnerships to marriage, California actually expanded its registration eligibility to both same sex and opposite couples and does not require imputed income for

[1] Some self-funded plans have not extended benefits to same sex spouses but this creates legal risk under Title VII.

state tax purposes for officially registered partnerships.
(See Alliant Insight - How to Impute Income for Domestic Partners Including State Tax Table)

When an employee's coverage of a Domestic Partner requires imputed income under Federal and/or State law, determining the FMV of that coverage can be complicated. IRS has not sanctioned a specific method to determine the FMV of coverage for purposes of imputing income. The following three ways to determine the FMV of group health plan benefits for purposes of imputing income are most commonly used:

1. COBRA Rate – The COBRA rate for employee-only coverage.
2. Incremental Cost – The additional cost of adding an individual to the coverage (e.g. the difference in cost between employee-only coverage and employee + 1 coverage, etc.). The incremental cost can never be zero. An insured plan with no incremental cost could use the employee only rate as well.
3. Actuarial Value – The value is determined by an actuary based on actual plan costs.

Although the source of the contribution (e.g., employer-paid or employee-paid) is generally irrelevant to the tax analysis, any amount the employee contributes toward the domestic partner's coverage on a post-tax basis should be subtracted from the fair market value amount imputed as income. Note that an employee can pay for Domestic Partner coverage through the cafeteria plan on a pre-tax basis, but in that situation the entire FMV is imputed (without subtracting post tax payments). Employers should work with their tax advisor and actuary to ensure imputed income is calculated correctly.

Affidavit and other Domestic Partner Documentation

The term domestic partner can refer to registered domestic partners recognized by state or local law as well as domestic partners that are simply recognized in an employer's plan eligibility provisions and usually confirmed by employee affidavit. It is important that employers clearly identify who is eligible as a domestic partner in all documents describing eligibility. Many employers originally used either state registration, carrier guidelines or meeting certain criteria such as cohabitation and shared expenses documented by affidavit to define and document eligibility. This continues to be a practical approach for employers, especially for employers with large numbers of California employees where registrations continue. For California state tax purposes it is important to also confirm whether a partnership is formally registered with the secretary of state (as opposed a local registration like San Francisco). However, employers should not require employees to produce certificate of registration if they do not require married spouses to produce marriage certificates. When assessing affidavit criteria most employers are generally just setting a minimum standard for a committed relationship. While this generally includes cohabitation this isn't a requirement (but cohabitation is required for federal qualifying relative tax status). Most affidavits also require a 6 month period between when one partner is dropped and another is added (also set as a common cohabitation minimum duration) to mirror many state divorce "cooling off" periods (a window from when divorce papers are filed to when the divorce can be finalized). The general idea is to put some constraints around adding and dropping affidavit domestic partners to simplify plan administration. Lastly, as noted above, an employee's domestic partner who qualifies as an employee's Code §152/105(b) tax dependent should complete a verifying affidavit to not have the FMV of coverage imputed as income under Federal or State law. Employers are obligated to request information on tax status and not to impute income when it is not required.

Sample affidavits are available through Alliant account teams.

HSAs and Domestic Partners

Health Savings Accounts (HSAs) are tax-favored individual trust or custodial accounts that can be contributed to by or on behalf of eligible individuals who are covered by a qualifying high-deductible health plan (HDHP) and no other incompatible coverage. Because of the tax favored status of HSA there are tax year contribution limits tied to the tier of HDHP coverage elected (individual or family coverage).

Where employees' domestic partners (and the children of a domestic partner) are eligible for the employer plan, employees enrolled in family HDHP coverage can contribute the family coverage limit to their HSAs. However, an employee cannot reimburse the expenses of the domestic partner out of the HSA unless that domestic partner is also a tax dependent (as defined by IRC § 152 as modified by § 105). Again, most domestic partners are not tax dependents. However, non-tax dependent domestic partners can establish their own individual HSAs as long as they have HDHP coverage and no disqualifying coverage (e.g., general purpose FSA or HRA, Medicare, Tricare). The domestic partner could also then contribute the full family coverage contribution limit to their own HSA. A domestic partner can also contribute the family coverage limit to their HSA if covered by family HDHP coverage.

For a detailed discussion of issues to consider regarding HDHP and HSAs see Alliant Insight - Implementing an HDHP HSA Benefit Option. See also our summary table of IRS Limits 2023 (updated annually).

HRAs and Domestic Partners

Health Reimbursement Arrangements (HRAs) are self-funded group health plans that reimburse employees for certain medical expenses incurred by employees and their dependents on a tax favored basis. Typically an employer will establish a "notional" or unfunded account for each participating employee, and then reimburse qualifying expenses until the account balance is exhausted. HRAs must be funded with employer dollars. The medical expenses of an employee's domestic partner cannot generally be reimbursed on a tax favored basis by an HRA unless the domestic partner is also a tax dependent (as defined by IRC § 152 as modified by § 105). While many plans exclude HRA coverage for non-tax dependents, some plans do choose to extend HRA coverage to non-tax dependent domestic partners and impute the fair market value of the reimbursement. To accomplish this, an employer must require employees to formally identify any such non-tax dependent domestic partners for coverage under the HRA before such coverage begins. A clear explanation of the tax consequences is also critical for the employee. Although the IRS has provided almost no guidance on how to impute income for HRA coverage provided to a non-tax dependent, the fair market value of this type of benefit is the amount that an individual would have to pay for the benefit in an arm's-length transaction. Although there are arguments that the full value of the HRA (the COBRA rate) must be imputed regardless of utilization, a more common and more practical approach is to impute only the value of reimbursements provided to the non-tax dependent domestic partner. Under any approach, the employer and HRA administrator must know who is covered by the account and for whom the reimbursement is being requested.

For a detailed discussion of these and other issues with HRAs see Alliant Insight - HRAs Rules and Issues.

H-FSA and DCAP Domestic Partner Considerations

A cafeteria plan is a funding vehicle under Code § 125 that allows employees to pay for certain qualified benefits on a pre-tax basis through payroll deductions. Qualified benefits can include employee salary reductions under a health flexible spending arrangement that can reimburse the medical expenses of employees and their §152/105(b) tax dependents. The medical expenses of an employee's domestic partner cannot generally be reimbursed on a tax favored basis by an H-FSA unless the domestic partner is also a tax dependent. There is no practical mechanism to allow the reimbursement and then impute income as H-FSAs are primarily funded by employee pre-tax salary reduction elections. Non-tax dependents are uniformly defined as ineligible to receive reimbursements under an H-FSA.

Dependent care assistance programs (DCAPs) (under Code §129) are another common cafeteria plan benefit that allows employees to exclude from income amounts paid or incurred by their employer for qualifying dependent care expenses. Like H-FSAs, those amounts are typically funded by employee salary reductions. Significantly, expenses paid or incurred to care for the child of a domestic partner ordinarily will not qualify for tax-free reimbursement. Although a household member who is not the child of a taxpayer (the child of a non-tax dependent domestic partner) can be a dependent if that person is not

the qualifying child of another taxpayer (e.g., the domestic partner), this is incredibly rare and most dependent care expenses for the child of a domestic partner will not be reimbursable.

For additional details on Cafeteria Plans see Alliant Insight - Cafeteria Plans Background and Basics.

COBRA and Domestic Partners

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and covered dependents (Qualified Beneficiaries) who lose health benefits due to certain listed Qualifying Events the right to continue group health benefits for limited periods of time. However, only employees, spouses, and dependent children may be Qualified Beneficiaries under COBRA. Domestic partners, therefore, will not have independent COBRA rights, even if they are recognized as dependents under the plan. Although domestic partners do not have independent COBRA rights, an employee who loses coverage and is offered COBRA can still cover a domestic partner as a dependent by electing the employee plus one (or plus dependent) tier of COBRA coverage. A domestic partner who loses eligibility for coverage due to dissolution of a domestic partnership or death of the employee cannot independently elect COBRA. To address this issue some employers choose (subject to carrier/stop loss approval) to offer COBRA-like continuation coverage to domestic partners. Employers choosing to offer COBRA-like benefits to domestic partners generally follow the same coverage, notice and premium rules for continuous coverage for married couples for ease of administration. Note that employers subject to state mini-COBRA regulations may have additional obligations with respect to domestic partners.

HIPAA Special Enrollment Rights and Partners

Once a plan extends coverage to domestic partners and their children, certain HIPAA special enrollment rights will be created as well. HIPAA requires group health plans to give "special enrollment" opportunities to employees, dependents, and COBRA qualified beneficiaries. Special enrollment is available: (1) on loss of eligibility for coverage by an eligible current employee or a dependent; (2) on becoming eligible for CHIP state premium assistance subsidy by an eligible current employee or dependent; and, (3) on acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption. Special enrollment is subject to strict time limits, generally 30 days from the date of the event (60-days for CHIP eligibility or losses of coverage). Whether an individual qualifies as a dependent for purposes of this HIPAA special enrollment right will depend on how eligibility under the plan is designed. If a plan covers domestic partners of employees, then such individuals will qualify as dependents for HIPAA special enrollment on loss of other coverage, or on birth, adoption or with respect to CHIP premium assistance eligibility for the eligible children of a domestic partner. A domestic partner will not be eligible for special enrollment on acquisition of a new spouse or dependent by marriage.

Medicare Issues Connected to Covering Domestic Partners

Employees covering a domestic partner (regardless of tax dependent status) should be aware of two significant issues regarding Medicare eligibility and coverage: (1) there are potentially significant late enrollment penalties for Medicare Part B when enrollment is delayed; and, (2) there are more nuanced issues in determining when Medicare will pay primary or secondary to active employee coverage.

A domestic partner will not count as a spouse for Medicare coverage because Social Security does not recognize a domestic partner as a spouse. Spouses of employees who work past age 65 can delay Part B enrollment until the spouse retires and qualify for a Special Enrollment Period (SEP) to sign up for Part B, without delay or penalty. However, because Social Security does not recognize a domestic partner as a spouse, the partner will not qualify for a Part B SEP, based on his or her partner's work record and if they are over age 65 when they enroll through the General Enrollment Period they will have a Part B late enrollment penalty, that is generally 20 percent of the cost of coverage owed for the duration of the coverage (for life). Therefore, a domestic partner should enroll in Medicare during their Initial Enrollment Period to avoid any potential penalties.

Next, there can be coordination of benefits issues with Medicare when the covered domestic partner of an employee is Medicare eligible. Medicare is generally a secondary payer for domestic partners with large employer group health coverage:

- When the domestic partner can get Medicare because of (non-ESRD) disability and is covered by a large group health plan through his/her own current employer or that of a family member (a domestic partner is considered a family member)
- For a 30-month coordination period when the domestic partner is eligible for Medicare due to End-Stage Renal Disease and is covered by a group health plan
- When the domestic partner can get Medicare because of age and has group health plan coverage through his/her own current employer

Medicare is primary payer for domestic partners with large employer group health plan coverage if a domestic partner can get Medicare due to his/her age and has group health plan coverage through his/her partner's current employer.

For a detailed discussion of Medicare and Group Health plan interactions and issues see Alliant Insight - Medicare and Group Health Plan Interaction.

Conclusion

Although most employers want to extend coverage to domestic partners out of an interest of increasing inclusion and to ensure that all employees feel like they are valued, there are significant tax and compliance issues to consider in connection with domestic partner coverage. It is particularly important that employees understand the tax consequences of covering a non-tax dependent domestic partner. This requires significant communication at open enrollment and in enrolling new hires. Ultimately, employees will need to determine federal tax status with their own tax advisor and be able to document or attest to that status for purposes of benefits administration and for eligibility for certain reimbursements.