

Valuing and Taxing Employment-Based Medical Benefits Provided to Domestic Partners and Same-Sex Spouses

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I. Introduction

Employers and employee organizations have for some time extended health insurance and other welfare and fringe benefits to domestic partners of their employees or members, as the case may be. This extension may be voluntary, pursuant to a state or local law, regulation or ordinance, or under the terms of a contract or collective bargaining agreement. Either way, employers that cover domestic partners (as well as individuals in same-sex marriages and civil unions) confront a host of unique employment, benefits and tax issues.

While the Internal Revenue Code (the “Code”)¹ and most state tax codes provide for tax-favored treatment of most welfare and fringe benefits furnished as a part of the employment relationship, the tax benefits are not usually available to domestic partners, and they are only made available in very limited instances to same-sex spouses and civil union partners and then only for state law purposes. Instead, the value of a benefit in the hands of a domestic partner and, to a lesser extent, a same-sex spouse or civil union is generally taxable to the employee or member. But what is not always clear is how benefits are valued for tax purposes.

Some employers are blissfully unaware that providing benefits to domestic partners, same-sex spouses of a partner to a civil union raises any unique tax issues or concerns. Others, while aware of the issues, are not certain what to do. Still others have developed practices and procedures for dealing with these issues, but they sometimes fail to understand or appreciate what options they have or whether the choices they have made will pass muster if challenged. These issues were muddied even further with the enactment of the Working Families Tax Relief Act of 2004² (WFTRA), which modified in certain key respect and sought to make uniform what it means to be a “dependent” for Code purposes, and more recently with the adoption of WFTRA technical amendments in the Gulf Opportunity Zone Act of 2005.³

This paper reviews the tax rules that apply to benefits provided to domestic partners, same-sex partners, and partners to civil unions. Under what circumstances are they taxable, and to whom, and when? While the principal focus is on group health insurance (including self-funded medical arrangements), the principles generally apply with equal force to other welfare and fringe benefits. The article next describes the

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¹ All section references are to the Code unless otherwise indicated.

² Pub. L. 108-311 (October 4, 2004).

³ Pub. L. 109-135 (December 21, 2005).

various approaches that employers have taken to comply with applicable tax rules and examines the valuation criteria established under applicable IRS guidance. The article concludes with recommendations for how employers and employee organizations might go about assuring compliance.

II. Background

The tax-favored status of employer-provided health insurance is so well known that employers and employees often take it for granted. Employers have been known to treat employee contributions to their group health plans as pre-tax contributions without adopting a section 125 cafeteria plan, for example. They do this assuming that these premiums are always tax-favored. They are shocked to learn that there is something they must do—i.e., adopt a written plan—for their employees to qualify for tax-favored treatment. So it behooves us to first refresh our understanding of the origins and contours of this favorable tax treatment.

(a) Code § 61(a) and the Basic Rule of Inclusion

The point of departure is § 61(a)(1), which provides, in relevant part,

“Except as otherwise provided in this subtitle, gross income means all income from whatever source derived, including (but not limited to) . . . compensation for services, including fees, commissions, fringe benefits, and similar items . . .”

Treasury regulations expand upon and clarify this basic rule. Treas. Reg. § 1.61-21(a)(3) tells us that a fringe benefit provided in connection with the performance of services is considered “to have been provided as compensation for such services,” and Treas. Reg. § 1.61-21(a)(2) directs us to other provisions of the Code to determine whether a particular fringe benefit is deductible, providing (again in relevant part)—

“To the extent that a particular fringe benefit is specifically excluded from gross income pursuant to another section of subtitle A of the Internal Revenue Code of 1986, that section shall govern the treatment of that fringe benefit. Thus, if the requirements of the governing section are satisfied, the fringe benefits may be excludable from gross income.”

Treas. Reg. § 1.61-21(a)(4)(i) provides the link between the non-employee domestic partner or same-sex spouse and the employee. It provides,

“A taxable fringe benefit is included in the income of the person performing the services in connection with which the fringe benefit is furnished. *Thus, a fringe benefit may be taxable to a person even though that person did not actually receive the fringe benefit.* If a fringe benefit is furnished to someone other than the service provider such benefit is considered in this section as furnished to the service provider, and use by

the other person is considered use by the service provider. . . .” (Emphasis added.)

Under Treas. Reg. § 1.61-21(b)(1), “an employee must include in gross income the amount by which the fair market value of the fringe benefit exceeds the sum of— (i) the amount, if any, paid for the benefit by or on behalf of the recipient, and (ii) the amount, if any, specifically excluded from gross income by some other section of subtitle A of the Internal Revenue Code of 1986.” For the reasons described below, pre-tax employee contributions made under cafeteria plan elections are treated as “employer” contributions. So no part of the benefit is treated as employee-paid for purposes of this regulatory provision, and the fair market value of the fringe benefit provided to the domestic partner is taxable to the employee under these circumstances.

Treas. Reg. § 1.61-21(b)(2) attempts to clarify the meaning of fair market value in this context. It says—

“In general, fair market value is determined on the basis of all the facts and circumstances. Specifically, the fair market value of a fringe benefit is the amount that an individual would have to pay for the particular fringe benefit in an arm’s-length transaction. Thus, for example, the effect of any special relationship that may exist between the employer and the employee must be disregarded. Similarly, an employee’s subjective perception of the value of a fringe benefit is not relevant to the determination of the fringe benefit’s fair market value nor is the cost incurred by the employer determinative of its fair market value.”

As a result of § 61, benefits that an employer provides to an employee, his or her spouse, or dependents are taxable as ordinary income. So if a benefit (such as group medical or group life insurance) is to be excluded from income, then there must be an exclusion elsewhere in the Code—which, of course, there is. But these exclusions do not extend to non-dependent, domestic partners or same-sex spouses.

(b) Code §§ 104(a)(3), 105, 106 and 125

The taxation of medical benefits is governed by four, interrelated sections of the Code. They are:

(1) *Code § 104.* Section 104 provides exclusions from an individual’s gross income for amounts received from workers’ compensation, as damages for personal injuries, and from accident and health benefit coverage not financed by an employer. Section 104(a)(3) provides that,

“Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include . . . amounts received through accident or health insurance (or through an arrangement

having the effect of accident or health insurance) for personal injuries or sickness (other than amounts received by an employee, to the extent such amounts (A) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (B) are paid by the employer) . . .”

While the wording of this provision is not easy to follow, it is easy to summarize: If an employee pays tax on the premium, he or she will not be taxed on the value of any benefits he or she receives. But if the employee does not pay tax on the premiums (e.g., employee premiums on a pre-tax basis under a cafeteria plan), he or she must include the value of the benefits in income. While including the benefit in income appears draconian, it is offset, at least to some extent, by the corresponding deduction under § 213(a) (with respect to medical expenses) but only to the extent that it exceeds 7.5% of adjusted gross income.

Example: X, an independent contractor, obtains coverage under her client’s fully paid medical plan. She does not include the premiums in income. While covered under the plan X undergoes coronary by-pass surgery, which costs \$250,000. X must include the \$250,000 in her gross income for the year in which the procedure was performed. X will have a corresponding deduction to the extent that \$250,000 exceeds 7.5% of her adjusted gross income.

(2) *Code § 105.* Under § 105(a), amounts received by an employee (and his or her spouse and dependents) through accident or health insurance for personal injuries or sickness are taxable to the extent such amounts are attributable to contributions by the employer which were not includible in the gross income of the employee, or are paid by the employer. But § 105(b) contains an important exception to the general rule of §105(a), which excludes from gross income amounts expended for medical care (i.e., medical expense reimbursements) paid—

“directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care (as defined in section 213(d)) of the taxpayer, his spouse, and his dependents (as defined in section 152).”

Similarly, § 105(c)(1) allows for payment for the permanent loss or loss of use of a member or function of the body, or the permanent disfigurement of the employee, his or her spouse, or a dependent, so long as the payments are computed with reference to the nature of the injury and without regard to the period the employee is absent from work.

(3) *Code § 106.* Section 106 provides that employer-paid premiums/coverage under an accident or health plan is not taxable to the employee if the coverage is for the employee, his or her spouse or dependents. Treas. Reg. § 1.106-1 describes the operation of § 106 as follows:

“The gross income of an employee does not include contributions which his employer makes to an accident or health plan for compensation (through insurance or otherwise) to the employee for personal injuries or sickness incurred by him, his spouse, or his dependents, as defined in section 152.”

Under a typical insured medical plan, § 106 ensures that premiums paid by the employer on an employee’s behalf are not included in the employee’s income, and § 105(b) exempts from the employee’s income any medical benefits paid on his or her behalf under the employer’s plan. These exclusions from income also extend to employment taxes and income tax withholding.⁴

(4) *Code § 125.* Sections 105 and 106 say nothing about employee contributions, which, in the absence of § 125, would be taxable. Section 106 first appeared in the Code in 1954 when the vast majority of employer sponsored accident and health plans were entirely employer-financed. Plans requiring employees to contribute to the costs of coverage came later. It was not until 1978, with the enactment of § 125, that employee contributions to accident and health plans became deductible.⁵ Section 125(d)(1) defines the term “cafeteria plan” to mean

“a written plan under which--(A) all participants are employees, and (B) the participants may choose among two or more benefits consisting of cash and qualified benefits.”⁶

While perhaps counterintuitive, amounts deducted from employees’ pay under a cafeteria plan election are treated as “employer” contributions. This is so because employee deferrals are made under a salary reduction agreement—the employee agrees to a reduction in salary in a specified amount and the employer agrees to contribute a like amount toward the purchase of qualified benefits (medical coverage, in this instance).⁷ Therefore, employee salary reductions are treated as employer contributions for purposes of §§ 105 and 106, the benefits of which are available only to taxpayers and their spouses and dependents.

⁴ Treas. Reg. §§ 3121(a)(2), 3306(b)(2) and 31.3401(a)-1(b)(8).

⁵ § 125 was added to the Code by the Revenue Act of 1978, Pub.L. No. 95-600, § 134(a), 92 Stat. 2763.

⁶ *See generally* § 125. In addition to requiring a written plan, the Code imposes certain non-discrimination and other requirements on cafeteria plans. For example, under §125(b)(1)(A), a cafeteria plan cannot discriminate in favor of “highly compensated individuals” as to eligibility to participate or “highly compensated participants” as to contributions and benefits. Sections 125(e)(1) and (2) define the term “highly compensated participant” and “highly compensated individual” to mean a participant who is (i) an officer, (ii) a shareholder owning more than 5% of the voting power or value of all classes of stock in the employer, (iii) highly compensated, or (iv) a spouse or dependent of such an individual. Similarly, § 125(b)(2) provides that qualified benefits provided to key employees under the plan may not exceed 25% of the aggregate of such benefits provided for all employees under the plan.

⁷ *See, Prop. Treas. Reg. § 1.125-1, Q&A 6., 49 Fed. Reg. 19321 (May 7, 1984).* (“A salary reduction agreement will have the effect of causing the amounts contributed thereunder to be treated as employer contributions under a cafeteria plan only to the extent the agreement relates to compensation that has not been actually or constructively received by the participant as of the date of the agreement (after taking section 125 into account) and, subsequently, does not become currently available to the participant.”)

Read together, these four statutory provisions govern the tax consequences of medical and disability benefits. Section 104 is not limited to employees. Any individual that purchases coverage with after-tax dollars will be able to exclude payments received as a result. For purposes of §§ 105 and 106, the term “employee” means and includes (i) a common law employee, (ii) a full-time life insurance agent who is a current statutory employee, (iii) a retired employee, (iv) a widow or widower of an individual who died while an employee, (v) a widow or widower of a retired employee, and (vi) a leased employee under § 414(n).⁸ Self-employed individuals, partners and 2% shareholders of S corporations are not employees for this purpose, but these individuals generally are treated the same as employees under § 104(a)(3). Therefore, a self-employed individual who pays premiums for medical or disability insurance on an after-tax basis will be able to exclude benefit payments from income.

(c) Status as a Spouse or Dependent

Coverage provided under an employer-sponsored accident and health plan for personal injuries or sickness incurred by individuals other than an employee, his or her spouse, or his or her dependents, is not excludable from the employee’s income under § 106, and reimbursements received by the employee are not excludable under § 105(b) unless the reimbursement is for medical expenses of the employee, his or her spouse, or his or her dependents.

So who is a spouse or dependent?

(1) *Dependents.* Before enactment of the WFTRA, Section 152 determined whether an individual was a dependent. Prior law Sections 152(a)(1) through (8) defined dependent in terms of support and relationship. Under these provisions, a “dependent” was an individual who (i) received more than half of his or her support from the taxpayer, and (ii) was related to the taxpayer in certain, specified ways. Section 152(a)(9) contained an alternative definition under which a “dependent” was an individual who (i) received more than half of his or her support from the taxpayer for the year, and (ii) who had the home of the taxpayer as his or her principal abode and was a member of the taxpayer’s household during the entire taxable year of the taxpayer.⁹ Lastly, prior law § 152(b)(5) provided an exception under which an individual is not considered a member

⁸ Treas. Reg. § 31.3401(c)-1 (defining an “employee” as a person performing services in an employer-employee relationship). Full-time life insurance agents are included within the definition of employee. § 7701(a)(20). *See also*, Rev. Rul. 56-400, 1956-2 C.B. 116; Rev. Rul. 85-121, 1985-2 C.B. 57; Rev. Rul. 82-196, 1982-2 C.B. 53 (holding that tax benefits of §§105 and 106 are available to employee's spouse and dependents before and after the employee's retirement and to the surviving spouse and dependents of a deceased employee).

⁹ *See also*, § 152(b)(5) as in effect prior to the WFTRA (providing an exception under which an individual was not considered a member of the taxpayer’s household if the relationship between the individual and the taxpayer is in violation of local law). This requirement was effectively read out of the Code by the U.S. Supreme Court in *Lawrence v. Texas*, 539 U.S. 558 (2003) (holding that a Texas criminal sodomy statute invalidated as unconstitutional intrusion on private sexual behavior).

of the taxpayer's household if the relationship between the individual and the taxpayer is in violation of local law.

The WFTRA entirely rewrote Code §152, effective January 1, 2005, to define the term “dependent” to mean either (i) a “qualifying child” or (ii) a “qualifying relative.”

- A “qualifying child” is a daughter, son, stepchild, sibling, or stepsibling (or descendent of any of any of these) who has the same principal place of abode as the taxpayer for more than one half of the taxable year and who (other than in the case of total disability) has not yet attained a specified age.
- A “qualifying relative” is a person who is not a qualifying child and who (i) has the same principal place of abode as the taxpayer for more than one half of the taxable year, (ii) receives more than half of his or her support from the taxpayer, and (iii) has gross income for the year in excess of the Code §151(d) exemption amount (\$3,300 in 2006).

Despite the introduction of new terminology, what it means to be a non-child “dependent” (or a qualifying relative) under the WFTRA changed little from prior law with one obvious and important difference—the addition of an annual income limit. WFTRA §207(9) amended §§105(b) and (c)(1), however, such that the newly introduced income limit does not apply when determining dependent status for purposes of group health plan benefits and reimbursements, which means that the income limit does not apply to health care reimbursements paid to “dependents. And although WFTRA failed to address the inclusion of employer-paid premiums, the IRS signaled it’s intend to accomplish this result by amending the regulations under §106 to parallel the §105 exception.¹⁰

Under WFTRA, the income limit applied in both to distributions under a dependent care assistance plan (including a dependent care flexible spending account) (collectively, “DCAPs”) and to the use of funds in a health savings account (HSA). Congress changed addresses these issues in technical corrections adopted as a part of the Gulf Opportunity Zone Act that are effective as though originally included in the WFTRA. Specifically, as a result of the Gulf Opportunity Zone Act, the exclusion from gross income for DCAP and HSAA distributions extends to “dependents.”

The Gulf Opportunity Zone Act did not change the WFTRA requirement in §152(d)(1) under which the definition of a “qualifying relative” excludes a “qualifying child” of another taxpayer. This requirement, which was not found in prior law, means that some children are no longer eligible for tax-free health coverage. For example, a child of a plan participant that lives with a grandparent for more than half the year is likely to be the grandparent’s qualifying child. The child in this instance cannot be the plan participant’s qualifying child because he or she does not live with the participant for more than half the year. But he or she will likely be the qualifying child of the

¹⁰ IRS Notice 2004-79, 2004-49 I.R.B. 898 (12/6/2004).

grandparent, which means that he or she cannot be a qualifying relative of plan participant.

Children of domestic partners are similarly affected. A child of a domestic partner who shares a place of abode with a plan participant will likely be the qualifying child of the domestic partner. This means that the child cannot be the qualifying relative of the plan participant since he or she is the qualifying child of another taxpayer.

Example: Plan participant A and her domestic partner B each have a minor child. B is a member of A's household and relies on A for support. B is A's dependent (i.e., qualifying relative) for purposes of group health coverage and tax-favored HSA distributions. A's child is also A's dependent (i.e., qualifying child) for these purposes and may also qualify for DCAP benefits. But, unlike the result under prior law, B's child is not A's dependent for any purpose under the Code.

(2) *Spouse.* Prior to the enactment of the Defense of Marriage Act,¹¹ state law determined the marital status of an individual.¹² Section 3 of the Defense of Marriage Act provides that,

“in determining the meaning of any Act of Congress, or of any ruling, regulation or interpretation of the various administrative bureaus or agencies of the United States, the word “marriage” means only a legal union between one man and one woman as husband and wife, and the word ‘spouse’ refers only to a person of the opposite sex who is a husband or a wife.”

So how do domestic partners fit into the equation? Domestic partners are not “married” for state law purposes. So unless an individual's domestic partner also qualifies as a dependent for Code purposes, the employee will not have access to accident and health benefits covering his or her domestic partner on a tax advantaged basis. Rather, coverage provided to the domestic partner will be taxed under § 104(a)(3)—i.e., premiums will be included in the income of the employee, but benefit payments and reimbursements will not be taxed either to the employee or the domestic partner.¹³

¹¹ Pub. L. No. 104-199, 110 Stat. 2419 (September 21, 1996).

¹² See, e.g., *Ensminger v. Commissioner*, 610 F.2d 189, 191 (4th Cir. 1979). (“The regulation of marriage, family life and domestic affairs ‘has long been regarded as a virtually exclusive province of the States.’ In its application of the tax laws there has been a consistent deference by Congress to state laws in such matters. . . . Congress undertook no determination of the legality of any kind of interpersonal relationship. Section 152(b)(5) leaves that determination entirely to the individual states and assures that Congress will not appear to reward behavior which may be in contravention of state law.”)

¹³ Priv. Ltr. Rul. 9034048 (May 29, 1990); Priv. Ltr. Rul. 9109060 (December 6, 1990); Priv. Ltr. Rul. 9231062 (May 7, 1992); Priv. Ltr. Rul. 9717018 (January 22, 1997); Priv. Ltr. Rul. 9850011 (September 10, 1998); Priv. Ltr. Rul. 200108010 (November 17, 2000); Priv. Ltr. Rul. 200339001 (June 13, 2003).

The Employee Retirement Income Security Act (ERISA)¹⁴ complicates the analysis where same-sex spouses are concerned. ERISA regulates most private sector employee benefit plans.¹⁵ ERISA generally “preempts” or takes precedence over state laws regulating employee benefit plans,¹⁶ but there is an important exception in the case of state laws that regulate insurance, banking and securities.¹⁷ Accordingly, state insurance laws will apply to same-sex couples that marry in any state that recognizes same-sex marriage, but the Defense of Marriage Act will control with respect to any other, non-insured benefit. As a result, insured benefits may be treated differently from self-funded benefits depending on the particular requirements of local law. Of course, ERISA governs only employee benefit plans. It does not regulate a broad array of employment-related policies, procedures and mandates covering such matters as diverse as workplace discrimination and bereavement, which are generally regulated by state law.

III. Establishing “Fair Market Value”

Where an employer provides coverage under its medical plan to a domestic partner, same-sex spouse, or civil union partner, the benefit will be taxed to the employee for Federal income and employment tax purposes, unless the domestic partner or same-sex spouse qualifies as the employee’s dependent. In the case of an insured plan, a same-sex spouse will be treated as a “spouse” to the extent mandated by local law, irrespective of whether the spouse is a dependent. Where it is determined that the benefit is taxable to the employee, he or she must include in income, and the employer must take into account for employment tax purposes and for income tax withholding purposes, the benefit’s “fair market value.”¹⁸

In Priv. Ltr. Rul. 9034048 (May 29, 1990) a city asked the Service whether “health care benefits provided by the City to its employees and their non-spouse cohabitants qualify for an exclusion from gross income under sections 105 and 106.” The Service said no, based on an analysis of §§ 61, 104(a)(3), 105 and 106. Citing Treas. Reg. § 1.61-21(b)(1), the Service held that the employee must include in income the fair market value of the health care benefit provided to the non-spouse cohabitant. The Service then opined that the fair market value of the benefit in this instance was the value “of such coverage determined, under principles set forth in section 1.61-21(b)(2) of the regulations, on the basis of the amount that an individual would have to pay for the particular coverage in an arm’s-length transaction (i.e., at *individual policy rates*.” (Emphasis added.) Fortunately, the Service later backed off this position¹⁹ and said that the appropriate measure of fair market value is the value of group coverage in the hands of the domestic partner.

¹⁴ Pub. L. No. 93-406, 88 Stat. 829 (September 4, 1974).

¹⁵ *Cf.*, ERISA § 4 (ERISA does not apply to governmental and church plans that do not affirmatively elect ERISA coverage. *See, Catholic Charities of Maine, Inc. v. Portland*, 304 F. Supp.2d 77 (D. Me. 2004). (holding that, in the case of an electing church plan, ERISA preempted a local ordinance requiring the coverage of domestic partners).

¹⁶ ERISA § 514(a)

¹⁷ *Id.*, § 514(b)(2) (this exception is commonly referred to as the insurance saving clause).

¹⁸ Treas. Reg. § 1.61-21(b)(1). *See, infra*, Section II(a).

¹⁹ Priv. Ltr. Rul. 9111018 (December 14, 1990).

But what exactly is the fair market value of the group coverage provided to a domestic partner or same-sex spouse? Since a determination of fair market value is an inherently factual matter, the Service will not issue any rulings that bless a particular approach in a particular instance.²⁰ Some of the possible measures of fair market value include the followings:

(1) *COBRA Rates.* Perhaps the most logical starting point is the plan's individual COBRA rate (less the 2% allocated to overhead and administration). The Service did not object to the use of COBRA rates as a proxy for fair market in the context of a ruling on related matters of law.²¹ Service personnel have also endorsed this position in informal remarks at industry conferences and other forums, but only after making clear that their remarks reflected their own views and did not bind the IRS or any other agency of government.

(2) *Difference Between Family and Individual Premiums.* If an employee has individual coverage then later adds a domestic partner or marries a same-sex spouse, it could be argued that the cost to him or her for covering the domestic partner or same-sex spouse is the difference in the premium cost between individual and family coverage. While employers have adopted this approach, it does not appear that this is in any way an "arm's length" criteria. Rather, this is based on the particulars of the employee's situation, and it also appears to contravene the provision of Treas. Reg. § 1.61-21(b)(2), under which the cost incurred by the employer does not determine fair market value.

(3) *Per Capita Allocation.* If the employee has, say, three dependents and a domestic partner, he or she might claim that the cost of the coverage for the domestic partner is one-fifth of the total family premium. While an actuary might view this claim with a great deal of suspicion, it does have a certain amount of visceral appeal. When domestic partner benefits first began to gain in popularity, some employers were persuaded to adopt this approach, though it appears to have been all but abandoned as employers have become incrementally savvier about the tax treatment of these benefits. The obvious problem is that fair market value is made to depend on a random number.

(4) *Incremental Cost.* If an employee with a dependent already has family coverage and then adds his or her domestic partner, there is no added cost. Does this mean that the fair market value of the benefit is zero? Some employees have made this argument, and some employers have bought it. But based on available guidance it is nonsensical, and the

²⁰ Rev. Proc. 2004-1, 2004-1 I.R.B. 1; Rev. Proc. 2004-3, 2004-1 I.R.B. 114.

²¹ Priv. Ltr. Rul. 200108010 (November 17, 2000).

Service would almost certainly reject it on audit.²² The benefit provided to the domestic partner or same-sex spouse has *some* value, and if group coverage the measure of that value, then a zero value appears unsupportable.

(5) *External Measure.* Since the Service insists that fair market value is based on what would be charged in an arm's length transaction, might an employer establish fair market value by turning to survey data or by hiring a consulting firm to conduct such a survey? This approach, while cumbersome in the extreme, is probably supportable. After all, in Priv. Ltr. Rul. 9111018, the Service did not say which group health plan was the measuring rod. Is it the employer's group health plan or some other group health plan or amalgam of other group health plans? Nonetheless, the author is not aware of any employer adopting this approach.

IV. Compliance Steps

Employers must first come to appreciate that (i) benefits provided to non-dependent domestic partners and same-sex spouses are treated differently for income and employment tax purposes than benefits provided to individuals in traditional marriages and their dependents and (ii) the fair market value of the group coverage furnished to a non-dependent domestic partner or same-sex spouse is taxable to the employee even though provided to his or her partner or spouse. Anecdotal evidence suggests that more than a few employers are not following the rules. Once employers gain an appreciation of the applicable rules, they must then decide on how best to comply.

The threshold issue is whether an employer wants or needs to cover domestic partners or same-sex spouses, and, if so, for what purposes. Employers may be bound by state law²³ or local ordinance²⁴ to provide benefits to domestic partners or individuals

²² See Treas. Reg. § 1.61-21(b)(2) (fair market values does not turn on an employee's "subjective perception of the value of [the] fringe benefit)."

²³ See, e.g., Cal. Fam. Code § 297.5(a) (2004) ("registered domestic partners shall have the same rights, protections and benefits . . . whether they derive from statutes, administrative regulations, court rules, government policies, common law or any other provisions or sources of law, as are granted to spouses."); Haw. Rev. Stat. § 572C (2003) ("upon issuance of a certificate of reciprocal beneficiary relationship, the parties named in the certificate shall be entitled to those rights and obligations provided by the law to reciprocal beneficiaries."); Vt. Stat. Ann. tit. 15, § 1204(a) (2003) ("parties to a civil union shall have all the same benefits, protections and responsibilities under law, whether they derive from statute, administrative or court rule, policy, common law or any other source of civil law, as are granted to spouses in a marriage."); N.J. Stat. § 17B:27-46.1bb (2004) ("A group health insurer that provides hospital or medical expense benefits under a policy that is delivered, issued, executed or renewed in this State . . . under which dependent coverage is available, shall offer dependent coverage to a covered person for a covered person's domestic partner.).

²⁴ See, e.g., San Francisco Admin. Code § 12B.1(b) (providing that "no contracting agency of the City shall execute any contract with any contractor that discriminates in the provision of . . . health benefits . . . between employees with domestic partners and employees with spouses where the domestic partnership has been registered with a governmental entity pursuant to State or local law authorizing such registration.")
But, cf., Air Transport Ass'n of America v. City and County of San Francisco, 992 F.Supp. 1149, 1160-

who are united in a “civil union.” And in states that recognize same-sex marriages,²⁵ employers that provide benefits through the purchase of regulated insurance products will be required to cover same-sex spouses (or, more accurately, the insurance contract under which benefits are provided will be required to cover same-sex spouses). In other instances, employers may choose to extend benefits to domestic partners and/or same-sex spouses even if they are not required to do so.

Since marriage is established and documented in accordance with state law, it is a relatively simple matter for employers to identify the individuals to whom coverage must be extended and under what circumstances. The same holds true for certain civil unions. But domestic partnerships require some additional attention. An employer might require, for example, that the employee submit an affidavit attesting to the existence of the domestic partnership,²⁶ or it might rely or be required to rely on an external domestic partner registry.

Establishing and documenting dependent status also requires attention. Whether a domestic partner or same-sex spouse is a dependent determines whether the premium cost is currently taxable to the employee. Moreover, the children of a domestic partner or same-sex spouse are not necessarily dependents of the employee. Therefore, employers might also want to address the status of these individuals in an affidavit before including them under their benefit plans.

Where the employer determines that all or some portion of a benefit is taxable to an employee on account of coverage provided to his or her domestic partner or same-sex spouse, it must decide how that benefit is to be valued. Of the approaches described above, it appears that COBRA rates are the most reliable proxy for the fair market value of group coverage. While the difference between the cost of family and individual coverage is perhaps defensible, it is likely to overstate fair market value since family coverage is typically more than twice the individual premium rate. While the survey approach is most likely to be acceptable, it is also cumbersome.

Having settled upon the amount that will be added to the employee’s compensation for the year by reason of benefits provided to the employee’s domestic partner or same-sex spouse, the employer must next decide how best to handle the mechanics. Rather than disturb existing cafeteria plan elections, the employer can simply add the value of the taxable coverage to the employee’s wage and income statement (Form W-2) at the end of the year. Where employment taxes are concerned, Treas. Reg. § 31.3501(a)-1T, Q&A 1 allows an employer to elect to deem most non-cash benefits to have been paid as of any date on or after the benefit is provided so long as that date is

1165 (N.D. Ca. 1998) (holding that although San Francisco Admin. Code § 12B.1(b) did not impose undue burdens on interstate commerce, the ordinance did violate the dormant Commerce Clause to the extent that it impermissibly regulated extraterritorial commerce).

²⁵ *Goodridge v. Dep’t of Pub. Health*, 798 N.E. 2d 941 (Mass. 2003) (holding that the Massachusetts constitution grants same-sex couples the right to marry).

²⁶ See, e.g., Priv. Ltr. Rul. 200339001 (describing an employer’s requirement of a signed and notarized “Domestic Partner Affidavit”); Priv. Ltr. Rul. 200108010 (requiring an annual certification as to the authenticity of the domestic partner relationship).

within the same calendar quarter. In Announcement 85-113,²⁷ the IRS enlarged this period to the full calendar year.²⁸ Employers can also treat this income as so-called “supplemental wages.” Under Treas. Reg. § 31.3402(g)-1(a)(2), so long as tax has been withheld from an employee’s regular wages, the employer can determine the tax to be withheld from any supplemental wages at flat rate.

V. Conclusion

While the benefits-related issues involving domestic partners and same-sex spouses are relatively new to the tax and benefits landscape, the underlying tax principles have been around for a long time. Some of these tax principles are a matter of black-letter law, e.g., whether an item of income is taxable and under what circumstances. But establishing fair market value is an inherently factual matter, so employers are left with the need to engage in some educated guessing.

Complicating the matter is the disparate tax treatment accorded employer-provided benefits by state and Federal law. This is particularly vexing for multi-state employers whose compliance efforts must track requirements across potentially dozens of jurisdictions. Moreover, the laws governing employer-provided benefits in the context of non-traditional relationships are in a great deal of flux. For example, the extraterritorial effect of Massachusetts same-sex marriages is unsettled, and it is not even clear the extent to which out of state employers with minimal Massachusetts contacts will need to comply with that state’s insurance or other mandates.

If experience is any guide, employers’ efforts to follow and comply with these rules will follow a predictable trajectory. At first, compliance will seem to be impossible (or nearly so). Over time, as employers adapt to the new regulatory landscape, compliance will be difficult. In the final stage, employers will grow accustomed to the new demands, and compliance will become easy (or nearly so). But the rules themselves are not yet settled, and even if they were, there is the looming possibility of a Constitutional amendment. So in addition to exercising diligence, employers and their advisors must also be prepared to be patient and vigilant. The final chapter on this topic is a long way from being written.

²⁷ 1985-31 I.R.B. 31 (based on News Release IR-85-70, dated July 19, 1985).

²⁸ *Id.*, § 1.