

Instructions on Completing 2022 MA Health Insurance Responsibility Disclosure (HIRD) Filing

The filing window for the 2022 Health Insurance Responsibility Disclosure (HIRD) with the Massachusetts Department of Revenue (DOR) will run from **November 15 to December 15, 2022.**

This filing is required of all Massachusetts employers with 6 or more employees. This includes all parishes, regardless of size.

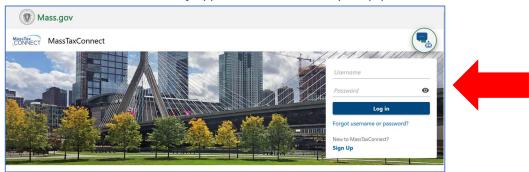
The HIRD form collects information about your employer-sponsored health insurance offerings and will be used to assist MassHealth in identifying its members with access to qualifying insurance who may be eligible for the MassHealth Premium Assistance Program. The Premium Assistance Program helps eligible working individuals and families pay for qualifying employer-sponsored insurance. For more information, please reference the <u>HIRD</u> FAQs.

Instruction documents for all of the processes noted below along with a recorded presentation are available on the Administrator Toolkit page of the Benefits Department website: <u>www.catholicbenefits.org/admins/admins.htm</u>.

- First-time user, need to set up online access
- Already have set up online access but need help retrieving your Username or Password

Important Note! Before you begin, find the cost sharing for your location for the Enhanced, Basic and High-Deductible Plans, **even if you have no employees enrolled in those plans**. The HIRD filing process should take approximately 15 minutes once you have that information.

1. Log into your MassTaxConnect Account at https://mtc.dor.state.ma.us/mtc//



2. Scroll down to the Withholding Tax section of the Summary page and select the "File a Health Insurance Responsibility Disclosure" link under the HIRD subsection.

Withholding Tax	HIRD	 File a Health Insurance Responsibility Disclosure
	2022 Return Depository Status Received	View or Amend Return
	Account	Make a Payment View Returns
	Depository Balance \$0.00	Close Tax Account

3. Click "Next."

Requirements for filing Form HIRD		
😔 Employer Health Insurance Responsibility Disclosure (HIRD) Form - General Information	on	
Per guidelines set forth by the Executive Office of Health and Human Services, you are required to file the HIRD form on MassTaxConnect	; if	
1. You are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due	date of this form (December 15th of filing year).	
2. You must complete this Form only for a plan(s) offered to Massachusetts employees for the employer's next upcoming Plan Year (a.k.a. Rate Year), if available. If plan information for the upcoming Plan Year is not available, employers must provide information only for a plan(s) offered to Massachusetts employees for the employer's current Plan Year. The employer's Plan Year (a.k.a. Rate Year) is defined as the effective date of any changes in a group Health Insurance plan during the Open Enrollment Period. If the employer's current Plan Year ends on or before December 31st of the filing year, you must report plan information for the upcoming Plan Year.		
3. Employers must complete all sections of this Form, unless otherwise specified in the instructions.		
⑦ Contact and Support Information		
For questions regarding the HIRD reporting requirement, please contact the Department of Revenue's customer service center at 617-464 HIRD representative. Note that any questions submitted in writing directly to the HIRD form web portal itself cannot be responded to.	6-3940, and choose the option to speak with an	
Cancel Save Draft	< Previous Next >	

4. Confirm the Company's Profile Information is correct.

Return Information
Form Year
오 Company's Profile
ID Туре
Federal Employer Identification Number
Legal Name
Trade name(s) (doing business as), if applicable (enter one DBA per line for multiple trade names)

5. Enter your contact information as the person completing the form.

* Direct Contact - Individual Responsible for Completing This Form			
Click For Help			
Name			
Phone Number			
Phone Extension			
Email Address			
Mailing Address - Street Name			
Mailing Address - City Name *			
Mailing Address - State			
Mailing Address - Zip Code			

6. Complete the questions under Company's Insurance Profile. Suggested responses are outlined below, which correspond to the screen shot below.

Question	Suggested Response
Does the employer offer group health insurance?	Yes
What is the minimum number of scheduled hours per week that the employer requires an employee to work to be considered eligible for health plan benefits?	20 for RCAB parish locations; 24 for parish schools; or a higher number (up to 30 per week) if your separately- incorporated location requires more hours to be worked for benefit eligibility.
What is the time period (in months) that a new employee must work before he or she is eligible for health plan benefits?	Enter 1 for any RCAB location; if your separately- incorporated location has a longer waiting period, enter the correct number of months.
Does employer determine employee eligibility for health plan benefits according to employment based categories for different groups of employees?	No
Does employer offer differing health plan benefits / rates for health plan benefits according to employment based categories for different groups of employees?	No, unless your location offers different cost sharing for at least one employee (more on that topic below, if applicable).
Does employer offer health plan(s) which use Massachusetts Health Connector Employee Choice Models?	No

Company's Insurance Profile		
Does the employer offer group health insurance? Click for help	No	Yes
What is the minimum number of scheduled hours per week that the employer requires an employee to work to be considered eligible for health plan benefits? Click for help		20.00
What is the time period (in months) that a new employee must work before he or she is eligible for health plan benefits? Value must be greater than or equal to 1, and less than or equal to 24. Click for help		1
Does employer determine employee eligibility for health plan benefits according to employment based categories for different groups of employees? Click for help	No	Yes
Does employer offer different health plan benefits / rates for health plan benefits according to employment based categories for different groups of employees? Click for help	No	Yes
Does employer offer health plan(s) which use Massachusetts Health Connector Employee Choice Models? Click for help	No	Yes

Select the employment-based categories that the employer utilizes. Leave as "No," unless your location offers different cost sharing for at least one employee.

Select the employment-based categories that the employer utilizes. (Select as many employment-based categories as necessary). Click for help		
Regular Full-time	No	Yes
Temporary Full-time	No	Yes
Salaried	No	Yes
Union	No	Yes
Regular Part-time	No	Yes
Temporary Part-time	No	Yes
Hourly	No	Yes
Non-Union	No	Yes
Management	No	Yes
Exempt	No	Yes
Wage Based	No	Yes
Other	No	Yes
Non-Management	No	Yes
Non-Exempt	No	Yes
Intern	No	Yes

Some locations have employees who pay less for health coverage based on date of hire. If this applies, choose "YES" under "Other" and then add the following under both boxes:

"The employer offers less expensive health insurance to employees who were hired on or before _____[date]. All employees are eligible for the RCAB Health Plans through Blue Cross if they are scheduled to work at least 1,000 [for separately-incorporated locations requiring more hours, insert correct data here] hours/year."

If the employer answered Yes to "other", describe the "other" employment-based category(ies) and indicate which specific health plan(s) the employees in each "other" category have access to.
If applicable, describe how the employer defines each employment-based category and the employer's eligibility requirements for health plan benefits according to each category. Click for help

For questions on union status and Plan dates:

Does the employer employ any union members who receive Group Health Insurance through a union rather than through the employer?	No. Then leave next box blank.
Open Enrollment period: Start Date	05/16/2022
Open Enrollment period: End Date	06/13/2022
Plan year's (a.k.a. rate year) Start date	07/01/2022
Plan year's (a.k.a. rate year) End date	06/30/2023

ppen enrollment period: Start Date Click for help 16-May-2022 ppen enrollment period: End Date Click for help 13-Jun-2022 lan year's (a.k.a rate year) Start date Click for help 01-Jul-2022 lan year's (a.k.a rate year) End date Click for help 30-Jun-2023 nly if necessary, use this space to report additional information not otherwise captured in this form that is necessary to explain the employer's group health insurance offerings and/or eligibility requirements. C r help	nelp		
pen enrollment period: End Date Click for help Ian year's (a.k.a rate year) Start date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End date Click for help In year's (a.k.a rate year) End da	applicable, list the unions from which the employer's unionized employees receive group health insurance. Click for help		
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lan year's (a.k.a rate year) Start date Click for help 01-Jul-2022 lan year's (a.k.a rate year) End date Click for help 30-Jun-2023 nly if necessary, use this space to report additional information not otherwise captured in this form that is necessary to explain the employer's group health insurance offerings and/or eligibility requirements. C or help		10-10ay-2022	
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nly if necessary, use this space to report additional information not otherwise captured in this form that is necessary to explain the employer's group health insurance offerings and/or eligibility requirements. C r help	lan year's (a.k.a rate year) Start date Click for help	01-Jul-2022	
r help	lan year's (a.k.a rate year) End date Click for help	30-Jun-2023	
r help			
	inly if necessary, use this space to report additional information not otherwise captured in this form that is necessary to explain the employer's group health insurat or help	nce offerings and/or eligibility r	equirements. Cli

7. Click "Next."

- 8. The following page will ask you to enter the Plan and cost share information for each of the three Health Plan options offered by RCAB; Enhanced, Basic and High-Deductible. <u>You must enter all three even if you do not have anyone currently enrolled in any one plan.</u>
- 9. Under Name of The Insurance Plan, click "Add a Plan."

Requirements for filing Form HIRD	HIRD Employer Details	HIRD Plans	
HIRD Plans			
			+ Add a
ame Of The Insurance	Plan		
Plan Name			
Add a Plan			

10. Enter the below for the **Enhanced Plan** under Plan's Profile:

Name of the Health Insurer	Roman Catholic Archdiocese of Boston
Name of Health Plan	Blue Cross Enhanced PPO Health Plan
Plan group numbers (these can be copy and pasted):	002370423
	002370425
	002370427
	002370428
	002370429
	002370430
Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)?	Yes
Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan?	No
Enter the date on which the following costs and coverage information became or will become effective for this plan.	07/01/2022

☑ Plan's Profile			
Name of the Health Insurer. Click for help	ROMAN CAT	HOLIC ARCH	HDIOCESE OI
Name of the Health Plan. (Only report comprehensive health insurance plans; do not report dental or vision plans) Click for help	BLUE CROSS	ENHANCED	PPO HEALTI
Plan group number(s) Click for help	002370423 002370425 002370427 002370428 002370429 002370430		
Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)? Click for help	No	Unknown	Yes
Most health plans offered in Massachusetts satisfy the Minimum Creditable Coverage requirements.			
Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan? Click for help	No		Yes
Enter the date on which the following costs and coverage information became or will become effective for this plan. Click for help	01-Jul-2022		i

<u>If</u> you answered YES to the question **"Does employer offer different benefits / rates for health plan benefits**, then the question **"Indicate the employment-based categories that have access..."** will appear, followed by the category which you selected. Answer **YES**, which will then require you to fill out <u>two</u> plan profiles for the Enhanced Plan—one for each of the different cost-sharing splits. These pages will be identical except for the dollar amounts for the cost-sharing.

If this question does <u>not</u> appear, continue to the "Levels of Coverage" section.

Indicate the emp	loyment-based	categories that have access to this plan (Select as many employment-based categories as necessary). Click for help
Other		
No	Yes	

Which levels of coverage are offered by this plan?

Individual = Yes Employee Plus One = Yes Employee Plus Children = No Family = Yes

Levels Of Coverage

Which levels of coverage are offered by this plan? Click for help		
Individual	No	Yes
Employee Plus One	No	Yes
Employee Plus Children	No	Yes
Family	No	Yes

For the Employee's Monthly Contribution and Employer's Monthly Contribution fields, calculate based on the location's cost sharing. These vary from location to location.

Example: If your cost sharing is **Enhanced Med (25% Ind/ 40% Fam)** Basic Med (15% Ind/ 35% Fam) Den (100% Ind/ 100% Fam):

Employ <u>ee</u> Enhanced Individual	\$768.56 x 25% = \$192.14
Employ <u>ee</u> Enhanced Individual + 1	\$1,728.69 x 40% = \$691.48
Employ <u>ee</u> Enhanced Family	\$2,151.24 x 40% = \$860.50
Employ <u>er</u> Enhanced Individual	\$768.56 x 75% = \$576.42
Employ <u>er</u> Enhanced Individual + 1	\$1,728.69 x 60% = \$1,037.21
Employ <u>er</u> Enhanced Family	\$2,151.24 x 60% = \$1,290.74
Total Monthly Cost Individual	\$768.56
Total Monthly Cost Individual + 1	\$1,728.69
Total Monthly Cost Family	\$2,151.24

The values entered in these fields should not factor in potential reductions from any wellness credits, Health Reimbursement Arrangements, Flexible Spe Accounts.	nding Arrangements, or Health Savings
Employee's Monthly Contribution	
Click for help	
Individual	192.14
Employee Plus One	691.48
Family	860.50
Employer's Monthly Contribution	
Click for help	
Individual	576.42
Employee Plus One	1,037.21
Family	1,290.74
Plan's Total Monthly Costs	
Click for help	
Individual	768.56
Employee Plus One	1,728.69
Family	2,151.24

Add the deductibles and Out of Pocket Max Expenses as shown below:

	In-Network Annual Deductible	Annual Out of Pocket Max Expense
Individual	\$500	\$3,000
Employee Plus One	\$1,000	\$6,000
Family	\$1,000	\$6,000

In-Network Annual Deductibles	
Click for help	
Individual	500.00
Employee Plus One	1,000.00
Family	1,000.00
Annual Out-of-Pocket Max Expenses	
Click for help	
Individual	3,000.00
Employee Plus One	6,000.00
Family	6,000.00

11. Then click "Add a Plan" to enter information for the Blue Cross **Basic** PPO Health Plan.

	+ Add a Plan × Remove a Plan
Cancel Save Draft	< Previous Next >

12. Follow the same steps for the **Basic Plan** under Plan's Profile:

Name of the Health Insurer	Roman Catholic Archdiocese of Boston
Name of Health Plan	Blue Cross Basic PPO Health Plan
Group Numbers (these can be copy and pasted):	002370431
	002370433
	002370435
	002370436
	002370437
	002370438
Do the benefits provided under the health insurance plan satisfy	
the minimum creditable coverage requirements of 956 CMR	Yes
5.03(1)(a)?	
Does the employer offer its employees wellness credits that may	
reduce the employee contribution to the premium for this plan?	No
Enter the date on which the following costs and coverage	07/01/2022
information became or will become effective for this plan.	07/01/2022

If you answered YES to the question **"Does employer offer different benefits / rates for health plan benefits**, then the question **"Indicate the employment-based categories that have access..."** will appear, followed by the category which you selected. Answer **YES**, which will then require you to fill out <u>two</u> plan profiles for the Enhanced Plan—one for each of the different cost-sharing splits. These pages will be identical except for the dollar amounts for the cost-sharing.

If this question does <u>not</u> appear, continue to the "Levels of Coverage" section.

Which levels of coverage are offered by this plan? Individual = Yes Employee Plus One = Yes Employee Plus Children = No Family = Yes

For the Employee's Monthly Contribution and Employer's Monthly Contribution fields, calculate based on the location's cost sharing. These vary from location to location.

Example: If your cost sharing is Enhanced Med (25% Ind/ 40% Fam) **Basic Med (15% Ind/ 35% Fam)** Den (100% Ind/ 100% Fam):

Employ <u>ee</u> Basic Individual	\$653.41 x 15% = \$98.01
Employ <u>ee</u> Basic Individual + 1	\$1469.69 x 35% = \$514.39
Employ <u>ee</u> Basic Family	\$1,828.95 x 35% = \$640.13
Employ <u>er</u> Basic Individual	\$653.41 x 85% = \$555.40
Employ <u>er</u> Basic Individual + 1	\$1,469.69 x 65% = \$955.30
Employ <u>er</u> Basic Family	\$1,828.95 x 65% = \$1,188.82
Total Monthly Cost Individual	\$653.41
Total Monthly Cost Individual + 1	\$1,469.69
Total Monthly Cost Family	\$1,828.95

Fill in the Deductibles and Out of Pocket Max Expenses fields as shown below:

	In-Network Annual Deductible	Annual Out of Pocket Max Expense
Individual	\$2,500	\$4,500
Employee Plus One	\$5,000	\$9,000
Family	\$5,000	\$9,000

13. Then click "Add a Plan" to enter information about the Blue Cross **High Deductible H**ealth Plan.

14. Enter the below for the **High Deductible Plan** under Plan's Profile:

Name of the Health Insurer	Roman Catholic Archdiocese of Boston
Name of Health Plan	Blue Cross High Deductible Health Plan
Group Numbers (these can be copy and pasted):	002374258
Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)?	Yes
Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan?	No
Enter the date on which the following costs and coverage information became or will become effective for this plan.	07/01/2022

If you answered YES to the question **"Does employer offer different benefits / rates for health plan benefits**, then the question **"Indicate the employment-based categories that have access..."** will appear, followed by the category which you selected. Answer **YES**, which will then require you to fill out <u>two</u> plan profiles for the Enhanced Plan—one for each of the different cost-sharing splits. These pages will be identical except for the dollar amounts for the cost-sharing.

If this question does <u>not</u> appear, continue to the "Levels of Coverage" section.

Which levels of coverage are offered by this plan?

Individual = Yes Employee Plus One = Yes Employee Plus Children = No Family = Yes

For the Employee's Monthly Contribution and Employer's Monthly Contribution fields, calculate based on the location's cost sharing. These vary from location to location.

The employee cost share for the HDHP is 5% for individual and 25% for family (select locations would be 0%).

Employ <u>ee</u> HDHP Individual	\$561.05 x 5% = \$28.05
Employ <u>ee</u> HDHP Individual + 1	\$1,261.94 x 25% = \$315.49
Employ <u>ee </u> HDHP Family	\$1,570.41 x 25% = \$392.60
Employ <u>er</u> HDHP Individual	\$561.05 x 95% = \$533.00
Employ <u>er</u> HDHP Individual + 1	\$1,261.94 x 75% = \$946.46
Employ <u>er</u> HDHP Family	\$1,570.41 x 75% = \$1,177.81
Total Monthly Cost Individual	\$561.05
Total Monthly Cost Individual + 1	\$1,261.94
Total Monthly Cost Family	\$1,570.41

Fill in the Deductibles and Out of Pocket Max Expenses fields as shown below:

	In-Network Annual Deductible	Annual Out of Pocket Max Expense
Individual	\$4,000	\$7,000
Employee Plus One	\$8,000	\$14,000
Family	\$8,000	\$14,000

15. Click "Next."

- 16. Review the Return Summary to ensure it is correct. If you need to go back to fix any data, click "Previous." Note the tabs across the top for the three Plans. Click on the correct tab to edit data.
- 17. Click the "Confirmation" box then "Submit"

Confirmation	
l understand that the HIRD form is considered final and complete once submitted. If I later realize I made a mistak electronic submission by logging into my MTC withholding account and selecting the "Amend a Health Insurance R Disclosure" hyperlink. I may only submit one amended HIRD form per day.	
Cancel Save Draft	< Previous Submit

18. Print the Submission page by clicking "Print Confirmation."

You should receive an email from the DOR confirming your submission. You can also return to the Home page and click "Submissions" and view Form HIRD under "Processed" Submissions.