MHC for Small Business
Outreach & Education Guide

maryland health connection℠

for small business

Contents

Introduction to MHC for Small Business

MHC for Small Business is a state-based health insurance marketplace created under the Affordable Care Act to provide a platform where individuals and small businesses can compare and purchase health insurance coverage. It offers employers the opportunity to provide health care coverage to their employees, promoting their well-being while improving employee retention and satisfaction. Maryland Health Benefit Exchange certifies these insurance plans to meet small businesses' unique needs and challenges, offering a range of benefits and coverage options that are more manageable and cost-effective for smaller workforce sizes.

In recognition of the challenges and aspirations that characterize small-scale operations, MHC for Small Business has emerged as a beacon of support, offering businesses an avenue to secure the health and well-being of their workforce. Understanding the critical role that health insurance plays in fostering a thriving workforce and a resilient business environment, this initiative stands as a testament to our commitment to nurturing the growth and prosperity of small businesses across the state.

Eligible employers who choose to obtain MHC for Small Business health insurance coverage could access tax credits provided to them under the Affordable Care Act provisions. This tax credit opportunity serves as an avenue to further alleviate the costs associated with providing comprehensive health coverage to their employees.

On-Exchange and Off-Exchange Small Group Plans

MHC for Small Business provides a valuable avenue for small businesses to access on-exchange health insurance coverage. This platform offers a range of advantages for employers seeking comprehensive and compliant health insurance options for their employees. Notably, MHBE certifies all private health plans presented by participating insurers, ensuring that the plans meet the stringent standards set forth by regulatory bodies. This meticulous certification process assures employers that the plans available through MHC for Small Business are of high quality and aligned with the mandated guidelines.

One of the standout features offered exclusively through MHC for Small Business is the employee choice model, an approach that fosters greater flexibility and personalization in health insurance. Detailed in the section on Traditional Small Group Plans of this guide, the employee choice model empowers the workforce by granting them the autonomy to select from a wide array of health insurance plans from different insurers. This distinctive feature accommodates varying healthcare needs and preferences among employees, thereby contributing to higher employee satisfaction and engagement.

Furthermore, small businesses that opt for coverage through MHC for Small Business stand to benefit from the small business health insurance tax credit. This incentive, designed to

alleviate the financial burden associated with providing health insurance, is exclusively available through MHC for Small Business.

The off-exchange market is an alternative for small businesses exploring their health insurance options. This route involves businesses partnering with experienced insurance brokers to navigate and select plans that best suit their needs. While the off-exchange market provides an alternative option, it's important to note that small group premium rates remain consistent whether businesses opt for on-exchange or off-exchange plans.

Understanding Small Business Health Insurance

Small Business health insurance refers to a type of health insurance coverage designed specifically for small businesses. In this context, a small group in Maryland typically refers to a business with under 50 employees.

Small group health insurance plans often offer certain advantages, such as potential tax incentives for employers offering health coverage, flexible coverage options, and the ability to provide a competitive benefits package that helps attract and retain quality talent.

One resource available to small business owners to help them understand their health insurance coverage options is the "Find Assistance" tool in MHC for Small Business. This tool serves as a bridge between employers and the expertise of authorized brokers. This collaboration not only simplifies the process of exploring health insurance options but also fosters trust and confidence in the decisions made.

Group Coverage Eligibility & Employer Contribution

Small employers meeting the eligibility criteria to acquire plans certified by the Maryland Health Connection for Small Business (MHC for Small Business) have the opportunity to secure medical plans directly from participating carriers with authorized brokers.

Eligibility Determination- An employer or designated group administrator can complete the MHC for Small Business Eligibility Application online. Upon completion, the form is submitted and transmitted to MHC for Small Business to determine group eligibility. Importantly, this process can occur concurrently with the implementation of the chosen plan. Access to the online MHC for Small Business platform is conveniently available on our official website at www.marylandhealthconnection.gov/smallbusiness.

To be eligible for enrollment in health insurance through MHC for Small Business, a small business or non-profit organization must meet the following criteria:

- Possess a primary business address within the state of Maryland.
- Enroll at least one employee in coverage who is not the owner, a business partner, or the spouse of the owner or business partner.
- Employ fewer than 50 full-time equivalent (FTE) employees.

- Extend coverage to all full-time employees.

The MHC for Small Business determination letter eligibility or ineligibility will be promptly available in the employer's MHC-SB inbox. The assigned authorized broker affiliated with the employer's account will also be able to access the employer's eligibility determination.

A group designated as eligible for MHC for Small Business must obtain its initial eligibility determination decision within the same tax year in which it initiates its plan. This prerequisite is vital to qualifying the group for the federal Small Business Health Care Tax Credit.

In Maryland, employers can offer an employer-sponsored plan without contributing to the cost of the employee's plan. However, to qualify for the Small Business Health Care Tax Credit, the employer must contribute a minimum of 50% toward the employee's share of the premium.

Payment

The initial payment to the insurance carrier is called a binder payment or binder check. MHC-SB accepts physical checks or electronic transfers, like ACH, as part of the initial group setup package. After the carrier implements the group, monthly premium payments are due. While MHC-SB usually offers a 30-day grace period for late payments, not following these payment rules could result in the group's contract being terminated.

Eligible Waivers of Participation

Employees may waive MHC for Small Business coverage without counting toward the employer's participation levels, for the following reasons:

- Employee covered under other private group health plan such as, a spousal and parent's health plan.
- Employee covered under public health care programs, including Medicare, Medicaid, or TRICARE.
- Employee has coverage, including Individual Marketplace coverage – with access to a Federal subsidy (due to minimum essential coverage or affordability provisions).
- COBRA enrollee or retiree.
- Employee has small business coverage through another State or Federal Marketplace.

Non-employees such as the owner and spouse of the owner are not included in the participation calculation unless they are full-time employees.

Small Business Health Care Tax Credit

Maryland-based small businesses and tax-exempt organizations may qualify for the Small Business Health Care Tax Credit if they meet the following criteria:

- Buy group health insurance coverage through Maryland Health Connection for Small Business.
- Have fewer than 25 full-time equivalent employees.
- You could still qualify with 25 or more employees if some are part-time.
    - Total FTEs don't include the owner, owner's spouse, or family members.
- Pay an average annual salary of less than $65,000 (adjusted for inflation in 2024).
    - The credit is most substantial for businesses with 10 or fewer FTEs and lower average wages.
- Contribute at least 50 percent toward employee-only health insurance premiums (35% for tax-exempt/nonprofit organizations).
    - Amounts paid toward dependent coverage, if offered, may also be included in this total.

FTE Calculation

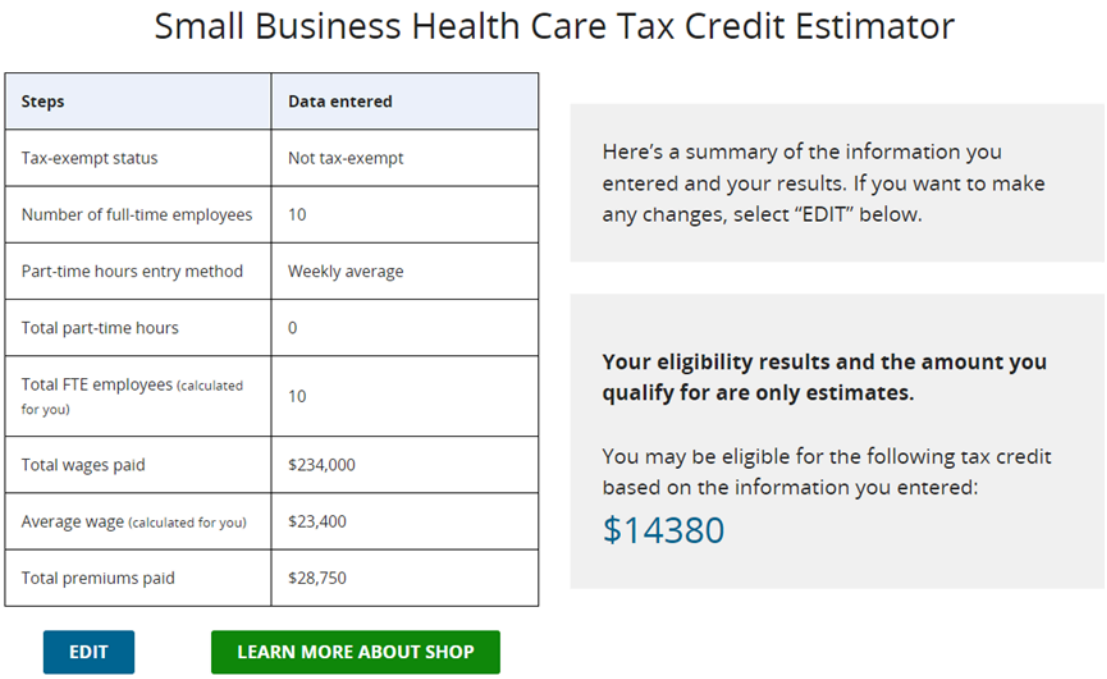
When calculating the number of full-time employees (working 30 or more hours per week) or part-time employees (under 30 hours per week) for the purposes of this credit, include:

- All employees who perform services for you during the year, unless excluded below
- All employees of corporations in a controlled group
- Members of an affiliated service group
- Employees of entities under common control
- Employees under a common group in other states

Don't include:

- Owners of a sole proprietorship
- Partners
- Shareholders owning more than 2% of an S corporation
- Owners of more than 5% of other businesses
- Family members or a member of the household who qualifies as a dependent on the individual income tax return of a person listed above. Family members include a spouse, child or descendant of a child, sibling or step-sibling, parent or ancestor of a parent, step-parent, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law.
- Seasonal employees working 120 days or less in a year
- Independent contractors (form 1099 workers)
- COBRA and retired enrollees

Case Study: Here is an example of how a small employer with 10 employees could calculate their Small Business Health Care Tax Credit for the tax year 2023, including the details of the employer's premiums, wages, and the health insurance plan offered to employees.



Small Business Health Care Tax Credit Estimator

Steps	Data entered
Tax-exempt status	Not tax-exempt
Number of full-time employees	10
Part-time hours entry method	Weekly average
Total part-time hours	0
Total FTE employees (calculated for you)	10
Total wages paid	$234,000
Average wage (calculated for you)	$23,400
Total premiums paid	$28,750

EDIT

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Here's a summary of the information you entered and your results. If you want to make any changes, select "EDIT" below.

Your eligibility results and the amount you qualify for are only estimates.

You may be eligible for the following tax credit based on the information you entered:

$14380

A small employer located in Baltimore, Maryland, has 10 employees who worked at least 1,580 hours (30 full-time equivalent hours). The total annual premium and employer's share for the health insurance plan, named "Plan A," are $28,750. The employer offers self-only coverage to all employees, with an annual cost of $5,750 per employee. The employer contributes $2,875 towards each employee's premium.

The total wages paid by the employer to all employees during the tax year 2023 amounts to $234,000. Based on the calculations, this small employer may be eligible for a Small Business Tax Credit of $14,380. This credit serves as a valuable incentive, helping small businesses like this one provide essential health insurance coverage to their employees while managing costs.

How to Claim the Small Business Health Care Tax Credit

To claim the Small Business Health Care Tax Credit, small businesses typically need to complete IRS Form 8941, the credit for Small Employer Health Insurance Premiums. This form is used to calculate and claim the tax credit. Small Businesses claiming the tax credit must also provide their MHC for Small Business eligibility letter.

Small businesses must attach Form 8941 to their annual tax return, either Form 1040 or Form 1041, for partnerships, S corporations, and tax-exempt organizations. The instructions for Form 8941 will help you complete the form and calculate the tax credit. Additionally, seeking guidance from a tax professional or accountant can help ensure the accurate completion of the necessary forms and calculations.

Enrollment and Enrollment Periods

Unlike the individual market, small businesses have the flexibility to provide health insurance to their employees throughout the year. Enrolling between **November 15th and December 15th** can be particularly beneficial, as it allows groups to avoid the Minimum Participation Rules.

MHC Employer Options

When evaluating health insurance plans, employers are presented with an array of options that cater to their unique business needs. These options include traditional small group plans, ICHRA plans, and the valuable opportunity to link employees with private health plans supplemented by subsidies. Navigating this landscape requires careful consideration of several critical factors.

Factors to consider when choosing a health insurance plan

Employers should thoroughly examine each plan's coverage options and benefit summaries. This involves understanding the scope of medical services covered, prescription drug benefits, preventive care provisions, and other healthcare essentials. Equally vital is evaluating the costs associated with the chosen plans. This entails comparing various financial aspects, such as monthly premiums, annual deductibles, and varying copayment structures. The interplay of these cost components contributes to determining the overall affordability of the chosen plan.

In essence, a comprehensive assessment of health insurance plans involves meticulously balancing the coverage offered with the financial implications. By scrutinizing coverage options, benefit summaries, and cost structures, employers can make informed decisions that align with their budgetary considerations and the health and well-being of their valued employees.

In the marketplace, health insurance plans are categorized into metal levels, each corresponding to a specific actuarial value that reflects the level of coverage provided. These metal levels, platinum, gold, silver, and bronze, serve as guideposts for employers and their employees seeking plans that align with their healthcare needs and financial considerations. Within these metal tiers, each plan comes with its distinct set of attributes, such as a deductible, out-of-pocket maximum, copays, and/or coinsurance for healthcare services, among others. Notably, a deductible is the amount an individual or family must pay for covered services before the insurance plan starts sharing the costs. The out-of-pocket maximum signifies the maximum amount a policyholder needs to pay for covered services within a given policy period, beyond which the insurance company covers the remaining costs.

The platinum tier, representing the highest actuarial value, typically offers the most comprehensive coverage. Plans in this tier have lower deductibles and out-of-pocket maximums, making them ideal for those who anticipate higher healthcare utilization or desire greater financial protection.

The gold and silver tiers offer a balanced compromise between coverage and cost-sharing. Gold plans usually have slightly higher premiums than silver plans but offer lower deductibles and out-of-pocket maximums. Silver plans, on the other hand, are popular choices, often eligible for cost-sharing reduction subsidies for individuals with lower incomes.

While the bronze tier features the lowest premiums, it has higher cost-sharing in terms of deductibles and out-of-pocket maximums. These plans can be suitable for individuals or families in relatively good health who are comfortable with the potential for higher out-of-pocket expenses.

Under the Affordable Care Act (ACA), young adults up to the age of 26 can typically remain on their parents' health insurance plans, regardless of their marital or student status. This provision has been instrumental in expanding coverage for young adults who may otherwise face challenges accessing affordable health insurance, especially if they are transitioning into the workforce or pursuing further education.

Adopting Section 125- Cafeteria Plans

Cafeteria plans, also known as Section 125 plans, allow employers to offer certain benefits to employees tax-free.

A cafeteria plan allows employees to choose between at least one taxable benefit (often cash) and at least one qualified benefit—a benefit whose cost to the employee is excludable from their taxable gross income. The employee’s share of the cost is paid through pretax payroll deductions. Without a Section 125 plan, employee contributions can only be made with after-tax dollars.

Pretax dollars can be used to pay for benefits, which can result in tax savings for employees. For example, an employee who spends $200 a month on benefits can save $60, assuming about 30% of the $200 would have gone to federal, state, local, and FICA (Social Security and Medicare) taxes.

The employer also saves on taxes: For each $200 a month that an employee sets aside, the employer saves about $15- the 7.65% of the employee’s wages that the employer would otherwise have paid in FICA taxes.

Types of cafeteria plans

- **Health Care Flexible Spending Account (FSA)**: This allows employees to set aside pre-tax dollars to cover eligible medical expenses not covered by insurance, such as co-pays, deductibles, and certain over-the-counter medications.
- **Premium Only Plan (POP):** This plan allows employees to pay their share of health insurance premiums on a pre-tax basis, reducing their taxable income. Employees pay less in taxes. Employers also benefit from POPs because they do not have to pay payroll taxes (such as Social Security and Medicare taxes) on the pre-tax contributions made by employees. This can result in savings for the employer as well.
- **Simple Cafeteria Plans:** An option for employers with 100 for fewer employees and requires the employer to contribute to each employee's benefits in exchange for a safe harbor from discrimination requirements and still allow employees to choose from a selection of benefits, such as health insurance, dental coverage, and retirement savings options. These plans have reduced administrative burdens and compliance requirements compared to traditional cafeteria plans.

Eligibility Requirements

Employers must meet certain eligibility criteria to establish a cafeteria plan under Section 125 of the Internal Revenue Code. employer eligibility for Section 125 cafeteria plans:

Employer Type: Under Section 125, any employer, including corporations, partnerships, sole proprietorships, non-profit organizations, and government entities, can establish a cafeteria plan.

Offering Benefits: Employers must intend to offer one or more qualified benefits through the cafeteria plan. Qualified benefits can include health insurance, dental and vision plans, flexible spending accounts (FSAs), health savings accounts (HSAs), dependent care assistance programs (DCAPs), and other similar benefits.

Non-Discrimination Rules: Employers must comply with the IRS's non-discrimination rules. These rules ensure that the plan does not unfairly favor highly compensated or key employees. Failure to comply can result in penalties.

Employee Contributions: The cafeteria plan allows employees to make pre-tax contributions towards their elected benefits. Employers must establish procedures for collecting and administering these contributions in compliance with IRS regulations.

Written Plan Document: Employers must adopt a written plan that outlines the cafeteria plan's terms and conditions. This document should detail the benefits offered, eligibility criteria, employee contribution rules, and other plan provisions.

IRS Reporting and Compliance: Employers are responsible for reporting and compliance with IRS regulations regarding cafeteria plans. This includes annual reporting requirements and maintaining records of plan transactions.

Employers of any size and type can establish a cafeteria plan under Section 125, provided they meet the eligibility criteria and comply with IRS regulations.

Traditional Small Group Plans

Opting for a traditional small group health insurance plan through MHC for Small Business allows employers to tailor their coverage options to suit the needs of their employees and the organization. Traditional health insurance plans typically come in two primary models: employee choice and employer choice models.

Employee Choice Model:

- In this model, employees have the flexibility to select from a range of health insurance options offered by different carriers. Employees can choose the plan that best fits their needs, preferences, and budget.
- Employers typically contribute a set amount toward the cost of coverage, and employees may be responsible for any additional costs beyond that contribution.
- This model empowers employees to take greater control over their healthcare decisions and allows them to tailor their coverage to suit their specific needs and preferences.

Employer Choice Model:

- The employer choice model involves the employer selecting one or more plans to offer to their employees.
- Employers may choose the plan based on cost, coverage options, network of healthcare providers, and workforce needs.
- Compared to the employee choice model, employees typically have less flexibility in choosing their coverage, as they are limited to the plans selected by their employer.
- This model can simplify administration for employers, as they only need to manage a single plan or a limited number of plans.

When deciding between these two models, employers must carefully consider the needs and preferences of their employees and their budgetary constraints. Additionally, they should evaluate the coverage options available through MHC for Small Business and work with licensed insurance brokers to navigate the complexities of selecting and implementing a traditional health insurance plan that aligns with their goals and objectives.

ICHRA Plans

Individual Coverage Health Reimbursement Arrangement (ICHRA) plans are an alternative approach to providing health insurance benefits for employers. ICHRA is a type of health reimbursement arrangement (HRA) established by employers to reimburse employees for medical expenses, including individual health insurance premiums. ICHRA offers employers greater flexibility and control over healthcare costs compared to traditional group health insurance plans. Employees have more choice and flexibility in selecting health insurance coverage that meets their individual needs. Employers can provide health benefits to employees without the administrative burden associated with traditional group health insurance plans.

- Employers determine the contribution amount for each employee, which can vary based on factors such as age, family size, and geographic location.
- Contributions made by the employer are tax-deductible for the business and tax-free for employees.

Employers establish an ICHRA and determine the amount they will contribute for each employee. The employer can set eligibility criteria, such as employment status, hours worked, or job classification. Employers must comply with IRS regulations and nondiscrimination rules when setting up and administering an ICHRA.

Employees can use the funds provided by the employer to purchase individual health insurance coverage that meets their needs. Employees have the flexibility to choose the plan that best fits their healthcare needs and preferences, including coverage levels, deductibles, and provider networks.
Employees can also use ICHRA funds to pay for qualified medical expenses, such as copayments, deductibles, and prescription drugs.

Employers must comply with regulatory requirements, including providing written notice to employees about the ICHRA, offering it on a nondiscriminatory basis, and reporting contributions on employees' W-2 forms. They must also ensure that the ICHRA meets the minimum essential coverage requirements under the Affordable Care Act.

Employers should carefully evaluate the impact of transitioning to an ICHRA on their workforce and consider factors such as employee satisfaction, recruitment, and retention. Employers should also ensure compliance with IRS and ACA regulations to avoid penalties and legal issues.

Marketplace Private Health Plans

When employers cannot provide their employees with traditional small-group health insurance coverage, they can explore alternative options. One option is to connect

employees with a broker to enroll in health insurance coverage through the individual marketplace. This option can provide employees with access to health insurance plans even if the employer doesn't directly provide a group plan.

Maryland Health Connection is a marketplace where individuals and families can shop for and purchase health insurance plans. These plans are compliant with the Affordable Care Act (ACA) regulations, which means they offer essential health benefits and must cover pre-existing conditions. Depending on income levels, some employees may qualify for federal subsidies to reduce the cost of health insurance for themselves and their families. Three types of federal assistance programs are available: Advanced Premium Tax Credits (APTC), Cost Sharing Reduction (CSR), and Young Adult Subsidies (YAS).

- **Advance Premium Tax Credit (APTC)** - A federal subsidy program that allows an individual and/or family to enroll in a health insurance plan through the Marketplace with financial assistance. Individuals can apply for the APTC based on their estimated income for the year. If they qualify, the government pays a portion of their monthly health insurance premium directly to the insurance company, reducing the amount the individual or family has to pay out of pocket each month. When the individual files their federal income tax return at the end of the year, the actual income for the year is reconciled with the estimated income used to determine the APTC. If the actual income is higher than estimated, the individual may have to repay a portion of the APTC received. Conversely, if the actual income is lower than estimated, they may receive additional tax credits or a refund.
- **Cost-sharing reduction (CSR)**: This subsidy program reduces out-of-pocket costs such as deductibles, copayments, and coinsurance for eligible individuals and families who enroll in a Silver-level health insurance plan through the Health Insurance Marketplace. Marylanders with incomes between 100% and 250% of the federal poverty level may qualify for CSR.
- **Young Adult Subsidies (YAS)** - Marylanders under 37 years old could be eligible for this extra savings under Maryland Health Connection.

Affordability & Family Glitch Act

Under the ACA, employees are generally not eligible for a federal premium tax credit to buy a qualified health plan through a Maryland Health Connection if their employer-sponsored health coverage is considered affordable. If an employer-sponsored health insurance plan is deemed affordable for the employee according to the ACA's standards, then the employee is not eligible for premium tax credits or subsidies through the health insurance marketplace.

To be considered affordable, an employee’s contribution for self-only coverage under the lowest plan cost option available cannot exceed 9.02% of the employee’s household income for the 2024 tax year.

IRS “Family Glitch Correction" Final Rule

Family members of employees who are not offered affordable, minimum-value employer-sponsored family coverage are now eligible for a premium tax credit to purchase marketplace coverage as a result of the IRS final rule correcting the ACA “family glitch.”

Offered Medical Carriers/Issuers

Kaiser Permanente, United Healthcare, and CareFirst BCBS are the carriers available through MHC for Small Business.

CareFirst BlueChoice	Small Group Health Plan Guide 2024
KAISER PERMANENTE	Explore Plans in Maryland
United Healthcare	MD SHOP Brochure (pdf)

Need to Know for Employers

Effectively managing health insurance costs involves selecting the right plan and actively engaging in strategies to control expenses. This involves a two-pronged approach: understanding the components that contribute to overall costs and making prudent healthcare decisions.

One key element in managing costs is controlling premiums. Premiums are the regular payments made to maintain health insurance coverage. Balancing the monthly premium with potential out-of-pocket costs, such as deductibles and copayments, is crucial. Additionally, comprehending cost-sharing mechanisms like coinsurance, where the policyholder pays a percentage of the covered service's cost, allows individuals to anticipate their financial responsibilities accurately.

Networks

In-network providers are healthcare professionals and facilities that have agreements to offer discounted services to plan members. Using in-network services reduces costs and ensures that the insurance company covers a larger portion of expenses. Weighing the options between in-network and out-of-network providers and services has implications that go beyond costs. Although in-network care is financially beneficial, certain medical situations may require seeking out-of-network care. Such situations may include emergencies or specialized treatments that are not available within the network. Understanding the

distinctions between in-network and out-of-network care is particularly important when seeking specialized treatments or medical services not available within the network.

Preauthorization and referrals are integral aspects of health insurance utilization. Preauthorization, or prior approval, may be necessary for certain medical procedures or treatments to ensure they are medically necessary. On the other hand, referrals involve getting permission from a primary care physician before seeing a specialist. Understanding when and how to navigate these processes streamlines access to required care and prevents potential coverage denials.

Value-add Programs

Prioritizing wellness and preventive care is a cornerstone of maintaining a healthy workforce. Preventive care lays the foundation for better overall health outcomes and reduced healthcare expenditures. By embracing wellness programs and resources, business owners can foster a culture of proactive health management.

Preventive care services such as routine check-ups, vaccinations, screenings, and early disease detection play a crucial role in identifying health concerns at their initial stages. These services aim to prevent the onset of illnesses or detect them early when treatments are more effective and less expensive. Regular health screenings, for example, can uncover conditions like high blood pressure, diabetes, and certain cancers before they advance, thereby reducing medical complications and related costs.

Wellness programs, which often include initiatives such as health assessments, exercise routines, nutritional guidance, and stress management, empower individuals to take charge of their well-being. These programs provide tools and resources to make informed decisions about healthy living, reducing the likelihood of chronic illnesses. By encouraging employees to participate in wellness activities, organizations create an environment where health promotion is a shared goal.

Promoting a healthy lifestyle and well-being goes beyond the workplace, enhancing employee satisfaction, productivity, and morale. When employees feel supported in their health goals, they are more likely to engage in positive behaviors that lead to better health outcomes. This, in turn, results in reduced absenteeism and improved overall performance.

Investing in wellness and preventive care is a strategic decision that offers both short-term and long-term benefits. It not only reduces immediate healthcare costs, but also fosters a healthier workforce that is better prepared to contribute effectively to the organization's success.

Maintaining Compliance with Regulations

Reporting requirements for small businesses play a vital role in ensuring transparency, compliance, and accurate record-keeping. Small businesses are often subject to various reporting obligations that vary based on factors such as size, industry, and jurisdiction.

These requirements are designed to fulfill legal and regulatory mandates, provide valuable information to government agencies, and facilitate fair and ethical business practices.

ERISA, or the Employee Retirement Income Security Act of 1974, is a federal law that sets standards for employee benefit plans, including health insurance plans. ERISA applies to a wide range of employee benefit plans, including retirement plans, health insurance plans, and other welfare benefit plans. While small-group health insurance plans are generally subject to less stringent requirements compared to large-group plans, they are still subject to certain compliance standards.

It's important for small business owners to be aware of their responsibilities under ERISA and to take steps to ensure compliance. Non-compliance with ERISA requirements can result in penalties and legal consequences. Consulting with legal or benefits professionals who are well-versed in ERISA regulations can help small business owners navigate these complexities and establish compliant health insurance plans for their employees.

Navigating these reporting requirements can be complex, especially for small businesses with limited resources. To ensure compliance and avoid penalties, small business owners need to stay informed about the specific reporting obligations that apply to their industry and location. Seeking guidance from health insurance brokers, financial advisors, legal experts, and industry associations can be beneficial in understanding and meeting these requirements effectively.

Resources and Support

- Online tools and resources for researching health insurance options: https://mhcsmallbiz.marylandhealthconnection.gov/anonymous-web/#/quote-engine/business-information
- Small Business Healthcare Tax Credit Calculator https://www.taxpayeradvocate.irs.gov/estimator/sb/
- FTE Calculator **full-time equivalent employees**

Utilizing insurance brokers and consultants

The Find Assistance tool is a valuable resource that allows businesses to connect with authorized small business brokers. These specialized brokers play a pivotal role in helping employers select the most suitable health insurance options for their workforce.

With the expertise and guidance of these authorized brokers, employers gain access to a wealth of knowledge and insights. These professionals are well-versed in the intricacies of the health insurance landscape, enabling them to effectively navigate the array of available plans. Their primary goal is to assist employers and employees in identifying health insurance options that strike a harmonious balance between affordability and quality. Through a comparison process, brokers help employers discern the nuances of different

plans, empowering them to make informed decisions that align with the unique needs of their employees.

Their role is to educate, simplify, and facilitate the enrollment process for the entire workforce, alleviating the administrative burden on employers. This ensures a smoother and more efficient enrollment process as employees are onboarded onto their selected health insurance plans.

The expense associated with using a broker is integrated into the premium rates for small group insurance, whether within or outside MHC for Small Business. Savvy employers take full advantage of this benefit.

Broker Requirements

Brokers authorized and trained by the MHBE are skilled professionals with comprehensive MHC for Small Business knowledge, including plan choices, rating systems, policies, procedures, and healthcare reforms at both state and national levels. Brokers are required to hold an active Maryland license and undergo specific training in MHC for Small Business. All brokers appointed by MHBE must also receive approval from carriers participating with MHC for Small Business, indicating their compliance with MHBE standards and carrier-specific training requirements on benefits and ratings. Additionally, carriers mandate brokers to acquire insurance coverage known as "errors and omissions" (E&O) coverage.

How to Find a Broker

To find and add a broker, employers can navigate to their account dashboard and click on add a broker. Employers can also follow this link: https://mhcsmallbiz.marylandhealthconnection.gov/anonymous-web/#/find-assistance. Once at the Find Assistance tool, you can search by the broker's name or your zip code.

Contact Us

If you still have questions after speaking with a broker/advisor, contact us at: mhc.smallbiz@maryland.gov.