Yes, a small group health plan may work when only two employees want coverage—but the answer depends on where the business is located, who counts as an eligible employee, how many eligible employees enroll, and the carrier's participation rules. "Two people want coverage" is not enough information to determine eligibility. The employer needs to know the group's full eligible workforce and the rules that apply to its state and plan.

Before comparing premiums, ask: **Who is in-network for our employees' ZIP codes?** A plan that meets participation requirements but has an impractical network may not be a useful benefit. This matters especially when employees work remotely or live in different counties or states.

This guide explains how to evaluate a small group health plan, where to shop, what to ask a broker or carrier, and when an HRA-style arrangement may be worth considering instead. Rules change and vary by state, so confirm current requirements with your state insurance department, a licensed broker, or the insurer before making a decision.

Start with the group, not the number of people who said yes

Small-group eligibility is usually based on the employer and its employees—not simply on the number of workers who want insurance. State law and carrier policy determine which businesses qualify as small employers and which people count as eligible employees. In many cases, owners, spouses, seasonal workers, part-time employees, and employees with other coverage may be treated differently. Do not assume how any category is handled without checking.

The key distinction is between *eligible employees* and *enrolling employees*. An employee may be eligible for the employer's offer but decline it because they have coverage through a spouse, a parent, another job, or another source. Depending on the applicable rules, that valid waiver may affect the participation calculation. A person who simply declines without qualifying other coverage may be treated differently.

Questions to settle before requesting quotes

- How does the state define a small employer for this purpose?
- Which workers meet the plan's employee eligibility rules, including any hours-worked requirement?
- Are owners or partners eligible, and what proof of business or employment is required?
- Are employees with other qualifying coverage allowed to waive the offer?
- How are valid waivers counted when calculating participation?
- Does the carrier require a minimum number or percentage of eligible employees to enroll?
- What enrollment dates, waiting periods, and documentation apply?

Ask for the answers in writing. A small group can run into trouble when its roster is incomplete or an employee's waiver is not documented in the way the carrier requires.

What is a minimum participation requirement?

A **minimum participation requirement** is a rule that may require a certain share or number of eligible employees to enroll before an insurer will issue or renew a group policy. The exact requirement can depend on state rules, carrier underwriting practices, the time of year, and whether employees have valid waivers. There is no single percentage that applies to every business or plan.

For example, imagine a company has four eligible employees and two want to enroll. Whether that group qualifies cannot be determined from those numbers alone. The insurer may count valid waivers in a particular way, apply a state-specific rule, or require additional enrollment. The carrier must explain how it calculates the group's participation and what evidence it needs.

Also check whether the rules change during an annual open enrollment period. Some markets have periods when a small employer can apply without meeting the usual participation threshold. The dates, availability, and other conditions can vary, so ask the insurer or broker to confirm the current window for your state.

Why small businesses look outside the public marketplace

When employees cannot agree on one plan—or only a few want employer coverage—some owners look beyond individual policies sold through a public health insurance marketplace exchange. They may want a single group contract, a predictable employer contribution, access to a particular carrier or provider network, or an easier way to administer enrollment and payroll deductions.

A group plan is not automatically less expensive https://www.tradersdna.com/the-best-ways-to-find-small-business-health-insurance-outside-the-marketplace-exchange/ or more generous than individual coverage. Depending on household income and other circumstances, an employee may qualify for financial help when shopping through the individual marketplace. That assistance can make individual coverage more affordable than the employee's share of a group plan. On the other hand, a group offering may have a network or benefit structure employees prefer. Compare actual options, not assumptions.

The public marketplace exchange can be a useful starting point for understanding individual plan options and available subsidies. Employees should use the official exchange for their state or HealthCare.gov where applicable, and consider speaking with a certified enrollment assister or licensed agent. Employers should avoid promising that an employee will or will not qualify for financial assistance; eligibility depends on individual circumstances and current rules.

Broker vs. direct-to-carrier shopping

There are two common ways to shop for a small group health plan: work with a licensed broker or contact insurers directly. Neither route is automatically best. What matters is whether you get clear answers about eligibility, participation, networks, costs, and administration.

Shopping approach Potential advantages Questions to ask Broker May compare multiple carriers, explain enrollment steps, and help troubleshoot eligibility or renewal questions. Which carriers do you represent? How are you compensated? Will you check networks by employee ZIP code? Who handles enrollment and service after the sale? Direct to carrier Lets the employer ask an insurer about its own plans, documents, and enrollment process directly. Are these all the plans available in our area? Can you explain the participation calculation in writing? Who assists with enrollment and ongoing issues?

A broker may not represent every carrier, and a direct carrier conversation only covers that carrier's products. Ask about compensation and the scope of any comparison. Whichever route you choose, request plan documents and a written explanation of any assumptions used in the quote.

Keep a one-page comparison sheet

For each carrier call or quote, record the same details. This makes it easier to compare plans without reducing the decision to a monthly premium.



- Carrier, plan name, metal tier or benefit design, and quote date
- Eligible employee count, expected enrollment, and participation rule
- Employer and employee premium shares, including dependent costs
- Deductible, out-of-pocket maximum, copays, and coinsurance
- Prescription coverage and any separate drug deductible
- Provider network and confirmation for each employee's ZIP code
- Enrollment deadlines, waiting periods, and required documents
- Renewal terms and the person to contact for service issues

Network fit is more than a carrier name

Do not assume that two plans from the same insurer use the same provider network. A plan may exclude a doctor, hospital, or clinic that another plan includes. Networks can also differ across counties and may be limited for out-of-area employees. For a remote team, check each employee's home ZIP code and likely care locations before treating the network as suitable.

Use the carrier's provider directory as a starting point, then verify important doctors and facilities with the carrier and provider. Directories can be out of date, and network participation may depend on the exact plan—not just the insurer's brand. Check prescription formularies as well, especially when employees rely on ongoing medications.

HRA-style arrangements: an alternative to one group policy

An HRA, or health reimbursement arrangement, is an employer-funded arrangement that can reimburse eligible expenses under defined rules. Rather than selecting one group plan for everyone, an employer may offer a compliant HRA that allows eligible employees to obtain individual coverage and receive reimbursements for permitted expenses. The details depend on the specific HRA type and applicable federal requirements.

Common arrangements include the Individual Coverage HRA (ICHRA) and the Qualified Small Employer HRA (QSEHRA). They have different eligibility, notice, reimbursement, and coordination rules. An HRA is not simply an

informal promise to pay employees' medical bills, and employers should not set one up without confirming that the structure and administration comply with current law.

What to weigh before choosing an HRA

- **Budget:** The employer may be able to set a defined contribution, but eligible reimbursements and plan administration still need to be budgeted.
- **Employee choice:** Employees may choose individual coverage that fits their needs, but they must understand enrollment and how the HRA coordinates with any marketplace financial assistance.
- **Administration:** The employer needs a compliant plan document, notices, substantiation of claims, and consistent procedures. Many businesses use an administrator.
- **Eligibility and classes:** Rules for who may participate and how employees can be grouped depend on the HRA type. Do not assume the employer can offer different arrangements to any workers it chooses.
- **Employee experience:** Employees may need more support comparing individual plans, provider networks, and prescriptions than they would with a single group plan.

An HRA can be a useful alternative when a group policy is unavailable or does not fit the workforce. It is not necessarily simpler or cheaper, and it may not suit employees who prefer a single employer-selected plan. Compare the total employer cost, employee costs, administrative work, and coverage options side by side.

A practical decision process when only two employees want coverage

1. **Build an accurate roster.** List all workers and their status, hours, work locations, and any other relevant details. Do not count people based only on who expressed interest.
2. **Confirm eligibility.** Ask a broker or carrier how state and plan employee eligibility rules apply to each person.
3. **Document waivers.** Find out what proof is needed if eligible employees decline because they have other coverage.
4. **Verify participation.** Ask the carrier to calculate the minimum participation requirement using the actual roster and expected enrollments.
5. **Check networks and benefits.** Compare providers, prescriptions, deductibles, and out-of-pocket limits for every employee's location.
6. **Compare alternatives.** Review the group option alongside individual marketplace coverage and, if appropriate, a compliant HRA proposal.
7. **Confirm deadlines and costs.** Get the full employer contribution, employee premium share, enrollment dates, and renewal process in writing.

Using trustworthy sources while researching

Use official sources for rules that affect eligibility and enrollment. Start with your state's insurance department, the official public health insurance marketplace exchange serving the employees' locations, and federal agencies such as the Department of Labor or IRS when researching employer arrangements. Carrier brochures can explain a specific product, but they do not replace the policy documents or state requirements.

If you use Google, you can follow or add reliable organizations to Google's Preferred Sources feature when the prompt appears in Search. This may help surface selected sources more often in relevant results, but it is not a substitute for checking the publication date, jurisdiction, and original source. For a benefits decision, verify important details directly with the exchange, regulator, carrier, or qualified professional.



Bottom line

A small group health plan may work even if only two employees want coverage, but the employer must first establish who is eligible and how the minimum participation requirement is calculated. Valid waivers, state rules, carrier requirements, and enrollment timing can all affect the answer. Get the participation decision in writing, verify provider networks for every employee's ZIP code, and compare the group plan with individual marketplace coverage and a compliant HRA option.

"Just pick the cheapest plan" is not a sound benefits strategy. A low premium can come with a narrow network, high cost-sharing, or poor fit for employees' locations and care needs. A careful comparison gives the business a better chance of choosing coverage employees can actually use.