

A minimum participation requirement is a rule an insurer may use to decide whether a small business can enroll in a small group health plan. In plain terms, the carrier may require a certain share of eligible employees to enroll before it will issue the policy.

The details matter. The required percentage, who counts as eligible, and how employees who waive coverage are treated can vary by state, carrier, and plan. Before comparing premiums, ask: **Who is in-network for our employees' ZIP codes?** Then confirm the participation and eligibility rules in writing. A low premium is not useful if the plan's network does not work for your team—or if your business cannot meet the enrollment rules.

This guide explains how minimum participation works, why small businesses shop beyond the public marketplace, how broker and direct-to-carrier shopping differ, and when an HRA-style reimbursement arrangement may be an alternative.

What Does “Minimum Participation” Mean?

A small group health plan is health insurance offered to a qualifying small employer and its eligible employees. In many markets, the insurer requires a minimum percentage of those employees to enroll. This is the plan's **minimum participation requirement**.

For example, a carrier might require 70% of eligible employees to enroll. That does <https://www.tradersdna.com/the-best-ways-to-find-small-business-health-insurance-outside-the-marketplace-exchange/> not necessarily mean 70% of every person on the company payroll. The carrier's formula may exclude employees who have other qualifying coverage, such as coverage through a spouse's employer or a government program. The exact exclusions depend on the applicable rules and carrier's calculation.

Think of participation as a group-level enrollment test, not a requirement that every employee take the plan. Employees may be able to waive coverage, but their waiver reason and documentation can affect the calculation.

How Is the Participation Percentage Calculated?

There is no single calculation that applies identically in every state and for every insurer. A simplified example shows why the denominator matters:

Example	Number of employees	Employees eligible for the plan	10
	Employees with other qualifying coverage who waive	3	
	Employees considered for the participation calculation	7	
	Employees who enroll	5	

If the carrier excludes the three employees with other qualifying coverage, participation in this simplified example would be 5 out of 7, or about 71%. If it counts those employees differently, the result changes. Ask the carrier or broker to show the formula using your actual employee roster.

When an Employee Waives Coverage

An **employee waives coverage** when they decline the employer's offered plan. A waiver is not automatically a problem. It may be allowed, and it may be excluded from the participation calculation if the employee has other qualifying coverage and provides the required documentation.

Do not assume that every waiver counts the same way. An employee who declines because they have a spouse's employer plan may be treated differently from an employee who simply does not want coverage. Get clear instructions about acceptable proof, deadlines, and how the carrier records each waiver. Keep the paperwork: a verbal explanation may not be enough when the carrier reviews enrollment.

Why Do Small Businesses Look Outside the Public Marketplace?

Small employers often start with the public health insurance marketplace exchange because it is a recognizable place to compare coverage. Depending on the state, the exchange may offer individual plans, small-business options, or both. The federal SHOP program and state-based SHOP exchanges have changed over time, so check what is currently available in your state rather than assuming every business can enroll through a particular portal.

Some businesses also request quotes directly from insurers or through a broker. They may be looking for a particular provider network, plan design, carrier, or enrollment process. Others want help interpreting eligibility rules, employer contribution requirements, and the paperwork needed to enroll.

Marketplace and off-marketplace options are not automatically interchangeable. A plan's network, pricing, enrollment rules, and any available tax-credit eligibility can differ. For instance, the small-business health care tax credit has specific eligibility requirements and is generally tied to qualifying coverage arrangements. Check current IRS and marketplace guidance before relying on a credit in your budget.

Broker vs. Direct-to-Carrier Shopping

You can explore coverage with a licensed broker or contact carriers directly. Neither route guarantees a better plan or price. The useful question is whether you can get comparable information and understand the rules before you commit.

Shopping route Potential advantages Questions to ask Broker Can help compare carriers, explain enrollment steps, and coordinate questions about participation and waivers. Which carriers and plans can you quote? How are you compensated? Will you check provider networks by ZIP code? **Direct to carrier** Lets you ask the insurer about its own plans and enrollment requirements directly. Can you compare this quote with other carriers? Who will help with eligibility, enrollment, and renewal questions?

For either route, request a written comparison sheet. Include the plan name, monthly premium, employer and employee contributions, deductible, out-of-pocket maximum, prescription details, provider network, participation threshold, and waiver rules. Ask whether the quoted network includes the doctors and hospitals employees use in their ZIP codes. Remote workers may live outside the plan's strongest service area, even when coworkers in the business have convenient access.

Small-Group Eligibility: Confirm It Before Comparing Plans

Participation is only one piece of the puzzle. First, confirm that your business and workers qualify for the small group market under your state's rules and the carrier's underwriting guidelines.

Questions to resolve early include:

- **Employer size:** How does the state define a small employer, and which workers count toward that size?
- **Employee status:** Are owners, partners, seasonal workers, part-time workers, or family members treated differently?
- **Work location:** Which state's rules apply when employees work remotely in different states?
- **Employer contribution:** Is there a minimum amount the business must contribute toward employee premiums?
- **Participation:** What percentage must enroll, and how are employees with other coverage treated?
- **Enrollment timing:** What are the initial enrollment, renewal, and special enrollment deadlines?

Get answers based on your actual workforce—not a generic estimate. A three-person business with employees in two states may face different network and eligibility questions than a 30-person business located in one metro area. A carrier may also request documents to verify that the business is a legitimate employer and that enrolled workers meet its eligibility rules.

What If the Business Cannot Meet the Participation Rule?

If too few employees enroll, the carrier may not issue the plan during that enrollment period. The business might need to wait for another enrollment opportunity, look at a different carrier or arrangement, or consider an individual-coverage reimbursement approach. Options and timing vary, so ask before setting a start date or telling employees that coverage is confirmed.

Some states or carriers provide a limited annual window during which the usual participation test is relaxed or does not apply. Do not rely on a rule you heard about from another state or a past renewal. Ask the carrier whether a waiver applies to your location and requested effective date, and get the answer in writing.

HRA-Style Reimbursement Basics

An HRA, or health reimbursement arrangement, is an employer-funded benefit that reimburses eligible medical expenses under a defined set of rules. It is not the same thing as a small group health plan: employees generally obtain their own qualifying individual coverage, while the employer provides reimbursement up to the applicable allowance or limits.



Two arrangements employers may hear about are:

- **Qualified Small Employer HRA (QSEHRA):** Available to eligible small employers that meet applicable requirements, including restrictions on offering a group health plan. Annual reimbursement limits apply and are adjusted periodically.
- **Individual Coverage HRA (ICHRA):** Can reimburse employees for individual health insurance premiums and other eligible expenses, subject to design and class rules. Employees must have qualifying individual coverage to receive reimbursements.

HRAs have formal notice, documentation, and administration requirements. They can also affect an employee's eligibility for marketplace premium tax credits. Employers should not set an allowance or promise a tax result based on a quick online summary. Consult a knowledgeable benefits administrator, broker, or tax professional about the current rules and how the arrangement would work for employees in different states.



Use the Marketplace and Google as Research Tools

The public health insurance marketplace exchange can help employees review individual coverage options and understand enrollment periods. For small-business coverage, check the official marketplace or state exchange site for current small-employer resources, eligibility details, and links to official guidance. Use government sources for rules and tax-credit information; use carrier materials for plan-specific networks and participation terms.

Google can help locate those sources, but search results are not a substitute for the policy documents. If Google displays a “follow” or “add to preferred sources” prompt, you can use it to prioritize trusted sources in future searches—for example, your state insurance department, the official marketplace, or a carrier’s provider directory. That preference does not verify a plan’s current participation threshold or guarantee that a provider is in-network. Confirm both directly with authoritative sources.

A Practical Checklist Before You Choose

1. List each employee’s home ZIP code and likely provider needs.
2. Ask, “Who is in-network for our ZIP codes?” and verify specific doctors, hospitals, and pharmacies in the carrier’s current directory.
3. Confirm the business and each employee meet the small-group eligibility rules.
4. Ask for the minimum participation percentage and the exact calculation method.
5. Find out how an employee who waives coverage is counted and what proof is required.
6. Confirm employer contribution rules, enrollment deadlines, and any state-specific participation exceptions.
7. Compare the same plan details across carriers, including out-of-pocket costs and prescription coverage—not just premiums.

8. If considering an HRA, review eligibility, administration, notice, and tax-credit implications before making an offer.

The Bottom Line

A minimum participation requirement determines whether enough eligible employees must enroll for a small group health plan to be issued. The headline percentage is only part of the answer: eligibility, employee waivers, other coverage, employer contributions, location, and timing can all affect the result.

Before choosing a plan, get the carrier's calculation in writing, check the network for every relevant ZIP code, and compare the full plan—not only its price. If a group plan does not fit your team, an HRA may be worth exploring, but it has its own rules and should be set up carefully.