

# Compliance Overview

## Highlights

### Employee Leave Laws

- Federal, state and local laws provide leave protections for eligible employees.
- Employees on protected leave may have rights to maintain health coverage during their leave.
- At the federal level, these laws include the FMLA, USERRA and the ADA. State and local laws may provide additional leave protections.

### ACA Pay-or-Play Rules

- Paid leave generally counts toward an employee's hours-of-service total, which can affect their full-time status determination.
- The look-back measurement method has rules for calculating hours during special unpaid leave periods.
- ALEs should generally maintain a full-time employee's health coverage during a stability period, even if the employee takes a leave.

# Bolton

## Health Plan Coverage for Employees on Leave

A common question that employers have when an employee takes a leave of absence is whether the employee remains eligible for group health plan coverage. The answer depends on several factors, including whether the leave qualifies for protection under federal, state or local law. For example, the federal Family and Medical Leave Act (FMLA) requires covered employers to maintain health plan coverage for employees taking FMLA leave on the same basis as if they had remained working during the entire leave period.

In addition, a health plan's eligibility rules may include minimum service requirements for eligibility. When an employee goes out on leave and their hours fall below that threshold, they may technically lose eligibility under the plan's terms. Employers should review their plan documents carefully to understand how coverage is affected when an employee takes leave. Applicable large employers (ALEs) should also consider how an employee's leave impacts full-time employee status and their corresponding coverage obligations under the Affordable Care Act's (ACA) employer shared responsibility, or "pay-or-play" rules.

Employers may choose to offer health plan coverage during leave that goes beyond what the law requires. Any such policies should be clearly documented, applied consistently, and approved in advance by the plan's health insurance issuer or stop-loss carrier to help avoid unintended liability.

## Links and Resources

- [The Employer's Guide to the Family and Medical Leave Act](#), a U.S. Department of Labor (DOL) resource
- U.S. Equal Employment Opportunity Commission [publication](#) on employer responsibilities under the Americans with Disabilities Act (ADA)
- DOL [resources](#) on the Uniformed Services Employment and Reemployment Rights Act (USERRA)
- IRS [final regulations](#) on the ACA's pay-or-play rules

Provided by **Bolton**

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# Compliance Overview

## Health Plan Eligibility During Leave

Whether an employee remains eligible for health plan coverage during a leave of absence depends mainly on the following three factors:

1. Whether the leave is **protected under federal, state or local law**;
2. The **health plan's eligibility rules**, as described in the official plan document; and
3. The employer's own **leave policies**.

If an employee on leave is no longer eligible for health coverage, the employer should terminate active coverage and offer continuation coverage (if applicable) under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or state continuation laws. Continuing to offer active coverage to ineligible employees can create significant risk for the employer. Issuers and stop-loss carriers may refuse to cover claims for employees who were not actually eligible under the plan's terms, leaving the employer potentially responsible for those costs. Employers may also face penalties for failing to properly administer COBRA.

On a related note, nondiscrimination rules under the Health Insurance Portability and Accountability Act (HIPAA) generally prohibit health plans from imposing "actively at work" or continuous-service requirements for employees who take leave before their health plan coverage begins. Under HIPAA, employers may not delay enrollment in the health plan until an employee is actively at work or completes a period of continuous service, unless individuals who are absent from work due to any health factor are treated, for purposes of health coverage, as being at work.

### **Protected Leave**

Protected leave is time away from work that is covered by federal, state or local law. Employees on protected leave generally retain certain rights during their absence, such as job protection, continued benefits and the right to be reinstated when they return. Common examples include the FMLA leave, military leave, and state medical and family leave. While employers can allow employees to take leave for other reasons (e.g., personal leave or educational leave), this type of leave is generally considered unprotected because it is not covered by law.

Employees who take a protected leave may be entitled to retain their eligibility for health plan coverage, depending on the leave law's specific requirements. At the federal level, there are three main laws providing protected leave, as summarized below.

Leave Law	Description	Health Plan Coverage
FMLA	The FMLA applies to employers with <b>50 or more employees</b> . It provides eligible employees with unpaid, job-protected leave for specified family and medical reasons.	During FMLA leave, an employer must maintain the employee's coverage under any group health plan <b>on the same basis as coverage would have been provided if the employee had been continuously employed during the entire leave period</b> . If the employer pays a portion of premiums for active employees, that same contribution must continue during FMLA leave. The obligation to maintain active coverage ends if the employee does not return to work at the conclusion of their FMLA leave or if the employee communicates before the leave ends that they do not intend to return to work. Also, if an employee chooses not to retain group health plan coverage during FMLA leave, they are entitled to have their coverage reinstated when they return to work, on the same terms as prior to taking the leave.

# Compliance Overview

Leave Law	Description	Health Plan Coverage
<b>USERRA</b>	USERRA applies to <b>all employers</b> , regardless of size. It provides job protections to individuals who are absent from employment due to military service.	<p>Employees who are away from work due to military service may elect to <b>continue their group health plan coverage for up to 24 months</b> after the absence begins or for the period of military service (plus the time allowed to apply for reemployment), whichever is shorter. When an employee's period of military service is for less than 31 days, the employer is required to pay its normal share of the premium for coverage. When the period of military service is 31 or more days, an employee who elects to continue health coverage may be required to pay 102% of the full premium for the coverage. If health coverage ends because the employee did not elect to continue coverage or failed to pay premiums, the employer must reinstate health coverage upon the employee's reemployment without any exclusions or waiting periods attributable to the military service.</p> <p>USERRA coverage is similar to COBRA continuation coverage, although the laws' specific requirements are different. USERRA does not prescribe specific procedures for electing or paying for continuation coverage, leaving employers to develop reasonable election processes and payment rules. Notably, an employee cannot be denied the opportunity to elect USERRA coverage in situations where making a timely election is impossible or unreasonable under the circumstances.</p>
<b>ADA</b>	The ADA applies to employers with <b>15 or more employees</b> . It prohibits employment discrimination on the basis of disability and requires employers to provide reasonable accommodations to employees with disabilities. In certain situations, leave may be considered a reasonable accommodation.	The ADA does not specifically require the maintenance of group health plan benefits for an employee who is taking leave as a reasonable accommodation unless the employer provides health plan benefits for other employees in the same leave status. That is, <b>if an employer maintains coverage for employees on leave for reasons other than disability, it must treat employees on reasonable accommodation leave in the same manner.</b>

State and local laws may provide leave rights that differ from, or go beyond, what federal law requires. Most states have their own family and medical leave laws, and many provide leave rights for other circumstances, such as bereavement or civic duties. Employers should be familiar with the leave laws in each location where their employees work and evaluate whether those laws offer any benefit protections beyond what federal law requires.

In general, employers are not required by law to maintain an employee's health benefits during a leave that is not covered by federal, state or local law (i.e., an unprotected leave). Whether an employee on unprotected leave remains eligible for health coverage generally depends on the health plan's written terms and the employer's leave policies.

# Compliance Overview

## *Health Plan Terms and Leave Policies*

When an employer is not required by law to maintain health plan coverage for an employee on leave, it should consider how the plan's written terms define eligibility for coverage. Employer-sponsored health plans typically include minimum service requirements for eligibility. For example, many health plans require employees to work an average of at least 30 hours per week to remain eligible for coverage. When an employee goes on leave and their hours fall below that threshold, they may lose eligibility under the plan's terms. As summarized below, ALEs should consider how an employee's leave impacts their coverage obligations under the ACA's pay-or-play rules.

In the absence of any legal obligation or specific language in the plan documents, employers should review their leave policies to determine how long an employee on an unprotected leave remains eligible for benefits. These policies should be clearly written and applied consistently across similarly situated employees to help guard against discrimination claims. Also, employers that extend health coverage for employees on unprotected leave should confirm these eligibility rules with their issuers or stop-loss carriers in advance. This helps to protect the employer from inadvertently assuming liability for claims payments.

## **Paying for Coverage During Leave**

Most employers allow employees to pay for their share of health plan premiums on a pre-tax basis through a Section 125 cafeteria plan. When an employee's leave is paid through payroll, employee contributions can continue to be deducted from their pay as usual. However, if the leave is unpaid (or paid through an outside source), employers should ensure they have a process for employees to make contributions for their health coverage.

[IRS regulations](#) for cafeteria plans provide three options for paying health plan premiums during an unpaid FMLA leave, as outlined below. A cafeteria plan may allow one or more of these options, subject to certain limitations. In general, whatever payment options are offered to employees on non-FMLA leave must be offered to employees on FMLA leave.

1. **Prepay option:** Employees are given the opportunity to pay their share of premiums before their leave begins, covering contributions that would otherwise come due during the leave period. To do this, employees voluntarily reduce their pay prior to starting leave to cover their share of premiums for all or part of the expected leave period. This cannot be the only payment option offered to employees on FMLA leave; however, this payment option may be limited exclusively to employees taking FMLA leave. Prepaying for coverage on a pre-tax basis is not allowed when the leave of absence spans two plan years;
2. **Pay-as-you-go option:** Employees pay their share of premiums in installments throughout the leave period. These contributions can be made with pre-tax dollars to the extent the employee receives any compensation during the leave period, such as paid time off or sick pay. Otherwise, the contributions can be made on an after-tax basis (e.g., by mailing a personal check); and
3. **Catch-up option:** The employer advances the employee's share of premium costs during the leave, with the employee's agreement to repay those amounts upon returning to work. Once the employee returns, they make special catch-up salary-reduction contributions to reimburse the employer for the premiums that were advanced on their behalf during the leave. This can be the sole option offered to employees on FMLA leave only if it is the sole option offered under other types of unpaid leave.

## **ACA's Pay-or-Play Rules**

The ACA's pay-or-play rules require ALEs to offer affordable, minimum value health coverage to their full-time employees (and dependents) or potentially pay a penalty to the IRS. An ALE is an employer that averaged at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year. A full-time employee is an employee who was employed, on average, at least **30 hours of service per week** (or 130 hours in a calendar month). The following two methods are available for determining full-time employee status:

# Compliance Overview

1. **Monthly measurement method:** This method involves a month-to-month analysis, where full-time employees are identified based on their hours of service for each calendar month; and
2. **Look-back measurement method:** Under this method, an ALE counts an employee's hours of service during one period (called a measurement period) to determine their full-time status for a future period (called a stability period). While the details of this method are complicated, it provides predictability for companies that have employees with varying hours or work schedules.

The obligation to offer health coverage to full-time employees becomes more complex when an employee goes on leave. To avoid potential penalties, ALEs should ensure that they understand how a leave affects an employee's hours of service and their full-time employee status under the pay-or-play rules.

To determine if employees meet the ACA's threshold for full-time status (i.e., 30 hours of service per week), an ALE must count each hour for which an employee is paid, or entitled to payment, for the performance of duties, as well as each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity, layoff, jury duty, military duty or leave of absence. This means that **paid leave generally counts toward an employee's hours-of-service total**, which can affect their full-time status determination.

The look-back measurement method has rules for calculating hours during certain **periods of unpaid leave**. During a measurement period, ALEs must average hours during "special unpaid leave periods," which include leave under the FMLA, USERRA or jury duty. Under the averaging method, ALEs can either:

- Determine the average hours of service per week for the employee during the measurement period, excluding the special unpaid leave period, and use that average as the average for the entire measurement period; or
- Treat employees as being credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave.

Also, under the look-back measurement method, an employee generally retains their full-time (or non-full-time) status **during the entire stability period**, regardless of their hours of service during the stability period, so long as they remain an employee of the ALE. Thus, to avoid potential penalties, an ALE should maintain health coverage for full-time employees during a stability period, even if they take an unprotected leave of absence during that period.

### HIGHLIGHTS

A recent report to Congress highlights the Departments' compliance activities regarding MHPAEA's comparative analysis requirement for NQTLs. Key takeaways for employer-sponsored health plans include the following:

- EBSA focuses on NQTLs that impact access to care, such as provider network admission standards;
- Health plans that proactively comply with MHPAEA's comparative analysis requirement tend to have better outcomes upon EBSA review; and
- Employers should reach out to their service providers to ensure a comparative analysis has been completed for the plan's NQTLs, as MHPAEA compliance is a health plan responsibility.

## Federal Agencies' Report on MHPAEA Compliance Highlights Importance of Comparative Analyses of NQTLs

The U.S. Departments of Labor, Health and Human Services, and the Treasury (Departments) recently submitted a [report](#) to Congress on the results of their review activities regarding comparative analyses of nonquantitative treatment limitations (NQTLs) under the Mental Health Parity and Addiction Equity Act (MHPAEA). This report, which covers the Departments' activities during a two-year period ending on July 31, 2025, emphasizes the importance of preparing complete comparative analyses of a health plan's NQTLs.

### Background

MHPAEA generally prohibits health plans and health insurance issuers from imposing barriers on access to mental health or substance use disorder (MH/SUD) benefits that do not apply to medical and surgical (M/S) benefits. MHPAEA's parity requirements apply to financial requirements, quantitative treatment limitations and NQTLs, which generally limit the scope or duration of benefits. MHPAEA requires health plans and issuers to perform and document comparative analyses of the design and application of NQTLs used for MH/SUD benefits compared to M/S benefits. Health plans and issuers must make their comparative analyses available upon request to the Departments, as well as applicable state authorities. The Departments must report to Congress annually on the results of their NQTL comparative analyses reviews.

### MHPAEA Compliance Report

The Department of Labor's [Employee Benefits Security Administration](#) (EBSA) oversees MHPAEA compliance of health plans maintained by private-sector employers. During the reporting period ending in 2025, EBSA issued 42 initial letters requesting comparative analyses for 77 NQTLs (30 letters to health plans and 12 letters to issuers). According to EBSA, while many comparative analyses were deficient when initially produced, most health plans and issuers worked with EBSA to correct deficiencies and remove problematic NQTLs. Consequently, EBSA only issued five final determinations of noncompliance during the reporting period. Key points from the report include the following:

- EBSA prioritizes NQTLs with the **most significant impact on access to care**, especially limitations related to network adequacy and composition and impermissible exclusions of MH/SUD treatment, such as exclusions of applied behavioral analysis for autism or methadone treatment for opioid use disorder;
- When health plans and issuers **proactively consider MHPAEA compliance** and have prepared complete comparative analyses, EBSA's investigations are resolved more quickly and have better outcomes; and
- Sponsors of self-insured health plans have frequently been surprised to learn that the **health plan itself (and not a service provider) is responsible for MHPAEA compliance**. In addition, many sponsors mistakenly believed their service provider already had a comparative analysis prepared or would create one for them, even when their contract did not assign that responsibility.