



MHPAEA update: Enforcement of the 2024 Final Rule Halted

By: Colin Clark

Introduction

In a move that many expected, the Department of Health and Human Services, Department of Labor, and the United States Treasury Department (the Departments) announced that they will immediately halt enforcement of the 2024 Final Rule under the Mental Health Parity and Addiction Equity Act ("MHPAEA"). As of May 15, 2025, the Departments will not enforce the 2024 Final Rule, nor will they pursue enforcement of any noncompliance with the 2024 Final Rule prior to a final decision in pending litigation, plus an additional 18 months. The so-called "Final Rule" was released on September 9, 2024, and is a set of updated regulations and amendments to the 2013 final rule. It has been met with fierce opposition, most notably in a lawsuit filed in January 2024 by the ERISA Industry Committee ("ERIC"), a group that represents the employee benefits interests of employers. Although the halted enforcement of the 2024 Final Rule could be seen as a relief for some health plan sponsors, certain obligations remain, and this is a developing area of the law that warrants close attention.

What Is in the 2024 Final Rule?

The 2024 Final Rule is a set of updated regulations and amendments to the 2013 final rule. The goal of the 2024 Final Rule, as

stated by the Departments, was "to strengthen consumer protections consistent with MHPAEA's fundamental purpose – to ensure that individuals in group health plans or with group or individual health insurance coverage who seek treatment for covered mental health conditions or substance use disorders do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or surgical procedure." The Departments were planning to implement this broad goal through, among other things, tighter restrictions on Non-Quantitative Treatment Limitations ("NQTLs"), enhanced data collection and evaluations, and prohibiting the use of potentially discriminatory information related to mental health and substance use disorder benefits.

The Decision to Halt Enforcement

The lawsuit filed by ERIC challenged the 2024 Final Rule on many grounds and is an attempt to have the 2024 Final Rule completely invalidated. While the 2024 Final Rule has not been completely invalidated, on May 9, 2025, the Departments asked the US District Court to hold the lawsuit in abeyance—essentially a pause in the litigation—while they reconsider the 2024 Final Rule. This move was likely influenced by the Trump Administration's latest Executive Order (Executive Order 14219, titled "Ensuring Lawful Governance and Implementing the President's 'Department of Government Efficiency' Deregulatory Initiative") which directs federal agencies



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to review certain regulations considered to be an overreach or unlawful. Just days later, the Departments, consistent with their request for a pause in the litigation, released a statement detailing their non-enforcement policy on the MHPAEA's 2024 Final Rule. It is important to note that while the 2024 Final Rule is in a state of limbo, and there is quite a long period of non-enforcement of the 2024 Final Rule provisions, sponsors must remain vigilant as their obligations under the MHPAEA remain.

Practical Implications

Despite the pause in litigation, the halting of any noncompliance enforcement, and the Departments' reconsideration of the 2024 Final Rule, sponsors are not relieved from their current obligations under the 2013 final rule, including the obligation to perform a comparative analysis. Sponsors should continue to comply with all current provisions of the MHPAEA. Until there is a conclusion to this current litigation, or further guidance or modification of the current regulation, it is imperative that sponsors comply with all applicable MHPAEA requirements (such as NQTLs). Plan sponsors should continue to monitor the court case and any statements provided by the Trump Administration or the Departments on MHPAEA compliance obligations.



The One, Big, Beautiful Bill (Employee Benefits Version)

By: Kate Belyayeva

On May 22, 2025, the U.S. House of Representatives passed "The One, Big, Beautiful Bill" (the "Bill"), which introduces significant changes to the Internal Revenue Code (the "Code"), with notable implications for employee benefits. The Bill extends and expands upon the 2017 Tax Cuts and Jobs Act ("TCJA"). The Bill was introduced as a centerpiece of former President Donald Trump's policy for his second term. The original TCJA lowered individual and corporate tax rates, increased the standard deduction, and reshaped the Code. However, many of the provisions are set to expire at the end of 2025. This article seeks to summarize the key provisions in the Bill relating to employee benefits; however, employers should familiarize themselves with the full text of the Bill and specific implications as to each employer.

Key Provisions

(1) **Cap on Tax-Free Employee Benefits.** Currently, employer contributions to certain benefits (i.e., health insurance) are

excluded from employees' taxable income. The Bill includes a provision that caps the tax exclusion for employer-provided benefits at \$12,000 per employee, annually. Employees may experience increased benefit costs if employers adjust benefits accordingly or shift more cost to the employees directly.

(2) **Affordable Care Act ("ACA") Changes.** The Bill introduces several changes to the ACA. Among other things, the Bill eliminates automatic enrollment for individuals receiving subsidies—now, individuals must actively re-enroll and verify income annually. Furthermore, DACA recipients will no longer be considered qualified individuals for ACA coverage. These measures are projected to reduce ACA enrollment in the near future. Notably, the aforementioned changes do not directly impact employers; however, the new requirements could cause employees previously enrolled in ACA plans to enroll in employer-sponsored coverage instead.

(3) **Expansion of Health Savings Accounts ("HSAs").** The Bill proposes certain expansions to HSAs. For example, the Bill seeks to allow Medicare Part A recipients and certain ACA plan holders to contribute to HSAs. Individuals with HSAs will also be permitted to withdraw from HSAs tax-free for specific fitness expenses (capped at \$500 year for individuals and \$1,000 for families). Certain health plans will become newly compatible with HSAs: (i) direct primary care arrangements; and (ii) qualified discounted health services available through an employer's on-site clinic. In addition, the Bill permits both spouses over age 55 to contribute catch-up funds to a single HSA account. With respect to spouses, the Bill permits those with a spouse enrolled in a flexible spending account to also have an HSA. Lastly, the contribution limits will be almost doubled. These changes will likely broaden the group of individuals eligible to contribute to an HSA.

(4) **Rebranding of Individual Coverage Health Reimbursement Arrangements ("ICHRA").** The Bill suggests codification of ICHRA into federal law as the custom health option and individual care expense ("CHOICE") arrangements. The rebranding of ICHRA will ensure longevity beyond administrative regulations. Employers with fewer than 50 employees could receive a two-year tax credit if they offer CHOICE arrangements. The general business credit amount is \$100 per employee, per month in the first year and \$50 per employee, per month in the second year. Employees will also be allowed to pay their share of the premium on a pre-tax basis through a cafeteria plan even if the policy is purchased on the Marketplace.

Employer Impact

In light of the changes proposed by the Bill, employers may need to reevaluate their benefits if the Bill becomes law in substantially the form passed by the House. The imposition of a cap on tax-free benefits could lead to increased taxable income to employees; thus, some employers may consider reducing the value of benefits provided to employees. At the same time, the expansion of HSAs could offer new avenues for tax-advantaged savings. Until the Bill is closer to the President's desk, it is difficult to fully grasp the financial and administrative impact on employees and employers alike. Employers should stay informed about these potential changes and, in turn, properly notify employees of potential impact on take-home pay, tax liabilities, and new opportunities.

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Conclusion

The future of the Bill is in the hands of the Senate, where passage is uncertain and a number of changes are likely to occur. If passed, the provisions could take effect as early as January 2026, with some taking effect sooner.



DOL Withdraws 2024 Independent Contractor Rule, Signals New Direction for FLSA Enforcement

By: Abby Blankenship

On May 1, 2025, the U.S. Department of Labor (DOL) issued Field Assistance Bulletin (FAB) No. 2025-1, titled “FLSA Independent Contractor Misclassification Enforcement Guidance.” In the bulletin, the DOL announced that it will no longer enforce the 2024 independent contractor rule established under the Biden administration. This decision signals a policy shift under the current administration, which is actively working to develop a new standard for determining whether a worker is classified as an employee or an independent contractor under the Fair Labor Standards Act (FLSA).

Background

In January 2024, the DOL, under the Biden administration, issued a final rule revising the standard for determining independent contractor status under the FLSA. This rule rescinded the 2021 Trump-era rule, which had applied a multifactor test but assigned greater weight to two “core factors”: (1) the nature and degree of the worker’s control over their work, and (2) the worker’s opportunity for profit or loss based on their initiative and investment. In contrast, the 2024 rule adopted a six-factor, totality-of-the-circumstances test that evaluates the economic realities of the worker’s relationship with the potential employer. The rule was designed to strengthen worker protections by making it more difficult for employers to classify workers as independent contractors rather than employees entitled to minimum wage and overtime under the FLSA.

Latest DOL Position

Although the 2024 rule remains in effect and continues to govern private litigation under the FLSA, the DOL has announced that it will no longer apply this rule in its own enforcement actions. This

means that, while courts may still rely on the 2024 standard, the DOL will use a different approach when assessing worker classification for its investigations and compliance efforts.

According to the bulletin, the DOL’s enforcement approach will revert to the “economic reality” framework outlined in Fact Sheet #13, originally issued in 2008. Under this framework, the determination of whether a worker is an employee or an independent contractor is based on several factors that assess the economic dependence of the worker on the employer. The following criteria will be considered in making that determination:

1. The extent to which the services rendered are an integral part of the business.
2. The permanency of the relationship.
3. The amount of the alleged contractor’s investment in facilities and equipment.
4. The nature and degree of control by the business.
5. The alleged contractor’s degree of control by the business.
6. The amount of initiative, judgment, or foresight in open market competition with others required for the success of the claimed independent contractor.

Takeaways

Although the bulletin confirms that the DOL is reconsidering the current rule, it remains unclear what a revised standard will ultimately entail. In the meantime, employers should proceed with caution when making worker classification decisions. While the DOL’s recent shift suggests an intent to make it easier for businesses to classify workers as independent contractors, employers must also account for applicable state laws, which may impose stricter classification standards.

Employers should also carefully document the rationale for any independent contractor classification. This includes maintaining written contracts, outlining the degree of control over work, detailing financial arrangements, and providing evidence that the worker operates an independent business. Such documentation can be essential in the event of an audit or legal dispute.

Finally, it is important to recognize that the independent contractor standard could shift again with a change in presidential administration. Employers should stay informed and be ready to adjust their classification practices as federal standards continue to evolve.



Compliance Corner: HIPAA Special Enrollment Rights

By: Colin Clark

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was enacted to protect the privacy and security of individuals' medical information. It sets standards for how healthcare providers, insurers, and other entities handle personal health information ("PHI"), ensuring that such data is kept confidential and secure. Among its various provisions, HIPAA also includes special enrollment rights, which allows individuals to enroll in a health plan outside of the usual open enrollment period if they experience certain qualifying events. So, what exactly are special enrollment rights and when do they apply?

What Are HIPAA Special Enrollment Rights?

In general, group health plans typically offer eligible employees two regular opportunities to elect health coverage—an initial enrollment period when they first become eligible and an annual open enrollment period before the beginning of each plan year. In addition to these two opportunities, HIPAA requires group health plans to provide special enrollment periods outside of the regular enrollment period due to specific life events. Special enrollment must be requested within a specific timeframe, typically within 30 or 60 days after such qualifying event occurs.

Which Health Plans are Affected by Special Enrollment Rights?

- Self-insured plans must provide special enrollment rights.
- Fully insured plans must provide special enrollment rights.
- There are certain categories of coverage that are except from HIPAA's special enrollment rules, such as limited-scope vision and dental benefits.
- Retiree-only plans and most health flexible spending accounts (FSAs) are also exempt from HIPAA's special enrollment rules.

When Do Special Enrollment Rights Apply?

Special enrollment rights must be provided in several specific scenarios:

Loss of Other Health Coverage

Employees who lose their existing health insurance due to job loss, reduction in work hours, or the end of COBRA continuation coverage are eligible for special enrollment.

For example, an employee declines to enroll in health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan then ceases. Under the special enrollment rules, that employee then can request enrollment in her own company's plan for herself and her dependents.

Change in Family Status

HIPAA requires a group health plan to provide special enrollment opportunities to certain employees who acquire a

new spouse or dependent by marriage, birth, adoption, or placement for adoption.

The regulations provide that the following individuals are eligible to enroll upon the acquisition of a new dependent through birth, marriage, adoption, or placement for adoption:

- a current employee who is eligible but not enrolled;
- a current employee who is eligible but not enrolled, and the spouse of such employee;
- a current employee who is eligible but not enrolled, and the newly acquired dependent of such employee;
- the spouse of an employee who is a participant;
- a current employee who is eligible but not enrolled, and the spouse and newly acquired dependent; and
- a newly acquired dependent of an employee who is a participant.

However, HIPAA is very clear that only the employee, spouse, and any newly acquired dependents receive special enrollment rights under this provision. Thus, other dependents (for example, siblings of a newborn child) are not entitled to special enrollment rights upon the employee's acquisition of a new dependent.

Individuals Who Lose Medicaid

If an employee or dependent ceases to become eligible for Medicaid and subsequently loses their Medicaid coverage, a HIPAA special enrollment right becomes available. The affected individual has at least 60 days after the coverage termination to request special enrollment.

Eligibility Under CHIPRA

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), group health plans and group health insurance issuers must offer special enrollment opportunities. Plans and issuers must permit employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon: losing eligibility for coverage under a State Medicaid or CHIP program, or becoming eligible for State premium assistance under Medicaid or CHIP.

In this scenario, the employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

When Do Special Enrollment Rights Take Effect?

The answer to this question depends on what triggers an employee's right to special enrollment. Those employees taking advantage of special enrollment as a result of a birth, adoption, or placement for adoption begin coverage no later than the day of the event.

For special enrollment due to marriage or loss of eligibility for other coverage, the new coverage will begin on the first day of the first month after the plan receives the enrollment request. For example, if the plan receives the request on March 3, coverage would begin on April 1.

What are the Notice Requirements Associated with Special Enrollment Rights?

Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan. In addition, employers that maintain a group

health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice (referred to as the Employer CHIP Notice) to all employees to inform them of possible opportunities in the state in which they reside.

For convenience, the Department of Labor has a model special enrollment notice that group health plans may use as a guide when crafting a special enrollment notice.



STAY IN THE KNOW...

- In April, Arkansas enacted a law that bans pharmacy benefit managers ("PBMs") from owning or operating pharmacies in Arkansas. Two separate lawsuits have been filed against the state – one by Cigna and the other by CVS – in an attempt to block the law. In the lawsuits, the plaintiffs cite federal laws (such as ERISA) as well as numerous constitutional violations. Many states have enacted legislation or filed lawsuits aimed at curtailing PBM influence, a trend that seems likely to continue.
- The IRS has announced the 2025 cost-of-living adjustments for various health and welfare benefit plans. Notable changes include an increase in the Health Flexible Spending Account (FSA) contribution limit to \$3,300 and the Health Savings Account (HSA) contribution limits rising to \$4,300 for individuals and \$8,550 for families.
- In *Holland v. Elevance Health Inc. f/k/a Anthem, Inc.*, the U.S. District Court for the District Court of Maine dismissed a proposed class action alleging that a health plan's exclusion of weight-loss drug coverage violated Section 1557 of the Affordable Care Act (ACA). The plaintiff, who claimed obesity as a disability, argued the exclusion was discriminatory. While the court found her individual allegation of disability plausible, it held that she failed to show she was denied coverage solely due to her disability. The court concluded her allegations did not support claims of intentional, proxy, disparate impact, or deliberate indifference discrimination.

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