CMS Unveils ‘CRUSH’ Proposed Rule Targeting Fraud, Waste, and Abuse Across Federal Health Programs

By: Mark Opara, Lori Beam, and John Neyens

On November 16, 2026, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule titled Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (CMS-6098-P). Unlike CMS’s annual payment rules, CRUSH is a stand-alone program integrity package that reaches nearly every federal health care program—Medicare fee-for-service, Medicare Advantage (MA), Part D, Medicaid, CHIP, and the ACA Marketplace. CMS projects roughly $90 billion in federal savings over 2027–2036 and has signaled that it expects to issue a similar program integrity rule every year.

Although CRUSH is not yet final, physicians, hospitals, home health agencies, hospices, DME suppliers, therapists, chiropractors, and other providers should begin assessing its impact now. Key provisions include:

Medicare Enrollment: Shorter Deadlines and Closer Scrutiny of Ownership

- **Uniform 30-day reporting window.** Today, certain changes (such as ownership, practice location, and final adverse actions) must be reported within 30 days, while others may be reported within 90 days. CMS would eliminate the 90-day category, so that every change to enrollment data—for example, a new managing employee, officer, bank account, billing agent, or mailing address—would be due within 30 days.
- **Unverifiable or high-risk owners.** CMS could deny or revoke enrollment when it cannot confirm the identity of an owner, partner, officer, director, or managing employee (domestic or foreign), or concludes that such a person presents an undue program integrity risk. Organizations with layered or investor-backed ownership should confirm their disclosures are complete.
- **Original Medicare enrollment as a condition of MA billing.** Other than in PACE, providers and suppliers that bill MA plans would need an approved Original Medicare enrollment, subjecting them to full fee-for-service screening. This requirement would begin with the plan year starting two years after the final rule is published.

Medicare Advantage and Part D: More Plan Reporting, More Provider Audits

MA organizations and Part D sponsors would be required—rather than merely encouraged—to refer suspected or substantiated fraud, waste, and abuse to CMS, and to report credible-allegation payment suspensions involving any provider type, not only pharmacies. The proposal would also codify Risk Adjustment Data Validation (RADV) audit policies, including extrapolation beginning with payment year 2018, that a federal court previously vacated. Network providers should expect more plan record requests, coding reviews, and payment holds.

Medicaid: New Provider-Level Obligations

- **60-day overpayment rule.** Medicaid fee-for-service providers would have to report and return identified overpayments to the state within 60 days, mirroring the Medicare standard. An

overpayment is treated as identified when the provider knows of it or acts in reckless disregard or deliberate ignorance of it, and funds kept past the deadline may give rise to False Claims Act liability.

- **Quicker payment suspensions.** States could base a Medicaid payment suspension on a credible allegation of fraud found by CMS or another federal agency, and the "good cause" exception to suspension would be narrowed.
- **Broader enrollment grounds and disclosures.** Medicaid and CHIP denial and termination grounds would be aligned with Medicare's (for example, felony convictions and abusive billing or prescribing), and providers would have to disclose more about their owners, managing employees, and adverse legal actions.
- **Electronic visit verification (EVV).** States would have to use EVV data in prepayment claim review and preliminary fraud investigations for home health and personal care services, making accurate visit documentation essential for home-based providers.

DME Suppliers

DMEPOS suppliers would have to list on Form CMS-855S related businesses that provide marketing, fulfillment, wholesale, or manufacturing services. The current restriction on unsolicited telephone contact with beneficiaries would be extended to text messages, social media direct messages, emails lacking an opt-out, and door-to-door solicitation.

Practical Steps

Providers should consider: (1) moving all Medicare enrollment updates to a 30-day timeline; (2) confirming that all owners, officers, directors, and managing employees are accurately reported; (3) identifying clinicians or sites billing MA without Original Medicare enrollment; (4) extending Medicare overpayment policies to Medicaid fee-for-service; (5) auditing EVV data (home health and personal care); and (6) reviewing vendor relationships and outreach practices (DME).

Comments are due 60 days after Federal Register publication (scheduled for November 19, 2026) under file code CMS-6098-P. We are available to help you evaluate how CRUSH may affect your organization and to prepare comments to CMS.

This article is general in nature and does not constitute legal advice. Readers with questions should contact Mark Opara (mopara@sb-kc.com), Lori Beam (lorib@sb-kc.com), John Neyens (johnn@sb-kc.com) or their regular Seigfreid Bingham contact at 816.421.4460.

By: Mark Opara (Healthcare and M&A Partner at Seigfreid Bingham, P.C.)

The market for corporate investment in medspas, dermatology, and cosmetic practices remains one of the most active sectors in healthcare private equity (PE). Driven by high cash-pay revenue, fragmented markets, and strong consumer demand, PE funds continue to aggressively roll up clinical practices.

However, transitioning from an independent, physician-owned practice to a PE-backed platform is a rigorous legal and financial undertaking. Sellers who understand the mechanics of valuation, corporate preparation, and transaction structuring are best positioned to maximize value while protecting their post-closing interests.

1. Valuation and EBITDA Considerations

Private equity transactions are fundamentally driven by a multiple of the practice's Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA). For independent cosmetic practices,

calculating a true “adjusted EBITDA” is the first critical hurdle.

- **The Valuation Gap:** Small, single-site medspas may command multiples of 4x to 6x EBITDA, whereas larger, multi-location dermatology platforms can command 10x to 14x+ EBITDA.
- **Normalizing Adjustments:** To find true EBITDA, the seller’s financial team must add back personal expenses run through the business, one-time legal fees, and above-market owner salaries.
- **The Provider Compensation Adjustment:** The most significant adjustment involves replacing the owner’s current draw with a market-rate salary or commission structure (e.g., 20–25% of personal net collections). Because this reduces EBITDA, balancing pre-sale cash flow expectations against the ultimate transaction multiple is a delicate legal and financial calculation.

2. Preparing for Due Diligence: Corporate Books and Records

PE buyers conduct exhaustive due diligence. Discovery of corporate or regulatory non-compliance mid-transaction can result in severe purchase price reductions or deal termination. Sellers must get their corporate house in order before signing a Letter of Intent (LOI).

- **Corporate Structure and Governance:** Buyers will review all historical organizational documents, meeting minutes, and equity issuance records. Missing stock certificates, unrecorded transfers, or unsigned operating agreements must be remediated.
- **Regulatory Compliance:** Due diligence will heavily scrutinize federal Anti-Kickback Statute (AKS) compliance, HIPAA data privacy protocols, and state law “fee-splitting” prohibitions.
- **Licensing and Credentialing:** Every provider—physicians, mid-levels, estheticians, and laser technicians—must have up-to-date licenses, proper oversight agreements, and documented certifications for the specific devices they operate.

3. The Quality of Earnings (QofE) Analysis

Relying on internal QuickBooks files or standard tax returns is insufficient in a PE transaction. Buyers will commission a third-party accounting firm to perform a Quality of Earnings (QofE) analysis. Forward-thinking sellers often commission a “sell-side” QofE before going to market.

- **Cash vs. Accrual Accounting:** Many cosmetic practices operate on a cash basis. A QofE converts these financials to accrual-based accounting (GAAP) to accurately match revenues with the period in which the services were actually performed.
- **Deferred Revenue Management:** Medspas frequently sell gift cards, packages, and membership subscriptions. A QofE analyzes how deferred revenue is tracked. Money collected up front for a cool-sculpting package cannot be recognized as earnings until the treatment is rendered, which significantly impacts closing-day working capital calculations.

4. The Heavy Lift of Disclosure Schedules; Interplay with Indemnification and Escrow

The Disclosure Schedules are arguably the most labor-intensive legal component of the definitive asset or stock purchase agreement, and they are inextricably linked to the transaction’s indemnification framework and escrow mechanics. Together, these three elements form the backbone of post-closing risk allocation between buyer and seller.

- **The Risk Allocation Function of Disclosure Schedules:** The disclosure schedules serve as the exceptions to the seller’s representations and warranties. For example, if a purchase agreement states “the seller is not a party to any material contracts over $X in annual expenditure,” the

disclosure schedule must list every single lease, vendor agreement, and software license that exceeds the applicable threshold. If an item is omitted and later causes a loss, the buyer can claim a breach of the seller's representations and seek indemnification — making the completeness of these schedules a critical predicate to the entire indemnification framework.

- **The Scope of Disclosures:** For cosmetic practices, these schedules require an exhaustive cataloging of all medical devices (and whether they are leased or owned), employee census data, active litigation, patient complaints, and historical regulatory audits. Preparation requires weeks of dedicated administrative effort.
- **Escrow as a Security Mechanism:** To ensure the seller's indemnification obligations are more than a contractual promise, buyers in cosmetic M&A transactions typically require that a portion of the purchase price — commonly **5% to 15%** — be deposited into an escrow account at closing, held by a third-party escrow agent. The escrow fund serves as the buyer's readily accessible source of recovery for indemnification claims without needing to pursue the seller directly. Escrow terms are a significant negotiating point: sellers push for shorter hold periods and smaller escrow amounts to accelerate receipt of full consideration, while buyers seek longer hold periods (often 12 to 18 months, matching the general representation survival period) and larger reserves to account for claims that may not surface immediately after closing. In transactions involving rollover equity, the escrow negotiation can take on additional complexity, as the seller's reinvestment in the platform may itself provide the buyer with a degree of comfort regarding the seller's ongoing alignment.
- **Indemnification Mechanics:** The indemnification provisions in the purchase agreement establish the buyer's primary remedy for post-closing losses arising from breaches of the seller's representations and warranties. In cosmetic healthcare transactions, buyers typically negotiate for **special indemnities** covering known high-risk areas — such as undisclosed regulatory violations, malpractice claims, HIPAA breaches, or noncompliance with the Corporate Practice of Medicine doctrine — that survive beyond the general survival period and may sit outside the indemnification cap. The scope of indemnification is often heavily negotiated, with key terms including survival periods (commonly 12 to 24 months for general representations, and longer for fundamental representations such as title, authority, and tax), indemnification caps (frequently 10% to 20% of the purchase price for general representations), deductible baskets or mini-baskets that set a threshold before claims become payable, and whether the indemnification obligation is the buyer's sole and exclusive remedy.
- **The Interplay — Schedules, Indemnification, and Escrow:** These three elements operate as an integrated risk-allocation system. The disclosure schedules define the baseline of what the seller has represented as true; the indemnification provisions create the contractual right to recover when those representations prove inaccurate; and the escrow ensures a funded source from which the buyer can satisfy those claims. A gap in any one element weakens the others — incomplete schedules undermine the basis for indemnification claims, narrow indemnification terms limit the buyer's recovery even when a breach is clear, and an undersized or short-duration escrow may leave the buyer without a practical remedy if the seller lacks sufficient assets or becomes difficult to locate post-closing. For this reason, experienced counsel in cosmetic healthcare transactions negotiate these provisions as a package rather than in isolation, calibrating the size of the escrow fund, the breadth of the indemnification obligations, and the specificity of the disclosure schedules to achieve a coherent allocation of post-closing risk.

5. Typical Transaction Structures

Because of state-level healthcare regulations and the PE desire to align incentives, cosmetic M&A transactions utilize highly sophisticated corporate structures.

The PE-Backed MSO Model

Most states enforce the Corporate Practice of Medicine (CPOM) doctrine, which prohibits non-physicians from owning medical practices or employing doctors. To bypass this, transactions are structured using a Management Services Organization (MSO) model. **Click here to view the model.**

The MSO buys the non-clinical assets of the practice (real estate, brand, technology, IP) and provides administrative services (billing, marketing, HR) to the clinical entity in exchange for a fair-market-value management fee. The clinical entity remains technically owned by a licensed physician compliant with CPOM laws.

The MSO model, however, is under heightened scrutiny. State legislatures and medical boards are increasingly looking past the form of MSO arrangements to evaluate whether the licensed physician owner actually controls the practice. California, for example, enacted legislation (SB 351), effective January 1, 2026, that prohibits private equity groups and hedge funds involved with physician and dental practices from interfering with providers' professional judgment or controlling key aspects of the practice—such as coding and billing decisions, payer contracting,

and the hiring and firing of clinical staff—and limits the enforceability of certain non-compete and non-disparagement provisions. Oregon has adopted even more restrictive limits on MSO ownership and control of professional corporations, and medical boards in other states are using existing CPOM and fee-splitting authority to discipline physicians who lend their licenses to management-driven structures.

Recent enforcement activity illustrates the risk. Regulators have disciplined physicians who served as nominal owners of professional corporations while a non-physician operator and its management company effectively controlled the practice and divided its revenue on a percentage basis—an arrangement regulators view as impermissible fee-splitting. Regulators have also pointed to physician owners and medical directors who were not meaningfully involved in supervision, chart review, or treatment protocols, as well as reliance on remote, third-party patient examinations that were not adequately documented in the patient record. The lesson for PE sponsors and sellers is that regulators are focused on whether money and clinical oversight actually move the way the MSA says they do—and whether that can be proven. Although, generally, no statute imposes a residency requirement, regulators in a growing number of states increasingly view in-state, proximate supervising physicians as a practical indicator of genuine oversight.

In response, a growing number of MSOs are moving away from "medical director matchmaking" and investing in technology-enabled infrastructure designed to make the MSA operational and auditable. On the financial side, "flow of funds" platforms deposit clinical revenue into a practice account—typically directly through the point-of-sale payment gateway—from which the MSO's fair-market-value management fees, eligible practice expenses, and debt service on any MSO-to-practice loans are debited according to the MSA's service schedule, while supervising physicians invoice the practice monthly for clinical services, with each transaction recorded in an audit ledger. For example, some platforms route patient payments through integrated point-of-sale systems into a practice account to which both the practice and the MSO have defined access rights, record any working-capital loans from the MSO to the practice as documented debt with scheduled repayment, and automatically debit management fees and other eligible expenses in accordance with the MSA. On the clinical side, some MSOs are integrating good faith examination workflows directly into the practice's electronic health record, creating a documented chain of custody from examination to treatment rather than relying on third-party clearance services. For PE buyers, these systems can materially strengthen due diligence and post-closing compliance—but technology is not a substitute for a properly structured arrangement. Management fees generally should still reflect fair market value for services actually rendered rather than a percentage of practice revenue, and the physician owner must exercise real control over clinical

decisions.

Rollover Equity

Buyers rarely pay 100% cash at closing. Instead, physician-owners are typically required to “roll over” 10% to 30% of their equity into the parent MSO. This ensures the founding providers remain incentivized to grow the broader platform, tying a portion of their wealth to a future “second bite of the apple” when the PE fund sells the consolidated platform to a larger fund.

Reduced Compensation Post-Closing

To maximize the EBITDA multiple at closing, sellers often agree to a lower post-closing compensation structure for their clinical work. While this yields a higher upfront payout, the physician must legally balance this against their required production quotas and lifestyle expectations post-closing.

Restrictive Covenants and Non-Competes

PE buyers are purchasing goodwill and patient loyalty. Consequently, purchase agreements will contain robust non-compete and non-solicitation covenants. These typically bar the selling physicians and key extenders from practicing cosmetic medicine within a specific geographic radius (e.g., 10 to 25 miles) for a period of 3 to 5 years post-closing.

6. Other Critical Transaction Considerations

- **Transfer of Control for Medical Devices:** Many laser and cosmetic device manufacturers require hefty transfer fees to transition software licenses and service contracts to a new corporate owner. The allocation of these costs must be negotiated early.
- **Tail Insurance:** Sellers are almost universally required to purchase “tail” medical malpractice and cyber-liability insurance policies to cover any claims arising from pre-closing incidents.
- **Key Employee Retention:** The value of a med-spa often rests on star estheticians or nurse injectors. Buyers will frequently condition the deal on these key employees signing new, restrictive employment agreements prior to closing.

Conclusion

Sell-side transactions in the cosmetic medicine sector offer extraordinary financial liquidity, but they demand rigorous legal navigation. By proactively aligning corporate records, undergoing a sell-side financial analysis, and structuring the MSO framework carefully, practices can protect their clinical integrity while capitalizing on peak market valuations.

This article is general in nature and does not constitute legal advice. If you have legal questions, please consult the author, Mark Opara (mopara@sb-kc.com) at 816.265.4140 or any of the other attorneys in Seigfried Bingham’s Health Care Law service group, or your regular contact at Seigfreid Bingham at 816.421.4460.

When your organization receives a subpoena demanding patient medical records, your staff’s instinct may be to comply — quickly and without question as it appears to be a court document. That instinct can expose your organization to devastating consequences: six-figure civil penalties, criminal prosecution, tort liability, and irreparable reputational harm.

This alert summarizes the critical compliance risks that healthcare organizations face when responding to subpoenas for protected health information (“PHI”), with particular emphasis on the heightened

requirements that apply to substance use disorder ("SUD") treatment records under 42 C.F.R. Part 2 ("Part 2"). If your organization treats patients with SUDs, the stakes are even higher, and the margin for error is essentially zero.

A Subpoena Is Not a Court Order, And the Distinction Is Everything

One of the most common and dangerous misunderstandings in this area is the assumption that a subpoena carries the same legal authority as a court order. It does not. A court order is issued and signed by a judge. A subpoena, by contrast, may be issued by a court clerk or even, in some jurisdictions, by an attorney alone. Under HIPAA, a covered entity may disclose PHI without patient authorization in response to a court order, but only to the extent expressly authorized by that order. A subpoena alone is legally insufficient to authorize disclosure.

Under HIPAA, disclosure in response to a subpoena alone requires additional "satisfactory assurances," specifically, that the requesting party has either (a) notified the patient of the request or (b) made reasonable efforts to secure a qualified protective order. Without those assurances, producing records in response to a subpoena is a HIPAA violation, regardless of how official the subpoena appears. This standard is a gray area and is often subject to additional litigation if a patient alleges they were not actually notified or did not consent to the disclosure. This risk makes a court order the vastly preferred option from a health care provider's standpoint.

Part 2 Imposes Even Stricter Requirements on SUD Records

If your organization either receives federal assistance and holds itself out as providing SUD diagnosis, treatment, or referral for treatment, or receives information from such an organization, then Part 2 applies to you. Under Part 2, SUD treatment records may not be disclosed in a civil proceeding unless the court issues a specialized court order based on a judicial finding of "good cause," and courts apply a strong presumption against disclosure. Even after such an order is entered, a separate subpoena must still be issued to compel production – the order alone does not require disclosure. Part 2's restrictions also extend to anyone who subsequently receives protected SUD records, including outside counsel.

The Consequences Are Severe

Mishandling a subpoena for PHI or Part 2-protected records can trigger any or all of the following:

Civil penalties under HIPAA ranging from $100 to $50,000 per violation, depending on the violator's mental state. Criminal penalties for intentional violations of up to $250,000 in fines and up to 10 years of imprisonment. Part 2 violations are subject to the same civil and criminal penalties imposed for HIPAA violations. State tort liability may also apply, including claims for negligence, medical malpractice, invasion of privacy, and breach of the physician-patient privilege. And the reputational consequences of a privacy breach involving vulnerable patients (particularly those with substance use disorders) cannot be overstated. Patients who fear that their SUD treatment records may be disclosed are less likely to seek or remain in treatment, compounding the public health crisis.

Where Organizations Get It Wrong

The most common, and most dangerous, errors include treating a subpoena as equivalent to a court order and producing records without verifying satisfactory assurances, disclosing SUD records without the required Part 2 court order, and failing to involve compliance officers or legal counsel before any records leave the building. Each of these missteps can independently trigger the full range of penalties described above.

What You Should Do Now

Do not wait for the next subpoena to arrive. Contact your legal counsel immediately to evaluate whether your current subpoena response procedures are adequate, particularly with respect to the subpoena-versus-court-order distinction and the heightened requirements of Part 2. The consequences of noncompliance fall on the provider, not on the party that issued the subpoena.

This article is general in nature and does not constitute legal advice. If you have legal questions, please consult any of the authors: John Neyens (816.265.4152; jneyens@sb-kc.com), John Fuchs (816.265.4228; jfuchs@sb-kc.com), Colby Stone (816.265.4162; cstone@sb-kc.com), or your regular contact at Seigfreid Bingham at 816.421.4460.

By: Kenzie Clark

On April 3, 2026, Kansas Governor Laura Kelly signed Senate Bill 55 (SB 55), which prohibits the assignment of post-loss benefits under residential property insurance policies. Effective as of July 1, 2026, contractors cannot solicit or accept the assignment of any insurance policy or benefit belonging to a client or receive any insurance payout directly. In the bill's words, such practices are "considered to be against public policy," and "null and void."

SB 55 was enacted to protect consumers from the illegitimate repairs and inflated prices caused by bad actors in the roofing industry. It targets roofers and contractors who insert themselves into the insurance process through assignment agreements. "Assignment agreement" is defined in the bill as any instrument by which post-loss benefits under a residential property insurance policy are assigned, transferred, or otherwise acquired, in whole or in part, to or from a person providing services, including but not limited to inspecting, protecting, repairing, or replacing the property, or mitigating against further damage to the property.

Notably, the bill's definition of assignment agreement includes Assignment of Benefits (AOB) forms, the use of which now constitutes an unfair and deceptive practice. The bill is silent on negotiations with insurance carriers or adjusters.

Penalties for Violation of SB 55

Parties found in violation of SB 55 may be exposed to additional penalties beyond the assignment itself being void. Violations will be treated as unfair or deceptive business practices and subject to investigation by the Insurance Commissioner. Penalties may include any or all of the following:

1. Payment of up to $1,000 for each violation, not to exceed an aggregate of $10,000, unless the party knew or reasonably should have known that its conduct constituted a violation, in which case the payment may increase up to $5,000 per violation;
2. Suspension or revocation of the party's license, if the party knew or reasonably should have known that its conduct constituted a violation; and
3. A refund of any premiums paid by, or the payment of any monies withheld from, any consumer, including interest, together with appropriate public notification of the violation.

Finally, in the event the Insurance Commissioner elects to conduct a hearing, the party who committed the violation may be responsible for costs incurred as a result of the hearing, including but not limited to, witness fees, mileage allowances, and the costs of reproducing documents.

What This Means for Contractors

Contractors should be aware that any AOB forms or AOB provisions in preexisting contracts will likely be considered a violation of Kansas Law under this new bill. While the assignment may be considered null and void, the agreement may still be enforceable. We recommend that contractors consult legal counsel to ensure that their current practices and forms comply with the statute in its current form.

We will continue to monitor any upcoming developments or changes to the enforceability of such assignment agreements and to this area of law.

This article is general in nature and does not constitute legal advice. If you have legal questions, please consult the author Kenzie Clark (kclark@sb-kc.com) at 816-265-4142 or any of the other attorneys in Seigfried Bingham's Construction Group, including Julie Parisi (jparisi@sb-kc.com) 816-265-4259, Cody Weyhofen (cweyhofen@sb-kc.com) 816-265-4163, or your regular contact at Seigfreid Bingham at 816-421-4460.

On February 25, 2026, the Kansas State Board of Healing Arts and Board of Pharmacy issued a significant new joint statement addressing the rapidly growing IV hydration and medical spa (medspa) industry. The **Kansas State Board of Healing Arts** and the **Kansas Board of Pharmacy** released this advisory in response to increasing complaints involving IV therapy services, including allegations of *"out?of?scope practice, delegation of medical treatments to unqualified individuals, unauthorized compounding… and the unlicensed practice of the healing arts and pharmacy."*

Although the statement is not a legally binding regulation, it signals the Boards' enforcement priorities and outlines expectations for any business offering IV hydration or vitamin infusion services in Kansas. Kansas medspas and clinics offering IV hydration services should review the statement and consider conducting an internal audit to identify and correct any practices that are not in line with current laws and regulations.

Highlights of the Boards' Joint Statement

1. **IV Therapy Is the Practice of the Healing Arts**

The Boards emphasize that any intravenous administration of drugs—including saline, vitamins, minerals, amino acids, and other additives— *"indisputably constitutes the practice of healing arts."*

2. **Strict Limits on Who May Administer IV Therapy**

The statement makes clear that only individuals with prescriptive authority may administer IV products. This is a significant tightening of expectations for many IV hydration clinics.

3. **Compounding Rules Apply to IV "Cocktails"**

The Boards take the position that mixing additives into saline constitutes the act of drug compounding. This restriction implicates medspas that prepare IV bags (e.g., combining vitamins with saline bags) on?site without a pharmacist or physician performing or supervising the compounding process.

4. **Pre?Set Menus Are Not Valid Prescriptions**

Many IV hydration businesses rely on pre?approved "menus" of IV cocktails. The Boards warn that they view this practice as non?compliant. As stated, *"A patient may not self?prescribe IV products…*

Prescriber involvement cannot be obviated by letting the patient direct their own care."

Seigfreid Bingham's health care lawyers will continue to monitor developments in this area and stand ready to assist clients with advice on the current medspa regulatory landscape. This article is general in nature and does not constitute legal advice. If you have legal questions, please consult either of the authors: Emily Crane (816.265.4175; ecrane@sb-kc.com), Colby Stone (816.265.4162; cstone@sb-kc.com), or your regular contact at Seigfreid Bingham at 816.421.4460.

On February 27, 2026, the United States Department of Labor (DOL) published a proposed rule revising the standards for determining whether a worker is an employee or independent contractor. As you might recall, approximately two years ago, in March 2024, the DOL, under the Biden administration, issued a new rule establishing a more employee-friendly six-factor analysis that businesses could use to determine if a worker was an employee or independent contractor. See our client alert from January 19, 2024, here. This Biden DOL rule replaced a 2021 Trump DOL rule that made it easier to classify workers as independent contractors. The new Trump DOL Proposed Rule essentially reinstates the 2021 Trump DOL Rule.

Highlights of the 2024 Biden DOL Six-Factor Rule

The 2024 Rule, under the Biden administration, essentially formalized long-standing case law applying a six-factor test (note: some states use a similar five-factor test) to determine whether a worker should be classified as an independent contractor or an employee. Those factors are:

1. Whether the worker has an opportunity to earn profits or suffer losses depending on the worker's own managerial skill.
2. The relative investments made by the worker and the employer.
3. The degree of permanence of the working relationship.
4. The nature and degree of control by the employer over the work.
5. Whether the work performed is an integral part of the employer's business.
6. Whether the worker uses specialized skills and initiative to perform the work.

Highlights of the 2026 Trump DOL Proposed Rule

1. Adopts an "economic reality" test to determine a worker's status as an employee or independent contractor, examining whether a worker is in business for him- or herself (independent contractor) or is economically dependent on a potential employer for work (employee);
2. Identifies and explains two "core factors": (1) the nature and degree of the worker's control over the work; and (2) the worker's opportunity for profit or loss based on initiative and/or investment, that federal courts primarily consider to answer the question of whether a worker is economically dependent on someone else's business or is in business for him- or herself;
3. Identifies three other factors relevant to the analysis, particularly when the two core factors do not point to the same classification: (1) the amount of skill required for the work; (2) the degree of permanence of the working relationship between the worker and the potential employer; and (3) whether the work is part of an integrated unit of production; and also notes that additional factors may be considered in the analysis;
4. Advises that the parties' actual practices are more relevant than what may be contractually or theoretically possible; and
5. Provides eight examples of how the economic reality factors would apply in certain real-life situations.

Significance of the 2026 Trump DOL Proposed Rule

1. In light of a ruling by the U.S. Supreme Court in *Loper Bright Enterprises v. Raimondo*, holding that courts can use their own analysis in construing statutes and that they need not defer to agency interpretations of ambiguous statutes, and given the DOL's flip flops on when a worker is an employee or independent contractor, it remains to be seen if the new Trump DOL Rule will change the result of very many cases where the issue involved is deciding whether a worker is an employee or independent contractor.
2. The 2026 Trump DOL Proposed Rule applies to the federal Fair Labor Standards Act (federal wage and hour laws), the Family and Medical Leave Act, and the Migrant and Seasonal Agricultural Worker Protection Act. However, bear in mind that there are other federal laws (including but not limited to the IRS laws) that have different tests for when a worker is an employee as opposed to an independent contractor. Moreover, most states have their own laws governing when a worker is an independent contractor, and some of those state laws are more employee-friendly than the 2026 Trump DOL Proposed Rule. Thus, caution should be exercised in determining whether an employee is actually an independent contractor.
3. Even if all courts do not follow the 2026 Trump DOL Proposed Rule, that Rule (when it becomes final – it is not the law yet) may provide protection to employers sued for misclassifying employees as independent contractors because under 29 U.S.C. 259, no employer shall be subject to liability or punishment for federal FLSA wage and hour violations if an omission was in good faith and based on a U.S. Wage and Hour Division regulation that has been relied upon by the employer.

Seigfreid Bingham's employment lawyers will continue to monitor developments in this area and stand ready to assist its clients with advice on worker classification issues. This article is general in nature and does not constitute legal advice. If you have legal questions, please consult the authors: John Vering (816.265.4109; jvering@sb-kc.com) and Shannon Johnson (816.265.4139; sjohnson@sb-kc.com), or your regular contact at Seigfreid Bingham at 816.421.4460.

By: Katie Conklin and John Vering

Background

As we explained in our previous client alert, on November 5, 2024, Missouri voters approved Proposition A by over 57%, which increased the Missouri Minimum Wage to $13.75, effective January 1, 2025, and increased it to $15.00 per hour, effective January 1, 2026. Thereafter, Proposition A provided that the Missouri Minimum Wage would be adjusted annually based on the Consumer Price Index. Further, Proposition A required that most Missouri non-governmental employers provide one hour of paid sick leave for every 30 hours worked, effective May 1, 2025. Proposition A also required that Missouri employers post and send a notice regarding paid sick leave to employees by April 15, 2025.

Repeal of Missouri Paid Sick Leave

As we explained in our client alert on May 16, 2025, on May 14, 2025, the Missouri Senate passed Missouri House Bill 567 (HB 567) which effectively repealed Missouri Paid Sick Leave, effective August 28, 2025, when HB 567 was signed by Governor Mike Kehoe on July 10, 2025.

Amendments to Missouri Minimum Wage Law

HB 567 does not change Proposition A's increase of the Missouri minimum wage to $13.75 per hour effective January 1, 2025 and its further increase to $15.00 per hour effective January 1, 2026.

However, HB 567 did repeal the portions of Proposition A that required mandatory adjustments to the minimum wage based on the Consumer Price Index, which were set to begin on January 1, 2027 and continue each January 1 in successive years.

HB 567 also amended the Missouri Minimum Wage Law to specify that, as of August 28, 2025, public employers (the State of Missouri, political subdivisions of the State of Missouri, including a department, agency, officer, bureau, division, board, commission, or instrumentality of the state or a city, county, town, village, school district, or other political subdivision of the state) would also be required to pay the Missouri minimum wage.

What Employers Should Do

Non-governmental employers need to comply with Missouri's Paid Sick Leave law until August 28, 2025, including tracking paid sick leave that employees accrue and use. We are prepared to assist Missouri employers with advice regarding compliance with Proposition A and how to handle sick leave and PTO policies in light of this legislative change. There are not only legal issues but also employee relations issues to be considered, including how to communicate these changes in the law and shifting paid sick leave law requirements in the middle of the year.

This article is general in nature and does not constitute legal advice. If you have legal questions, please consult the authors, John Vering (jvering@sb-kc.com) at 816.265.4109 or Katie Conklin (kconklin@sb-kc.com) at 816.265.4114, or other attorneys in Seigfreid Bingham's Employment Law Group, including: John Neyens (johnn@sb-kc.com) 816.265.4152, Mark Opara (mopara@sb-kc.com) 816.265.4140, Shannon Cohorst Johnson (sjohnson@sb-kc.com) 816.265.4139, or your regular contact at Seigfreid Bingham at 816.421.4460.

By: John Vering and John Neyens

Nebraska Legislature Amends Paid Sick Leave Requirement

In November of 2024, Nebraska voters approved Initiative 436 which adopts the Nebraska Healthy Families and Workplaces Act which provides paid sick leave to most non-governmental employees. On June 4, 2025, Nebraska Governor Jim Pillen signed LB415 which made some significant changes to the Act which becomes **effective October 1, 2025**.

Who is Covered?

The Act applies to employees who work in Nebraska for at least 80 hours in a calendar year, except that it does not cover seasonal and temporary workers employed in agriculture, employees under age 16, employers with fewer than 11 employees, employees covered by the federal Railroad Unemployment Insurance Act, or employees of federal or state agencies, state departments, and political subdivisions.

Accrual and Use Rules

Under the Act, employees are entitled to a minimum of one hour of paid sick leave for every 30 hours worked up to a cap (40 or 56 hours depending on the employer's size). Employers with 11-19 employees must provide up to 40 hours of PSL per year. Employers with 20 or more employees must provide up to 56 hours of PSL per year. Employees exempt from overtime are presumed to work 40 hours per week unless their typical workweek is less than 40 hours per week. PSL provided to an employee on or after January 1, 2025 and before October 1, 2025 shall be counted toward an employer's obligations under the Act for calendar year 2025.

Carryover Requirements and Frontloading Option

Employers must allow employees to carry over unused PSL to the next year. Alternatively, employers are permitted to pay an employee for unused sick time at the end of the year and frontload the employee at the beginning of the year with the amount of PSL (40 or 56 hours) specified in the preceding paragraph depending on the number of employees. Employers also have the option to loan PSL to an employee is advance of accrual by such employee.

Integration with Existing PTO Policies

Most employers offer some kind of vacation, sick leave, and/or PTO policies. Employers with PTO policies that provide an annual amount of PTO sufficient to meet the requirements of Nebraska's new PSL law, including allowing PTO to be used for the same purposes and under the same conditions as provided in the new PSL law, are not required to provide additional PSL benefits beyond those provided in existing PTO policies. However, employers may be required to re-write some of their PTO policies to ensure that existing PTO policies are properly integrated with Nebraska's new PSL law and include appropriate provisions for employees to provide notice of the need to use PSL. The Act does not require payment for unused PSL when an employee separates from the employer.

PSL May be Used for Many Reasons

PSL may be taken for:

- Care of self for mental or physical illness, injury, health condition, medical diagnosis or preventative care or treatment; or
- Care of a family member for mental or physical illness, injury, health condition, medical diagnosis or preventative care or treatment or in the case of a child, to attend a meeting necessitated by the child's mental or physical illness, injury or health condition, at a school or place where the child is receiving care; or
- In a public health emergency where the employee's place of business or the child's school or place of care is closed or where the employee needs to care for oneself or a family member where health authorities or a health care provider determines that the family member's presence in the community may jeopardize the health of others by potentially exposing them to a communicable disease, whether or not the employee or family member has actually contracted the disease.

The definition of "family member" is extremely broad and includes, regardless of age, biological, adopted or foster child, stepchild, legal ward, and/or a child to whom the employee stands in loco parentis.

"Family member" also includes biological, foster, stepparent or adoptive parent or legal guardian of the employee or an employee's spouse or an individual who stood in loco parentis when the employee or employee's spouse was a minor child, an individual to whom the employee is legally married or a grandparent, grandchild, or sibling, whether of a biological, foster, adoptive, or step relationship with the employee or the employee's spouse. Family member also includes any other individual related by blood to the employee or whose close association with the employee is the equivalent of a family relationship.

Employee Notice Requirements

The Nebraska PSL statute specifies that PSL shall be provided upon oral request of the employee, but for paid sick leave for more than three consecutive work days, the employer may require reasonable documentation that the paid sick leave was used for a purpose covered by the Act.

Employer Notice and Record Keeping-Requirements

The Act requires that employers provide written notice to employees of their rights under this new law upon commencement of employment or September 15, 2025, whichever is later. Employers are also required to display a poster regarding Nebraska PSL. We expect the Nebraska Department of Labor to publish a model notice for employers to use along with a form of poster that employers are required to post, but to date, the Nebraska Department of Labor has not done so. Employers must provide or make available to employees each pay period information on the amount of PLS available and taken and the amount of pay received for PSL.

Guidance from Nebraska Department of Labor

The Nebraska Department of Labor (NDOL) issued Revised Answers to Frequently Asked Questions on June 9, 2025 FAQs Paid Sick Leave.pdf and may issue additional guidance in the future.

Legal Liability for Failing to Comply with Nebraska Paid Sick Leave Law

In a significant change to the Act, LB451 removes an employee's right to file a lawsuit if an employer violates the Act. Employees can file complaints with the Nebraska Dept. of Labor which will investigate complaints that an employer failed to comply with the Act and can fine offending employers who violate the Act up to $500 for the first violation and up to $5,000 for the second and any subsequent violation of the Act. This article is general in nature and does not constitute legal advice. Readers with legal questions or desiring assistance in reviewing or amending employment policies to comply with Neabrask's paid sick leave law should consult the authors, John Vering (jvering@sb-kc.com) and John Neyens (jneyens@sb-kc.com) or other members of the Seigfreid Bingham's Employment Law Group, including Shannon Cohorst Johnson (sjohnson@sb-kc.com), Mark Opara (mopara@sb-kc.com), Katie Conklin (KConklin@sb-kc.com), or your regular contact at Seigfreid Bingham at 816.421.4460.

By: Katie Conklin and John Vering

Background

As we explained in our previous client alert, on November 5, 2024, Missouri voters approved Proposition A by over 57%, which increased the Missouri Minimum Wage to $13.75, effective January 1, 2025, and increased it to $15.00 per hour, effective January 1, 2026. Thereafter, Proposition A provided that the Missouri Minimum Wage would be adjusted annually based on the Consumer Price Index. Further, Proposition A required that most Missouri non-governmental employers provide one hour of paid sick leave for every 30 hours worked, effective May 1, 2025. Proposition A also required that Missouri employers post and send a notice regarding paid sick leave to employees by April 15, 2025.

On April 29, 2025, the Missouri Supreme Court issued a decision rejecting challenges to Proposition A. A summary of the decision may be found on the Court's website here.

Repeal of Missouri Paid Sick Leave

On May 14, 2025, the Missouri Senate passed Missouri House Bill 567 (HB 567) which will effectively repeal Missouri Paid Sick Leave, effective August 28, 2025, if signed by Governor Mike Kehoe. We expect the Governor to sign this bill, but if he does not, we will supplement this Client Alert.

Amendments to Missouri Minimum Wage Law

HB 567 does not change Proposition A's increase of the Missouri minimum wage to $13.75 per hour effective January 1, 2025 and its further increase to $15.00 per hour effective January 1, 2026. However, HB 567 did repeal the portions of Proposition A that required mandatory adjustments to the

minimum wage based on the Consumer Price Index, which were set to begin on January 1, 2027 and continue each January 1 in successive years.

HB 567 also amended the Missouri Minimum Wage Law to specify that, as of August 28, 2025, public employers (the State of Missouri, political subdivisions of the State of Missouri, including a department, agency, officer, bureau, division, board, commission, or instrumentality of the state or a city, county, town, village, school district, or other political subdivision of the state) would also be required to pay the Missouri minimum wage.

What Employers Should Do

We recommend that non-governmental employers comply with Missouri's Paid Sick Leave law until August 28, 2025. We are prepared to assist Missouri employers with advice regarding compliance with Proposition A and how to handle sick leave and PTO policies in light of this legislative change. There are not only legal issues but also employee relations issues to be considered, including how to communicate these changes in the law and shifting paid sick time law requirements in the middle of the year.

This article is general in nature and does not constitute legal advice. If you have legal questions, please consult the authors, John Vering (jvering@sb-kc.com) at 816.265.4109 or Katie Conklin (kconklin@sb-kc.com) at 816.265.4114, or other attorneys in Seigfreid Bingham's Employment Law Group, including: John Neyens (johnn@sb-kc.com) 816.265.4152, Mark Opara (mopara@sb-kc.com) 816.265.4140, Shannon Cohorst Johnson (sjohnson@sb-kc.com) 816.265.4139, or your regular contact at Seigfreid Bingham at 816.421.4460.

By: John Vering and Katie Conklin

On April 29, 2025, the Missouri Supreme Court issued a decision rejecting challenges to Missouri Proposition A, which increased the Missouri Minimum Wage and created a requirement that most Missouri employees be entitled to receive paid sick leave. A summary of the decision may be found on the Court's website here.

The Court found that the ballot summary and fiscal note summary for Proposition A, which appeared on the November 2024 election ballot, were not inaccurate or misleading so as to constitute an irregularity casting doubt on the election. As to the claims challenging Proposition A on the basis that it is unconstitutional because it violates the single subject and clear title provisions of the Missouri Constitution in that it deals with two subjects (raising the minimum wage and creating paid sick time), the Court found that it did not have jurisdiction to decide that question and dismissed these claims without prejudice, meaning a trial court will need to issue a decision on the claims, which could then be appealed. This process would take many months.

The bottom line is that the Missouri Supreme Court did not stop Proposition A from taking effect.

It is our understanding that the prospects of the Missouri Legislature passing a repeal or revision to Missouri Paid Sick Leave that would take effect by Proposition A's May 1, 2025 effective date are slim but not impossible.

Therefore, we recommend that Missouri employers (1) plan to comply with Proposition A's May 1, 2025 effective date and (2) be prepared to publish their policies on Missouri's Paid Sick Time within the week following May 1, 2025 in case there is a last-minute legislative repeal.

Background

As we explained in our previous client alert, on November 5, 2024, Missouri voters approved Proposition

A by over 57%, which increased the Missouri Minimum Wage to $13.75, effective January 1, 2025, and will increase it to $15.00 per hour, effective January 1, 2026. Thereafter, the Missouri Minimum Wage will be adjusted annually based on the Consumer Price Index. Further, Proposition A requires that most Missouri non-governmental employers provide one hour of paid sick leave for every 30 hours worked, effective May 1, 2025. Proposition A also requires that Missouri employers post and send a notice regarding paid sick leave to employees by April 15, 2025. On March 19, 2025, we published another client alert with an update on the litigation challenging Proposition A and potential legislative changes to Proposition A.

We are prepared to assist Missouri employers with advice regarding compliance with Proposition A. We will continue to monitor the latest developments, guidance, and legal requirements in this area of law.

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