UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

THOMAS E. PEREZ, Secretary, United States Department of Labor, Plaintiff,	)	
v.	)	Civil Action No._____
MAGNACARE ADMINISTRATIVE SERVICES, LLC and MAGNACARE, LLC, Defendants.	)	

COMPLAINT FOR ERISA VIOLATIONS

Thomas E. Perez, Secretary of the United States Department of Labor (the "Secretary"), alleges as follows:

1. This action is filed under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1001 et seq., against defendants MagnaCare Administrative Services, LLC and MagnaCare, LLC (collectively, "MagnaCare"), for violating ERISA in connection with the service fees they charged ERISA-covered healthcare benefit plans, their handling of emergency services claims, and their handling of claims for which third parties may be liable. A proposed Consent Order to resolve this case will be filed shortly.

2. MagnaCare charged fees that were not disclosed to its ERISA plan clients. In addition to charging a per-employee monthly fee, which was disclosed, MagnaCare charged the plans an undisclosed markup over and above the actual amounts paid by MagnaCare to the providers of ancillary medical services such as laboratories and standalone radiology and imaging services. This markup, which MagnaCare called a "Network Management Fee," was hidden in the overall charges for ancillary medical services MagnaCare submitted to the plans.

The plans paid MagnaCare the full amount, yet MagnaCare remitted the lower actual charges to the providers and retained the undisclosed markup. By operating under this fee arrangement and charging an undisclosed fee that was not approved by plan fiduciaries independent of MagnaCare, MagnaCare breached its fiduciary duties and committed prohibited transactions, including dealing with plan assets in its own interest. ERISA fiduciaries may not use their authority over plan assets to set their own compensation, even if the fiduciaries believe that their compensation is reasonable. ERISA generally requires that another fiduciary determine the amount, timing and nature of the compensation.

3. In addition, MagnaCare's procedures for adjudicating claims arising out of services provided in hospital emergency rooms did not fully comply with the "prudent layperson" standard established under the Affordable Care Act, 42 U.S.C. §§ 18001 et seq. Specifically, MagnaCare did not tell participants and beneficiaries whose claims had diagnoses not on MagnaCare's "True ER List" that they had an opportunity to submit additional medical records before the claims were denied so that MagnaCare could determine whether the prudent layperson standard had been satisfied. MagnaCare's explanation of benefits for denied emergency services claims also failed to comply with the Department's claims procedures regulation, 29 C.F.R § 2560.503-1.

4. Furthermore, MagnaCare's procedures for identifying claims potentially payable by a third party were not adequate to fully and fairly determine whether third-party coverage was available, did not always take into account the governing plan's provisions, and did not ensure compliance with the Department's claims procedures regulation.

JURISDICTION AND VENUE

5. This Court has subject matter jurisdiction over this action pursuant to ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1).

6. Venue with respect to this action lies in the United States District Court for the Southern District of New York, pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because the breaches took place in this district, and all defendants are New York limited liability companies doing business within this district, specifically with places of business at One Penn Plaza, 46th Floor, New York, NY 10119.

7. The defendants provide healthcare services to more than one hundred employee benefit plans established pursuant to ERISA § 3(1), 29 U.S.C. § 1002(1), including plans that maintain their principal offices in New York, NY.

PARTIES

8. The Secretary, pursuant to ERISA §§ 502(a)(2) and (5), 29 U.S.C. §§ 1132(a)(2) and (5), is vested with authority to enforce the provisions of Title I of ERISA by filing and prosecuting claims against persons who violate the provisions of ERISA and the regulations promulgated thereunder.

9. Defendant MagnaCare Administrative Services, LLC is a full service third-party administrator ("TPA"), providing third-party administrative and claims adjudication services ("Plan Management"), as well as access to providers of healthcare services and products ("Network Access"), to ERISA-covered health plans in the New York and New Jersey area.

10. Defendant MagnaCare, LLC provides services in connection with the Network Access business. This enables participants to obtain healthcare from providers at reduced, in-network rates.

11. Defendants are under common management, control, and ownership.

GENERAL ALLEGATIONS

12. At times relevant to this complaint, MagnaCare provided, and continues to provide, services to employee welfare benefit plans, as defined in ERISA § 3(1), 29 U.S.C. § 1002(1), that provide medical, surgical, or hospital care or benefits to employees

13. Many health plans contract directly with MagnaCare ("Plans"). These Plans' healthcare benefits are funded directly from the assets of the Plan or the employer; they are not funded through insurance policies. MagnaCare also provides services to other TPAs, which, in turn, service ERISA-covered health plans ("TPA Clients").

14. MagnaCare offers Network Access and Plan Management to the Plans. Some Plans ("Direct Access Clients") only purchase Network Access, i.e., access to MagnaCare's preferred provider organization ("PPO") network. Some Plans ("Plan Management Clients") also purchase Plan Management services. Plan Management is only available to Plans that also purchase Network Access.

15. MagnaCare has assembled a network consisting of doctors, hospitals, and providers of "Ancillary Services." Ancillary Services include laboratory, radiology and imaging services, durable medical equipment, home-healthcare, and ambulance, but do not include services provided to inpatients in a hospital setting.

16. MagnaCare negotiates an individual agreement with each provider to establish the in-network fee for each type of service performed by the provider ("Provider Rates").

17. MagnaCare charges a per-employee monthly fee for Network Access and Plan Management Clients. The exact amount of the per-employee monthly fee is disclosed in MagnaCare's contracts.

18. For Ancillary Services, MagnaCare also assesses a Network Management Fee. MagnaCare's contracts made reference to a management fee of an unspecified amount, but the monthly bills did not identify such fees or disclose the amount of such fees, and the year-end summaries sent to plans of the direct and indirect fees paid by the plans to MagnaCare that year did not include the amounts paid as management fees.

19. MagnaCare provides Plan Management by receiving, processing, and adjudicating healthcare claims for services provided by healthcare providers such as doctors, hospitals, and Ancillary Services providers. MagnaCare also receives, processes, and adjudicates emergency room claims for Plans that purchase Plan Management.

20. MagnaCare will also, upon a Plan's request, identify and deny healthcare claims where third-party coverage, such as workers' compensation or automobile accident insurance, may be present.

ERISA VIOLATIONS

MagnaCare Unilaterally Set Its Fees for Ancillary Services

21. MagnaCare charges the Plans the Provider Rates, which MagnaCare negotiates with doctors and hospitals, in addition to the per-employee monthly fee.

22. However, for participants and beneficiaries utilizing Ancillary Services, MagnaCare charges the Plans the Provider Rate, which MagnaCare negotiates with Ancillary Services providers, plus a Network Management Fee (collectively, the "Plan Charges"), in addition to the per-employee monthly fee.

23. The Network Management Fee, which MagnaCare retains, consists of the difference between the Plan Charges, which MagnaCare unilaterally determines, and the

Provider Rates. The amount of this undisclosed markup varies depending on the provider and on the type of Ancillary Service.

24. At times relevant to this Complaint, MagnaCare acted in own interest when it kept the difference between the Plan Charges and the Provider Rates as additional compensation without disclosing the amounts to the Plans.

25. The bills that MagnaCare submitted to the Plans did not disclose the Provider Rates for Ancillary Services or the differential between the Provider Rates and the Plan Charges. Instead, the bills characterized the entire Plan Charges as the amounts that the providers charged for providing Ancillary Services. Consequently, MagnaCare's clients had no way of knowing what the provider actually received and what MagnaCare kept as its Network Management Fee.

26. Upon request, MagnaCare provided Plans with year-end summaries of its direct and indirect compensation for services rendered to Plans. MagnaCare knew the Plans would use the summaries for reporting on the Form 5500, a document the Plans are required to file annually with the federal government to truthfully report certain information, including the amount of fees they paid to the Plans' service providers. The summaries provided by MagnaCare did not include the amount of the Network Management Fee that MagnaCare charged and received from the Plans, and the Plans could not report those amounts on the Forms 5500 because MagnaCare did not tell them those amounts.

27. MagnaCare was able to unilaterally increase Plan Charges, thereby increasing the embedded Network Management Fee, without advance notice to the Plans. MagnaCare increased the Plan Charges, thereby increasing the Network Management Fee for Ancillary Services without the knowledge or consent of the Plans, twice since 2008, with the most recent increase occurring in 2013.

28. By charging an undisclosed fee (the Network Management Fee) that was not approved by plan fiduciaries independent of MagnaCare, MagnaCare acted in its own interest and used its authority over plan assets to set its own compensation.

Improper Procedures for Adjudicating Emergency Services Claims

29. The Affordable Care Act ("ACA"), 42 U.S.C. §§ 18001 et seq., amended ERISA to make the market reform provisions of Title XXVII of the Public Health Service Act, 42 U.S.C. §§ 300gg et seq., applicable to group health plans. ERISA § 715(a)(1), 29 U.S.C. § 1185d.

30. Since at least 2011, the prudent layperson standard has been the appropriate level of review for non-grandfathered ERISA plans covering hospital emergency services ("ER Claims"). 42 U.S.C. § 300gg-19a(b)(2)(A) and (B).[1] Section 2719A of the Public Health Service Act defines "emergency services" as certain services within the capability of a hospital emergency department to evaluate and treat as an emergency medical condition. 42 U.S.C. § 300gg-19a(b)(2)(B). An "emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

[1] Certain requirements of the ACA do not apply to group health plans in which an individual was enrolled on the date of enactment of the ACA, March 23, 2010. These plans are known as grandfathered plans. Plans relinquish their grandfathered status when they make certain changes to coverage. If a Plan does not meet the conditions of any of the regulatory exceptions that would allow it to retain grandfathered status, it is subject to the ACA's requirements for plans that are not grandfathered, including participant protections for emergency services.

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

42 U.S.C. § 300gg-19a(b)(2)(A) citing 42 U.S.C. § 1395dd(e)(1)(A)(i)-(iii).

31. The Department's claims procedures regulation requires, among other things, that plans have reasonable claims procedures for the filing of claims, notification of benefit determinations, and appeal of adverse benefit determinations. It also prohibits unduly inhibiting or hampering the initiation or processing of claims. 29 C.F.R. § 2560.503-1(b) and (b)(3). The regulation further provides that when participants receive adverse benefit determinations, the participant must be provided with, among other things: the specific reasons for the adverse benefit determination; the specific plan provisions on which the determination is based; a description of any additional material or information necessary for the claimant to perfect the claim; an explanation of why such material or information is necessary; and a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review. 29 C.F.R. § 2560.503-1(g)(1).

32. Providers submit all claims, including ER Claims, to MagnaCare on standardized forms adopted by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("Standardized Forms"). Providers report the services on the Standardized Forms using the Current Procedure Terminology and the diagnoses using the International Classification of Diseases ("Diagnosis Codes").

33. MagnaCare adjudicates ER Claims for most Plans by first comparing the Diagnosis Codes on the Standardized Forms to a list of Diagnosis Codes that MagnaCare has developed and termed the "True ER List."

34. If any Diagnosis Code on an ER Claim matches a Diagnosis Code on MagnaCare's True ER List, then MagnaCare adjudicates that claim as payable. If the Diagnosis Codes are not on the True ER List, then MagnaCare will deny the claim, absent the submission of additional information indicating that the claim constitutes an emergency medical condition.

35. If, however, MagnaCare subsequently receives more information, in the form of additional medical records or explanations from the provider or any other source, concerning an ER Claim with Diagnosis Codes that are not on the True ER List, MagnaCare then reviews that information and may adjudicate the ER Claim as payable.

36. At times relevant to this Complaint, if an ER Claim was not automatically paid and no additional information demonstrating that there was an emergency medical condition was submitted to MagnaCare by a participant, beneficiary, or provider, then the claim was denied.

37. MagnaCare did not notify participants, beneficiaries, or providers of the prudent layperson standard for adjudicating ER Claims when the Standardized Forms lacked a Diagnosis Code on the True ER List.

38. Before denying ER Claims, MagnaCare did not systematically seek additional information from participants, beneficiaries, or providers when the Standardized Forms lacked a Diagnosis Code on the True ER List.

39. MagnaCare did not apply the prudent layperson standard to some ER Claims in that it did not notify participants, beneficiaries, and providers with Diagnosis Codes not on the True ER List that they could supplement the information on the Standardized Forms in order to establish that there was an emergency medical condition.

40. MagnaCare's Explanation of Benefits ("EOB") forms for denied ER Claims also failed to comply with the Department's claims procedures regulation.

41. As to denied ER Claims, participants and beneficiaries were sent an EOB form that usually gave the following reason for denial: "only sudden and serious diagnosis [sic] are covered in the emergency room."

42. MagnaCare's EOB forms did not reference the prudent layperson standard for approving ER Claims or explain that the claim was denied for lack of sufficient information demonstrating an emergency medical condition pursuant to the prudent layperson standard.

43. The EOB forms also did not reference the specific plan provisions on which the adverse benefit determination was based, and the EOB forms did not describe the Plans' review procedures, applicable time limits, or that the participant or beneficiary has a right to bring a civil action under ERISA § 502(a).

Inadequate Procedures for Adjudicating Possible Third-Party Coverage Claims

44. Another service that MagnaCare provides to some of its Plans is the identification and denial of claims that might be covered by a party other than a Plan, such as workers' compensation or automobile accident insurance ("Possible Third-Party Coverage Claims").

45. At times relevant to this Complaint, where a healthcare provider identified a claim as a claim relating to work-place injury, auto accident, or other accident, MagnaCare denied the claim and sent an EOB to the participant to whom medical services were provided. MagnaCare did not send any notification to the provider.

46. MagnaCare also maintained a list of Diagnosis Codes that it associated with employment-related or accident-related injuries. When a claim was submitted that included one of the Diagnosis Codes on that list, MagnaCare sent a letter to the participant who received medical services, asking if the claim related to an employment or accident-related injury. This letter advised the participant that the claim might be denied if the participant did not respond by

a certain deadline. If the participant failed to respond by the deadline, or if the participant indicated that the claim arose from an employment or accident-related injury, then MagnaCare denied the claim and sent an EOB to the participant. Again, MagnaCare did not send any notification to the provider.

47. MagnaCare referred to the procedures described in paragraphs 44 through 46 as subrogation procedures. However, MagnaCare's procedures functioned more like exclusions, because the subject claim was denied rather than the benefits being coordinated with a third-party source.

48. MagnaCare did not ensure that its procedures relating to Possible Third-Party Coverage Claims fully complied with the Department's claims procedures regulation.

FIDUCIARY AND PARTY IN INTEREST STATUS

49. At times relevant to this action, MagnaCare was a fiduciary under ERISA §§ 3(21)(a)(i) and (iii), 29 U.S.C. §§ 1002(21)(a)(i) and (iii), because, in setting its own compensation, it exercised discretionary authority or discretionary control respecting management of plans or authority or control respecting management or disposition of plan assets and had discretionary authority or discretionary responsibility in the administration of such Plans and TPA Clients.

50. At times relevant to this action, MagnaCare was a fiduciary under ERISA §§ 3(21)(a)(i) and (iii), 29 U.S.C. §§ 1002(21)(a)(i) and (iii), because, in adjudicating claims, it exercised discretionary authority or discretionary control respecting management of plans or authority or control respecting management or disposition of plan assets and had discretionary authority or discretionary responsibility in the administration of such Plans.

51. At times relevant to this action, MagnaCare was a party in interest under ERISA §§ 3(14)(A) and (B), 29 U.S.C. §§ 1002(14)(A) and (B), because it was a fiduciary under ERISA as discussed herein, and because it provided services, including Network Access and Plan Management, to Plans and TPA Clients.

FIRST CLAIM FOR RELIEF
(Unilaterally Set and Undisclosed Fees)

52. The Secretary hereby incorporates by reference the allegations of paragraphs 1 through 28 and 49 through 51.

53. At times relevant to this Complaint, MagnaCare failed to protect the Plans, the TPA Clients, and their participants' and beneficiaries' interests by, among other things:

(a) unilaterally exercising discretion to increase Plan Charges, and thus to increase the amount of its own compensation from the Plans, without the knowledge or consent of the Plans or the TPA Clients; and

(b) unilaterally setting and collecting its own compensation in the form of Network Management Fees, without disclosing the amount of the fees to Plans or TPA Clients.

54. By the conduct described above, MagnaCare:

(a) violated the loyalty and prudence provisions of ERISA §§ 404(a)(1)(A) and (B), 29 U.S.C. §§ 1104(a)(1)(A) and (B);

(b) caused the Plans and the TPA Clients to engage in transactions that it knew or should have known constituted transfers of the Plans' and TPA Clients' assets to, or for the benefit of MagnaCare, which is itself a party in interest, in violation of ERISA § 406(a)(1)(D), 29 U.S.C. § 1106(a)(1)(D); and

(c) dealt with assets of the Plans in its own interest and acted on its own interest while its interests were adverse to those of the Plans, in violation of ERISA §§ 406(b)(1) and (2), 29 U.S.C. §§ 1106(b)(1) and (2).

55. As a direct and proximate result of the conduct described herein, MagnaCare caused the Plans to suffer financial losses for which all defendants are jointly and severally liable, and received unjust profits which they are liable to disgorge, pursuant to ERISA § 409(a), 29 U.S.C. § 1109(a), and ERISA §§ 502(a)(2) and (5), 29 U.S.C. §§ 1132(a)(2) and (5).

SECOND CLAIM FOR RELIEF
(Improper Procedures for Adjudication of ER Claims)

56. The Secretary hereby incorporates by reference the allegations of paragraphs 1 through 20, 29 through 43, and 49 through 51.

57. At times relevant to this Complaint, MagnaCare failed to protect the Plans and their participants' and beneficiaries' interests by, among other things:

(a) failing to ensure the application of the prudent layperson standard for ER Claims adjudication or to advise participants, beneficiaries or providers of the prudent layperson standard for adjudicating ER Claims;

(b) failing to notify providers, participants and beneficiaries with Diagnosis Codes not on the True ER List that they could submit additional supporting medical records and information satisfying the prudent layperson standard so that MagnaCare could apply the prudent layperson standard in adjudicating their ER Claims before denying their claims; and

(c) failing to comply with plan documents in that MagnaCare did not fully comply with the prudent layperson standard where it was incorporated into the plan documents; and

(d) failing to establish and maintain reasonable claims procedures for adjudicating ER Claims.

58. By the conduct described above, MagnaCare:

(a) violated the loyalty, prudence, and adherence to plan documents provisions of ERISA §§ 404(a)(1)(A), (B), and (D), 29 U.S.C. §§ 1104(a)(1)(A), (B) and (D);

(b) failed to ensure the application of the prudent layperson standard for ER Claims adjudication, thereby failing to administer the Plans in full compliance with ERISA § 715, 29 U.S.C. §1185d, incorporating Public Health Service Act § 2719A(b)(2)(A), 42 U.S.C. § 300gg-19a(b)(2)(A), and failed to establish and maintain reasonable claims procedures in full compliance with the claims procedures regulation, 29 C.F.R. § 2560.503-1, as modified by 29 C.F.R. § 2590.715-2719(b); and

(c) failed to provide adequate notice in writing to participants and beneficiaries whose claims for benefits had been denied, setting forth the specific reasons for such a denial and written in a manner calculated to be understood by the participants and beneficiaries, thereby failing to administer the Plans in full compliance with ERISA § 503, 29 U.S.C. § 1133, and the claims procedures regulation, 29 C.F.R. § 2560.503-1, as modified by 29 C.F.R. § 2590.715-2719(b).

59. As a direct and proximate result of the conduct described herein, MagnaCare caused Plans and their participants and beneficiaries to suffer harm for which all defendants are jointly and severally liable and for which the Plans and their participants and beneficiaries are entitled to relief pursuant to ERISA § 409(a), 29 U.S.C. § 1109(a) and ERISA §§ 502(a)(2) and (5), 29 U.S.C. §§ 1132(a)(2) and (5).

THIRD CLAIM FOR RELIEF
(Inadequate Procedures for Adjudication of Possible Third-Party Coverage Claims)

60. The Secretary hereby incorporates by reference the allegations of paragraphs 1 through 20 and 44 through 51.

61. At times relevant to this Complaint, MagnaCare failed to protect the Plans and their participants' and beneficiaries' interests by, among other things,

(a) failing to ensure that its procedures fully and fairly determined whether third-party coverage was available; and

(b) failing to ensure that its procedures complied with the Department's claims procedures regulation.

62. By the conduct described above, MagnaCare:

(a) violated the loyalty and prudence provisions of ERISA §§ 404(a)(1)(A) and (B), 29 U.S.C. §§ 1104(a)(1)(A) and (B); and

(b) failed to administer the Plans in full compliance with the requirements set forth in the claims procedures regulation, 29 C.F.R. § 2560.503-1.

63. As a direct and proximate result of the conduct described herein, MagnaCare caused Plans and their participants and beneficiaries to suffer harm for which all defendants are jointly and severally liable and for which the Plans and their participants and beneficiaries are entitled to relief pursuant to ERISA § 409(a), 29 U.S.C. § 1109(a) and ERISA §§ 502(a)(2) and (5), 29 U.S.C. §§ 1132(a)(2) and (5).

PRAYER FOR RELIEF

WHEREFORE, the Secretary prays that this Court enter an Order, pursuant to ERISA §§ 409(a), 502(a)(2) and (5), 29 U.S.C. §§ 1109(a) and 1132(a)(2) and (5):

1. Requiring MagnaCare to restore to the Plans all losses suffered and disgorge all profits received as a result of MagnaCare's fiduciary breaches and prohibited transactions, plus prejudgment and post-judgment interest;

2. Requiring MagnaCare to disclose its Network Management Fees to the Plans on a claim by claim basis or otherwise to operate under a fee arrangement that does not enable it to affect its own compensation;

3. Requiring MagnaCare to reform its procedures for receiving, processing, and adjudicating emergency services claims and claims for which third parties may be liable to comply with ERISA and, in particular, to comply with ERISA's claims adjudication procedures;

4. Requiring MagnaCare to re-adjudicate all denied ER Claims that have not been appealed;

5. Enjoining defendants from committing future violations of ERISA; and

6. Granting such other relief as may be equitable, just, and proper.

Respectfully submitted,

For the Secretary:

M. PATRICIA SMITH
Solicitor of Labor

G. WILLIAM SCOTT
Associate Solicitor
Plan Benefits Security Division

JEFFREY S. ROGOFF (# JR3129)
Regional Solicitor, New York

_____/s/_____ Date: September 30, 2016
DARREN COHEN (# DC4382)
Deputy Regional Solicitor

RISA D. SANDLER
Counsel for Fiduciary Litigation

SYMA AHMAD
D. MARC SARATA
Trial Attorneys
Plan Benefits Security Division
Office of the Solicitor
P.O. Box 1914
Washington, DC 20013
Telephone: (202) 693-5600
Facsimile: (202) 693-5610

SUZANNE DEMITRIO CAMPBELL (# SD4071)
MICHAEL HARTMAN (# MH8975)
Senior Trial Attorneys
Office of the Solicitor
201 Varick Street, Room 983
New York, New York 10014
Telephone: (646) 264-3674
Facsimile: (646) 264-3660