

MANAGER OF HEALTH CARE NETWORK TO REIMBURSE PLANS FOR FEES

MagnaCare agrees to return at least \$14.5M to ERISA-covered health benefit plans

NEW YORK – The U.S. Department of Labor and a third-party administrator that provides employee health benefit plans with access to a network of doctors, hospitals and other medical providers have reached an agreement in which the administrator has committed to improve its communications with health plans and to return certain fees the plans paid for claims administration that the department alleged were not fully disclosed to the plans.

The agreement with MagnaCare LLC resolves alleged violations of the Employee Retirement Income Security Act, and was negotiated in 2016. The U.S. District Court for the Southern District of New York approved the agreement on July 14, 2017.

Under the agreement, MagnaCare agrees to return at least \$14.5 million in network management fees to ERISA health benefit plans – with possible additional payments of \$4.5 million based upon business volume through 2019. The Long Island-based company has also agreed to implement revisions to its disclosures to employee health plans and participants to provide greater transparency on fees and claims procedures. It will also offer to adjudicate certain claims where participants may not have clearly understood the requirements for submitting documentation.

“This case serves as a reminder that a fiduciary must fully disclose fees to plan clients under federal law, as MagnaCare has agreed to do,” said Jonathan Kay, New York regional director for the department’s Employee Benefits Security Administration. “Benefit plans must receive accurate fee disclosures so that they can make informed decisions when selecting service providers.”

In 2016, the department filed its complaint with the U.S. District Court for the Southern District of New York following an EBSA investigation. The agency alleged that the company did not fully disclose its network management fees and provided incomplete year-end summaries of its fees to certain plan clients. By doing so, they prevented these clients from filing accurate federal Form 5500 financial reports with the government.

The department also alleged that the administrator’s claims processing procedure did not give plan participants and medical providers an opportunity to submit enough information for MagnaCare to determine whether hospital emergency room claims satisfied the “prudent layperson” standard. The standard requires certain plans to pay emergency claims if plan participants reasonably believe their condition requires immediate medical attention. Contemporaneously with the complaint, the department and MagnaCare filed a consent order resolving these allegations and memorializing their agreement.

Additional details are in the complaint and consent order.

EBSA’s New York Regional Office, with the assistance of the Office of the Solicitor’s Plan Benefits Security Division in Washington, D.C. and the New York Regional Solicitor’s Office, conducted the investigation.

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Acosta v. MagnaCare Administrative Services, LLC and MagnaCare LLC
Civil Action No.: 1:16-cv-07695-DAB

EBSA News Release: 07/25/2017

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Release Number: 17-0552-NEW