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JUSTIN MARMOR,
on behalf of himself and all others
similarly situated

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

JUSTIN MARMOR, on behalf of himself and all others similarly situated, Plaintiff, v. ANTHEM, INC.; ANTHEM UM SERVICES, INC., Defendants.	Case No.: 2:18-cv-8157 **CLASS ACTION** **COMPLAINT FOR BENEFITS, DETERMINATION OF RIGHTS AND BREACH OF FIDUCIARY DUTY UNDER ERISA**

Plaintiff, Justin Marmor, on behalf of himself and all others similarly situated, herein sets forth the allegations of his Complaint against Defendants Anthem, Inc. and Anthem UM Services, Inc.

INTRODUCTION

1. Defendant Anthem, Inc. states that "[w]e are one of the largest health benefit companies in terms of medical membership in the United States serving 40.2 million medical members through our affiliated health plans as of December 31, 2017."[1] Anthem, Inc. owns "Blue" organizations in California and many other states, as well as other subsidiaries.[2] Through its wholly-owned subsidiaries, including Defendant Anthem UM Services, Inc. ("Anthem UM"), Anthem, Inc. acts as a fully integrated company that is in the business of insuring and/or administering health insurance plans (both fully insured and self-insured), most of which are employer-sponsored and governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. ("Anthem plans").

2. With respect to all Anthem plans, Anthem UM serves as the claims administrator, responsible for determining whether claims are covered under Anthem plans (both fully insured and self-insured) and effectuating any resulting benefit payment. Anthem, Inc. aids Anthem UM in its administrative duties by, among other things, participating with Anthem UM in the development of coverage guidelines, collaborating with Anthem UM on the types of claims that will be approved or denied, including the scheme to deny emergency services claims alleged herein, and assisting Anthem UM in carrying out its various other administrative duties. As such,

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[1] Anthem Inc.'s 2017 10-K filing, p. 3.

[2] Anthem, Inc. and its subsidiaries operate under the "Blue" moniker in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Anthem also conducts business through subsidiaries such as Amerigroup, Simply Healthcare Holdings, HealthLink, UniCare, and CareMore Health Group, Inc.

Defendants Anthem, Inc. and Anthem UM (jointly "Anthem") have acted as ERISA fiduciaries with respect to all Anthem plans, including Plaintiff's plan.

3. Plaintiff brings this action to address Anthem's practice of improperly selecting for review, and denying, claims for emergency services made by members under ERISA plans.

JURISDICTION AND VENUE

4. This action is brought under 29 U.S.C. §§ 1132(a), (e), (f) and (g) as it involves claims by Plaintiff for employee benefits under employee benefit plans regulated and governed by ERISA. Subject matter jurisdiction is predicated under these code sections as well as 28 U.S.C. § 1331 as this action involves a federal question.

5. The Court has personal jurisdiction over Defendants because ERISA provides for nationwide service of process, and each Defendant has minimum contacts with the United States. *See* 29 U.S.C. § 1132(e)(2).

6. The claims of Plaintiff and the putative class arise out of policies Defendants issued, administered, and/or implemented in this District. Thus, venue is proper in this judicial district pursuant to 29 U.S.C. § 1132(e)(2) (setting forth special venue rules applicable to ERISA actions).

THE PARTIES

7. Plaintiff was at all relevant times covered under an employee benefit plan regulated by ERISA and pursuant to which Plaintiff is entitled to health care benefits.

8. Anthem, Inc. and Anthem UM are corporations with their principal place of business in Indianapolis, Indiana. They administer and make benefit determinations related to ERISA health care plans around the country.

9. Anthem, Inc. and Anthem UM do not operate independently and in their own interests, but serve solely to fulfill the purpose, goals and policies of each other.

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SUBSTANTIVE ALLEGATIONS

A. Anthem's emergency services claims practices.

10. Anthem developed an internal plan to target emergency services, and attendant hospital admissions, for a restrictive review. As part of this plan, Anthem developed a list of certain complaints and diagnoses that would trigger the restrictive review and denial of a claim that should be paid.

11. Anthem's actions caused the Office of United States Senator Claire McCaskill ("McCaskill's Office") to undertake an investigation into Anthem's emergency services claims practices. McCaskill's Office determined that Anthem had "implemented a policy to deny reimbursement for claims for emergency room (ER) services related to conditions it later deems non-emergent."

12. Senator McCaskill wrote to Anthem CEO Joseph R. Swedish in December of 2017 regarding Anthem's reimbursement practice for emergency services. In response, Anthem produced a limited set of documents.

13. Anthem admitted to McCaskill's Office that it had "developed a list of diagnosis codes that often are not associated with emergency care" that trigger a review to determine, in hindsight, if the services were for an emergent condition. Anthem declined to provide its list of diagnosis codes to McCaskill's Office.

14. McCaskill's Office issued a report in July of 2018 entitled "Coverage Denied: Anthem Blue Cross Blue Shield's Emergency Room Initiative." Although the report was handicapped by the incomplete information provided by Anthem, it concludes:

> By implementing a policy to no longer cover emergency room services for care the company later deems non-emergent, Anthem has essentially required patients to act as medical professionals when they experience urgent medical events. Given the stakes involved—thousands of dollars in medical costs, in some cases—Anthem, at the very least, owes its beneficiaries careful consideration during the claims determination process. As discussed above, however, the company overturned 62% of appealed decisions on Missouri ER claims between July 2017 and

> November 2017—and the rate of decisions overturned on appeal increased almost every month in this period. Similar results applied in Georgia and Kentucky. These statistics raise the concern that Anthem employees may lack the necessary experience or training to apply ER claims policies correctly in the first instance. The fact that Anthem added "enhancements" to its policies in January 2018—resulting in a sharp decline in denials—also suggests the company pursued an overly restrictive initial approach to its review of ER claims.

15. Anthem has not remedied their wrongful emergency services claims practices.

16. Anthem's practices violate the terms of the Anthem plans and the provisions of ERISA by:

(a) failing to establish reasonable claims procedures (29 C.F.R. § 2560.503-1(b)) for handling emergency services claims by requiring patients to self-diagnose themselves before seeking emergency services;

(b) failing to establish reasonable claims procedures (29 C.F.R. § 2560.503-1(b)) for handling emergency services claims by using an overly restrictive standard for assessing the emergent nature of services that is not in keeping with the "prudent layperson" standard found in 45 C.F.R. § 147.138(b)(4)(i);[3]

(c) using an undisclosed diagnosis code to select for restrictive review, and then deny, members' claims without disclosing the reason for the denial in the notices of adverse benefit determination (29 C.F.R. 2560.503-1(g)(1)(i));

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[3] That subsection provides: "The term *emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to 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; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)"

(d) maintaining and using a secret list of diagnosis codes to select for restrictive review, and then deny, members' claims without disclosing the criteria relied upon the notices of adverse benefit determination (29 C.F.R. 2560.503-1(g)(1)(v)(A));

(e) denying claims for emergent services as "not medically necessary" without providing either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request (29 C.F.R. 2560.503-1(g)(1)(v)(B)).

B. Anthem's denial of Plaintiff Justin Marmor's emergency medical services.

17. During the relevant time period, Justin Marmor was covered under an employee benefit plan providing medical benefits that was governed by ERISA. Anthem acted as the administrator of the plan by making decisions regarding the covered nature of claims made by members, including claims for emergency services.

18. On April 15, 2018 Justin Marmor was seen at the emergency room of Cedars Sinai hospital for a condition that required emergency services and that lead to his admission to the hospital.

19. In a letter dated April 23, 2018, Anthem UM stated that it "provides utilization management services for Anthem Blue Cross Life and Health Insurance Company." While Anthem refused to pay Mr. Marmor's claim for emergency services, including his hospitalization, it only advised why it was not paying for the hospitalization.

20. In making its decision to deny Mr. Marmor's claim for emergency services and attendant hospitalization, Anthem employed a standard that required Mr. Marmor to self-diagnose himself at the time he presented in the emergency room. This standard was erroneous and was not compliant with the prudent layperson standard.

21. In a letter dated July 5, 2018, Mr. Marmor advised Anthem that he was appealing its decision denying his claim for emergency services and his admission at

Cedars Sinai hospital.

22. In a letter dated August 2, 2018, Anthem UM advised Mr. Marmor that it was denying his appeal of his claim for hospitalization benefits. Anthem failed to address Mr. Marmor's appeal of its denial of the emergency services rendered Mr. Marmor.

CLASS ACTION ALLEGATIONS

23. Plaintiff brings this action on behalf of themselves and all others similarly situated as a class action pursuant to Federal Rules of Civil Procedure Rule 23. Pursuant to Rule 23(b)(1) and (b)(2), Plaintiff seeks certification of the following class:

> All persons covered under ERISA health plans, self-funded or fully insured, that are administered by Anthem and whose claims for emergency services were denied as "not medically necessary" pursuant to Anthem's practice of selecting for restrictive review, and denying, claims based upon Anthem's secret list of diagnosis codes.

24. Plaintiff and the class members reserve the right under Federal Rule of Civil Procedure Rule 23(c)(l)(C) to amend or modify the class to include greater specificity, by further division into subclasses, or by limitation to particular issues.

25. This action has been brought and may be properly maintained as a class action under the provisions of Federal Rules of Civil Procedure Rule 23 because it meets the requirements of Rule 23(a) and Rule 23(b)1 and (b)(2).

A. Numerosity.

26. The potential members of the proposed class as defined are so numerous that joinder of all the members of the proposed class is impracticable. While the precise number of proposed class members has not been determined at this time, Plaintiff is informed and believes that there are a substantial number of individuals covered under Anthem plans who have been similarly affected.

B. Commonality.

27. Common questions of law and fact exist as to all members of the proposed class.

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C. Typicality.

28. The claims of the named Plaintiff are typical of the claims of the proposed class. Plaintiff and all members of the class are similarly affected by Anthem's wrongful conduct.

D. Adequacy of representation.

29. Plaintiff will fairly and adequately represent and protect the interests of the members of the proposed class. Counsel who represent Plaintiff are competent and experienced in litigating large and complex class actions, including class actions against health plans such as Anthem.

E. Superiority of class action.

30. A class action is superior to all other available means for the fair and efficient adjudication of this controversy. Individual joinder of all members of the proposed class is not practicable, and common questions of law and fact exist as to all class members.

31. Class action treatment will allow those similarly situated persons to litigate their claims in the manner that is most efficient and economical for the parties and the judicial system. Plaintiff is unaware of any difficulties that are likely to be encountered in the management of this action that would preclude its maintenance as a class action.

F. Rule 23(b) requirements.

32. Inconsistent or varying adjudications with respect to individual members of the class would establish incompatible standards of conduct for Anthem.

33. Adjudications with respect to individual class members would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests.

34. Anthem have acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole.

FIRST CLAIM FOR RELIEF
DENIAL OF PLAN BENEFITS AND FOR CLARIFICATION OF RIGHTS UNDER AN ERISA PLAN [29 U.S.C. § 1132(a)(1)(B)]

35. Plaintiff and the class members repeat and re-allege each and every allegation set forth in all of the foregoing paragraphs as if fully set forth herein.

36. 29 U.S.C. § 1132(a)(1)(B) entitles Plaintiff to recover benefits due and to enforce and clarify his rights to the benefits at issue.

37. As set forth above, Anthem has denied claims for emergency services based on the selection and review of certain diagnosis codes that Anthem keeps secret. Once such a diagnosis code is flagged, the claim is reviewed under a restrictive standard that requires the member to self-diagnosis his or her condition and does not comply with the prudent layperson standard.

38. Anthem has denied Mr. Marmor's claim for emergency services and attendant hospital admission to Cedars Sinai hospital, as alleged herein. In making its decision to deny Mr. Marmor claim for emergency services and attendant hospitalization, Anthem employed a standard that required Mr. Marmor to self-diagnose himself at the time he presented in the emergency room. This standard was erroneous and was not compliant with the prudent layperson standard.

39. Mr. Marmor has exhausted his administrative remedies, as alleged above.

40. Based on the foregoing, Plaintiff and the class members seek the payment of medical expenses, interest thereon, a clarification of rights, and attorney fees.

SECOND CLAIM FOR RELIEF
BREACH OF FIDUCIARY DUTY AND EQUITABLE RELIEF UNDER AN ERISA PLAN [29 U.S.C. § 1132(a)(3)]

41. Plaintiff and the class members repeat and re-allege each and every allegation set forth in all of the foregoing paragraphs as if fully set forth herein.

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42. As alleged herein, Anthem has acted as an ERISA fiduciary with respect to the administration and claims decisions under Anthem plans and, in particular, has acted as an ERISA fiduciary in denying claims for emergency services, as alleged herein.

43. Anthem improperly denied Plaintiff's and the class members' claims for emergency services in beach of its fiduciary duties, as alleged herein.

44. Pursuant to 29 U.S.C. § 1132(a)(3), Plaintiff and the class members seek declaratory, equitable and remedial relief as follows:

a. An order declaring that Anthem's denials of claims for emergency services are wrong and improper;

b. An injunction requiring Anthem to reevaluate and reprocess Plaintiff's and class members' claims without the erroneous denial bases under appropriate and valid emergency services criteria;

c. An injunction requiring Anthem to provide notice of the reevaluation and reprocessing in the form and manner required by ERISA to all class members;

d. An injunction requiring Anthem to comply with ERISA claims procedure as set forth in 29 C.F.R. § 2560.503-1 in the handling and denial of emergency services claims, including the development of proper claims procedures and notices of adverse benefit determination;

e. An accounting of any profits made by Anthem from the monies representing the improperly denied claims and disgorgement of any profits;

f. Such other equitable and remedial relief as the Court may deem appropriate; and

g. Attorneys fees in an amount to be proven.

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REQUEST FOR RELIEF

Wherefore, Plaintiff and the class members pray for judgment against Anthem as follows:

1. Benefits denied Plaintiff in an amount to be proven at trial, including interest;

2. A clarification of rights to future benefits under the plan for all class members;

3. Injunctive and declaratory relief, as described above;

4. An accounting of any profits made and retained through the improper denial of claims and disgorgement of any profits;

5. Attorneys' fees; and

6. Such other equitable and remedial relief as the Court may deem just and proper.

DATED: September 20, 2018

GIANELLI & MORRIS

By: /s/ Adrian J. Barrio
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