From: Paul Sullivan [mailto:sullivanpaul01@gmail.com]
Sent: Tuesday, October 24, 2017 11:10 AM
To: EBSA, E-ORI - EBSA
Subject: RIN 1210 AB 39

It has been my privilege to represent claimants in regard to their claims for benefits from ERISA-governed employee welfare benefit plans for the last 30 years -- commencing with the arrival of *Pilot Life*.

It has been my experience that as a regular matter most plans and their insurers and third-party administrators are NOT forthcoming when it comes to disclosing anything at all with regard to their internal rules and protocols governing claims. (Coincidentally, I am in litigation right now against a prominent disability insurance company which outright and repeatedly denied me access to such information during the administrative processes prior to suit.) This has become in my experience the accepted modus operandi throughout the industry.

The only resolution, if it may be termed one, is to file suit in federal district court and force the insurer or TPA to admit its violation of the claims regulation after, so to speak, the horse has already left the barn.

It baffles me how anyone can claim a costs increase to plans or insurers by requiring them to adhere to the well known requirements of the claims regulation.

Moreover, the laxity of many federal courts in calling them on it is couched in terms of "substantial compliance." This so-called doctrine hides a multitude of sins. The simple clarity of the claims regulation's language apparently cannot be left un-muddied by insurers and TPAs. Many pages of court cases and vast amounts of time and expense are devoted AFTER suit is filed in the vast majority of cases to whether the non-compliance by the individual insurer or TPA was "substantial."

This is a disgrace. The simple requirements of the regulation can virtually be automated and produced virtually at the stroke of a key, if the insurers and TPAs genuinely wanted to save expense. Their conduct belies their motivation.

Wanted or not, they make it a trek through the desert of administrative review which only the hardiest souls can hope to survive. If the claimant attempts to "perfect" the claim, it is in the nebulous world of guesswork about what the internal protocols, that is, the safeguards and verification protocols hypothetically applicable to the particular type of claim, might be.

Lengthy denial letters often recite plan provisions but give little or no hint as to how or why the denial came about. They often invite the claimant to send to the insurer or TPA additional materials which seem indistinct from what was already submitted -- again with little explanation at all as to what relevance, if any, the additional material might have to the claim or the denial of the claim.

It seems that "ready access" to the federal courts has become over time the modern-day version of P.T. Barnum's famous invitation: "25 cents to the Egress!"

Sincerely yours,

Paul Sullivan

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