

A-Engrossed
Senate Bill 1148

Ordered by the Senate April 22
Including Senate Amendments dated April 22

Sponsored by Senator TAYLOR

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act makes changes to laws with respect to certain insurance policies. (Flesch Readability Score: 60.7).

Prohibits disability income insurers from requiring a person to use **or apply for** other available benefits for which the person is eligible prior to being eligible for disability benefits offered by the insurer.

A BILL FOR AN ACT

1
2 Relating to disability income insurance policies; creating new provisions; and amending ORS
3 743B.260.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1.** ORS 743B.260 is amended to read:

6 743B.260. (1) As used in this section:

7 (a) "Adverse benefit determination" means a denial, reduction, termination of or failure to pro-
8 vide or pay, in whole or in part, for a benefit, including:

9 (A) A denial, reduction, termination of or failure to provide or pay for a benefit that is based
10 on a determination of a participant's or beneficiary's eligibility to participate in a policy; and

11 (B) A rescission of coverage with respect to a participant or beneficiary.

12 (b) "Claim procedure" means an insurer's procedure for filing benefit claims, providing notice
13 of benefit determinations and appealing adverse benefit determinations.

14 (2) An insurer that offers, issues or renews a disability income insurance policy in this state
15 may not:

16 (a) Unduly delay, inhibit or hamper a claimant's submission of a claim for benefits under the
17 disability income insurance policy or the insurer's processing, consideration or determination of the
18 claim;

19 (b) Require a claimant to request more than two appeals of an adverse benefit determination to
20 exhaust the insurer's appeals process; [*or*]

21 (c) Require mandatory arbitration of an adverse benefit determination unless the arbitration:

22 (A) Constitutes one of the appeals described in paragraph (b) of this subsection and complies
23 with the requirements that apply to an appeal; and

24 (B) Does not preclude the claimant from challenging the result of the arbitration under appli-
25 cable law[.]; **or**

26 **(d) Require a person eligible for benefits to utilize or apply for any available benefit pro-**

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

1 **vided under ORS chapter 657B prior to being eligible for disability benefits offered by the**
2 **disability income insurance policy.**

3 (3) An insurer that issues or renews a disability income insurance policy in this state shall:

4 (a) Describe and provide to each person eligible for benefits under the policy a written summary
5 of all claim procedures, timelines and deadlines that apply to claims under the policy.

6 (b) Permit an authorized representative of a claimant to act on the claimant's behalf in making
7 a claim or appealing an adverse benefit determination, subject to the insurer's reasonable determi-
8 nation as to whether the claimant has in fact authorized the representative to act on the claimant's
9 behalf.

10 (c) Establish and administer processes and safeguards to ensure and verify that the insurer:

11 (A) Determines benefit claims in accordance with the provisions of the policy and all other ap-
12 plicable laws, regulations and procedures; and

13 (B) Applies policy provisions consistently among claims.

14 (d) Determine and adjudicate all claims and appeals in a manner that ensures the independence
15 and impartiality of the individuals who make the determinations or adjudications.

16 (e) Notify each claimant of an adverse benefit determination not later than 45 days after re-
17 ceiving a claim, except that an insurer may extend the time within which the insurer may give the
18 notification for a maximum of two additional 30-day periods if the insurer determines that the
19 insurer needs additional information from the claimant or the delay is the result of circumstances
20 beyond the insurer's control and:

21 (A) The insurer notifies the claimant of each extension before the expiration of the initial 45-day
22 period or the first extension, as appropriate; and

23 (B) The insurer explains, describes or states, as appropriate, in each notification of an extension:

24 (i) The standards that apply to the determination;

25 (ii) Any unresolved issues that prevent a determination;

26 (iii) Any additional information the claimant must provide for the determination, giving a date
27 not later than 45 days from the date of the notification for the claimant to provide the information;
28 and

29 (iv) The date by which the insurer expects to make the determination.

30 (f) Notify the claimant in writing, by printed or electronic means, of the details of each adverse
31 benefit determination, including any adverse benefit determination that follows an appeal of a pre-
32 vious adverse benefit determination. The Director of the Department of Consumer and Business
33 Services may adopt rules that specify:

34 (A) The form and format of the notification; and

35 (B) Contents of the notification that include, at a minimum:

36 (i) The specific reason for the adverse benefit determination;

37 (ii) The specific policy provisions on which the insurer based the adverse benefit determination;

38 (iii) A description of any additional information the claimant must provide to complete a claim
39 or appeal and an explanation of why the information is necessary;

40 (iv) A description of the insurer's claim procedures and time limits within which a claimant must
41 request an appeal, along with a statement that the claimant has a right to bring a civil action fol-
42 lowing the adverse benefit determination once the claimant exhausts the claimant's remedies under
43 the insurer's appeals process;

44 (v) An explanation of the insurer's determination that includes, if applicable:

45 (I) Reasons why the insurer did not agree with or follow advice, opinions or recommendations

1 from vocational consultants or health care providers who evaluated or treated the claimant and that
2 the claimant included in the claim, or why the insurer disagreed with a determination by the United
3 States Social Security Administration; and

4 (II) The advice, opinions and recommendations of the insurer's medical or vocational consult-
5 ants, even if the insurer did not rely on the advice, opinions or recommendations in making the
6 adverse benefit determination;

7 (vi) Specific summaries or citations of the insurer's claim procedures, internal rules, guidelines,
8 protocols, standards or other criteria on which the insurer relied in making the adverse benefit de-
9 termination, or a statement that the insurer does not have or did not use specific claim procedures,
10 rules, guidelines, protocols, standards or other criteria; and

11 (vii) A statement that explains the claimant's reasonable right of access, upon request and free
12 of charge, to copies of all documents, records and other information that are related to the claim
13 and the adverse benefit determination, along with procedures for obtaining the documents, records
14 and other information.

15 (g) Establish and maintain a claim procedure under which a claimant has a reasonable oppor-
16 tunity to appeal an adverse benefit determination under conditions that ensure a full and fair con-
17 sideration of the claim and the adverse benefit determination. The insurer in the claim procedure
18 shall give the claimant:

19 (A) At least 180 days after the date of the adverse benefit determination within which to appeal;

20 (B) An opportunity to submit written comments, documents, records and other information re-
21 lated to the claim;

22 (C) Upon request and free of charge, reasonable access to and copies of all of the insurer's
23 documents, records and other information related to the claim;

24 (D) Due consideration of the comments, documents, records and other information the claimant
25 submits during the appeal, without regard to whether the claimant submitted the comments, docu-
26 ments, records or other information for the initial determination;

27 (E) A proceeding in which the official that conducts the proceeding:

28 (i) Does not defer to the adverse benefit determination;

29 (ii) Is not the official who made the adverse benefit determination or a subordinate of the offi-
30 cial; and

31 (iii) Consults with a health care provider who has appropriate training and experience to make
32 an informed medical judgment concerning the claim, if a determination of the claim requires a
33 medical judgment, but who is not a health care provider who participated in the adverse benefit
34 determination, or a subordinate of the health care provider; and

35 (F) The identities of medical providers or vocational consultants from whom the insurer obtained
36 advice, opinions or recommendations concerning the adverse benefit determination, even if the
37 insurer did not rely on the advice, opinions or recommendations in making the adverse benefit de-
38 termination.

39 (4)(a) If in an appeal of an adverse benefit determination an insurer intends to consider evidence
40 or a rationale that the insurer did not previously consider in making the adverse benefit determi-
41 nation, the insurer shall, as soon as possible and before making a determination in the appeal, notify
42 the claimant of the evidence and the rationale and in the notification provide the claimant with
43 copies of the evidence and an explanation of the rationale, free of any charge. The insurer's notifi-
44 cation must allow the claimant a reasonable time within which to respond to the evidence or ra-
45 tionale.

1 (b) An insurer shall complete an appeal of an adverse benefit determination and notify the
2 claimant of the insurer's determination of the appeal not later than 45 days after receiving the
3 claimant's request for the appeal, except that the insurer may extend for not more than an addi-
4 tional 45 days the time within which the insurer may complete the appeal if the insurer:

5 (A) Determines that special circumstances require the delay; and

6 (B) Gives the claimant:

7 (i) Notice of the extension before the expiration of the initial 45-day period;

8 (ii) An explanation of the special circumstances that caused the delay; and

9 (iii) A date by which the insurer expects to make and give the claimant notice of a determi-
10 nation of the appeal.

11 (5) The period of time within which an insurer must make a determination on a claim or an
12 appeal begins when the insurer receives notice of the claim or appeal, even if the notice does not
13 include all information necessary to make a determination with respect to the claim or appeal. If
14 the insurer must extend the period within which the insurer must make a determination because the
15 claimant failed to submit necessary information, the period is tolled from the date on which the
16 insurer notifies the claimant of the need for additional information until the date on which the
17 claimant responds to the notice.

18 (6)(a) Except as provided in paragraph (b) of this subsection, a claimant has exhausted the
19 claimant's administrative remedies with respect to a claim or appeal of an adverse benefit determi-
20 nation if the insurer does not adhere strictly to the requirements of this section.

21 (b) An insurer's failure to adhere strictly to the requirements of this section that is de minimis
22 and does not or is not likely to cause prejudice or harm to the claimant does not constitute a
23 claimant's exhaustion of the claimant's administrative remedies with respect to a claim or appeal if
24 the failure is not part of a pattern or practice of failures by the insurer and the insurer demon-
25 strates that the failure:

26 (A) Was for good cause or was a result of circumstances beyond the insurer's control; and

27 (B) Occurred in the context of an ongoing, good-faith exchange of information between the
28 insurer and the claimant.

29 (c) A claimant may request from the insurer a written explanation of the failure, which the
30 insurer must provide within 10 days after receiving the request. In the explanation, the insurer must
31 specify the basis for any assertion by the insurer that the failure does not constitute an exhaustion
32 of the claimant's administrative remedies with respect to the claim or appeal.

33 **SECTION 2. The amendments to ORS 743B.260 by section 1 of this 2025 Act apply to**
34 **policies offered, issued or renewed on or after January 1, 2026.**

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