Senate Bill 46

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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 **as introduced.**

Requires insurer that issues or renews disability insurance policy in this state to establish, maintain and follow certain procedures with respect to claims, determinations of claims that are adverse to claimant, appeals of determinations, communications with claimant and related operations.

Becomes operative on January 1, 2022.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to an insurer's treatment of claims under a disability insurance policy; and prescribing an effective date.

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

SECTION 1. Section 2 of this 2021 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section, "adverse benefit determination" means an insurer's action that:

(a) Denies, reduces or terminates:

(A) A person's eligibility to participate in a disability insurance policy; or

(B) A benefit that is available under a disability insurance policy;

(b) Denies a payment of a benefit available under a disability insurance policy, in whole or in part; or

(c) Rescinds, cancels or discontinues coverage under a disability insurance policy, with or without retroactive effect, unless the action is a response to a failure to timely pay a premium or other contribution to the cost of coverage under the policy.

(2) An insurer that issues or renews a disability insurance policy in this state may not:

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

(b) Require a claimant to request more than two appeals of an adverse benefit determination before seeking judicial review of the adverse benefit determination; or

(c) Require mandatory arbitration of an adverse benefit determination.

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

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

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

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.

to act on the claimant's behalf.

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

(A) Determines benefit claims in accordance with the provisions of the policy and all other applicable laws, regulations and procedures; and

(B) Applies policy provisions consistently among similarly situated claimants.

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

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

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

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

(i) The standards that apply to the determination;

(ii) Any unresolved issues that prevent a determination;

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

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

(f) Notify the claimant in writing, by printed or electronic means, of the details of each adverse benefit determination, including any adverse benefit determination that follows an appeal of a previous adverse benefit determination, subject to rules of the Director of the Department of Consumer and Business Services that specify:

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

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

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

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

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

(iv) A description of the insurer's procedures and time limits within which a claimant must request an appeal, along with a statement that the claimant has a right to judicial review of the adverse benefit determination once the claimant exhausts the claimant's administrative remedies under the policy;

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

(I) Reasons why the insurer did not agree with or follow advice, opinions or recommendations from vocational consultants or health care providers who evaluated or treated the claimant and that the claimant included in the claim, or why the insurer disagreed with a determination by the United States Social Security Administration; and

(II) The advice, opinions and recommendations of the insurer's medical or vocational consultants, even if the insurer did not rely on the advice, opinions or recommendations in

making the adverse benefit determination;

(vi) Specific summaries or citations of the insurer's internal rules, guidelines, protocols, standards or other criteria on which the insurer relied in making the adverse benefit determination, or a statement that the insurer does not have or did not use specific rules, guidelines, protocols, standards or other criteria; and

(vii) A statement that explains the claimant's right to obtain, and procedures for obtaining upon request and free of charge, copies of all documents, records and other information that is related to the claim and the adverse benefit determination.

(g) Establish and maintain a procedure under which a claimant has a reasonable opportunity to appeal an adverse benefit determination under conditions that ensure a full and fair consideration of the claim and the adverse benefit determination. The insurer in the procedure shall give the claimant:

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

(B) An opportunity to submit written comments, documents, records and other information related to the claim;

(C) Reasonable access to and copies of all of the insurer's documents, records and other information related to the claim;

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

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

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

(ii) Is not the official who made the adverse benefit determination or a subordinate of the official; and

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

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

(4)(a) If in an appeal of an adverse benefit determination an insurer intends to consider evidence or a rationale that the insurer did not previously consider in making the adverse benefit determination, the insurer shall, as soon as possible and before making a determination in the appeal, notify the claimant of the evidence and the rationale and in the notification provide the claimant with copies of the evidence and an explanation of the rationale, free of any charge. The insurer's notification must allow the claimant a reasonable time within which to respond to the evidence or rationale.

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

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

(B) Gives the claimant:

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

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

(iii) A date by which the insurer expects to make and give the claimant notice of a determination of the appeal.

(5)(a) In all written notifications to a claimant under this section, an insurer, in addition to communicating all information in the English language, shall:

(A) Communicate all information in the language in which the claimant is most proficient, if the insurer has actual or constructive knowledge of the claimant's proficiency in the language. The insurer has actual knowledge of the claimant's proficiency in the language if the claimant submitted the claim or materials related to the claim to the insurer in the language or previously requested from the insurer translations or interpretations of communications from the insurer into the language. The insurer has constructive knowledge of the claimant's proficiency in the language if the claimant resides in a county of this state in which 10 percent or more of the residents of the county are proficient only in the language.

(B) In any materials the insurer provides to the claimant in the English language:

(i) State that language services in the language in which the claimant is most proficient are available from the insurer; and

(ii) Explain how the claimant can get access to the language services.

(b) An insurer shall provide services to a claimant in the language in which the claimant is most proficient, which must include answering the claimant's questions in the language and providing assistance in the language with submitting claims, requests for appeals and other materials related to a claim or appeal.

(c) An insurer at a claimant's request shall provide any notice to a claimant in the language in which the claimant is most proficient.

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

(7)(a) Except as provided in paragraph (b) of this subsection, a claimant has exhausted the claimant's administrative remedies with respect to a claim or appeal and may seek judicial review of an adverse benefit determination if the insurer does not adhere strictly to the requirements of this section.

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

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

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

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

SECTION 3. Section 2 of this 2021 Act applies to a policy of disability insurance that an insurer issues or renews on or after the operative date specified in section 4 of this 2021 Act.

SECTION 4. (1) Section 2 of this 2021 Act becomes operative on January 1, 2022.

(2) The Director of the Department of Consumer and Business Services may adopt rules and take any other action before the operative date specified in subsection (1) of this section that is necessary to enable the director, on and after the operative date specified in subsection (1) of this section, to undertake and exercise all of the duties, functions and powers conferred on the director by section 2 of this 2021 Act.

SECTION 5. This 2021 Act takes effect on the 91st day after the date on which the 2021 regular session of the Eighty-first Legislative Assembly adjourns sine die.