

Chapter 735 — Alternative Insurance

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ESSENTIAL PROPERTY INSURANCE

- 735.005 Definitions for ORS 735.005 to 735.145
- 735.015 Purpose
- 735.025 Construction
- 735.035 Application
- 735.045 Oregon FAIR Plan Association; insurers required to be members; plan of operation
- 735.055 Association board of directors; appointment; compensation, expenses of members; quorum
- 735.065 Required association functions
- 735.075 Discretionary association functions
- 735.085 Plan of operation; submission to director; approval of plan; compliance with plan
- 735.095 Contents of plan of operation
- 735.105 Regulation of association as insurer; financial report to director
- 735.115 Exemption of association from fees and taxes
- 735.145 Immunity from legal action in carrying out duties

MARKET ASSISTANCE PLANS; JOINT UNDERWRITING ASSOCIATIONS

- 735.200 Legislative findings; purpose
- 735.205 Definitions for ORS 735.200 to 735.260
- 735.210 Formation of market assistance plans
- 735.215 Findings prior to formation of joint underwriting association; hearing
- 735.220 Formation of joint underwriting association; funds
- 735.225 Membership in joint underwriting association
- 735.230 Rates; approval
- 735.235 Board of directors
- 735.240 Annual statement
- 735.245 Conditions for policyholder surcharge

- 735.250 Exemption from liability
- 735.255 State not liable to pay debts of association
- 735.260 Rules
- 735.265 Liquor liability insurance risk and rate classifications

LIABILITY RISK RETENTION LAW

- 735.300 Purpose of ORS 735.300 to 735.365
- 735.305 Definitions for ORS 735.300 to 735.365
- 735.310 Qualifications for risk retention group; plan of operation; application; notification to National Association of Insurance Commissioners
- 735.315 Foreign risk retention groups; conditions of doing business in Oregon; prohibited acts
- 735.320 Relationship to insurance guaranty fund and joint underwriting association
- 735.325 Exemption of purchasing groups from certain laws
- 735.330 Purchasing groups; notice of intent to do business; registration; exceptions
- 735.335 Purchase of insurance by purchasing group
- 735.340 Insurance Code enforcement authority subject to federal law
- 735.345 Violation of ORS 735.300 to 735.365; penalties
- 735.350 Agent or broker; license
- 735.355 Court orders enforceable in Oregon
- 735.360 Rules
- 735.365 Short title

SURPLUS LINES LAW

- 735.400 Purposes of ORS 735.400 to 735.495
- 735.405 Definitions for ORS 735.400 to 735.495
- 735.410 Conditions for procuring insurance through nonadmitted insurer
- 735.415 Qualifications for placement of coverage with nonadmitted insurer
- 735.420 Declaration of ineligibility of surplus lines insurer
- 735.425 Filing by licensee after placement of surplus lines insurance

- 735.430 Surplus Lines Association of Oregon
- 735.435 Evidence of insurance; contents; change; penalty; notice regarding Insurance Guaranty Association
- 735.440 Validity of contracts
- 735.445 Effect of payment of premium to surplus lines licensee
- 735.450 Requirements for surplus lines insurance agent license
- 735.455 Authority of licensee
- 735.460 Records of licensee; examination
- 735.465 Monthly reports
- 735.470 Premium tax; collection; payment; refund; rules
- 735.475 Suit to recover unpaid tax
- 735.480 Suspension or revocation of license; refusal to renew; grounds
- 735.485 Actions against surplus lines insurer
- 735.490 Jurisdiction in action against insurer; service of summons and complaint; response
- 735.495 Short title; severability

MEDICAL INSURANCE POOL

- 735.600 Legislative intent
- 735.605 Definitions for ORS 735.600 to 735.650
- 735.610 Oregon Medical Insurance Pool Board; members; authority; rules
- 735.612 Oregon Medical Insurance Pool Account; sources; uses
- 735.614 Assessments for expenses of pool
- 735.615 Eligibility for pool coverage
- 735.616 Eligibility for portability coverage under pool
- 735.620 Administering insurer; selection; duties
- 735.625 Coverage; rules
- 735.630 Exemption from liability
- 735.635 Exemption from taxation
- 735.640 Study; adjustment of operation and benefits plans

735.645 Notice of existence of pool

735.650 Application of provisions of Insurance Code

HEALTH INSURANCE POOL

(Generally)

735.700 Definitions for ORS 735.700 to 735.740

735.702 Policy

735.704 Insurance Pool Governing Board; qualifications; term; vacancies

735.706 Insurance Pool Governing Board Account

735.708 Expenses; chairperson; quorum; meetings; rules

735.710 Board duties

735.712 Board to encourage health insurance coverage among small employers

(Family Health Insurance Assistance Program)

735.720 Definitions for ORS 735.720 to 735.740

735.722 Family Health Insurance Assistance Program; eligibility for participation; selection of administrator

735.724 Application to participate in program; issuance of subsidies; restrictions; employment group health plan enrollment

735.726 Level of assistance determinations

735.728 Subsidies limited to funds appropriated; enrollment restrictions

735.730 Establishment of minimum benefit amounts for plan subsidy

735.732 Confidentiality of information in enrollment applications; exchange of information with governmental agencies; use of Social Security numbers

735.734 Rules

735.736 Family Health Insurance Assistance Program Account

735.738 Reports of program operation

735.740 Sanctions for violation of program requirements; civil penalties

ESSENTIAL PROPERTY INSURANCE

735.005 Definitions for ORS 735.005 to 735.145. As used in ORS 735.005 to 735.145, unless the context requires otherwise:

(1) "Association" means the Oregon FAIR Plan Association created by ORS 735.045.

(2) "Board" means the board of directors of the association.

(3) “Essential property insurance” means insurance against direct loss to property as defined and limited in standard fire policies and extended coverage indorsements thereon, as approved by the Director of the Department of Consumer and Business Services, and insurance against the perils of vandalism and malicious mischief. “Essential property insurance” does not include automobile insurance or insurance on such types of manufacturing risks as may be excluded by the director.

(4) “Inspection bureau” means the person or persons designated by the association with the approval of the director to make inspections as required under ORS 731.418, 733.010 and 735.005 to 735.145 and to perform such other duties as may be authorized by the association.

(5) “Service insurer” means any insurer designated as such by the board.

(6) “Member insurer” means an insurer authorized to transact insurance in this state that writes any kind of essential property insurance.

(7) “Net direct written premiums” means direct gross premiums written in this state on insurance policies to which ORS 735.005 to 735.145 applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers.

(8) “Plan” means the plan of operation of the association established pursuant to ORS 735.085. [1971 c.321 §5; 1979 c.818 §2]

735.015 Purpose. The purpose of ORS 735.005 to 735.145 is:

(1) To assure stability in the property insurance market for certain property located in this state.

(2) To assure the availability of essential property insurance to the owners of insurable property.

(3) To encourage maximum use, in obtaining essential property insurance, of the normal insurance market provided by authorized insurers.

(4) To provide for the equitable distribution among authorized insurers of the responsibility for insuring certain insurable property for which essential property insurance cannot be obtained through the normal insurance market by the establishment of the Oregon FAIR Plan Association. [1971 c.321 §2]

735.025 Construction. ORS 735.005 to 735.145 shall be liberally construed to effect the purpose provided in ORS 735.015. [1971 c.321 §3]

735.035 Application. ORS 735.005 to 735.145 applies only to essential property insurance on domestic risks. [1971 c.321 §4]

735.045 Oregon FAIR Plan Association; insurers required to be members; plan of operation. There is hereby created the Oregon FAIR Plan Association. Each insurer that is a member insurer shall become and remain a member of the association as a condition of its authority to transact insurance in this state. The association shall perform its functions in accordance with a plan of operation established pursuant to ORS 735.085, and shall exercise its powers through its board of directors. [1971 c.321 §6]

735.055 Association board of directors; appointment; compensation, expenses of members; quorum. (1) The board of directors of the Oregon FAIR Plan Association shall consist of five members selected by the member insurers, subject to the approval of the Director of the Department of Consumer and Business Services, and four persons selected by the Governor, one of whom shall be an insurance agent holding an appointment as an Oregon agent of a member insurer. Of the other three persons appointed by the Governor, one shall be a resident of a county of over 400,000 population and none shall have been an employee or agent of a member insurer. The term of each member shall be as specified in the plan, but in no event for longer than four years. A vacancy on the board shall be filled for the remainder of the unexpired term in the same manner as for the initial selection.

(2) In making or approving selections to the board, the Director of the Department of Consumer and Business Services shall consider among other things whether member insurers are fairly represented.

(3) A member of the board shall receive no compensation for services as a member. However, a member shall be reimbursed from the assets of the association for actual and necessary travel and other expenses incurred by the member in the performance of duties.

(4) A majority of the members of the board constitutes a quorum for the transaction of business. [1971 c.321 §7; 1979 c.818 §2a]

735.065 Required association functions. (1) The Oregon FAIR Plan Association shall:

(a) Have authority on behalf of its members to arrange for the issuance of property insurance policies by service insurers and to reinsure any of those policies in whole or in part and to cede such reinsurance, subject to the plan.

(b) Assess member insurers the amounts necessary to pay the expenses incurred by the association in meeting its obligations and exercising its duties and powers under ORS 735.005 to 735.145.

(2) Except as provided in subsection (3)(a) and (b) of this section, the assessment of each member insurer for a particular calendar year shall be in the proportion that the net direct written premiums of the member insurer for the second preceding calendar year bears to the net direct written premiums of all member insurers for the second preceding calendar year. Each member insurer shall be notified of an assessment not later than the 30th day before the day it is due. If the funds of the association do not provide in any one year an amount sufficient to pay the expenses of the association, the funds available shall be prorated among the expenses and the unpaid portion shall be paid as soon thereafter as funds become available. If an assessment would cause a member insurer's financial statement to reflect an amount of surplus less than the minimum amount required for a certificate of authority by any jurisdiction in which the member insured is authorized to transact insurance, the association may, in whole or in part, exempt the member insurer from payment of the assessment or defer payments.

(3)(a) The maximum assessment of a member insurer for any calendar year shall be two percent of the insurer's net direct written premiums for the second preceding calendar year.

(b) The minimum assessment of a member insurer for any calendar year shall be \$50.

(4) Reimburse inspection bureaus, service insurers and employees of the association for expenses incurred in the inspection or insuring of property on behalf of the association, and pay all other expenses the association incurs in carrying out the provisions of ORS 735.005 to 735.145.

(5) Undertake a continuing public education program in cooperation with member insurers and agents to assure that the plan receives adequate attention.

(6) Undertake a continuing education program to advise the public of the steps which may be taken to make property more insurable against crime, personal liability and the perils named in ORS 735.005 (3). [1971 c.321 §8; 1979 c.818 §3]

735.075 Discretionary association functions. The Oregon FAIR Plan Association may:

(1) With the approval of the Director of the Department of Consumer and Business Services, employ or retain such persons and designate such inspection bureaus and service insurers as are necessary to handle applications, inspect and insure property and perform the other duties of the association.

(2) Borrow funds as necessary to carry out ORS 735.005 to 735.145 in such manner as may be specified in the plan.

(3) Sue or be sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out ORS 735.005 to 735.145.

(5) At the end of any calendar year, refund to member insurers, in proportion to each insurer's payments to the association, the amount by which the board of directors finds that the funds of the association exceed its current liabilities plus the liabilities estimated for the coming year.

(6) Perform such other acts as are necessary or proper to carry out ORS 735.005 to 735.145. [1971 c.321 §9]

735.085 Plan of operation; submission to director; approval of plan; compliance with plan. (1) The Oregon FAIR Plan Association shall submit to the Director of the Department of Consumer and Business Services, not later than September 7, 1971, a plan of operation, and may thereafter submit such amendments thereto as will provide for the reasonable and equitable exercise of the duties and powers of the association. The plan of operation, and any amendments thereto, shall become effective upon approval in writing by the director.

(2) If the association fails to submit a plan that receives the approval of the director as provided in subsection (1) of this section, or if the association after such approval fails to maintain a plan satisfactory to the director, the director shall by rule prescribe a plan of operation that meets the standards provided in subsection (1) of this section. A plan prescribed by the director shall remain in effect until the director by rule provides otherwise.

(3) No member insurer shall fail to comply with the currently effective plan. [1971 c.321 §10]

735.095 Contents of plan of operation. The plan shall:

(1) Establish procedures for the submission and processing of applications for insurance and the payment of claims for losses.

(2) Establish procedures for record keeping, payment of other expenses and administration of all other financial affairs of the Oregon FAIR Plan Association.

(3) Establish times and places for meetings of the board.

(4) Establish procedures for selection of members of the board and for approval of such selections by the Director of the Department of Consumer and Business Services.

(5) Establish a procedure for appeal to the director of final actions or decisions of the association.

(6) Establish such other procedures as may be necessary or proper to carry out the duties and powers of the association.

(7) Provide that the association shall file periodically with the director statements of the insurance provided through the association and estimates of anticipated claims against the association. [1971 c.321 §11; 1979 c.818 §4]

735.105 Regulation of association as insurer; financial report to director. The Oregon FAIR Plan Association is subject to regulation by the Director of the Department of Consumer and Business Services in the same manner as an insurer, to the extent determined by the director to be necessary to carry out the purpose of ORS 735.005 to 735.145. Not later than March 30 of each year the board shall submit to the director, in a form approved by the director, a financial report for the preceding calendar year. [1971 c.321 §12]

735.115 Exemption of association from fees and taxes. Except for taxes levied on real or personal property, the Oregon FAIR Plan Association shall be exempt from the payment of all fees and taxes levied by this state or by any city, county, district or other political subdivision of this state. [1971 c.321 §13]

735.125 [1971 c.321 §14; repealed by 1979 c.818 §5]

735.135 [1971 c.321 §15; repealed by 1979 c.818 §5]

735.145 Immunity from legal action in carrying out duties. No person shall have a cause of action against the Oregon FAIR Plan Association or its employees or servicing facilities, any member of the board, or the Director of the Department of Consumer and Business Services or the employees of the director for any action taken by them in carrying out ORS 735.005 to 735.145. [1971 c.321 §16]

MARKET ASSISTANCE PLANS; JOINT UNDERWRITING ASSOCIATIONS

735.200 Legislative findings; purpose. (1) The Legislative Assembly finds that:

(a) Some businesses and service providers in Oregon have experienced major problems in both the availability and affordability of commercial liability insurance. Premiums for such insurance policies have recently grown as much as 500 percent and the availability of such insurance in Oregon markets has greatly diminished.

(b) These businesses and service providers are essential to achieve goals such as increased workforce productivity, family self-sufficiency and the maintenance and improvement of the health of the citizens of Oregon. The lack of adequate commercial liability insurance threatens these businesses and services.

(2) The Legislative Assembly therefore declares it is the purpose of ORS 735.200 to 735.260 to remedy the problem of unavailable commercial liability insurance for these businesses and service providers by authorizing the Director of the Department of Consumer and Business Services to assist in the establishment of a market assistance plan for providing commercial liability insurance for these businesses and service providers, or, if necessary, by requiring all insurers authorized to write commercial liability insurance in Oregon to be members of one or more joint underwriting associations created to provide commercial liability insurance for these businesses and service providers. [1987 c.774 §73]

735.205 Definitions for ORS 735.200 to 735.260. As used in ORS 735.200 to 735.260:

(1) "Joint underwriting association" means a mechanism requiring casualty insurers doing business in Oregon to provide commercial liability insurance to certain businesses and service providers on either an assigned risk basis or through a joint underwriting pool underwritten to standards adopted under the Insurance Code.

(2) "Market assistance plan" means a mechanism through which admitted casualty insurers in this state provide commercial liability insurance for classes of risks designated by the Director of the Department of Consumer and Business Services. [1987 c.774 §74]

735.210 Formation of market assistance plans. (1) After a public hearing, the Director of the Department of Consumer and Business Services may by rule require insurers authorized to write and writing commercial liability insurance in this state to form a market assistance plan to assist businesses and service providers unable to purchase specified classes of commercial liability insurance in adequate amounts from either the admitted or nonadmitted market.

(2) The market assistance plan shall operate under a plan of operations prepared by admitted insurers, eligible surplus line insurers and agents, and approved by the director. [1987 c.774 §75]

735.215 Findings prior to formation of joint underwriting association; hearing. (1) The Director of the Department of Consumer and Business Services may mandate the formation of a joint underwriting association under ORS 735.220 if after directing the formation of a market assistance plan and allowing it a reasonable time to alleviate insurance availability problems, the director finds that:

(a) There exist in Oregon certain businesses or service providers for which no commercial liability insurance is available; and

(b) There is a need in Oregon for the goods or services provided by these businesses or service providers and the lack of available commercial liability insurance will cause a substantial number of the entities to cease operations within the state.

(2) Notwithstanding subsection (1) of this section, if the lack of availability of insurance is due to legitimate insurance underwriting considerations, including past claims experience, licensing noncompliance or inadequate risk management, formation of a joint underwriting association shall not be appropriate.

(3) The director may make the findings required under subsection (1) of this section only after conducting a public hearing according to the applicable provisions of ORS 183.310 to 183.550. The director must specify the specific classes of business or lines of insurance determined to be unavailable.

(4) At least once each year, the director shall hold a public hearing to determine if the classes of business or lines of insurance offered by the joint underwriting association are still unavailable in the voluntary insurance market. If any class or line is found to be available, the joint underwriting association shall cease to underwrite such class of business or line of insurance. [1987 c.774 §76]

735.220 Formation of joint underwriting association; funds. After finding under ORS 735.215 that there is a need in Oregon for a joint underwriting association, the Director of the Department of Consumer and Business Services may form and put into operation a temporary, nonprofit, nonexclusive joint underwriting association constituting a legal entity separate and distinct from its members for commercial liability insurance subject to the conditions and limitations contained in the Insurance Code. All funds and reserves of the association shall be separately held and invested. [1987 c.774 §77]

735.225 Membership in joint underwriting association. The joint underwriting association established under ORS 735.220 shall be comprised of all insurers authorized to write and who are writing commercial liability insurance within this state on a direct basis, including the commercial liability portions of multiperil policies. Every such insurer shall remain a member of the association as a condition of its authority to continue to transact insurance in this state. [1987 c.774 §78]

735.230 Rates; approval. The board of directors of the joint underwriting association shall engage the services of an independent actuarial firm to develop and recommend actuarially sound rates, rating plans, rating rules and classifications. The Director of the Department of Consumer and Business Services shall approve rates filed by the joint underwriting association in accordance with ORS 737.310. All rates approved for the joint underwriting association shall be actuarially sound and calculated to be self-supporting. [1987 c.774 §79]

735.235 Board of directors. The joint underwriting association formed under ORS 735.220 shall be under the administrative control of a seven person board of directors appointed by the Governor. Two directors shall represent insurance carriers participating in the association; one director shall represent insurance agents; three directors shall represent the affected classes of insureds; and one director shall be a public member with no ties to the insurance industry. The board shall elect one of its members as chairperson. [1987 c.774 §80]

735.240 Annual statement. The joint underwriting association shall file an annual statement prepared by an independent certified public accountant containing a financial statement, a summary of its transactions and operations for the prior year and other information as prescribed by the Director of the Department of Consumer and Business Services by rule. [1987 c.774 §81]

735.245 Conditions for policyholder surcharge. (1) Upon a determination of the board of directors that the joint underwriting association will be unable to pay its outstanding lawful obligations as they mature, the board shall certify the existence of this condition to the Director of the Department of Consumer and Business Services. A schedule for policyholder surcharges shall be submitted by the board at the time of certification.

(2) The surcharge schedule shall become final 30 days after certification unless the director finds, after a public hearing, that the surcharge amounts are unreasonable or unjustifiable. Such surcharges may be adjusted to take into consideration the past and prospective loss and expense experience in different geographical areas within the state. Such surcharges shall be in addition to and not in lieu of the premiums charged for the coverages provided.

(3) Moneys collected in accordance with subsection (2) of this section shall be held in a fund separate from other joint underwriting association funds. Such funds shall be invested in accordance with applicable law governing publicly held trust funds. The association shall file an annual financial statement covering such funds.

(4) Surcharge funds shall be subject to the control of the board of directors and may be used to satisfy the legal obligations of the joint underwriting association.

(5) No part of the profit or loss of the joint underwriting association shall inure to the benefit of any member insurer or be an obligation of any member insurer. [1987 c.774 §82]

735.250 Exemption from liability. There shall be no liability or cause of action against any member insurer, self-insurer, or its agents or employees, the joint underwriting association or its agents or employees, members of the board of directors, the Department of Consumer and Business Services or its representatives for any action taken by or statement made by them in performance of their powers and duties under ORS 735.210 to 735.260. [1987 c.774 §83]

735.255 State not liable to pay debts of association. The state is not liable to pay any debts or obligations of any association formed under ORS 735.220 and no person may assert any claim against the state or any of its agencies for any act or omission of the association. [1987 c.774 §84]

735.260 Rules. The Director of the Department of Consumer and Business Services may adopt all rules necessary to insure the efficient, equitable operation of the market assistance plan or the joint underwriting association, including but not limited to rules requiring or limiting certain policy provisions. [1987 c.774 §85]

735.265 Liquor liability insurance risk and rate classifications. If a market assistance plan is formed under ORS 735.210, or a joint underwriting association is formed under ORS 735.220, the Director of the Department of Consumer and Business Services shall by rule establish such liquor liability insurance risk and rate classifications as may be necessary to facilitate the availability and affordability of this commercial insurance product. Risk and rate classifications shall be established for all facets of the liquor industry including those who sell at wholesale or retail and the State of Oregon, as allowed by law. Risk classifications and rating plans shall be developed upon considerations including, but not limited to, the following factors:

- (1) Past loss experience and prospective loss experience of different license types.
- (2) Past loss experience and prospective loss experience in different geographic areas.
- (3) Prior claims experience of the individual licensee.
- (4) Prior compliance with public safety and alcoholic beverage laws, rules and ordinances pertaining to the sale and service of alcoholic beverages.
- (5) Evidence of responsible management policies including, but not limited to, procedures and actions which:
 - (a) Encourage persons not to become intoxicated if they consume alcoholic beverages on the licensee's premises;
 - (b) Promote availability of nonalcoholic beverages and food;
 - (c) Promote safe transportation alternatives to driving while intoxicated;
 - (d) Prohibit employees and agents of the licensee from consuming alcoholic beverages while acting in their capacity as employee or agent;
 - (e) Establish promotions and marketing efforts which publicize responsible business practices to the licensee's customers and community;

- (f) Implement comprehensive training procedures; and
 - (g) Maintain an adequate, trained number of employees and agents for the type and size of licensee's business.
- [1987 c.774 §88]

LIABILITY RISK RETENTION LAW

735.300 Purpose of ORS 735.300 to 735.365. The purpose of ORS 735.300 to 735.365 is to regulate the formation and operation of risk retention groups and purchasing groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 (P.L. 99-563). [1987 c.774 §98; 1989 c.700 §10]

735.305 Definitions for ORS 735.300 to 735.365. As used in ORS 735.300 to 735.365:

- (1) "Director" means the Director of the Department of Consumer and Business Services of this state or the commissioner, director or superintendent of insurance in any other state.
- (2) "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site that is not owned or controlled by any person who performs that work or by any person who hires an independent contractor to perform that work. The term also includes liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability.
- (3) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means:
 - (a) For a corporation, the state in which the purchasing group is incorporated; and
 - (b) For an unincorporated entity, the state of its principal place of business.
- (4) "Hazardous financial condition" means that a risk retention group, based on its present or reasonably anticipated financial conditions, although not yet financially impaired or insolvent, is unlikely to be able:
 - (a) To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or
 - (b) To pay other obligations in the normal course of business.
- (5) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance and any other arrangement for shifting and distributing risk that is determined to be insurance under the laws of this state.
- (6) "Liability":
 - (a) Means legal liability for damages, including costs of defense, legal costs and fees and other claims expenses, because of injuries to other persons, damage to their property or other damage or loss to such other persons resulting from or arising out of:
 - (A) Any business that is for-profit or not-for-profit, or any trade, product, premises, operations or services, including professional services; or
 - (B) Any activity of any state or local government, or any agency or political subdivision thereof.
 - (b) Does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq.).
- (7) "Personal risk liability" means liability for damages because of injury to any person, damage to property or other loss or damage resulting from any personal, familial or household responsibilities or activities, rather than from responsibilities or activities referred to in subsection (6) of this section.
- (8) "Plan of operation or a feasibility study" means an analysis that presents the expected activities and results of a risk retention group, and includes at a minimum:
 - (a) The coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer;
 - (b) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;
 - (c) Pro forma financial statements and projections;
 - (d) Appropriate opinions by a qualified independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and prevent a hazardous financial condition;
 - (e) Identification of management, underwriting procedures, managerial oversight methods and investment policies; and
 - (f) Other matters that the director requires for liability insurance companies authorized by the insurance laws of the state in which the risk retention group is chartered.
- (9) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage, including damages resulting from the loss of use of property, arising out the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product. The term

does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

(10) "Purchasing group" means any group that:

(a) Has as one of its purposes the purchase of liability insurance on a group basis;

(b) Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph (c) of this subsection;

(c) Is composed of members whose business or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and

(d) Is domiciled in any state.

(11) "Risk retention group" means any corporation or other limited liability association formed under the laws of any state:

(a) Whose primary activity consists of assuming and spreading all, or any portion of, the liability exposure of its group members;

(b) That is organized for the primary purpose of conducting the activity described in paragraph (a) of this subsection;

(c) That:

(A) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(B) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of that state. However, any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the federal Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986, before the date of the enactment of the federal Liability Risk Retention Act of 1986 (P.L. 99-563);

(d) That does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

(e) That:

(A) Has as its members only persons who have an ownership interest in the group and has as its owners only persons who are members that are provided insurance by the risk retention group; or

(B) Has as its sole member and sole owner an organization that is owned by persons who are provided insurance by the risk retention group;

(f) Whose members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

(g) Whose activities do not include the provision of insurance other than:

(A) Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(B) Reinsurance with respect to the liability of any other risk retention group, or any members of such other group, that is engaged in businesses or activities so that such group or member meets the requirement described in paragraph (f) of this subsection for membership in the risk retention group that provides such reinsurance; and

(h) The name of which includes "Risk Retention Group."

(12) "State" means any state of the United States or the District of Columbia. [1987 c.774 §99; 1993 c.744 §29]

735.310 Qualifications for risk retention group; plan of operation; application; notification to National Association of Insurance Commissioners. (1) A risk retention group seeking to be organized in this state:

(a) Must be organized as a liability insurer in this state and authorized by a subsisting certificate of authority issued by the director to transact liability insurance in this state, as provided in ORS chapter 732; and

(b) Except as otherwise provided in ORS 735.300 to 735.365, must comply with all laws, rules and other requirements applicable to such insurers authorized to transact insurance in this state and with ORS 735.315 to the extent the requirements under ORS 735.315 are not a limitation on other laws, rules or requirements of this state.

(2) Before a risk retention group may offer insurance in any state, the risk retention group shall submit for approval to the director of this state a plan of operation or a feasibility study and revisions of such plan or study if the group

intends to offer any additional lines of liability insurance.

(3) Immediately upon receipt of an application for organization, the director shall provide summary information concerning the filing to the National Association of Insurance Commissioners, including the name of the risk retention group, the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded and the states in which the group intends to operate. Providing notification to the National Association of Insurance Commissioners is in addition to and shall not be sufficient to satisfy the requirements of ORS 735.300 to 735.365. [1987 c.774 §100]

735.315 Foreign risk retention groups; conditions of doing business in Oregon; prohibited acts. Risk retention groups chartered in states other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state as follows:

(1) Before transacting insurance in this state, a risk retention group shall submit to the director:

(a) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, its date of chartering, its principal place of business and such information, including information on its membership, as the director may require to verify that the risk retention group is qualified under ORS 735.305 (11);

(b) A copy of its plan of operation or a feasibility study and revisions of such plan or study submitted to its state of domicile. The requirement of the submission of a plan of operation or a feasibility study shall not apply with respect to any line or classification of liability insurance that:

(A) Was defined in the federal Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986, before October 27, 1986; and

(B) Was offered before October 27, 1986, by any risk retention group that had been chartered and operating for not less than three years before October 27, 1986; and

(c) A statement of registration that designates the director as its agent for the purpose of receiving service of legal documents or process.

(2) A risk retention group doing business in this state shall submit to the director:

(a) A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist, under criteria established by the National Association of Insurance Commissioners;

(b) A copy of each examination of the risk retention group as certified by the director or public official conducting the examination;

(c) Upon request by the director, a copy of any audit performed with respect to the risk retention group; and

(d) Such information as may be required to verify its continuing qualification as a risk retention group under ORS 735.305 (11).

(3) A risk retention group is subject to taxation in this state as follows:

(a) All premiums paid for coverage within this state to risk retention groups shall be subject to taxation at the rate applicable to foreign admitted insurers and the taxes owing shall be subject to the same interest, fines and penalties for nonpayment as those applicable to foreign admitted insurers.

(b) To the extent agents or brokers are used, they shall report and pay the taxes for the premiums for the risks that they have placed with or on behalf of a risk retention group not organized in this state.

(c) To the extent agents or brokers are not used or fail to pay the tax, each risk retention group shall pay the tax for risks insured within the state. Further, each risk retention group shall report all premiums paid to it for risks insured within the state.

(4) A risk retention group and its agents and representatives shall comply with ORS 746.230 and 746.240. If the director seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

(5) A risk retention group must submit to an examination by the director to determine its financial condition if the director of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within 60 days after a request by the director of this state. Any such examination shall be coordinated to avoid unjustified repetition. Examinations may be conducted in accordance with the examiner handbook of the National Association of Insurance Commissioners.

(6) A policy issued by a risk retention group shall contain in 10 point type on the front page and the declaration

page, the following notice:

Notice

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and rules of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(7) The following acts by a risk retention group are prohibited:

(a) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

(b) The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

(8) No risk retention group shall be allowed to do business in this state if an insurer is directly or indirectly a member or owner of the risk retention group, other than in the case of a risk retention group all of whose members are insurers.

(9) No risk retention group may offer insurance policy coverage prohibited by the Insurance Code.

(10) A risk retention group not organized in this state and doing business in this state must comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the insurance commissioner of any state if there has been a finding of financial impairment after an examination under subsection (5) of this section. [1987 c.774 §101]

735.320 Relationship to insurance guaranty fund and joint underwriting association. (1) No risk retention group shall be permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state. No risk retention group, or its insureds, shall receive any benefit from any such fund for claims arising out of the operations of the risk retention group.

(2) A risk retention group shall participate in this state's joint underwriting associations and mandatory liability pools as provided by the Insurance Code. [1987 c.774 §102]

735.325 Exemption of purchasing groups from certain laws. Any purchasing group meeting the criteria established under the provisions of the federal Liability Risk Retention Act of 1986 (P.L. 99-563), shall be exempt from any law of this state relating to the creation of groups for the purchase of insurance or the prohibition of group purchasing, or any law that would discriminate against a purchasing group or its members. In addition, an insurer shall be exempt from any law of this state that prohibits providing or offering to provide advantages to a purchasing group or its members based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters. A purchasing group shall be subject to all other applicable laws of this state. [1987 c.774 §103]

735.330 Purchasing groups; notice of intent to do business; registration; exceptions. (1) A purchasing group that intends to do business in this state shall furnish notice to the director, which shall:

(a) Identify the state in which the group is domiciled;

(b) Specify the lines and classifications of liability insurance that the purchasing group intends to purchase;

(c) Identify the insurer from which the group intends to purchase its insurance and the domicile of the insurer;

(d) Identify the principal place of business of the group; and

(e) Provide such other information as may be required by the director to verify that the purchasing group is qualified under ORS 735.305 (10).

(2) The purchasing group shall register with the director and designate the director as its agent solely for the purpose of receiving service of legal documents or process, except that such requirements shall not apply in the case of a purchasing group that meets the following qualifications:

(a) That:

(A) Was domiciled before April 1, 1986, in any state; and

(B) Is domiciled on and after October 27, 1986, in any state;

(b) That:

- (A) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state; and
- (B) On and after October 27, 1986, purchased insurance from an insurance carrier licensed in any state;
- (c) That was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986, before October 27, 1986; and
- (d) That does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Risk Retention Act of 1981, as in effect before October 27, 1986. [1987 c.774 §104]

735.335 Purchase of insurance by purchasing group. A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of that state. [1987 c.774 §105]

735.340 Insurance Code enforcement authority subject to federal law. The director is authorized to make use of any of the powers established under the Insurance Code to enforce the laws of this state so long as those powers are not specifically preempted by the federal Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986. This includes, but is not limited to, the director's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders and impose penalties. With regard to any investigation, administrative proceedings or litigation, the director may rely on the procedural law and rules of the state. The injunctive authority of the director in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction. [1987 c.774 §106]

735.345 Violation of 735.300 to 735.365; penalties. A risk retention group that violates any provision of ORS 735.300 to 735.365 is subject to criminal and civil penalties applicable to insurers generally, and to suspension or revocation of its certificate of authority to transact insurance. [1987 c.774 §107]

735.350 Agent or broker; license. Any person acting or offering to act as an agent or broker for a risk retention group or purchasing group that solicits members, sells insurance coverage, purchases coverage for its members located within this state or otherwise does business in this state shall, before commencing any such activity, obtain a license as an agent from the director under ORS chapter 744. [1987 c.774 §108; 1989 c.701 §71]

735.355 Court orders enforceable in Oregon. An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance or operating in any state or in all states or in any territory or possession of the United States, upon a finding that such a group is in a hazardous financial condition shall be enforceable in the courts of this state. [1987 c.774 §109]

735.360 Rules. The director may adopt rules that the director determines are necessary for carrying out ORS 735.300 to 735.365. [1987 c.774 §110; 1989 c.700 §11]

735.365 Short title. ORS 735.300 to 735.365 shall be known and may be cited as the Oregon Liability Risk Retention Law. [1987 c.774 §98a]

SURPLUS LINES LAW

735.400 Purposes of ORS 735.400 to 735.495. ORS 735.400 to 735.495 shall be liberally construed and applied to promote its underlying purposes which include:

- (1) Protecting persons seeking insurance in this state;
- (2) Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state pursuant to ORS 735.400 to 735.495;
- (3) Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state; and
- (4) Protecting revenues of this state. [1987 c.774 §117]

735.405 Definitions for ORS 735.400 to 735.495. As used in ORS 735.400 to 735.495:

- (1) "Admitted insurer" means an insurer authorized to do an insurance business in this state.

- (2) "Capital" means funds paid in for stock or other evidence of ownership.
- (3) "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance.
- (4) "Export" means to place surplus lines insurance with a nonadmitted insurer.
- (5) "Insurance producer" has the meaning given that term in ORS 744.052.
- (6) "Kind of insurance" means one of the types of insurance required to be reported in the annual statement which must be filed with the Director of the Department of Consumer and Business Services by authorized insurers.
- (7) "Nonadmitted insurer" means an insurer not authorized to do an insurance business in this state. This definition shall include insurance exchanges as authorized under the laws of various states.
- (8) "Producing agent" means the individual agent dealing directly with the party seeking insurance.
- (9) "Surplus" means funds over and above liabilities and capital of the insurer for the protection of policyholders.
- (10) "Surplus lines licensee" means an agent licensed under ORS chapter 744 to place insurance on risks resident, located or to be performed in this state with nonadmitted insurers eligible to accept such insurance. [1987 c.774 §118; 1991 c.810 §25; 2001 c.191 §44a]

735.410 Conditions for procuring insurance through nonadmitted insurer. (1) Insurance may be procured through a surplus lines licensee from a nonadmitted insurer if:

- (a) The insurer is an eligible surplus lines insurer;
- (b) A diligent search has first been made among the insurers who are authorized to transact and are actually writing the particular kind and class of insurance in this state, and it is determined that the full amount or kind of insurance cannot be obtained from those insurers; and
- (c) All other requirements of ORS 735.400 to 735.495 are met.

(2) Subsection (1) of this section does not apply to a placement of surplus lines insurance outside this state by a nonresident surplus lines licensee or by a nonresident surplus lines insurance producer who is not licensed to transact surplus lines insurance in this state when the insurance covers a risk with exposures both in this state and outside this state, if both of the following conditions are met:

- (a) If the nonresident surplus lines licensee or insurance producer is licensed in the state as an insurance producer to transact surplus lines policies in the state in which the insurance is placed and is in good standing in that state; and
- (b) If the surplus lines policy complies with all of the requirements for placement of nonadmitted insurance in the state in which the insurance is placed.

(3) The Director of the Department of Consumer and Business Services by rule may establish requirements applicable to the placement of surplus lines insurance outside this state by a nonresident surplus lines licensee or by a nonresident surplus lines insurance producer who is not licensed in this state, when the insurance covers a risk with exposures both in this state and outside this state. The rules may include such matters as the procurement of surplus lines insurance, eligibility of the insurer, the conditions under which surplus lines insurance may be obtained, the necessary evidence of insurance, filing requirements and other matters necessary for regulation of surplus lines insurance transactions that affect risk exposures in this state. The rules may not interfere with or hinder implementation of the federal Gramm-Leach-Bliley Act (P.L. 106-102) with respect to licensing reciprocity among the states. [1987 c.774 §119; 2001 c.191 §44b]

735.415 Qualifications for placement of coverage with nonadmitted insurer. (1) A surplus lines licensee may not place any coverage with a nonadmitted insurer unless at the time of placement the nonadmitted insurer has done all of the following:

- (a) Established satisfactory evidence of good repute and financial integrity.
- (b) Qualified under one of the following subparagraphs:
 - (A) Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction that equals either the minimum capital and surplus requirements under the laws of this state or \$5 million, except that the requirements of this paragraph may be satisfied by an insurer possessing less than \$5 million capital and surplus upon an affirmative finding of acceptability by the Director of the Department of Consumer and Business Services. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends and company record and reputation within the industry. In no event shall the director make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than \$3 million.
 - (B) Except as otherwise provided in subparagraph (C) of this paragraph, an alien insurer qualifies under this

subsection if it maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, in an amount not less than \$1.5 million for the protection of all its policyholders in the United States and such trust fund consists of cash, securities, irrevocable letters of credit, or of investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this state. Such trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall have an expiration date which at no time shall be less than five years.

(C) In the case of a group of insurers that includes incorporated and individual unincorporated underwriters, maintains a trust fund of not less than \$50 million as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and such trust shall likewise comply with the terms and conditions established in subparagraph (B) of this paragraph for alien insurers, except that the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulators as are the unincorporated members.

(D) In the case of an insurance exchange created by the laws of individual states, maintains capital and surplus, or the substantial equivalent thereof, of not less than \$15 million in the aggregate. For insurance exchanges that maintain funds for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent thereof, of not less than \$1.5 million. In the event the insurance exchange does not maintain funds for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements of subparagraph (A) of this paragraph.

(c) Provided to the director no more than six months after the close of the period reported upon a certified copy of its current annual statement that is:

(A) Filed with and approved by the regulatory authority in the domicile of the nonadmitted insurer;

(B) Certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile; or

(C) In the case of an insurance exchange, an aggregate combined statement of all underwriting syndicates operating during the period reported.

(2) When a nonresident surplus lines licensee or nonresident surplus lines insurance producer who is not licensed to transact surplus lines insurance in this state places surplus lines insurance outside this state that covers a risk with exposures both in this state and outside this state, the licensee or insurance producer is not subject to the requirements of subsection (1) of this section if the nonadmitted insurer with which the coverage is placed:

(a) Meets the requirements for nonadmitted placement of insurance in the state in which the insurance is placed; or

(b) Is an authorized or admitted insurer in the state in which the insurance is placed. [1987 c.774 §120; 1995 c.99 §2; 2001 c.191 §44c]

735.420 Declaration of ineligibility of surplus lines insurer. (1) The Director of the Department of Consumer and Business Services may declare a surplus lines insurer described in ORS 735.415 (1) ineligible if the director has reason to believe that the surplus lines insurer:

(a) Is in unsound financial condition;

(b) Is no longer eligible under ORS 735.415;

(c) Has willfully violated the laws of this state; or

(d) Does not make reasonably prompt payment of just losses and claims in this state or elsewhere.

(2) The director shall promptly mail notice of all such declarations to each surplus lines licensee. [1987 c.774 §121; 2001 c.191 §44d]

735.425 Filing by licensee after placement of surplus lines insurance. (1) Within 90 days after the placing of any surplus lines insurance in this state, each surplus lines licensee shall file with the Director of the Department of Consumer and Business Services:

(a) An affidavit signed by the licensee regarding the insurance, which shall be kept confidential as provided in ORS 705.137, including the following:

(A) The name and address of the insured;

(B) The identity of the insurer or insurers;

(C) A description of the subject and location of the risk;

(D) The amount of premium charged for the insurance; and

(E) Such other pertinent information as the director may reasonably require.

(b) A statement on a standardized form furnished by the director, as to the diligent efforts by the producing agent to place the coverage with admitted insurers and the results thereof. The statement shall be signed by the producing agent and shall affirm that the insured was expressly advised prior to placement of the insurance that:

(A) The surplus lines insurer with whom the insurance was to be placed is not licensed in this state and is not subject to its supervision; and

(B) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

(2) The director may direct that filings required under subsection (1) of this section be made to the Surplus Lines Association of Oregon. The director may also require that such filings be made electronically but may exempt a licensee from the requirement for good cause shown.

(3) A nonresident surplus lines licensee or nonresident insurance producer who places a surplus lines policy on a risk with exposures located both in this state and outside this state shall satisfy filing requirements established by the director by rule. The director shall ensure that the rules facilitate interstate regulation of surplus lines insurance transactions. [1987 c.774 §122; 1993 c.182 §1; 2001 c.377 §§13,13a]

735.430 Surplus Lines Association of Oregon. (1) The Surplus Lines Association of Oregon shall be the advisory organization of surplus lines licensees to:

(a) Facilitate and encourage compliance by its members with the laws of this state and the rules of the Director of the Department of Consumer and Business Services relative to surplus lines insurance;

(b) Provide means for the examination, which shall remain confidential as provided in ORS 705.137, of all surplus lines coverage written by its members to determine whether such coverages comply with such laws;

(c) Communicate with organizations of admitted insurers with respect to the proper use of the surplus lines market;

(d) Receive and disseminate to its members information relative to surplus lines coverages; and

(e) Receive and collect on behalf of the state and remit to the state premium receipts tax for surplus lines insurance.

(2) The Surplus Lines Association of Oregon shall file with the director:

(a) A copy of its constitution, articles of agreement or association or certificate of incorporation;

(b) A copy of its bylaws and rules governing its activities;

(c) A current list of members;

(d) The name and address of a resident of this state upon whom notices or orders of the director or processes issued at the direction of the director may be served;

(e) An agreement that the director may examine the Surplus Lines Association of Oregon in accordance with the provisions of this section; and

(f) A schedule of membership fees and charges.

(3) The director may make or cause to be made an examination of the surplus lines advisory organization. The reasonable cost of any such examination shall be paid by the surplus lines advisory organization upon presentation to it by the director of a detailed account of each cost. The officers, managers, agents and employees of the surplus lines advisory organization may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The director shall furnish two copies of the examination report to the surplus lines advisory organization examined and shall notify such organization that it may, within 20 days thereof, request a hearing on the report or on any facts or recommendations therein. If the director finds the surplus lines advisory organization or any member thereof to be in violation of ORS 735.400 to 735.495, the director may issue an order requiring the discontinuance of such violation. [1987 c.774 §123; 2001 c.377 §14]

735.435 Evidence of insurance; contents; change; penalty; notice regarding Insurance Guaranty Association.

(1) Upon placing surplus lines insurance, the surplus lines licensee shall promptly deliver to the insured or the producing agent the policy, or if such policy is not then available, a certificate as described in subsection (4) of this section, cover note, binder or other evidence of insurance. The certificate, as described in subsection (4) of this section, cover note, binder or other evidence of insurance shall be executed by the surplus lines licensee and shall show the description and location of the subject of the insurance, coverages including any material limitations other than those in standard forms, a general description of the coverages of the insurance, the premium and rate charged and taxes to be collected from the insured, and the name and address of the insured and surplus lines insurer or insurers and proportion of the entire risk assumed by each, and the name of the surplus lines licensee and the licensee's license number.

(2) No surplus lines licensee shall issue or deliver any evidence of insurance or represent that insurance will be or

has been written by any eligible surplus lines insurer, unless the licensee has authority from the insurer to cause the risk to be insured, or has received information from the insurer in the regular course of business that such insurance has been granted.

(3) If, after delivery of any such evidence of insurance, there is any change in the identity of the insurers, or the proportion of the risk assumed by any insurer, or any other material change in coverage as stated in the surplus lines licensee's original evidence of insurance, or in any other material as to the insurance coverage so evidenced, the surplus lines licensee shall promptly issue and deliver to the insured or the original producing agent an appropriate substitute for, or indorsement of the original document, accurately showing the current status of the coverage and the insurers responsible thereunder.

(4) As soon as reasonably possible after the placement of any such insurance the surplus lines licensee shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producing agent to replace any evidence of insurance theretofore issued. Each certificate or policy of insurance shall contain or have attached thereto a complete record of all policy insuring agreements, conditions, exclusions, clauses, indorsements or any other material facts that would regularly be included in the policy.

(5) Any surplus lines licensee who fails to comply with the requirements of this section shall be subject to the penalties provided.

(6) Every evidence of insurance negotiated, placed or procured under the provisions of ORS 735.400 to 735.495 issued by the surplus lines licensee shall bear the name of the licensee and the following legend in bold type: "This is evidence of insurance procured and developed under the Oregon surplus lines laws. It is NOT covered by the provisions of ORS 734.510 to 734.710 relating to the Oregon Insurance Guaranty Association. If the insurer issuing this insurance becomes insolvent, the Oregon Insurance Guaranty Association has no obligation to pay claims under this evidence of insurance."

(7) The Director of the Department of Consumer and Business Services by rule may establish requirements relating to evidence of insurance and other applicable requirements governing placement of insurance by a nonresident surplus lines licensee outside this state that covers a risk with exposures located both in this state and outside this state. [1987 c.774 §124; 2001 c.191 §45a]

735.440 Validity of contracts. Insurance contracts procured under ORS 735.400 to 735.495 shall be valid and enforceable as to all parties. [1987 c.774 §125]

735.445 Effect of payment of premium to surplus lines licensee. A payment of premium to a surplus lines licensee acting for a person other than the surplus lines licensee in negotiating, continuing or renewing any policy of insurance under ORS 735.400 to 735.495 shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the policy or contract notwithstanding. [1987 c.774 §126]

735.450 Requirements for surplus lines insurance agent license. (1) A person shall not procure any contract of surplus lines insurance with any nonadmitted insurer unless the person is licensed under ORS chapter 744 as an agent authorized to transact property insurance, casualty insurance or both and is further authorized under the license to transact surplus lines insurance. The prohibition in this subsection does not apply to a nonresident surplus lines licensee or to a nonresident surplus lines producer who is not a licensee in this state if:

(a) The insurance contract covers a risk with exposures both in this state and outside this state;
(b) Procurement of the insurance contract described in paragraph (a) of this subsection did not occur in this state;
and

(c) The licensee or producer is licensed to transact surplus lines insurance in the state in which the insurance contract described in paragraph (a) of this subsection was procured.

(2) The Director of the Department of Consumer and Business Services may amend the license of an agent authorized to transact property insurance, casualty insurance or both to authorize the agent to transact insurance as a surplus lines agent if the agent has applied under ORS 744.063 to have the class of surplus lines insurance added to the agent license and has satisfied all requirements therefor under ORS 744.052 to 744.089. This subsection applies to resident and nonresident agents. [1987 c.774 §127; 1989 c.288 §1; 1991 c.810 §26; 1995 c.639 §14; 2001 c.191 §46]

735.455 Authority of licensee. A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other agent duly licensed as to the kinds of insurance involved, and the surplus lines licensee may compensate such agent therefor. [1987 c.774 §128]

735.460 Records of licensee; examination. (1) Each surplus lines licensee shall keep a full and true record of each surplus lines insurance contract placed by or through the licensee on each risk resident in this state as required by ORS 744.068, including a copy of the policy, certificate, cover note or other evidence of insurance showing any of the following items that are applicable:

- (a) Amount of the insurance and perils insured;
- (b) Brief description of the property insured and its location;
- (c) Gross premium charged;
- (d) Any return premium paid;
- (e) Rate of premium charged upon the several items of property;
- (f) Effective date of the contract and the terms thereof;
- (g) Name and address of the insured;
- (h) Name and address of the insurer;
- (i) Amount of tax and other sums to be collected from the insured; and
- (j) Identity of the producing agent, any confirming correspondence from the insurer or its representative and the application.

(2) The record of each contract shall be kept open at all reasonable times to examination by the Director of the Department of Consumer and Business Services without notice for a period not less than five years following termination of the contract. [1987 c.774 §129; 2001 c.191 §47]

735.465 Monthly reports. (1) On or before the end of each month, each surplus lines licensee shall file with the Director of the Department of Consumer and Business Services, as prescribed by the director, a verified report of all surplus lines insurance transacted on risks resident in this state during the preceding 90 days. The report need not show transacted surplus lines insurance that was reported in an earlier report. The report shall show:

- (a) Aggregate gross premiums written;
- (b) Aggregate return premiums; and
- (c) Amount of aggregate tax.

(2) The director may direct that reports required under subsection (1) of this section be made to the Surplus Lines Association of Oregon and that the Surplus Lines Association of Oregon file a combined report thereof with the director. The director may also require that reports required under subsection (1) of this section be made electronically but may exempt a licensee from the requirement for good cause shown.

(3) For the purpose of collecting taxes on insurance covering the Oregon portion of risks when the insurance is placed outside this state and covers a risk with exposures located both in this state and outside this state, the director may establish by rule requirements for filing reports on surplus lines insurance transacted outside this state on risks with exposures located both in this state and outside this state. [1987 c.774 §130; 2001 c.191 §48]

735.470 Premium tax; collection; payment; refund; rules. (1) The surplus lines licensee shall pay the Director of the Department of Consumer and Business Services an amount equal to the tax which would have been imposed under ORS 731.816 (1993 Edition) if that section were in effect and operative, and the tax which is imposed by ORS 731.820, on authorized insurers for the premiums shown in the report required by ORS 735.465. The tax shall be collected by the surplus lines licensee as specified by the director, in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing agent, if any. The surplus lines licensee is prohibited from absorbing such tax and from rebating for any reason, any part of such tax.

(2) The surplus lines tax is due quarterly on the 45th day following the calendar quarter in which the premium is collected. The tax shall be paid to and reported on forms prescribed by the director or upon the director's order paid to and reported on forms prescribed by the surplus lines association.

(3) Notwithstanding subsection (2) of this section, if a surplus lines license is terminated or nonrenewed for any reason, the taxes described in this section are due on the 30th day after the termination or nonrenewal.

(4) In applying ORS 731.816 (1993 Edition) for purposes of this section, the rate shall be two percent rather than two and one-quarter percent.

(5) The director by rule shall establish procedures for payment of taxes on the Oregon portion of risks covered by surplus lines insurance policies transacted outside this state that cover risks with exposures both in this state and

outside this state. [1987 c.774 §131; 1989 c.288 §2; 1995 c.786 §10; 2001 c.191 §48a]

735.475 Suit to recover unpaid tax. If the tax collectible by a surplus lines licensee under ORS 735.400 to 735.495 is not paid within the time prescribed, the same shall be recoverable in a suit brought by the Director of the Department of Consumer and Business Services against the surplus lines licensee. [1987 c.774 §132; 1989 c.288 §3; 2001 c.191 §48b]

735.480 Suspensions or revocation of license; refusal to renew; grounds. The Director of the Department of Consumer and Business Services may suspend, revoke or refuse to renew the license of a surplus lines licensee after notice and hearing as provided under the applicable provision of this state's laws upon any one or more of the following grounds:

- (1) Removal of the surplus lines licensee's office from this state, if the licensee is a resident agent;
- (2) Removal of the surplus lines licensee's office accounts and records from the principal place of business of the licensee under ORS 744.068 during the period during which such accounts and records are required to be maintained under ORS 735.460;
- (3) Closing of the surplus lines licensee's office for a period of more than 30 business days, unless permission is granted by the director;
- (4) Failure to make and file required reports;
- (5) Failure to transmit required tax on surplus lines premiums;
- (6) Violation of any provision of ORS 735.400 to 735.495; or
- (7) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under ORS 744.074. [1987 c.774 §133; 1989 c.288 §4; 2001 c.191 §49]

735.485 Actions against surplus lines insurer. (1) A surplus lines insurer may be sued upon any cause of action arising in this state under any surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus lines licensee pursuant to the procedure provided in ORS 735.490. Any surplus lines policy issued by the surplus lines licensee shall contain a provision stating the substance of this section and designating the person to whom process shall be delivered.

(2) Each surplus lines insurer assuming surplus lines insurance shall be considered thereby to have subjected itself to ORS 735.400 to 735.495.

(3) The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers.

(4) A surplus lines insurance contract covering risks with exposures both in this state and outside this state that is placed outside this state by a nonresident surplus lines licensee, and the surplus lines insurer of the contract, are not subject to the provisions of subsection (2) of this section or ORS 735.490:

(a) If the nonresident surplus lines licensee is currently licensed as an insurance producer authorized to transact surplus lines insurance contracts in the state in which the surplus lines insurance contract is placed and is in good standing in that state; and

(b) If the surplus lines insurance contract complies with all of the requirements for placement of nonadmitted insurance in the state in which the surplus lines insurance contract is placed.

(5) When a nonresident surplus lines insurance producer who is not a surplus lines licensee in this state transacts outside this state a surplus lines insurance contract covering risks with exposures both in this state and outside this state, the producer and the surplus lines insurer of the contract are subject to this section and to ORS 735.490 or to rules adopted by the director in lieu thereof unless:

(a) The producer is currently licensed to transact surplus lines policies in the state in which the surplus lines insurance contract is placed and is in good standing in that state; and

(b) The surplus lines insurance contract complies with all of the requirements for placement of nonadmitted insurance in the state in which the surplus lines insurance contract is placed. [1987 c.774 §134; 1989 c.288 §5; 2001 c.191 §49a]

735.490 Jurisdiction in action against insurer; service of summons and complaint; response. (1) An insurer transacting insurance under the provisions of ORS 735.400 to 735.495 may be sued upon any cause of action, arising under any policy of insurance so issued and delivered by it, in the courts for the county where the agent who registered or delivered such policy resides or transacts business, by the service of summons and complaint made upon such agent

for such insurer.

(2) Any such agent served with summons and complaint in any such cause shall forthwith mail the summons and complaint, or a true and complete copy thereof, by registered or certified mail with proper postage affixed and properly addressed, to the insurer being sued.

(3) The insurer shall have 40 days from the date of the service of the summons and complaint upon such agent in which to plead, answer or defend any such cause.

(4) Upon service of summons and complaint upon such agent for such insurer, the court in which the action is begun shall be deemed to have duly acquired personal jurisdiction of the defendant insurer so served.

(5) An insurer and policyholder may agree to waive the provisions of subsections (1) to (4) of this section governing service and venue with respect to a surplus lines insurance contract for commercial property and casualty risk if the waiver is specifically referred to in the contract or in an indorsement attached to the contract. [1987 c.774 §137; 2001 c.191 §49b]

735.495 Short title; severability. (1) ORS 735.400 to 735.495 shall be known and may be cited as “The Oregon Surplus Lines Law.”

(2) If any provisions of ORS 735.400 to 735.495, or the application of such provision to any person or circumstance, is held invalid, the remainder of ORS 735.400 to 735.495 and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected. [1987 c.774 §§116,136]

MEDICAL INSURANCE POOL

735.600 Legislative intent. The intent of the Legislative Assembly in enacting ORS 735.600 to 735.650 is to provide access to medical insurance coverage to all residents of this state who are denied adequate medical insurance, while at the same time avoiding undue financial impact on the state and on private insurers. [1987 c.838 §2]

735.605 Definitions for ORS 735.600 to 735.650. As used in ORS 735.600 to 735.650:

(1) “Benefits plan” means the coverages to be offered by the pool to eligible persons pursuant to ORS 735.600 to 735.650.

(2) “Board” means the Oregon Medical Insurance Pool Board.

(3) “Insured” means any individual resident of this state who is eligible to receive benefits from any insurer.

(4) “Insurer” means:

(a) Any insurer as defined in ORS 731.106 or fraternal benefit society as defined in ORS 748.106 required to have a certificate of authority to transact health insurance business in this state, and any health care service contractor as defined in ORS 750.005 (2), issuing medical insurance in this state on or after September 27, 1987.

(b) Any reinsurer reinsuring medical insurance in this state on or after September 27, 1987.

(c) To the extent consistent with federal law, any self-insurance arrangement covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state on or after September 27, 1987.

(d) All self-insurance arrangements not covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state on or after September 27, 1987.

(5) “Medical insurance” means any health insurance benefits payable on the basis of hospital, surgical or medical expenses incurred and any health care service contractor subscriber contract. Medical insurance does not include accident only, disability income, hospital confinement indemnity, dental or credit insurance, coverage issued as a supplement to liability insurance, coverage issued as a supplement to Medicare, insurance arising out of a workers’ compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(6) “Medicare” means coverage under both part A and part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(7) “Plan of operation” means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to ORS 735.600 to 735.650.

(8) “Pool” means the Oregon Medical Insurance Pool as created by ORS 735.610.

(9) “Reinsurer” means any insurer as defined in ORS 731.106 from whom any person providing medical insurance to Oregon insureds procures insurance for itself in the insurer, with respect to all or part of the medical insurance risk

of the person.

(10) "Self-insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide health care services or benefits to their employees or members in this state, either directly or indirectly through a trust or third party administrator, unless the health care services or benefits are provided by an insurance policy issued by an insurer other than a self-insurance arrangement. [1987 c.838 §3; 1989 c.838 §6]

735.610 Oregon Medical Insurance Pool Board; members; authority; rules. (1) There is created in the Department of Consumer and Business Services the Oregon Medical Insurance Pool Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.

(2) The board shall consist of nine individuals, eight of whom shall be appointed by the Director of the Department of Consumer and Business Services. The Director of the Department of Consumer and Business Services or the director's designee shall be a member of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, one representative of reinsurers and two members of the general public who are not associated with the medical profession, a hospital or an insurer.

(3) The director may fill any vacancy on the board by appointment.

(4) The board shall have the general powers and authority granted under the laws of this state to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 735.600 to 735.650 including the authority to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Recover any assessments for, on behalf of, or against insurers;

(c) Take such legal action as is necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates may not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of ORS 735.600 to 735.650;

(f) Appoint from among insurers appropriate actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the board;

(g) Seek advances to effect the purposes of the pool; and

(h) Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to 735.650.

(5) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(6) The Director of the Department of Consumer and Business Services shall adopt rules, as provided under ORS 183.310 to 183.550, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650.

(7) In consultation with the board, the director shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650. [1987 c.838 §4; 1989 c.838 §7; 1993 c.744 §190; 1995 c.79 §361; 2001 c.356 §1]

735.612 Oregon Medical Insurance Pool Account; sources; uses. (1) There is established in the State Treasury, the Oregon Medical Insurance Pool Account, which shall consist of:

(a) Moneys appropriated to the account by the Legislative Assembly to obtain the coverage described in ORS 735.625.

(b) Interest earnings from the investment of moneys in the account.

(c) Assessments and other revenues collected or received by the Oregon Medical Insurance Pool Board.

(2) All moneys in the Oregon Medical Insurance Pool Account are continuously appropriated to the Oregon Medical Insurance Pool Board to carry out the provisions of ORS 735.600 to 735.650.

(3) The Oregon Medical Insurance Pool Board shall transfer to the Consumer and Business Services Fund created by ORS 705.145 an amount equal to the operating budget authorized by the Legislative Assembly or as that budget may be modified by the Emergency Board or the Oregon Department of Administrative Services, for operation of the Oregon Medical Insurance Pool Board. [1989 c.838 §§2,3; 1993 c.744 §191]

735.614 Assessments for expenses of pool. (1) If the Oregon Medical Insurance Pool Board determines at any time that funds in the Oregon Medical Insurance Pool Account are or will become insufficient for payment of expenses of the pool in a timely manner, the board shall determine the amount of funds needed and shall impose and collect assessments against insurers, as provided in this section, in the amount of the funds determined to be needed.

(2) Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of Oregon insureds and certificate holders insured or reinsured by each insurer, and the denominator of which equals the total of all Oregon insureds and certificate holders insured or reinsured by all insurers, all determined as of the end of the prior calendar year.

(3) The board shall ensure that each insured and certificate holder is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains reinsurance for its insureds and certificate holders to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or part. The board shall allow an insurer who is a reinsurer to exclude from its number of insureds those that have been counted by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection.

(4) Each insurer shall pay its assessment as required by the board.

(5) If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future net losses or to reduce pool premiums. For purposes of this subsection, future net losses include reserves for incurred but not reported claims.

(6) Each insurer's proportion of participation in the pool shall be determined by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board. The board may use any reasonable method of estimating the number of insureds and certificate holders of an insurer if the specific number is unknown. With respect to insurers that are reinsurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer.

(7) The board may abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this section. The insurer receiving the abatement or deferment shall remain liable to the board for the deficiency for four years.

(8) The board shall abate or defer assessments authorized by this section if a court orders that assessments cannot be made applicable to reinsurers. However, if a court orders that assessments cannot be made applicable to reinsurers, the board may continue to assess insurers to the end of the biennium in which the determination is made.

(9)(a) Subject to the approval of the Director of the Department of Consumer and Business Services, the board shall develop a program for adjusting the assessment of an insurer in the individual health benefits market based on that insurer's contribution to reducing the enrollment in the Oregon Medical Insurance Pool. The program shall include criteria that provide for an insurer's assessment to be reduced by a percentage, up to and including elimination of the entire assessment, that correlates to the insurer's level of participation, level of health benefit plan coverage offered and assumption of risk in the individual health benefits market.

(b) Subject to the approval of the director, the board shall develop an interim program for adjusting by a fixed percentage the assessments of an insurer that continues to participate actively in the individual health benefits market until such time as the director approves a permanent adjustment program under paragraph (a) of this subsection. [1989 c.838 §4; 1991 c.333 §1; 1995 c.603 §28]

735.615 Eligibility for pool coverage. (1) Except as provided in subsection (3) of this section, any individual person who is a resident of this state, as defined by the Oregon Medical Insurance Pool Board, shall be eligible for pool coverage if:

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made within a time

frame established by the board an adverse underwriting decision, as defined in ORS 746.600 (1), on individual medical insurance for health reasons while the person was a resident;

(b) The person has a history of any medical or health conditions on the list adopted by the board under subsection (2) of this section; or

(c) The person is a spouse or dependent of a person described in this subsection.

(2) The board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for individual medical insurance pursuant to this section.

(3) A person is not eligible for coverage under ORS 735.600 to 735.650 if:

(a) Except as provided in ORS 735.625 (3)(b), the person is eligible for health care benefits under ORS chapter 414 that exceed those adopted by the board or is eligible for Medicare;

(b) The person has terminated coverage in the pool within the last 12 months and the termination was for a reason other than becoming eligible for health care benefits under ORS chapter 414;

(c) The board has paid out \$1 million in benefits on behalf of the person;

(d) The person is an inmate of or a patient in a public institution named in ORS 179.321;

(e) The person has, on the date of issue of coverage by the board, coverage under health insurance or a self-insurance arrangement which is substantially equivalent to coverage under ORS 735.625; or

(f) The person has the premiums paid or reimbursed by a public entity or a health care provider for the sole purpose of reducing the financial loss or obligation of the payer.

(4) A person applying for coverage shall establish initial eligibility by such evidence as the plan of operation shall require.

(5)(a) Notwithstanding ORS 735.625 (4)(c) and subsection (3)(a) of this section, if a person becomes eligible for Medicare after being enrolled in the pool for a period of time as determined by the board by rule, that person may continue coverage within the pool as secondary coverage to Medicare.

(b) The board may adopt rules concerning the terms and conditions for the coverage provided under paragraph (a) of this subsection. [1987 c.838 §5; 1989 c.838 §11; 1993 c.130 §1; 1993 c.212 §1; 1999 c.754 §1]

735.616 Eligibility for portability coverage under pool. (1) In addition to individuals otherwise qualified under ORS 735.615, the following individuals qualify for portability health insurance coverage under the Oregon Medical Insurance Pool if an application for coverage is made not later than the 63rd day after the date of first eligibility, as provided in subsection (2) of this section, and the individual is an Oregon resident at the time of such application:

(a) An individual who has left coverage that was continuously in effect for a period of 180 days or more under one or more group health benefit plans, if:

(A) The terminated coverage was in a plan issued or established in a state other than Oregon; and

(B) The individual was an Oregon resident for at least 180 consecutive days immediately prior to the termination of coverage;

(b) An eligible individual, as defined in ORS 743.760, who has left coverage under a group health benefit plan or a portability health benefit plan and whose carrier cannot offer a portability plan under ORS 743.760 (6) because of:

(A) A change in residence of the eligible individual within Oregon;

(B) A change in the geographic area served by the group carrier; or

(C) The carrier's withdrawal from the group market in Oregon in accordance with ORS 743.737 and 743.754;

(c) An individual who has left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans and the terminated coverage was provided by:

(A) An employee welfare benefit plan that is exempt from state regulation under the federal Employee Retirement Income Security Act of 1974, as amended;

(B) A multiple employer welfare arrangement subject to ORS 750.301 to 750.341; or

(C) A public body of this state in accordance with ORS 731.036; and

(d) On or after January 1, 1998, an individual who meets the eligibility requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1, 1998, and does not otherwise qualify to obtain portability coverage from an Oregon group carrier in accordance with ORS 743.760.

(2) Eligibility for coverage pursuant to subsection (1) of this section is subject to the following provisions:

(a) An eligible individual does not include:

(A) An individual who remains eligible for the individual's prior group coverage or would remain eligible for prior group coverage in a plan under the federal Employee Retirement Income Security Act of 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual;

(B) An individual who is covered under another health benefit plan at the time that portability coverage would commence;

(C) An individual who is eligible to enroll in another health benefit plan offered by the employer, other than as a late enrollee, at the time that portability coverage would commence; or

(D) An individual who is eligible for the federal Medicare program.

(b) If an eligible individual has left group coverage issued by an insurance company, a health care service contractor or a health maintenance organization, the date of first eligibility is the day following the termination date of the group coverage, including any period of continuation coverage that was elected by the individual under federal law or under ORS 743.600 or 743.610.

(c) If an eligible individual has left group coverage issued by an entity other than an insurance company, a health care service contractor or a health maintenance organization, the date of first eligibility is the day following the termination date of the group coverage, including the full extent of continuation coverage available to the individual under federal law and ORS 743.600 and 743.610.

(d) If an individual is eligible for coverage pursuant to subsection (1)(b) of this section, the date of first eligibility is the day following the loss of the group or portability coverage.

(3) Coverage under the Oregon Medical Insurance Pool pursuant to subsection (1) of this section shall be offered according to the following provisions:

(a) Coverage is subject to ORS 743.760 (2) and (8);

(b) Coverage may not be subject to a preexisting conditions provision, exclusion period, waiting period, residency period or other similar limitation on coverage; and

(c) The individual shall be required to pay a premium rate not more than the applicable portability risk rate determined by the Oregon Medical Insurance Pool Board pursuant to ORS 735.625. [Formerly 743.763; 1999 c.987 §1; 2001 c.356 §2]

735.620 Administering insurer; selection; duties. (1) The Oregon Medical Insurance Pool Board shall select an insurer or insurers through a competitive bidding process to administer the insurance program. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) The insurer's proven ability to handle individual medical insurance.

(b) The efficiency of the insurer's claim paying procedures.

(c) An estimate of total charges for administering the plan.

(d) The insurer's ability to administer the pool in a cost-effective manner.

(2)(a) The administering insurer shall serve for a period of three years subject to removal for cause.

(b) At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(3) The administering insurer shall:

(a) Perform all eligibility and administrative claims payment functions relating to the pool.

(b) Establish a premium billing procedure for collection of premiums from insured persons on a periodic basis as determined by the board.

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(A) Making available information relating to the proper manner of submitting a claim for benefits and distributing forms upon which submission shall be made.

(B) Evaluating the eligibility of each claim for payment.

(d) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board.

(e) Following the close of each calendar year, determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board on a form as prescribed by the board.

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services. [1987 c.838 §6; 1989 c.838 §12]

735.625 Coverage; rules. (1) Except as provided in subsection (3)(b) of this section, the Oregon Medical

Insurance Pool Board shall offer major medical expense coverage to every eligible person.

(2) The coverage to be issued by the board, its schedule of benefits, exclusions and other limitations, shall be established through rules adopted by the board, taking into consideration the advice and recommendations of the pool members. In the absence of such rules, the pool shall adopt by rule the minimum benefits prescribed by section 6 (Alternative 1) of the Model Health Insurance Pooling Mechanism Act of the National Association of Insurance Commissioners (1984).

(3)(a) In establishing the pool coverage, the board shall take into consideration the levels of medical insurance provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be equivalent to the portability health benefit plans established under ORS 743.760.

(b) The board may provide a separate Medicare supplement policy for individuals under the age of 65 who are receiving Medicare disability benefits. The board shall adopt rules to establish benefits, deductibles, coinsurance, exclusions and limitations, premiums and eligibility requirements for the Medicare supplement policy.

(4)(a) Premiums charged for coverages issued by the board may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

(c) The board shall determine the applicable medical and portability risk rates either by calculating the average rate charged by insurers offering coverages in the state comparable to the pool coverage or by using reasonable actuarial techniques. The risk rates shall reflect anticipated experience and expenses for such coverage. Rates for pool coverage may not be more than 125 percent of rates established as applicable for medically eligible individuals or 100 percent of rates established as applicable for portability eligible individuals.

(d) The board shall annually determine adjusted benefits and premiums. Such adjustments will be in keeping with the purposes of ORS 735.600 to 735.650, subject to a limitation of keeping pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member self-insurance arrangements. The board may determine the total number of persons that may be enrolled for coverage at any time and may permit and prohibit enrollment in order to maintain the number authorized. Nothing in this paragraph authorizes the board to prohibit enrollment for any reason other than to control the number of persons in the pool.

(5)(a) Pool coverage may not exclude coverage for a period exceeding six months following the effective date of coverage of an insured pursuant to a preexisting conditions provision or impose a waiting period longer than 90 days.

(b) In determining whether a preexisting conditions provision applies to an eligible enrollee, except as provided in this subsection, the board shall credit the time the eligible enrollee was covered under a previous health benefit plan if the previous health benefit plan was continuous to a date not more than 63 days prior to the effective date of the new coverage under the Oregon Medical Insurance Pool, exclusive of any applicable waiting period. The Oregon Medical Insurance Pool Board need not credit the time for previous coverage to which the insured or dependent is otherwise entitled under this subsection with respect to benefits and services covered in the pool coverage that were not covered in the previous coverage.

(6) For purposes of this section, a "preexisting conditions provision" means a provision that excludes coverage for services, charges or expenses incurred during a specified period not to exceed six months following the insured's effective date of coverage, for a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the insured's effective date of coverage.

(7)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid.

(b) The board shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(8) Except as provided in ORS 735.616, no mandated benefit statutes apply to pool coverage under ORS 735.600 to 735.650.

(9) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care. [1987 c.838 §8; 1989 c.838 §13; 1993 c.130 §2; 1995 c.603 §27; 1999 c.987 §2; 2001 c.356 §3]

735.630 Exemption from liability. Neither participation in the pool as members, the establishment of rates, forms or procedures, nor any other action taken in the performance of the powers and duties under ORS 735.600 to 735.650 shall be the basis of any legal action, criminal or civil liability or penalty against the Oregon Medical Insurance Pool Board, any members, the Director of the Department of Consumer and Business Services or any of their agents or employees. [1987 c.838 §9; 1989 c.838 §14]

735.635 Exemption from taxation. The pool established pursuant to ORS 735.600 to 735.650 shall be exempt from any and all taxes assessed by the State of Oregon. [1987 c.838 §10; 1989 c.838 §15]

735.640 Study; adjustment of operation and benefits plans. After two years of operation of the pool, and every two years thereafter, the Oregon Medical Insurance Pool Board shall conduct a study of the pool and adjust the plan of operation and benefits plan to reflect the findings of the study. The board may also recommend amendments to ORS 735.600 to 735.650 and other statutes as necessary to the Legislative Assembly to address the claims loss experience of the pool. [1987 c.838 §12; 1989 c.838 §16]

735.645 Notice of existence of pool. On and after the date the pool becomes operational, every insurer shall include a notice of the existence of the Oregon Medical Insurance Pool in any adverse underwriting decision on individual medical insurance, as defined in ORS 735.615 (1)(a), for reasons of the health of the applicant. [1987 c.838 §13; 1989 c.838 §17; 1993 c.130 §3]

735.650 Application of provisions of Insurance Code. (1) The following provisions of the Insurance Code shall apply to the pool to the extent applicable and not inconsistent with the express provisions of ORS 735.600 to 735.650: ORS 731.004 to 731.022, 731.052 to 731.146, 731.162, 731.216 to 731.328, 742.023, 742.028, 742.046, 742.051, 742.056, 743.024, 743.027, 743.028, 743.041, 743.050, 743.100 to 743.106, 743.402, 743.707, 743.721, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.809, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.834, 743.837, 743.839, 743.845, 746.005 to 746.370 and 746.600 to 746.690.

(2) For the purposes of this section only, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance and pool coverage contracts shall be deemed policies. [1987 c.838 §14; 1989 c.701 §72; 1989 c.838 §18; 1999 c.987 §3; 2001 c.356 §4]

HEALTH INSURANCE POOL

(Generally)

735.700 Definitions for ORS 735.700 to 735.740. As used in ORS 735.700 to 735.740, unless the context requires otherwise:

(1) “Board” means the Insurance Pool Governing Board established under ORS 735.704.

(2) “Carrier” means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation.

(3) “Class of employee” means an employee classed as either management or nonmanagement employee.

(4) “Eligible employee” means an employee of an employer who is employed by the employer for an average of at least 17.5 hours per week who elects to participate in one of the group benefit plans provided through board action, and sole proprietors, business partners, and limited partners. The term does not include individuals:

(a) Engaged as independent contractors.

(b) Whose periods of employment are on an intermittent or irregular basis.

(c) Who have been employed by the employer for fewer than 90 days.

(5) “Family member” means an eligible employee’s spouse and any unmarried child or stepchild within age limits and other conditions imposed by the board with regard to unmarried children or stepchildren.

(6) “Health benefit plan” means a contract for group medical, surgical, hospital or any other remedial care recognized by state law and related services and supplies.

(7) “Premium” means the monthly or other periodic charge for a health benefit plan. [Formerly 653.705]

Note: 735.700 to 735.740 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 735 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

735.702 Policy. It is the intent of the Legislative Assembly by enactment of ORS 735.700 to 735.740 to increase access to health insurance and health care by providing:

- (1) Information about health benefit plans and the premiums charged for those plans to self-employed individuals and small employers in Oregon;
- (2) Direct assistance to health insurance agents and health insurance consumers regarding health benefit plans;
- (3) A central source for information about resources for health care and health insurance; and
- (4) Health benefit plans for small employers that have not provided a group health benefit plan for eligible employees for a period of at least one year. [Formerly 653.715]

Note: See note under 735.700.

735.704 Insurance Pool Governing Board; qualifications; term; vacancies. (1) There is established an Insurance Pool Governing Board consisting of seven voting members six of whom shall be appointed by the Governor. Of the members appointed by the Governor, two shall be employers and one shall be an employee representing organized labor. At least two shall be knowledgeable about insurance but who are not officers or employees of a carrier and not consultants to a carrier or contractor. The Director of the Department of Consumer and Business Services shall appoint a consumer representative who shall serve as a voting member.

(2) The term of office of each member is three years, but a voting member serves at the pleasure of the appointing authority. Before the expiration of the term of a member, the appointing authority shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective for the unexpired term.

(3) The appointing authority shall not allow any position on the board to remain vacant for more than 60 days after the vacancy occurs. [Formerly 653.725]

Note: See note under 735.700.

735.706 Insurance Pool Governing Board Account. The Insurance Pool Governing Board Account is established separate and distinct from the General Fund. All moneys received by the Insurance Pool Governing Board, other than appropriations from the General Fund and except for moneys in the account established by ORS 735.736, shall be deposited into the account and are continuously appropriated to the board to carry out the duties, functions and powers of the board. [2001 c.716 §16]

Note: See note under 735.700.

735.708 Expenses; chairperson; quorum; meetings; rules. (1) A member of the Insurance Pool Governing Board shall not be compensated but is entitled to reimbursement for expenses as provided in ORS 292.495 (2).

(2) The board shall select one of its voting members as chairperson and one of its voting or nonvoting members as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(3) A majority of the members of the board constitutes a quorum for the transaction of business.

(4) The board shall meet at least once every three months at a place, day and hour determined by the board. The board also shall meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(5) In accordance with applicable provisions of ORS 183.310 to 183.550, the board may adopt rules necessary for the administration of the laws that the board is charged with administering. [Formerly 653.735]

Note: See note under 735.700.

735.710 Board duties. (1) In carrying out its duties under ORS 735.700 to 735.740, the Insurance Pool Governing Board shall:

- (a) Enter into contracts for administration of ORS 735.700 to 735.740 including collection of premiums and paying carriers.
 - (b) Retain consultants and employ staff.
 - (c) Enter into contracts with carriers or health care providers for health benefit plans, including contracts where final payment may be reduced if usage is below a level fixed in the contract.
 - (d) Set premium rates for eligible employees and small employers.
 - (e) Perform other duties to provide low-cost health benefit plans of types likely to be purchased by small employers.
 - (f) Establish contributions to be paid by small employers toward the premiums incurred on behalf of covered eligible employees.
- (2) Notwithstanding any other health benefit plan contracted for and offered by the board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees and small employers.
- (3) The board may approve more than one carrier for each type of plan contracted for and offered, but the number of carriers shall be held to a number consistent with adequate service to eligible employees and family members.
- (4) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members of the employee.
- (5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional cost or premium.
- (6) Transfer of enrollment from one health benefit plan to another shall be open to all eligible employees and family members under rules adopted by the board.
- (7) If the board requests less health care service or benefit than is otherwise required by state law, a carrier is not required to offer such service or benefit.
- (8) Health benefit plans for small employers contracted for and offered by the board must provide a sufficient level of benefits to be eligible for a subsidy under ORS 735.724.
- (9) The board may employ whatever means are reasonably necessary to carry out the purposes of ORS 735.700 to 735.740. Such authority includes but is not limited to authority to seek clarification, amendment, modification, suspension or termination of any agreement or contract which in the board's judgment requires such action. [Formerly 653.745]

Note: See note under 735.700.

735.712 Board to encourage health insurance coverage among small employers. (1) The Insurance Pool Governing Board shall encourage increased health insurance coverage among small employers:

(a) By providing information, benefit comparisons, premium comparisons and technical assistance on obtaining employee benefits and on incentives including, but not limited to, information on the pretax health benefit options allowed under section 125 of the United States Internal Revenue Code; and

(b) By using other means necessary to market health benefit plan coverage to small employers.

(2) The Insurance Pool Governing Board shall provide information about other resources for accessing health care and shall assist consumers in accessing those resources. [Formerly 653.747]

Note: 735.712 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 735 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

(Family Health Insurance Assistance Program)

735.720 Definitions for ORS 735.720 to 735.740. For purposes of ORS 735.720 to 735.740:

(1) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the Insurance Pool Governing Board, or meets exception criteria established by the board;

(d) Except as otherwise provided by the board, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the board; and

(f) Meets other eligibility criteria established by the board.

(2) "Family" means:

(a) A single individual who is not claimed as a dependent for state income tax purposes;

(b) An adult and the adult's spouse;

(c) An adult and the adult's spouse and all unmarried, dependent children under 23 years of age, including adopted children and children placed for adoption; or

(d) An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children and children placed for adoption.

(3)(a) "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a medical savings account, health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance.

(4) "Income" means gross income in cash or kind available to the applicant or recipient.

(5) "Investment and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the board may establish that are available to the applicant or recipient to contribute toward meeting the needs of an applicant or eligible individual.

(6) "Medicaid" means medical assistance provided under 42 U.S.C. section 1396a (section 1902 of the Social Security Act).

(7) "Medical savings account" means a trust that is created exclusively for the purpose of paying qualified medical expenses of the account holder and that qualifies for tax deduction under section 220 of the Internal Revenue Code. "Medical savings account" includes an associated high deductible health benefit plan.

(8) "Resident" means an individual who demonstrates to the Insurance Pool Governing Board that the individual is lawfully residing in Oregon and intends to reside in Oregon permanently.

(9) "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with insurance carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

(10) "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health insurance benefit programs. [Formerly 653.800]

Note: See note under 735.700.

735.722 Family Health Insurance Assistance Program; eligibility for participation; selection of administrator. (1) There is established the Family Health Insurance Assistance Program in the Insurance Pool Governing Board. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income less than 200 percent of the federal poverty level, and investment and savings less than the limit established by the board, while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer sponsored health benefit plan coverage.

(2) The Insurance Pool Governing Board shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research, in consultation with the Oregon Health Council, shall make recommendations to the board regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and insurance carrier participation. The board shall adopt all policy recommendations made by the Administrator of the Office for Oregon Health Policy and Research pursuant to this subsection.

(3) The board shall enter into a contract with a third-party administrator to administer the Family Health Insurance Assistance Program. Duties of the third-party administrator may include but are not limited to:

- (a) Eligibility determination;
- (b) Data collection;
- (c) Assistance payments;
- (d) Financial tracking and reporting; and
- (e) Such other services as the board may deem necessary for the administration of the program.

(4) In entering into a contract with a third-party administrator pursuant to subsection (3) of this section, the board shall engage in competitive bidding. The board shall evaluate bids according to criteria established by the board, including but not limited to:

- (a) The applicant's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;
- (b) The efficiency of the applicant's payment procedures;
- (c) The estimate provided of the total charges necessary to administer the program; and
- (d) The applicant's ability to operate the program in a cost-effective manner. [Formerly 653.805]

Note: See note under 735.700.

735.724 Application to participate in program; issuance of subsidies; restrictions; employment group health plan enrollment. (1) To enroll in the Family Health Insurance Assistance Program established in ORS 735.720 to 735.740, an applicant shall submit a written application to the Insurance Pool Governing Board or to the third-party administrator contracted by the board to administer the program pursuant to ORS 735.722 in the form and manner prescribed by the board. Except as provided in ORS 735.728, if the applicant qualifies as an eligible individual, the applicant shall either be enrolled in the program or placed on a waiting list for enrollment.

(2) After an eligible individual has enrolled in the program, the individual shall remain eligible for enrollment for the period of time established by the board.

(3) After an eligible individual has enrolled in the program, the board or third-party administrator shall issue subsidies in an amount determined pursuant to ORS 735.726 to either the eligible individual or to the health insurance carrier designated by the eligible individual, subject to the following restrictions:

- (a) Subsidies may not be issued to an adult unless all children, if any, in the adult's family are covered under a health benefit plan or Medicaid.
 - (b) Subsidies may not be used to subsidize premiums on a health benefit plan whose premiums are wholly paid by the eligible individual's employer without contribution from the employee.
 - (c) Such other restrictions as the board may adopt.
- (4) The board may issue subsidies to an eligible individual in advance of a purchase of a health benefit plan.
- (5) To remain eligible for a subsidy, an eligible individual must enroll in a group health benefit plan if a plan is available to the eligible individual through the individual's employment and the employer makes a monetary contribution toward the cost of the plan, unless the board implements specific cost or benefit structure criteria that make enrollment in an individual health insurance plan more advantageous for the eligible individual. [Formerly 653.810]

Note: See note under 735.700.

735.726 Level of assistance determinations. (1) The Insurance Pool Governing Board shall determine the level of assistance to be granted under ORS 735.724 based on a sliding scale that considers:

- (a) Family size;
- (b) Family income;
- (c) The number of members of a family who will receive health benefit plan coverage subsidized through the Family Health Insurance Assistance Program; and
- (d) Such other factors as the board may establish.

(2) Notwithstanding the sliding scale established in subsection (1) of this section, the board may establish different assistance levels for otherwise similarly situated eligible individuals based on factors including but not limited to whether the individual is enrolled in an employer-sponsored group health benefit plan or an individual health benefit plan. [Formerly 653.815]

Note: See note under 735.700.

735.728 Subsidies limited to funds appropriated; enrollment restrictions. (1) Notwithstanding eligibility criteria and subsidy amounts established pursuant to ORS 735.720 to 735.740, subsidies shall be provided only to the extent the Legislative Assembly specifically appropriates funds to provide such assistance.

(2) The Insurance Pool Governing Board shall prohibit or limit enrollment in the Family Health Insurance Assistance Program to ensure that program expenditures are within legislatively appropriated amounts. Prohibitions or limitations allowed under this section may include but are not limited to:

(a) Lowering the allowable income level necessary to qualify as an eligible individual; and

(b) Establishing a waiting list of eligible individuals who shall receive subsidies only when sufficient funds are available. [Formerly 653.820]

Note: See note under 735.700.

735.730 Establishment of minimum benefit amounts for plan subsidy. The Insurance Pool Governing Board may, based on the recommendation of the Administrator of the Office for Oregon Health Policy and Research, establish minimum benefit requirements for individual health benefit plans subject to subsidy pursuant to the Family Health Insurance Assistance Program, including but not limited to the type of services covered and the amount of cost-sharing to be allowed. [Formerly 653.825]

Note: See note under 735.700.

735.732 Confidentiality of information in enrollment applications; exchange of information with governmental agencies; use of Social Security numbers. (1) Except as otherwise provided in this section, information provided to the Insurance Pool Governing Board as part of an application for enrollment in the Family Health Insurance Assistance Program shall remain confidential.

(2) The board may exchange information provided to the board with other state and federal agencies for the purposes of verifying eligibility for the program, improving provision of services and identifying economic trends relevant to administration of the program.

(3) In accordance with applicable state and federal law, the board may require applicants to provide their Social Security numbers and use those numbers in the administration of the program. [Formerly 653.830]

Note: See note under 735.700.

735.734 Rules. The Insurance Pool Governing Board, in consultation with the Administrator of the Office for Oregon Health Policy and Research, shall adopt all rules necessary for the implementation and operation of the Family Health Insurance Assistance Program. [Formerly 653.835]

Note: See note under 735.700.

735.736 Family Health Insurance Assistance Program Account. There is established in the State Treasury the Family Health Insurance Assistance Program Account, which shall consist of moneys appropriated to the account by the Legislative Assembly and interest earnings from the investment of moneys in the account. All moneys in the Family Health Insurance Assistance Program Account are continuously appropriated to the Insurance Pool Governing Board to carry out the provisions of ORS 735.720 to 735.740. [Formerly 653.840]

Note: See note under 735.700.

735.738 Reports of program operation. The Administrator of the Office for Oregon Health Policy and Research shall report biennially to the appropriate interim human resources committee and to the Legislative Assembly on the effectiveness and efficiency of the Family Health Insurance Assistance Program, including the use of medical savings accounts, services and benefits covered under the purchased health insurance plans, consumer satisfaction and other program operational issues. [Formerly 653.845]

Note: See note under 735.700.

735.740 Sanctions for violation of program requirements; civil penalties. (1) The Insurance Pool Governing Board may impose sanctions against an individual who violates any provision of ORS 735.720 to 735.740 or rules adopted thereto, including but not limited to suspension or termination from the Family Health Insurance Assistance Program and repayment of any subsidy amounts paid due to the fraudulent misrepresentation of an applicant or enrolled individual. Sanctions allowed under this subsection shall be imposed in the manner prescribed in ORS 183.310 to 183.550.

(2) In addition to the sanctions available pursuant to subsection (1) of this section, the board may impose a civil penalty not to exceed \$1,000 against any individual who violates any provision of ORS 735.720 to 735.740 or rules adopted pursuant thereto. Civil penalties imposed pursuant to this section shall be imposed pursuant to ORS 183.090. [Formerly 653.850]

Note: See note under 735.700.

735.990 [1987 c.774 §135; repealed by 1991 c.810 §29]