Chapter 735

2013 EDITION

Alternative Insurance

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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 apply, 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 apply 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 producer holding an appointment as an Oregon insurance producer 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 insurance producer 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; 2003 c.364 §88]

735.065 Required association functions; assessments. (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 insurance producers 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; 2003 c.364 §89]

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; rules. (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]

CAPTIVE INSURERS

735.150 Definitions for ORS 735.150 to 735.190. As used in ORS 735.150 to 735.190:

(1)(a) "Affiliate" means a business entity that, because of common ownership, common control, common operation or common management, is in the same corporate system as a parent or a member organization.

(b) For purposes of this subsection, "common ownership, common control, common operation or common management" means that two or more business entities are owned, controlled, operated or managed by the same person or group of persons with:

(A) Direct or indirect ownership of 80 percent or more of the outstanding voting stock of the stock corporation for a captive insurer that is a stock corporation;

(B) Direct or indirect ownership of 80 percent or more of the surplus and the voting power of the mutual corporation for a captive insurer that is a mutual corporation; or

(C) Direct or indirect ownership by the same member or members of 80 percent or more of the membership interests in the limited liability company for a captive insurer that is a limited liability company.

(2) "Alien captive insurer" means an insurer:

(a) Formed to transact insurance for a parent or affiliate of the insurer; and

(b) Licensed under the laws of a nation other than the United States that imposes statutory or regulatory standards:

(A) On a business entity transacting insurance in the other nation; and

(B) In a form acceptable to the Director of the Department of Consumer and Business Services.

(3) "Association" means a legal association of two or more persons that has been in continuous existence for at least one year if the association or its member organizations:

(a) Own, control, or hold with power to vote, all of the outstanding voting securities of an association captive insurer incorporated as a stock insurer;

(b) Have complete voting control over an association captive insurer incorporated as a mutual insurer; or

(c) Have complete voting control over an association captive insurer formed as a limited liability company.

(4) "Association captive insurer" means a business entity that insures the risks of:

(a) A member organization of the association;

(b) An affiliate of a member organization of the association; or

(c) The association.

(5) "Branch captive insurer" means an alien captive insurer that holds a certificate of authority from the Director of the Department of Consumer and Business Services to transact insurance in this state through a business division with a principal place of business in this state.

(6) "Branch operation" means a business operation of a branch captive insurer in this state.

(7) "Captive insurer" means any of the following that is formed or holds a certificate of authority issued under ORS 735.150 to 735.190:

(a) A pure captive insurer;

(b) A branch captive insurer;

(c) An association captive insurer; or

(d) A captive reinsurer.

(8) "Captive reinsurer" means a reinsurer that is:

(a) Formed or holds a certificate of authority under ORS 735.150 to 735.190;

(b) Wholly owned by a qualifying reinsurer parent company; and

(c) A stock corporation.

(9) "Controlled unaffiliated business" means a business entity:

(a) That is not in the same corporate system as a parent or the parent's affiliate but has a contractual relationship with a parent or affiliate; and

(b) Whose risks are managed by a pure captive insurer in accordance with rules adopted by the Director of the Department of Consumer and Business Services under ORS 735.154.

(10) "Foreign captive insurer" means an insurer:

(a) Formed to transact insurance for a parent or affiliate of the insurer; and

(b) Licensed under the laws of another state that imposes statutory or regulatory standards:

(A) On a business entity transacting insurance in the other state or jurisdiction; and

(B) In a form acceptable to the Director of the Department of Consumer and Business Services.

(11) "Member organization" means a person that belongs to an association.

(12) "Parent" means a person that directly or indirectly owns, controls, or holds with power to vote, more than 50 percent of:

(a) The outstanding voting securities of a pure captive insurer; or

(b) The pure captive insurer, if the pure captive insurer is formed as a limited liability company.

(13) "Pure captive insurer" means a business entity that insures risks of a parent or affiliate of the business entity.

(14)(a) "Qualifying reinsurer parent company" means an accredited reinsurer in this state that has:

(A) A consolidated GAAP net worth of not less than $500 million; and

(B) Complies with the consolidated debt to total capital ratio established by rule by the Director of the Department of Consumer and Business Services.

(b) For purposes of this subsection "consolidated GAAP net worth" means the consolidated shareholders' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission. [2012 c.84 §2]

Note: 735.150 to 735.190 were added to and made a part of the Insurance Code by legislative action but were not added to ORS chapter 735 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

735.152 Application of laws. (1) The provisions of the Insurance Code cited in ORS 735.150 to 735.190 apply to captive insurers. In addition, the provisions of the Insurance Code set forth in ORS chapter 731 relating to administration of the insurance laws apply to captive insurers to the extent not inconsistent with the express provisions of ORS 735.150 to 735.190.

(2) In addition to the provisions of the Insurance Code set forth in subsection (1) of this section, ORS 705.137 and 705.139 apply to captive insurers. [2012 c.84 §3]

Note: See note under 735.150.

735.154 Rules. The Director of the Department of Consumer and Business Services may adopt rules for the administration of ORS 735.150 to 735.190. [2012 c.84 §4]

Note: See note under 735.150.

735.156 Confidentiality of documents and materials; public disclosure. All documents, materials and other information in the possession of the Department of Consumer and Business Services under ORS 735.150 to 735.190 are confidential and subject to public disclosure only as provided in ORS 705.137. [2012 c.84 §5]

Note: See note under 735.150.

735.158 Certificate of authority; restriction on types of insurance; requirements for certification; requirements for corporations; fees; expiration and renewal of certificate. (1)(a) When permitted by its articles of incorporation or its charter and bylaws, a captive insurer may apply to the Director of the Department of Consumer and Business Services for a certificate of authority to transact any class of insurance.

(b) Notwithstanding paragraph (a) of this subsection:

(A) A pure captive insurer may not insure a risk other than a risk of its parent or affiliate or a controlled unaffiliated business.

(B) An association captive insurer may not insure a risk other than a risk of:

(i) An affiliate;

(ii) A member organization of its association; or

(iii) An affiliate of a member organization of its association.

(C) A captive insurer may not provide workers' compensation insurance, life insurance, health insurance or any personal property or personal casualty line of insurance, including but not limited to personal motor vehicle insurance coverage and homeowner's insurance, and any component of such coverage.

(D) A captive insurer may not accept or cede reinsurance except as provided in ORS 735.168.

(2) To transact insurance in this state, a captive insurer must:

(a) Obtain from the director a certificate of authority that authorizes the captive insurer to transact insurance in this state;

(b) Appoint a resident registered agent to accept service of process and to otherwise act on behalf of the captive insurer in this state; and

(c)(A) Hold at least once each year in this state a board of directors meeting; and

(B) Maintain in this state:

(i) The principal place of business of the captive insurer; or

(ii) In the case of a branch captive insurer, the principal place of business for the branch operations of the branch captive insurer.

(3) In the case of a captive insurer formed as a corporation, if the registered agent cannot be found with reasonable diligence at the registered office of the captive insurer, the director is the agent of the captive insurer upon whom process, notice or demand may be served.

(4)(a) An applicant captive insurer formed as a corporation shall file with the director:

(A) Certified copies of the articles of incorporation or the charter and bylaws of the corporation;

(B) A statement under oath of the president and secretary of the corporation showing the financial condition of the corporation; and

(C) Any other statement or document required by the director as adopted by rule.

(b) In addition to the other information required by this subsection, an applicant captive insurer shall file with the director evidence of:

(A) The amount and liquidity of the assets of the applicant captive insurer relative to the risks to be assumed by the applicant captive insurer;

(B) The adequacy of the expertise, experience and character of the individual who will manage the applicant captive insurer;

(C) The overall soundness of the plan of operation of the applicant captive insurer;

(D) The adequacy of the loss prevention programs for any parent or member organization of the applicant captive insurer; and

(E) Any other factor the director adopts by rule and considers relevant in ascertaining whether the applicant captive insurer is able to meet the policy obligations of the applicant captive insurer.

(5)(a) A captive insurer shall pay to the department nonrefundable fees established by the director by rule for:

(A) Examining, investigating and processing the captive insurer's application for issuance of a certificate of authority;

(B) Obtaining a certificate of authority for the year the director issues a certificate of authority to the captive insurer in an amount not less than $5,000; and

(C) Renewing a certificate of authority in an amount not less than $5,000.

(b) The fees a captive insurer pays to the Department of Consumer and Business Services for obtaining or renewing a certificate of authority are in lieu of any payment of premium assessment on receipt of premium by the captive insurer. Fees for obtaining or renewing a certificate of authority may be increased by the department by rule and may be scaled on the basis of premiums the captive insurer collects in any given year.

(c) The director may retain legal, financial and examination services from outside the department to perform any functions described in ORS 735.150 to 735.190 and may

charge the applicant captive insurer the reasonable cost of services performed.

(6) If the director is satisfied that the documents and statements filed by the applicant captive insurer meet the requirements of ORS 735.150 to 735.190, the director may issue a certificate of authority that authorizes the captive insurer to transact insurance in this state.

(7) A certificate of authority issued under this section expires annually and must be renewed by December 31 of each year beginning with the year following the year that the original certificate was issued.

(8) Upon approval of the director, a foreign or alien captive insurer may become a domestic captive insurer by complying with all of the requirements of the Insurance Code relative to the organization and licensing of a domestic captive insurer of the same or equivalent type in this state and by filing with the director certified copies of the insurer's articles of association, charter or other organizational document, together with any appropriate amendments adopted in accordance with the laws of this state bringing those articles of association, charter or other organizational document into compliance with the laws of this state. After complying with these requirements, the captive insurer is entitled to the necessary or appropriate certificates and licenses to continue transacting insurance in this state and is subject to the authority and jurisdiction of this state. In connection with this redomestication, the director may waive any requirements for public hearings. It is not necessary for a captive insurer redomesticating into this state to merge, consolidate, transfer assets or otherwise engage in any other reorganization, other than as specified in this section. [2012 c.84 §6]

Note: See note under 735.150.

735.160 Business name. A captive insurer may assume a business name only if consistent with the provisions of ORS 731.430. [2012 c.84 §7]

Note: See note under 735.150.

735.162 Capital and surplus requirements; form permitted; security for branch captive insurers; dividends and distributions. (1) To qualify for authority to transact insurance in this state, a captive insurer shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than:

(a) $250,000 for a pure captive insurer.

(b) $750,000 for an association captive insurer incorporated as a stock insurer or as a mutual insurer.

(c) $300,000,000 for a captive reinsurer.

(2) In accordance with ORS 731.554 (6), for the protection of the public, the Director of the Department of Consumer and Business Services may require a captive insurer to possess and maintain capital or surplus, or any combination thereof, in excess of the amount otherwise required under this section.

(3) The capital and surplus required under subsections (1) and (2) of this section may be in the form of:

(a) Cash or cash equivalent; or

(b) An irrevocable letter of credit issued by an insured institution, as described in ORS 731.510, and approved by the director.

(4)(a) Except as provided in paragraph (d) of this subsection, a branch captive insurer, as security for the payment of liabilities attributable to branch operations, must establish and maintain, through its branch operations, a trust fund funded by an irrevocable letter of credit or other asset approved by the director.

(b) The trust fund established under this subsection shall be for the benefit of United States policyholders and United States ceding insurers under insurance policies issued or reinsurance contracts issued or assumed.

(c) The amount of the security required under this subsection must be equal to or greater than:

(A) The capital and surplus required under this section applicable to the line of business written by the captive insurer; and

(B) The net reserves on the insurance policies or reinsurance contracts described in this subsection, including:

(i) Case basis loss and allocated loss adjustment expense reserves;

(ii) Losses and allocated loss adjustment expense amounts incurred but not reported; and

(iii) Unearned premiums with regard to insurance transacted by branch operations.

(d) In accordance with ORS 731.510, the director may permit a branch captive insurer that is required to post security for loss reserves on insurance transacted by its reinsurer to reduce the funds in the trust fund established under this section by the same amount as the security posted if the security remains posted with the reinsurer.

(5) A captive insurer may pay dividends or make distributions if all the following requirements are met:

(a) Submission of a report to the director listing all dividends and distributions within five business days following the declaration, and not less than 10 business days prior to payment, of the dividends and distributions,

commencing from the date of receipt of the report by the director.

(b) The report required under paragraph (a) of this subsection must demonstrate that the combined capital and surplus of the captive insurer following any dividend or distribution is reasonable in relation to the captive insurer's outstanding liabilities and adequate to the captive insurer's financial needs.

(c) A captive insurer may pay dividends or distributions only from earned surplus unless the director gives prior approval for payment from another source. [2012 c.84 §8]

Note: See note under 735.150.

735.164 Incorporation of pure captive insurer and association captive insurer; application; fee; approval; alien captive insurer; application of corporation laws. (1) A pure captive insurer must be incorporated as a stock insurer with the capital of the pure captive insurer divided into shares and held by the shareholders of the pure captive insurer.

(2) An association captive insurer may be:

(a) Incorporated as a stock insurer with the capital of the association captive insurer divided into shares and held by the shareholders of the association captive insurer; or

(b) Incorporated as a mutual insurer without capital stock, with a governing body elected by the member organizations of the association captive insurer.

(3) The requirements of ORS 732.085 apply to the incorporators of a captive insurer.

(4) Any person desiring to organize a captive insurer must first file an application with the Director of the Department of Consumer and Business Services for a permit to organize the captive insurer. The applicant shall pay the applicable fee to the director at the time the application is filed. The application shall be on forms provided by the director and shall be signed by the applicants and verified. The form shall specify information about the following:

(a) The character, reputation, financial responsibility and purposes of the proposed incorporators;

(b) The character, reputation, financial responsibility, insurance experience and business qualifications of the proposed officers and directors and the proposed managers;

(c) Any information provided to the Department of Consumer and Business Services in the application for a certificate of authority or that is maintained in the department's files; and

(d) Other aspects the director considers advisable.

(5) The director shall approve an application for a permit to organize a captive insurer only if the director finds that:

(a) The application is complete;

(b) The documents filed with the application are in the proper form;

(c) The proposed financial structure is adequate;

(d) The character, reputation, financial responsibility and general fitness of the persons named in the application or otherwise found to be associated with or have an interest in the proposed insurer are such as to command the confidence of the public;

(e) The proposed directors are collectively competent to assume responsibility for the management and general policies and procedures of the captive insurer;

(f) The proposed management, collectively, possess the requisite general business ability and experience in the business of insurance of the class or classes specified in the application; and

(g) No fact is then known to the director that would prevent the proposed insurer from completing its organization and receiving a certificate of authority to transact insurance as a captive insurer.

(6) To the extent not otherwise inconsistent with the provisions of ORS 735.150 to 735.190, ORS 732.095, 732.105 and 732.115 apply for the filing of the articles of incorporation of a captive insurer.

(7)(a) An alien captive insurer applying to the director for a certificate of authority to act as a branch captive insurer shall obtain from the director a certificate finding that:

(A) The nation of an alien captive insurer imposes statutory or regulatory standards, in a form acceptable to the director, on captive insurers transacting insurance in that nation; and

(B) After considering the character, reputation, financial responsibility, insurance experience and business qualifications of the officers and directors of the alien captive insurer, and other relevant information, the establishment and maintenance of the branch operations will promote the general good of this state.

(b) After the director issues a certificate under paragraph (a) of this subsection, the alien captive insurer may register with the department to do business in this state as a branch captive insurer.

(8) The capital stock of a captive insurer incorporated as a stock insurer may not be issued at less than par value.

(9) At least one-quarter of the members of the board of directors of a captive insurer formed as a corporation shall be residents of this state.

(10)(a) A captive insurer formed as a corporation under ORS 735.150 to 735.190 has the privileges of and is subject to ORS 735.150 to 735.190 and ORS chapters 60 and 732.

(b) If a conflict exists between a provision of ORS chapters 60 and 732 and a provision of ORS 735.150 to 735.190, ORS 735.150 to 735.190 shall control.

(c) Except as provided in paragraph (d) of this subsection, the provisions of ORS 735.150 to 735.190 pertaining to a merger, consolidation, conversion, mutualization and redomestication apply in determining the procedures to be followed by a captive insurer in carrying out any of the transactions described in those provisions.

(d) The director may waive or modify the requirements of this subsection.

(11) The articles of incorporation or bylaws of a captive insurer may not authorize a quorum of a board of directors to consist of less than one-third of the fixed or prescribed number of directors as provided in rules adopted by the director. [2012 c.84 §9]

Note: See note under 735.150.

735.166 Investment requirements for association captive insurer. (1)(a) An association captive insurer must comply with the investment requirements of ORS 733.510 to 733.780.

(b) Notwithstanding paragraph (a) of this subsection, the Director of the Department of Consumer and Business Services may by rule approve the use of alternative reliable methods of valuation and rating for an association captive insurer.

(2)(a) A pure captive insurer is not subject to any restrictions on allowable investments under ORS 733.510 to 733.780.

(b) The director may prohibit or limit an investment that threatens the solvency or liquidity of a pure captive insurer.

(3) A captive insurer may not make loans to the parent of the captive insurer or an affiliate of the captive insurer. [2012 c.84 §10]

Note: See note under 735.150.

735.168 Allowable risks for captive insurer; risk distribution pool; annual actuarial opinion; rules. (1) A captive insurer may provide reinsurance on risks ceded by an affiliate of the insurer or a controlled unaffiliated business.

(2) A captive insurer may take credit for reserves on risks or portions of risks ceded to reinsurers if the credit is acceptable to the Director of the Department of Consumer and Business Services.

(3) Subject to the prior written approval of the director, a captive insurer may participate in a pool for the purpose of risk distribution sharing. However, a captive insurer may not join or contribute financially to a plan, pool, association or guaranty or insolvency fund in this state, and a captive insurer, or its insured or its parent or any affiliated company or any member organization of its association, may not receive a benefit from a plan, pool, association or guaranty or insolvency fund for claims arising out of the operations of the captive insurer.

(4) A captive reinsurer must annually file with the department an actuarial opinion provided by a qualified actuary on loss and loss adjustment expense reserves. The qualified actuary providing the actuarial opinion must be independent and may not be an employee of the captive reinsurer or an affiliate of the captive reinsurer for which the actuarial opinion is filed.

(5) A captive reinsurer may discount its loss and loss adjustment expense reserves only as allowed in rules adopted by the director.

(6) The director may disallow the discounting of loss and loss adjustment reserves of a captive reinsurer if the captive reinsurer violates any provision of ORS 735.150 to 735.190. [2012 c.84 §11]

Note: See note under 735.150.

735.170 Rating organization. A captive insurer is not required to join a rating organization. [2012 c.84 §12]

Note: See note under 735.150.

735.172 Reporting; contents; filing date; waiver of annual statement for alien captive insurer; rules. (1) A captive insurer is not required to make a report except as specified in this section.

(2)(a) Before March 1 of each year, or in accordance with rules adopted under subsection (6) of this section, a captive insurer shall submit to the Director of the Department of Consumer and Business Services a report of the financial condition of the captive insurer, verified by oath of two of the executive officers of the captive insurer.

(b) A captive insurer shall report:

(A) Using generally accepted accounting principles, except to the extent that the director requires, approves or accepts the use of statutory accounting principles;

(B) Using a useful or necessary modification or adaptation to an accounting principle that is required, approved or accepted by the director for the type of insurance and kind of insurer to be reported upon; and

(C) Supplemental or additional information required by the director.

(c) Except as otherwise provided in ORS 735.150 to 735.190, an association captive insurer shall file the financial statement required by ORS 731.574.

(d) For the purposes of this subsection, "statutory accounting" means a method of accounting using rules that insurance companies must follow in filing an annual financial statement with the Department of Consumer and Business Services.

(3)(a) A pure captive insurer may make a written request to file the required report on a fiscal year end that is consistent with the fiscal year of the parent company of the pure captive insurer.

(b) If the director grants an alternative reporting date for a pure captive insurer as described under paragraph (a) of this subsection, the annual report is due 60 days after the fiscal year end.

(4)(a) Not later than 60 days after the fiscal year end, an alien captive insurer operating as a branch captive insurer in this state shall file with the director a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurer is formed, verified by oath by two of the alien captive insurer's executive officers.

(b) If the director is satisfied that the annual report filed by the alien captive insurer in the jurisdiction in which the alien captive insurer is formed provides adequate information concerning the financial condition of the alien captive insurer, the director may waive the requirement for completion of the annual statement required for a captive insurer under this section with respect to business written in the alien jurisdiction.

(c) A waiver granted by the director under paragraph (b) of this subsection shall be in writing and is subject to public inspection.

(5) All captive insurers transacting insurance in this state shall engage a qualified actuary with knowledge of this state for purposes of determining and setting premiums to be charged by the captive insurer.

(6) The director may establish by rule criteria to waive or modify the requirements of this section relating to the frequency of reporting and the contents of the report. [2012 c.84 §13]

Note: See note under 735.150.

735.174 Examination; frequency; scope; payment of expenses. (1)(a) The Director of the Department of Consumer and Business Services shall examine the affairs of each captive insurer once in each three-year period.

(b) The three-year period described in paragraph (a) of this subsection is determined on the basis of three full annual accounting periods of operation.

(c) The examination is to be made as of December 31 of the full three-year period or as of the last day of the month of an annual accounting period authorized for a captive insurer under this section.

(d) In addition to an examination required under this subsection, the director may examine a captive insurer whenever the director determines it to be prudent.

(2) During an examination under this section, the director shall thoroughly examine the affairs of the captive insurer to ascertain:

(a) The financial condition of the captive insurer;

(b) The ability of the captive insurer to fulfill the obligations of the captive insurer; and

(c) Whether the captive insurer meets the requirements of ORS 735.150 to 735.190.

(3) The director may expand the three-year period described in subsection (1) of this section to five years if during that period a captive insurer is subject to a comprehensive annual audit:

(a) Of a scope satisfactory to the director; and

(b) Performed by independent auditors approved by the director.

(4) The director may accept a comprehensive annual independent audit in lieu of an examination if the scope of the examination is satisfactory to the director and the examination is performed by a qualified independent auditor.

(5) A captive insurer that is examined under this section shall pay the expenses and charges of the examination. [2012 c.84 §14]

Note: See note under 735.150.

735.176 Compliance with sound actuarial principles. Notwithstanding the limits of risk set forth in ORS 731.504, any captive insurer for which the Director of the Department of Consumer and Business Services issues a certificate of authority under ORS 735.150 to 735.190 must comply with sound actuarial principles as determined by the director and must submit reports demonstrating such compliance to the director. [2012 c.84 §15]

Note: See note under 735.150.

735.178 Suspension or revocation of certificate of authority. (1) The Director of the Department of Consumer and Business Services may suspend or revoke the certificate of authority issued to a captive insurer to transact insurance in this state if the captive insurer:

(a) Is insolvent or impaired as defined in ORS 734.014;

(b) Fails to meet the requirements of ORS 735.150 to 735.190;

(c) Refuses or fails to submit an annual report required by ORS 735.172 or any other report or statement required by law or by order of the director;

(d) Fails to comply with the charter, bylaws or other organizational document of the captive insurer;

(e) Fails to submit to an examination under ORS 735.174 or 735.182 or any legal obligation relative to an examination under ORS 735.174 or 735.182;

(f) Refuses or fails to pay the cost of examination under ORS 735.174 or 735.182;

(g) Uses methods that, although not otherwise specifically prohibited by law, render:

(A) The operation of the captive insurer detrimental to the public or the policyholders of the captive insurer according to standards adopted by the director by rule; or

(B) The condition of the captive insurer unsound with respect to the public or to the policyholders of the captive insurer; or

(h) Otherwise fails to comply with laws of this state.

(2) If the director finds, upon examination, hearing or other evidence that a captive insurer has committed any of the acts specified in subsection (1) of this section, the director may suspend or revoke the certificate of authority issued to the captive insurer if the director considers it in the best interest of the public and the policyholders of the captive insurer. [2012 c.84 §16]

Note: See note under 735.150.

735.180 Branch captive insurer as pure captive insurer; rules. Except as otherwise provided in ORS 735.150 to 735.190, a branch captive insurer must be a pure captive insurer with respect to business operations in this state, unless otherwise permitted by rule of the Director of the Department of Consumer and Business Services. [2012 c.84 §17]

Note: See note under 735.150.

735.182 Examination of branch captive insurer and alien captive insurer; payment of charges and expenses. (1) The Director of the Department of Consumer and Business Services shall examine only the branch operations of, and the insurance transacted by, a branch captive insurer in this state if the branch captive insurer:

(a) Provides annually to the director a certificate of compliance, or an equivalent, issued by or filed with the licensing authority of the jurisdiction in which the branch captive insurer is formed; and

(b) Demonstrates to the satisfaction of the director that the branch captive insurer is operating in sound financial condition in accordance with ORS 735.150 to 735.190 and all applicable laws and regulations of the jurisdiction in which the branch captive insurer is formed.

(2) As a condition of its authority as a branch captive insurer, an alien captive insurer must authorize the director to examine the affairs of the alien captive insurer in the jurisdiction in which the alien captive insurer is formed.

(3) An alien captive insurer that is examined under this section shall pay the expenses and charges of the examination. [2012 c.84 §18]

Note: See note under 735.150.

735.184 Requirements for foreign captive insurer to provide insurance in this state. Notwithstanding ORS 731.022, a foreign captive insurer may provide insurance in this state if the foreign captive insurer meets both of the following conditions:

(1) The foreign captive insurer is domiciled in a state that regulates the foreign captive insurer as a captive insurer and the captive insurer is in good standing in that state.

(2) All activities related to the placement of the insurance occurs in the domicile state and the insurance otherwise complies with the laws of the domicile state, including the proposal to make an insurance contract, taking or receiving an application for insurance, collecting a premium or other consideration for the insurance and issuing or delivering policies of insurance. [2012 c.84 §19]

Note: See note under 735.150.

735.186 Management of assets of captive reinsurer. At least 35 percent of the assets of a captive reinsurer must be managed by an asset manager domiciled in this state. [2012 c.84 §20]

Note: See note under 735.150.

735.188 Application of captive reinsurer for certificate of authority. If permitted by its articles of incorporation or charter, and in accordance with ORS 735.158 and 735.190, a captive reinsurer may apply to the Director of the Department of Consumer and Business Services for a certificate of authority to transact reinsurance. [2012 c.84 §21]

Note: See note under 735.150.

735.190 Incorporation of captive reinsurer. (1) A captive reinsurer must be incorporated as a stock insurer with its capital divided into shares and held by the captive reinsurer's shareholders. In incorporating, a captive reinsurer must comply with the requirements of ORS 735.164.

(2) The capital stock of a captive reinsurer must be issued at par value or greater.

(3) At least one member of the board of directors of a captive reinsurer incorporated in this state must be a resident of this state. [2012 c.84 §22]

Note: See note under 735.150.

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; rules. (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 insurance producers, and approved by the director. [1987 c.774 §75; 2003 c.364 §90]

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 chapter 183. 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 producers; 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; 2003 c.364 §91]

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; rules. 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 es-

tablished 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 insurance producers 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 insurance producers 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.

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(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; 2003 c.364 §92]

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 insurance producer acting pursuant to the surplus lines laws and regulations of that state. [1987 c.774 §105; 2003 c.364 §93]

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 insurance producer 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 insurance producer from the director under ORS chapter 744. [1987 c.774 §108; 1989 c.701 §71; 2003 c.364 §94]

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) "Affiliated group" means any group of entities that, with respect to an insured, exercise control over the insured, are under the control of the insured, or are under common control with the insured.

(3) "Capital" means funds paid in for stock or other evidence of ownership.

(4) "Control" means a situation where a controlling entity:

(a) Directly, or acting through one or more other persons, owns or has the power to vote 25 percent or more of any class of voting securities of the controlled entity; or

(b) Directs in any manner the election of a majority of directors or trustees of the controlled entity.

(5) "Eligible surplus lines insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance.

(6) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement:

(a) Employs or retains a qualified risk manager to negotiate insurance coverage;

(b) Has paid aggregate nationwide commercial property and casualty insurance premiums in excess of $100,000 in the immediately preceding 12 months; and

(c) Meets at least one of the following criteria:

(A) The person possesses a net worth in excess of $10 million, as such amount is adjusted pursuant to ORS 735.406.

(B) The person generates annual revenues in excess of $20 million, as such amount is adjusted pursuant to ORS 735.406.

(C) The person employs more than 50 full-time or full-time equivalent employees for each insured or is a member of an affiliated group employing more than 100 employees in the aggregate.

(D) The person is a not-for-profit organization or public entity generating annual budgeted expenses of at least $30 million, as such amount is adjusted pursuant to ORS 735.406.

(E) The person is a municipality with a population in excess of 50,000 individuals.

(7) "Export" means to place surplus lines insurance with a nonadmitted insurer.

(8) "Home state" means, with respect to an insured:

(a) The state in which an insured maintains the insured's principal place of business or, in the case of an individual, the individual's principal residence;

(b) If 100 percent of the insured risk is located out of the state described in paragraph (a) of this subsection, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated; or

(c) If two or more insureds from an affiliated group are named as insureds on a single nonadmitted insurance contract, the state, as determined pursuant to paragraph (a) or (b) of this subsection, of the member of the affiliated group that has the greatest percentage of premium attributed to it under the insurance contract.

(9) "Kind of insurance" means one of the types of insurance required to be reported in the annual statement that must be filed with the Director of the Department of Consumer and Business Services by authorized insurers.

(10) "Nonadmitted insurer" means an insurer not authorized to do an insurance business in this state. "Nonadmitted insurer" includes insurance exchanges as authorized under the laws of various states. "Nonadmitted insurer" does not include a risk retention group as defined in ORS 735.305.

(11) "Premium tax" means any tax, assessment or other charge imposed by this state directly or indirectly based upon any payment made as consideration for insurance in an insurance contract.

(12) "Producing insurance producer" means the individual insurance producer dealing directly with the party seeking insurance.

(13) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(a) The person is an employee of, or third party consultant retained by, the commercial policyholder.

(b) The person provides skilled services in:

(A) Loss prevention;

(B) Loss reduction; or

(C) Risk and insurance coverage analysis and purchase of insurance.

(c) The person has:

(A) A bachelor's degree, from an accredited college or university, in risk management, business administration, finance, economics or any other field determined by an insurance commissioner or other regulatory official of this or any other state to demonstrate minimum competence in risk management, and has:

(i) Three years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

(ii) Any designation, certification or license issued by a national insurance certification organization that is determined by the Director of the Department of Consumer and Business Services to demonstrate minimum competency in risk management;

(B) At least seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance, and has a designation, certification or license specified in subparagraph (A)(ii) of this paragraph;

(C) At least 10 years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance; or

(D) A graduate degree, from an accredited college or university, in risk management, business administration, finance, economics or any other field determined by the director to demonstrate minimum competence in risk management.

(14) "Surplus" means funds over and above liabilities and capital of the insurer for the protection of policyholders.

(15) "Surplus lines licensee" means an insurance producer licensed under ORS chapter 744 to place insurance on Oregon home state risks with nonadmitted insurers. [1987 c.774 §118; 1991 c.810 §25; 2001 c.191 §44a; 2003 c.364 §38; 2011 c.660 §6]

735.406 Cost of living adjustment to net worth, revenues and expenses of exempt commercial purchasers. Beginning on January 1, 2015, and each fifth January 1 occurring thereafter, the amounts in ORS 735.405 (6)(c)(A), (B) and (D) shall be adjusted to reflect the percentage change for such five-year period in the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items as published by the Bureau of Labor Statistics of the United States Department of Labor. [2011 c.660 §7]

735.410 Conditions for procuring insurance through nonadmitted insurer; rules. (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)(b) of this section does not apply to a surplus lines licensee seeking to procure or place nonadmitted insurance in this state for an exempt commercial purchaser if:

(a) The surplus lines licensee procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(b) The exempt commercial purchaser has subsequently requested in writing that the surplus lines licensee procure or place such insurance from a nonadmitted insurer.

(3) The Director of the Department of Consumer and Business Services by rule may establish requirements applicable to the placement of surplus lines insurance on Oregon home state risks by a nonresident surplus lines licensee. 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, or the Nonadmitted and Reinsurance Reform Act of 2010 (P.L. 111-203, Title V, Subtitle B). [1987 c.774 §119; 2001 c.191 §44b; 2011 c.660 §9]

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) Obtained authorization to write the kind of insurance to be placed by the surplus lines licensee by the insurance supervisory official in the insurer's domiciliary jurisdiction.

(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 the greater of either the minimum capital and surplus requirements of its domiciliary jurisdiction or $15 million, except that the requirements of this subparagraph may be satisfied by an insurer possessing less than the minimum 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, market availability and company record and reputation within the industry. In no event shall the director make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than $4.5 million.

(B) In the case of an alien insurer, in addition to the requirements in subparagraph (A) of this paragraph, 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 $5.4 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 that are not listed in accordance with subparagraph (E) of this paragraph, maintains a trust fund of not less than $100 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 may 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 $75 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 $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.

(E) Is listed on the NAIC Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners and meets additional requirements regarding the use of the list established by rule of the director.

(c) Unless qualified under paragraph (b)(E) of this subsection, 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 places surplus lines insurance outside this state that covers an Oregon home state risk, the licensee or insurance producer is subject to the requirements of subsection (1) of this section. [1987 c.774 §120; 1995 c.99 §2; 2001 c.191 §44c; 2005 c.185 §11; 2011 c.660 §10]

735.417 Insured required to report and pay taxes on independently procured insurance covering Oregon home state risks. (1) Each insured in this state who obtains independently procured insurance, or continues or renews independently procured insurance on Oregon home state risks, other than insurance procured through a surplus lines licensee, shall file, within 30 days after the date the insurance was procured, continued or renewed, a written report with the

Director of the Department of Consumer and Business Services showing:

(a) The name and address of the insurer;

(b) The subject of the insurance;

(c) The amount of premium currently charged; and

(d) Additional pertinent information reasonably requested by the director.

(2) The insured filing a report under subsection (1) of this section shall pay, at the time of filing the report, the director an amount equal to the taxes imposed under ORS 735.470 for the premium reported under subsection (1)(c) of this section. The filing of the report and payment of the taxes may be made by a person authorized by the insured to act on the insured's behalf.

(3)(a) The director may require that reports filed under subsection (1) of this section be filed with the Surplus Line Association of Oregon. The director may require that such filings be made electronically, but may allow an exemption to this requirement for good cause shown.

(b) The director may require that amounts to be paid to the director under subsection (2) of this section be paid to the Surplus Line Association of Oregon. [2011 c.660 §5]

735.418 Director authorized to enter into interstate compact for premium tax allocation. For purposes of carrying out the Nonadmitted and Reinsurance Reform Act of 2010 (P.L. 111-203, Title V, Subtitle B), after receiving express legislative approval, the Director of the Department of Consumer and Business Services is authorized to enter into a compact or to otherwise establish procedures with other states to allocate among the states the premium taxes paid to an insured's home state. [2011 c.660 §4]

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 on an Oregon home state risk, each surplus lines licensee shall file with the Director of the Department of Consumer and Business Services:

(a) A statement 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 insurance producer to place the coverage with admitted insurers and the results thereof. The statement shall be signed by the producing insurance producer 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) A surplus lines licensee placing nonadmitted insurance in this state for an exempt commercial purchaser satisfies the requirements of subsection (1)(b) of this section if the surplus lines licensee provides proof of compliance with ORS 735.410 (2).

(3) The director may direct that filings required under subsection (1) of this section be made to the Surplus Line 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.

(4) A nonresident surplus lines licensee who places a surplus lines policy on an Oregon home state risk shall satisfy the requirements in ORS 735.410 and the filing requirements in subsections (1) and (2) of this section.

(5) Facsimile signatures and electronic signatures subject to ORS 84.001 to 84.061 are acceptable and have the same force as original signatures. [1987 c.774 §122; 1993 c.182 §1;

2001 c.377 §§13,13a; 2003 c.364 §39; 2005 c.185 §12; 2011 c.660 §11]

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

(a) Facilitate and encourage compliance by resident and nonresident surplus lines licensees 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 resident and nonresident surplus lines licensees to determine whether the coverages comply with the Oregon Surplus Lines Law;

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

(d) Receive and disseminate to resident and nonresident surplus lines licensees information relative to surplus lines coverages; and

(e) At the request of the director, receive and collect on behalf of the state and remit to the state premium receipts taxes for surplus lines insurance pursuant to ORS 735.417 or 735.470.

(2) The Surplus Line 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 Line Association of Oregon in accordance with the provisions of this section; and

(f) A schedule of fees and charges.

(3) The director may make or cause to be made an examination of the Surplus Line Association of Oregon. The reasonable cost of any such examination shall be paid by the association upon presentation to it by the director of a detailed account of each cost. The officers, managers, agents and employees of the association 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 association and shall notify the association 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 association 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.

(4)(a) The Surplus Line Association of Oregon may charge resident and nonresident surplus lines licensees and nonresident producing insurance producers a fee for reviewing surplus lines policies and for collecting, on behalf of the state, taxes imposed under ORS 735.470.

(b) The association may charge insureds a fee for collecting, on behalf of the state, reports required and taxes imposed under ORS 735.417.

(c) The association shall adopt bylaws implementing paragraphs (a) and (b) of this subsection. [1987 c.774 §123; 2001 c.377 §14; 2005 c.185 §13; 2007 c.71 §235; 2011 c.660 §12]

735.435 Evidence of insurance; contents; change; penalty; notice regarding Insurance Guaranty Association; rules. (1) Upon placing surplus lines insurance on an Oregon home state risk, the surplus lines licensee shall promptly deliver to the insured or the producing insurance producer the policy, or if such policy is not then available, a certificate as described in subsection (4) of this section, cover note or binder. The certificate, as described in subsection (4) of this section, cover note or binder 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) A surplus lines licensee may not issue or deliver any insurance policy or certificate 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 an insurance policy or certificate 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 cov-

erage as stated in the surplus lines licensee's original insurance policy, or in any other material as to the insurance coverage, the surplus lines licensee shall promptly issue and deliver to the insured or the original producing insurance producer 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 insurance producer to replace an insurance policy or certificate 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 in ORS 731.988.

(6) Each insurance policy or certificate of insurance negotiated, placed or procured under the provisions of ORS 735.400 to 735.495 by the surplus lines licensee shall bear the name of the licensee and the following legend in bold type: "This insurance was 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 insurance."

(7) The Director of the Department of Consumer and Business Services by rule may establish requirements relating to insurance policies and certificates of insurance and other applicable requirements governing placement of insurance by a nonresident surplus lines licensee outside this state that covers an Oregon home state risk. [1987 c.774 §124; 2001 c.191 §45a; 2003 c.364 §40; 2011 c.660 §13]

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 license as surplus lines insurance licensee. A person may not procure any contract of surplus lines insurance with any nonadmitted insurer for an Oregon home state risk unless the person is licensed under ORS chapter 744 to transact surplus lines insurance. A person may obtain a license to transact surplus lines insurance only if the person is licensed as an insurance producer under ORS chapter 744 to transact property and casualty insurance. [1987 c.774 §127; 1989 c.288 §1; 1991 c.810 §26; 1995 c.639 §14; 2001 c.191 §46; 2003 c.364 §41; 2011 c.660 §14]

735.455 Authority of licensee; rules. (1) A surplus lines licensee may originate surplus lines insurance on an Oregon home state risk or accept such insurance from any other insurance producer duly licensed as to the kinds of insurance involved on an Oregon home state risk, and the surplus lines licensee may compensate the insurance producer therefor.

(2) A surplus lines licensee may charge a producing insurance producer a fee or a combination of a fee and a commission when transacting surplus lines for the producing insurance producer if the surplus lines licensee has a written agreement with the producing insurance producer prior to the binding or issuance of a surplus lines insurance policy. When a surplus lines licensee transacts surplus lines insurance directly for a prospective insured, the surplus lines licensee may charge the prospective insured a fee or a combination of a fee and a commission if the surplus lines licensee has a written agreement with the prospective insured prior to the binding or issuance of a surplus lines insurance policy.

(3) A producing insurance producer may charge a fee to a prospective insured when the producing insurance producer pays a fee or a combination of a fee and a commission to a surplus lines licensee under subsection (2) of this section if the producing insurance producer has a written agreement with the prospective insured prior to the binding or issuance of the surplus lines insurance policy. The fee may not exceed the amount of compensation paid by the producing insurance producer to the surplus lines licensee.

(4) For the purpose of determining the charge under subsection (2) of this section, the producing insurance producer and the surplus lines licensee may agree to any allocation of the fee that the producing insurance producer charges the prospective insured under this section.

(5) The fee or the fee and commission charged by a surplus lines licensee under subsection (2) of this section must be com-

mensurate with the services provided by the surplus lines licensee. The Director of the Department of Consumer and Business Services may establish by rule minimum conditions for written agreements entered into under this section. An insurer or insurance producer who enters into a written agreement as provided in this section is not in violation of ORS 746.035 or 746.045. [1987 c.774 §128; 2003 c.364 §42; 2011 c.660 §15]

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 on an Oregon home state risk by or through the licensee 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 insurance producer, 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; 2003 c.364 §43; 2011 c.660 §16]

735.465 Monthly reports; rules. (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 Oregon home state risks 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 Line Association of Oregon and that the Surplus Line 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 Oregon home state risks when the insurance is placed outside this state, the director may establish by rule requirements for filing reports on surplus lines insurance transacted outside this state on Oregon home state risks. [1987 c.774 §130; 2001 c.191 §48; 2007 c.71 §236; 2011 c.660 §17]

735.470 Premium tax; collection; payment; refund; rules. (1)(a) The surplus lines licensee shall pay the Director of the Department of Consumer and Business Services a surplus lines premium tax equal to two percent of the gross amount of premiums received on Oregon home state risks as shown in the report required by ORS 735.465.

(b) Notwithstanding ORS 731.820, the surplus lines licensee shall also pay to the director a tax equal to 0.3 percent of the premium or fees charged by the insurer or the insurer's insurance producer and other intermediaries for the insurance, for the purpose of maintaining the office of the State Fire Marshal and paying the expenses incident thereto.

(c) The taxes shall be collected by the surplus lines licensee as specified by the director, in addition to the gross amount of premiums charged by the insurer or the insurer's insurance producer and other intermediaries for the insurance. The taxes 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 insurance producer, if any. The surplus lines licensee is prohibited from absorbing the taxes, and from rebating for any reason, any part of the taxes.

(2) The surplus lines taxes are due quarterly on the 45th day following the calendar quarter in which the premium is collected. The taxes 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 Line Association of Oregon.

(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) For the purposes of carrying out the Nonadmitted and Reinsurance Reform Act of 2010 (P.L. 111-203, Title V, Subtitle B), the director may collect taxes on 100 percent of the gross amount of premiums on Oregon home state risks. If the director enters into a compact or otherwise establishes procedures with other states pursuant to ORS 735.418, the director by rule shall establish procedures to facilitate the reporting, collection, payment, allocation and disbursement of premium taxes on Oregon home state risks that also include risks allocable to other states.

(5) As used in this section, "gross amount of premiums" has the meaning given that term in ORS 731.808. [1987 c.774 §131; 1989 c.288 §2; 1995 c.786 §10; 2001 c.191 §48a; 2003 c.364 §44; 2007 c.71 §237; 2011 c.660 §8]

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 Suspension 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 insurance producer;

(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; 2003 c.364 §45]

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 on an Oregon home state risk 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) When a nonresident surplus lines insurance producer transacts outside this state a surplus lines insurance contract covering an Oregon home state risk, 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. [1987 c.774 §134; 1989 c.288 §5; 2001 c.191 §49a; 2011 c.660 §18]

735.490 Jurisdiction in action against insurer; service of summons and complaint; response. (1) An insurer transacting insurance on an Oregon home state risk 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 insurance producer who registered or delivered the policy resides or transacts business, by the service of summons and complaint made upon the insurance producer for the insurer.

(2) Any insurance producer 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 the insurance producer in which to plead, answer or defend any such cause.

(4) Upon service of summons and complaint upon the insurance producer for the 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; 2003 c.364 §46; 2011 c.660 §19]

735.492 Application of certain Insurance Code provisions to surplus lines insurers. ORS 731.324, 731.328, 731.512 and 731.624 do not apply to surplus lines insurers. [2005 c.185 §17]

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]

RETAINER MEDICAL PRACTICE

735.500 Requirements for certification as retainer medical practice; disclosures; rules. (1) As used in this section and ORS 735.510:

(a) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting stock, by contract or otherwise. A person who is the owner of 10 percent or more ownership interest in a retainer medical practice or applicant for a certificate to operate a retainer medical practice is presumed to have control.

(b) "Primary care" means outpatient, nonspecialty medical services or the coordination of health care for the purpose of:

(A) Promoting or maintaining mental and physical health and wellness; and

(B) Diagnosis, treatment or management of acute or chronic conditions caused by disease, injury or illness.

(c) "Provider" means a health care professional licensed or certified under ORS chapter 677, 678, 684 or 685 who provides primary care in the ordinary course of business or practice of a profession.

(d) "Retainer medical agreement" means a written agreement between a retainer medical practice and a patient or a legal representative or guardian of a patient specifying a defined and predetermined set of primary care services to be provided in consideration for a retainer medical fee.

(e) "Retainer medical fee" means any fee paid to a retainer medical practice pursuant to a medical retainer agreement.

(f) "Retainer medical practice" means a provider, a group of providers or a person that employs or contracts with a provider or a group of providers to provide services under the terms of a retainer medical agreement.

(2) A retainer medical practice must be certified by the Department of Consumer and Business Services. To qualify to become a certified retainer medical practice or to renew a certificate, the practice:

(a) May not have or have ever had a certificate of authority to transact insurance in this state.

(b) May not be or have ever been licensed, certified or otherwise authorized in this state or any other state to act as an insurer, managed care organization, health care service contractor or similar entity.

(c) May not be controlled by an entity described in paragraph (a) or (b) of this subsection.

(3) A certified retainer medical practice:

(a) Must provide only primary care and must limit the scope of services provided or the number of patients served to an amount that is within the capacity of the practice to provide in a timely manner;

(b) May not bill an insurer, a self-insured plan or the state medical assistance program for a service provided by the practice to a patient pursuant to a retainer medical agreement;

(c) Must be financially responsible and have the necessary business experience or expertise to operate the practice;

(d) Must give the written disclosures described in subsection (4) of this section;

(e) May not use or disseminate misleading, deceptive or false statements in marketing, advertising, promotional, sales or informational materials regarding the practice or in communications with patients or prospective patients;

(f) May not engage in dishonest, fraudulent or illegal conduct in any business or profession; and

(g) May not discriminate based on race, religion, gender, sexual identity, sexual preference or health status.

(4) A certified retainer medical practice must make the following written information available to prospective patients by prominently disclosing, in the manner prescribed

by the department by rule, in marketing materials and retainer medical agreements:

(a) That the practice is not insurance;

(b) That the practice provides only the limited scope of primary care services specified in the retainer medical agreement;

(c) That a patient must pay for all services not specified in the retainer medical agreement; and

(d) Any other disclosures required by the department by rule.

(5) The department may by written order deny, suspend or revoke a retainer medical practice certificate or may refuse to renew a retainer medical practice certificate if the department finds that:

(a) The retainer medical practice does not meet the criteria in subsections (2) to (4) of this section;

(b) The retainer medical practice has provided false, misleading, incomplete or inaccurate information in the application for a certificate or renewal of a certificate;

(c) The retainer medical practice provides medical services through a provider whose license to provide the medical services offered on behalf of the retainer medical practice is revoked;

(d) The authority of the retainer medical practice to operate a retainer medical practice or similar practice in another jurisdiction is denied, suspended, revoked or not renewed;

(e) The retainer medical practice, a person who has control over the retainer medical practice or a health care provider providing services on behalf of the retainer medical practice is charged with a felony or misdemeanor involving dishonesty; or

(f) The retainer medical practice fails to comply with subsection (7) of this section.

(6) With respect to a certified retainer medical practice or a retainer medical practice operating without a certificate, the department is authorized to:

(a) Investigate;

(b) Subpoena documents and records related to the business of the practice; and

(c) Take any actions authorized by the Insurance Code that are necessary to administer and enforce this section.

(7) A retainer medical practice subject to an investigation under subsection (5) of this section must:

(a) Within five business days, respond to inquiries in the form and manner specified by the department; and

(b) Reimburse the expenses incurred by the department in conducting the investigation.

(8) A retainer medical practice may contest any order made under subsection (5) of this section in accordance with ORS chapter 183.

(9) A certificate issued under subsection (2) of this section is effective for one year or for a longer period as prescribed by the department by rule.

(10) The department may adopt rules necessary or appropriate to implement the provisions of this section. [2011 c.499 §2]

Note: 735.500 and 735.510 were added to and made a part of the Insurance Code by legislative action but were not added to ORS chapter 735 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

735.510 Notice to department of specified changes to practice. A certified retainer medical practice shall:

(1) Notify the Department of Consumer and Business Services immediately whenever:

(a) The license of a provider who has provided services on behalf of the practice is denied, suspended, revoked or not renewed in this state or in any other jurisdiction; or

(b) The authority of the practice to operate in another jurisdiction is denied, suspended, revoked or not renewed.

(2) Notify the department no later than 30 days after any change to the name, address or contact information that is provided in the application for certification under ORS 735.500. [2011 c.499 §3]

Note: See note under 735.500.

DENTAL SERVICES CONTRACTS

735.515 Charges for services not covered by contract. (1) As used in this section:

(a) "Dental services contract" means a contract between an insurer and a provider or a group of providers to provide dental health services for enrollees. "Dental services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(b) "Enrollee" means a person entitled to receive dental health benefits from an insurer.

(c) "Provider" means a person licensed or otherwise authorized by the laws of this state to administer dental health services in the ordinary course of business or practice of a profession.

(2) A dental services contract may not restrict the price that a provider may charge for services provided to an enrollee unless the services are covered by the insurer. [2010 c.74 §2]

Note: 735.515 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 735 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

PHARMACY BENEFIT MANAGERS

735.530 Definitions for ORS 735.530 to 735.552. As used in ORS 735.530 to 735.552:

(1) "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or service.

(2) "Insurer" has the meaning given that term in ORS 731.106.

(3) "Pharmacist" has the meaning given that term in ORS 689.005.

(4) "Pharmacy" has the meaning given that term in ORS 689.005.

(5)(a) "Pharmacy benefit manager" means a person that contracts with pharmacies on behalf of an insurer, a third party administrator or the Oregon Prescription Drug Program established in ORS 414.312 to:

(A) Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;

(B) Pay pharmacies or pharmacists for prescription drugs or medical supplies; or

(C) Negotiate rebates with manufacturers for drugs paid for or procured as described in this paragraph.

(b) "Pharmacy benefit manager" does not include a health care service contractor as defined in ORS 750.005.

(6) "Third party administrator" means a person licensed under ORS 744.702. [2013 c.570 §2]

Note: 735.530 to 735.552 were added to and made a part of the Insurance Code by legislative action but were not added to ORS chapter 735 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

735.532 Registration of pharmacy benefit managers; fees; rules. (1) To conduct business in this state, a pharmacy benefit manager must register with the Department of Consumer and Business Services and annually renew the registration.

(2) To register under this section, a pharmacy benefit manager must:

(a) Submit an application to the department on a form prescribed by the department by rule.

(b) Pay a registration fee, not to exceed $50, adopted by the department by rule.

(3) To renew a registration under this section, a pharmacy benefit manager must pay a renewal fee, not to exceed $50, adopted by the department by rule.

(4) The department shall deposit all moneys collected under this section into the Consumer and Business Services Fund created in ORS 705.145. [2013 c.570 §3]

Note: See note under 735.530.

735.534 Claim reimbursement; maximum allowable costs. (1) As used in this section:

(a) "List" means the list of drugs for which maximum allowable costs have been established.

(b) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.

(c) "Multiple source drug" means a therapeutically equivalent drug that is available from at least two manufacturers.

(d) "Network pharmacy" means a retail drug outlet registered under ORS 689.305 that contracts with a pharmacy benefit manager.

(e) "Therapeutically equivalent" has the meaning given that term in ORS 689.515.

(2) A pharmacy benefit manager:

(a) May not place a drug on a list unless there are at least two therapeutically equivalent, multiple source drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.

(b) Shall ensure that all drugs on a list are generally available for purchase by pharmacies in this state from national or regional wholesalers.

(c) Shall ensure that all drugs on a list are not obsolete.

(d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the maximum allowable cost pricing of the pharmacy benefit manager.

(e) Shall make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy.

(f) Shall update each list maintained by the pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format.

(g) Shall ensure that dispensing fees are not included in the calculation of maximum allowable cost.

(3) A pharmacy benefit manager must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to maximum allowable cost pricing. A network pharmacy may appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. An appeal requested under this section must be completed within 30 calendar days of the pharmacy making the claim for which appeal has been requested.

(4) A pharmacy benefit manager must provide as part of the appeals process established under subsection (3) of this section:

(a) A telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals;

(b) A final response to an appeal of a maximum allowable cost within seven business days; and

(c) If the appeal is denied, the reason for the denial and the national drug code of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the maximum allowable cost.

(5)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall make an adjustment on the date that the pharmacy benefit manager makes the determination. The pharmacy benefit manager shall make the adjustment effective for all similarly situated pharmacies in this state that are within the network.

(b) If the request for an adjustment has come from a critical access pharmacy, as defined by the Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, the adjustment approved under paragraph (a) of this subsection shall apply only to critical access pharmacies.

(6) This section does not apply to the state medical assistance program. [2013 c.570 §11]

Note: The amendments to 735.534 by section 13, chapter 570, Oregon Laws 2013, become operative January 1, 2015, and apply to contracts entered into, renewed or extended on or after January 1, 2015. See sections 12 and 14, chapter 570, Oregon Laws 2013. The text that is operative on and after January 1, 2015, is set forth for the user's convenience.

735.534. (1) As used in this section:

(a) "List" means the list of drugs for which maximum allowable costs have been established.

(b) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.

(c) "Multiple source drug" means a therapeutically equivalent drug that is available from at least two manufacturers.

(d) "Network pharmacy" means a retail drug outlet registered under ORS 689.305 that contracts with a pharmacy benefit manager.

(e) "Therapeutically equivalent" has the meaning given that term in ORS 689.515.

(2) A pharmacy benefit manager:

(a) May not place a drug on a list unless there are at least two therapeutically equivalent, multiple source drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.

(b) Shall ensure that all drugs on a list are generally available for purchase by pharmacies in this state from national or regional wholesalers.

(c) Shall ensure that all drugs on a list are not obsolete.

(d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the maximum allowable cost pricing of the pharmacy benefit manager.

(e) Shall make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy.

(f) Shall update each list maintained by the pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format.

(g) Shall ensure that dispensing fees are not included in the calculation of maximum allowable cost.

(3) A pharmacy benefit manager must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to maximum allowable cost pricing. A network pharmacy may appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. An appeal requested under this section must be completed within 30 calendar days of the pharmacy making the claim for which appeal has been requested.

(4) A pharmacy benefit manager must provide as part of the appeals process established under subsection (3) of this section:

(a) A telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals;

(b) A final response to an appeal of a maximum allowable cost within seven business days; and

(c) If the appeal is denied, the reason for the denial and the national drug code of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the maximum allowable cost.

(5)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall make an adjustment for the pharmacy that requested the appeal from the date of initial adjudication forward.

(b) If the request for an adjustment has come from a critical access pharmacy, as defined by the Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, the adjustment approved under paragraph (a) of this subsection shall apply only to critical access pharmacies.

(6) This section does not apply to the state medical assistance program.

Note: See note under 735.530.

735.540 Definitions for ORS 735.540 to 735.552. As used in ORS 735.540 to 735.552:

(1) "Audit" means an on-site or remote review of the records of a pharmacy by or on behalf of an entity.

(2) "Clerical error" means a minor error:

(a) In the keeping, recording or transcribing of records or documents or in the handling of electronic or hard copies of correspondence;

(b) That does not result in financial harm to an entity; and

(c) That does not involve dispensing an incorrect dose, amount or type of medication or dispensing a prescription drug to the wrong person.

(3) "Entity" includes:

(a) A pharmacy benefit manager;

(b) An insurer;

(c) A third party administrator;

(d) A state agency; or

(e) A person that represents or is employed by one of the entities described in this subsection.

(4) "Fraud" means knowingly and willfully executing or attempting to execute a scheme, in connection with the delivery of or payment for health care benefits, items or services, that uses false or misleading pretenses, representations or promises to obtain any money or property owned by or under the custody or control of any person. [2013 c.570 §4]

Note: See note under 735.530.

735.542 Pharmacy claims audits; requirements. An entity that audits claims or an independent third party that contracts with an entity to audit claims:

(1) Must establish, in writing, a procedure for a pharmacy to appeal the entity's findings with respect to a claim and must provide a pharmacy with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the pharmacy's claims;

(2) May not conduct an audit of a claim more than 24 months after the date the claim was adjudicated by the entity;

(3) Must give at least 15 days' advance written notice of an on-site audit to the pharmacy or corporate headquarters of the pharmacy;

(4) May not conduct an on-site audit during the first five days of any month without the pharmacy's consent;

(5) Must conduct the audit in consultation with a pharmacist who is licensed by this or another state if the audit involves clinical or professional judgment;

(6) May not conduct an on-site audit of more than 250 unique prescriptions of a pharmacy in any 12-month period except in cases of alleged fraud;

(7) May not conduct more than one on-site audit of a pharmacy in any 12-month period;

(8) Must audit each pharmacy under the same standards and parameters that the entity uses to audit other similarly situated pharmacies;

(9) Must pay any outstanding claims of a pharmacy no more than 45 days after the earlier of the date all appeals are concluded or the date a final report is issued under ORS 735.550 (3);

(10) May not include dispensing fees or interest in the amount of any overpayment assessed on a claim unless the overpaid claim was for a prescription that was not filled correctly;

(11) May not recoup costs associated with:

(a) Clerical errors; or

(b) Other errors that do not result in financial harm to the entity or a consumer; and

(12) May not charge a pharmacy for a denied or disputed claim until the audit and the appeals procedure established under subsection (1) of this section are final. [2013 c.570 §5]

Note: See note under 735.530.

735.544 Pharmacy claims audits; standards for review of claims. An entity's finding that a claim was incorrectly presented or paid must be based on identified transactions and not based on probability sampling, extrapolation or other means that project an error using the number of patients served who have a similar diagnosis or the number of similar prescriptions or refills for similar drugs. [2013 c.570 §6]

Note: See note under 735.530.

735.546 Pharmacy claims audits; auditors. An entity that contracts with an independent third party to conduct audits may not:

(1) Agree to compensate the independent third party based on a percentage of the amount of overpayments recovered; or

(2) Disclose information obtained during an audit except to the contracting entity, the pharmacy subject to the audit or the holder of the policy or certificate of insurance that paid the claim. [2013 c.570 §7]

Note: See note under 735.530.

735.548 Pharmacy claims audits; validation of claims. For purposes of ORS 735.540 to 735.552, an entity, or an independent third party that contracts with an entity to conduct audits, must allow as evidence of validation of a claim:

(1) An electronic or physical copy of a prescription that complies with ORS chapter 689 if the prescribed drug was, within 14 days of the dispensing date:

(a) Picked up by the patient or the patient's designee;

(b) Delivered by the pharmacy to the patient; or

(c) Sent by the pharmacy to the patient using the United States Postal Service or other common carrier;

(2) Point of sale electronic register data showing purchase of the prescribed drug, medical supply or service by the patient or the patient's designee; or

(3) Electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited pharmacy's central operations and any other reasonably clear and accurate electronic documentation that corresponds to a claim. [2013 c.570 §8]

Note: See note under 735.530.

735.550 Pharmacy claims audits; reports of findings; opportunity to resubmit claim and to contest finding. (1)(a) After conducting an audit, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the pharmacy no later than 45 days after the date on which the audit was completed and must be sent:

(A) By mail or common carrier with a return receipt requested; or

(B) Electronically with electronic receipt confirmation.

(b) An entity shall provide a pharmacy receiving a preliminary report under this subsection no fewer than 45 days after receiving the report to contest the report or any findings in the report in accordance with the appeals procedure established under ORS 735.542 (1) and to provide additional documentation in support of the claim. The entity shall consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report.

(2) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including facsimile, mail or electronic mail.

(3) An entity must provide a pharmacy that is the subject of an audit with a final report of the audit no later than 60 days after the later of the date the preliminary report was received or the date the pharmacy contested the report using the appeals procedure established under ORS 735.542 (1). The final report must include a final accounting of all moneys to be recovered by the entity.

(4) Recoupment of disputed funds from a pharmacy by an entity or repayment of funds to an entity by a pharmacy, unless otherwise agreed to by the entity and the pharmacy, shall occur after the audit and the appeals procedure established under ORS 735.542 (1) are final. If the identified discrepancy for an individual audit exceeds $40,000, any future payments to the pharmacy may be withheld by the entity until the audit and the appeals procedure established under ORS 735.542 (1) are final. [2013 c.570 §9]

Note: See note under 735.530.

735.552 Pharmacy claims audits; exception for fraud. ORS 735.540 to 735.552 do not:

(1) Preclude an entity from instituting an action for fraud against a pharmacy;

(2) Apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is evidenced by physical review, review of claims data or statements or other investigative methods; or

(3) Apply to a state agency that is conducting audits or a person that has contracted with a state agency to conduct audits of pharmacy records for prescription drugs paid for by the state medical assistance program. [2013 c.570 §10]

Note: See note under 735.530.

MEDICAL INSURANCE POOL
(Oregon 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]

Note: 735.600 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

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.

(b) Any reinsurer reinsuring medical insurance in this state.

(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.

(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.

(5) "Medical insurance" means insurance of humans against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness or childbirth, or against expense incurred in prevention of sickness, in dental care or optometrical service, and every insurance appertaining thereto, including insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan. "Medical insurance" does not include workers' compensation coverages.

(6) "Medicare" means coverage under Part A, Part B and Part D of Title XVIII of the Social Security Act, 42 U.S.C. 1395c 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; 2003 c.33 §4; 2005 c.634 §4; 2009 c.695 §1]

Note: 735.605 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

735.610 Oregon Medical Insurance Pool Board; members; authority; rules. (1) There is created in the Oregon Health Authority 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 and sections 1, 2 and 4, chapter 698, Oregon Laws 2013.

(2)(a) The board shall consist of 12 individuals, 10 of whom shall be appointed by the Director of the Oregon Health Authority. The Director of the Department of Consumer and Business Services or the director's designee and the Director of the Oregon Health Authority or the director's designee shall be members 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:

(A) One representative of a domestic insurance company licensed to transact health insurance;

(B) One representative of a domestic not-for-profit health care service contractor;

(C) One representative of a health maintenance organization;

(D) One representative of reinsurers; and

(E) Four members of the general public:

(i) Who are not associated with the medical profession, a hospital or an insurer; and

(ii) Two of whom represent businesses that purchase health insurance coverage that is subject to the assessments under section 2, chapter 698, Oregon Laws 2013.

(b) A majority of the voting members of the board constitutes a quorum for the transaction of business. An act by a majority of a quorum is an official act of the board.

(3) The Director of the Oregon Health Authority may fill any vacancy on the board by appointment.

(4) The board shall have 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 organiza-

tions 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) Appoint from among insurers appropriate actuarial and other committees as necessary to provide technical assistance in the operation of the pool and the Oregon Reinsurance Program, and for any other function within the authority of the board;

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

(f) Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to 735.650 and the operation of and participation of issuers of reinsurance eligible health benefit plans in the program.

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

(6) The Director of the Oregon Health Authority shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650 and sections 1, 2 and 4, chapter 698, Oregon Laws 2013.

(7) In consultation with the board, the Director of the Oregon Health Authority shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650 and sections 1, 2 and 4, chapter 698, Oregon Laws 2013. [1987 c.838 §4; 1989 c.838 §7; 1993 c.744 §190; 1995 c.79 §361; 2001 c.356 §1; 2003 c.364 §95; 2009 c.595 §1118; 2009 c.828 §71; 2011 c.70 §19; 2013 c.698 §6]

Note: 735.610 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

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.

(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 and sections 1, 2 and 4, chapter 698, Oregon Laws 2013.

(3) The Oregon Medical Insurance Pool Board shall transfer to the Oregon Health Authority Fund established in ORS 413.101 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; 2009 c.595 §1119; 2013 c.698 §14]

Note: 735.612 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

735.614 [1989 c.838 §4; 1991 c.333 §1; 1995 c.603 §28; 2005 c.304 §1; 2005 c.635 §1; 2009 c.595 §1120; 2009 c.695 §3; 2011 c.131 §1; repealed by 2013 c.698 §42 and 2013 c.640 §20]

735.615 Eligibility for pool coverage; rules. (1) Except as provided in subsection (3) of this section, a person who is a resident of this state, as defined by the Oregon Medical Insurance Pool Board, is eligible for medical 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)(a)(A), (B) or (D), 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;

(c) The person is a spouse or dependent of a person described in paragraph (a) or (b) of this subsection; or

(d) The person is eligible for the credit for health insurance costs under section 35 of the federal Internal Revenue Code, as amended and in effect on December 31, 2004.

(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) and subsection (5) of this section, the person is eligible for Medicare;

(b) The person is eligible to receive health services as defined in ORS 414.025 that meet or exceed those adopted by the board;

(c) The person has terminated coverage in the pool within the last 12 months and the termination was for:

(A) A reason other than becoming eligible to receive health services as defined in ORS 414.025; or

(B) A reason that does not meet exception criteria established by the board;

(d) The person has exceeded the maximum lifetime benefit established by the board;

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

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

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

(4) A person applying for coverage shall establish initial eligibility by providing evidence that the board requires.

(5)(a) Notwithstanding ORS 735.625 (4)(c), if a person:

(A) 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) Is eligible for Medicare but is not yet eligible to enroll in Medicare Parts B and D, the individual may receive coverage under the pool until enrolled in Medicare Parts B and D.

(b) The board may adopt rules concerning the terms and conditions for the coverage provided under paragraph (a) of this subsection.

(6) The board may adopt rules to establish additional eligibility requirements for a person described in subsection (1)(d) of this section. [1987 c.838 §5; 1989 c.838 §11; 1993 c.130 §1; 1993 c.212 §1; 1999 c.754 §1; 2005 c.305 §§1,3; 2005 c.634 §1; 2005 c.635 §§2,3; 2009 c.695 §4; 2011 c.70 §20; 2011 c.602 §57]

Note: 735.615 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

735.616 Portability coverage under pool. (1) An applicant may qualify for portability health insurance coverage under the Oregon Medical Insurance Pool if:

(a) An application for coverage is made not later than the 63rd day after the date of first eligibility and is made before December 1, 2013; and

(b) The individual is an Oregon resident at the time of the application.

(2) 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:

(a) An individual who has left coverage that was in effect for a minimum of 180 consecutive days under one or more group health benefit plans, if the terminated coverage was in a plan issued or established in a state other than Oregon;

(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 in effect for an uninterrupted 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.

(3) Eligibility for coverage pursuant to subsections (1) and (2) 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 (2)(b) of this section, the date of first eligibility is the day following the loss of the group or portability coverage.

(4) Coverage under the Oregon Medical Insurance Pool pursuant to subsections (1) and (2) 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; 2009 c.695 §5; 2013 c.698 §15]

Note: 735.616 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

Note: 743.760 was repealed by section 65, chapter 681, Oregon Laws 2013, as amended by section 21, chapter 640, Oregon Laws 2013. The text of 735.616 was not amended by enactment of the Legislative Assembly to reflect the repeal. Editorial adjustment of 735.616 for the repeal of 743.760 has not been made.

735.620 Administration of insurance pool program. (1) Except as provided in subsection (4) of this section, the Oregon Medical Insurance Pool Board shall select an insurer or insurers through a competitive bidding process to administer the insurance program or components of the insurance program. The board shall evaluate bids submitted based on criteria established by the board that include but are not limited to:

(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 be responsible for one or more of the following:

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

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

(c) Performing 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) Submitting 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, determining net written and earned premiums, the expense of administration and the paid and incurred losses for the year and reporting this information to the board on a form prescribed by the board.

(f) Being paid as provided in the plan of operation for its expenses incurred in the performance of its services.

(4) The board may contract with third party administrators or other vendors to provide services described in subsection (5) of this section that are in addition to or that

replace services provided by the administering insurer.

(5) A third party administrator or vendor may provide services that include but are not limited to:

(a) Any or all of the services provided by an administering insurer.

(b) Disease case management.

(c) Direct provider or provider network contracts.

(d) Pharmacy benefit management. [1987 c.838 §6; 1989 c.838 §12; 2005 c.635 §4]

Note: 735.620 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

735.625 Coverage; rules. (1) Except as provided in subsection (3)(c) of this section, the Oregon Medical Insurance Pool Board shall offer major medical expense coverage to every eligible person. The board may not offer coverage under this section after December 31, 2013.

(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 portability coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to the portability health benefit plans established under ORS 743.760.

(b) In establishing medical insurance coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to those found in the commercial group or employer-based medical insurance market.

(c) 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.

(d) In establishing medical insurance coverage for persons eligible for coverage under ORS 735.615 (1)(d), the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations to create benefit plans that qualify the person for the credit for health insurance costs under section 35 of the federal Internal Revenue Code, as amended and in effect on December 31, 2004.

(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 for persons eligible for pool coverage under ORS 735.615 (1)(d), or 100 percent of rates established as applicable for portability eligible individuals.

(d) The board shall annually determine adjusted benefits and premiums. The adjustments shall 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) The board may apply:

(A) A waiting period of not more than 90 days during which the person has no available coverage; or

(B) Except as provided in paragraph (c) of this subsection, a preexisting conditions provision of not more than six months from the effective date of coverage under the pool.

(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.

(c) The board may adopt rules applying a preexisting conditions provision to a person who is eligible for coverage under ORS 735.615 (1)(d).

(d) For purposes of this subsection, 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.

(6)(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 the Medicaid portion of the medical assistance program.

(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.

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

(8) 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; 2003 c.684 §5; 2005 c.634 §2; 2005 c.635 §5a; 2009 c.595 §1120a; 2013 c.688 §93; 2013 c.698 §16]

Note: 735.625 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

Note: 743.760 was repealed by section 65, chapter 681, Oregon Laws 2013, as amended by section 21, chapter 640, Oregon Laws 2013. The text of 735.625 was not amended by enactment of the Legislative Assembly to reflect the repeal. Editorial adjustment of 735.625 for the repeal of 743.760 has not been made.

735.630 Exemption from liability. Neither participation in the Oregon Medical Insurance Pool or the Oregon Reinsurance Program 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 and sections 1, 2 and 4, chapter 698, Oregon Laws 2013, 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 Oregon Health Authority, 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; 2009 c.595 §1121; 2013 c.698 §7]

Note: 735.630 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

735.635 Exemption from taxation. The Oregon Medical Insurance Pool established pursuant to ORS 735.600 to 735.650 and the Oregon Reinsurance Program established in section 1, chapter 698, Oregon Laws 2013, shall be exempt from any and all taxes assessed by the State of Oregon. [1987 c.838 §10; 1989 c.838 §15; 2013 c.698 §8]

Note: 735.635 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

735.640 [1987 c.838 §12; 1989 c.838 §16; repealed by 2013 c.698 §42 and 2013 c.640 §20]

735.645 Notice of existence of pool. Every insurer shall include a notice of the existence of the Oregon Medical Insurance Pool in any adverse underwriting decision, issued on or before November 30, 2013, on individual medical insurance for reasons of the health of the applicant, as described in ORS 735.615 (1)(a). [1987 c.838 §13; 1989 c.838 §17; 1993 c.130 §3; 2005 c.22 §489; 2005 c.634 §3; 2013 c.698 §17]

Note: 735.645 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

735.650 Application of provisions of Insurance Code. 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, 743.801, 743.803, 743.804,

743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.834, 743.837, 743.839, 743.845, 743A.084, 743A.090, 746.005 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690. [1987 c.838 §14; 1989 c.701 §72; 1989 c.838 §18; 1999 c.987 §3; 2001 c.356 §4; 2003 c.87 §20; 2013 c.698 §18]

Note: 735.650 is repealed July 1, 2017. See section 42, chapter 698, Oregon Laws 2013, as amended by section 20, chapter 640, Oregon Laws 2013.

735.700 [Formerly 653.705; 2003 c.742 §§1,6; 2005 c.238 §§1,2; 2005 c.262 §§1,2; 2005 c.727 §§1,2; 2005 c.744 §§14,15; 2011 c.70 §23; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.701 [2005 c.744 §2; 2009 c.595 §1123; 2009 c.867 §49; 2013 c.365 §5; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.702 [Formerly 653.715; 2003 c.364 §96; 2003 c.742 §§2,7; 2005 c.744 §§16,17; 2011 c.70 §24; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.703 [2005 c.744 §3; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.704 [Formerly 653.725; repealed by 2005 c.744 §41]

735.705 [2005 c.744 §4; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.706 [2001 c.716 §16; 2005 c.744 §18; 2009 c.595 §1124; repealed by 2009 c.595 §1204]

735.707 [2005 c.744 §5; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.708 [Formerly 653.735; repealed by 2005 c.744 §41]

735.709 [2005 c.744 §10; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.710 [Formerly 653.745; 2003 c.742 §§3,8; 2005 c.238 §§3,4; 2005 c.262 §§3,4; 2005 c.727 §§3,4; 2005 c.744 §§19,20; 2011 c.70 §25; 2013 c.365 §6; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.711 [2007 c.619 §3; repealed by 2011 c.720 §228]

735.712 [Formerly 653.747; 2005 c.744 §21; repealed by 2013 c.681 §65 and 2013 c.640 §21]

735.714 [2003 c.742 §12; 2005 c.744 §22; repealed by 2011 c.70 §26]

735.720 [Formerly 653.800; 2003 c.684 §8; 2005 c.727 §§5,5a; 2005 c.744 §§23d,23e,23g; 2007 c.70 §317; renumbered 414.841 in 2009]

COMMUNITY-BASED HEALTH CARE INITIATIVES

735.721 Definitions for ORS 735.721 to 735.727. As used in ORS 735.721 to 735.727:

(1) "Community" means the area of geographically contiguous political subdivisions as determined by the Office for Oregon Health Policy and Research in collaboration with the board of directors of a community-based health care initiative.

(2) "Qualified employee" means an individual who:

(a) Is employed by a qualified employer;

(b) Resides or works within a community;

(c) Does not have health insurance; and

(d) Does not qualify for publicly funded health care.

(3) "Qualified employer" means an employer that:

(a) Employs 1 to 50 full-time equivalent employees;

(b) Pays a median wage to its employees that is equal to or below an amount that is 300 percent of the federal poverty guidelines;

(c) For two months prior to enrollment in a community-based health care improvement program, or for the duration of the employer's operation if the employer has been in operation less than two months, has not provided to employees employer-based health insurance coverage for which the employer contributes at least 50 percent of the cost of premiums;

(d) Offers community-based health care services through a community-based health care improvement program to all qualified employees and their dependents regardless of health status;

(e) Agrees to participate in a community-based health care improvement program for at least 12 months; and

(f) Agrees to provide information that is deemed necessary by the community-based health care initiative to determine eligibility, assess dues and pay claims. [2009 c.470 §1; 2013 c.69 §1]

Note: 735.721 to 735.727 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.

735.722 [Formerly 653.805; 2003 c.128 §1; 2003 c.683 §4; 2003 c.784 §12; 2005 c.238 §6; 2005 c.262 §6; 2005 c.727 §6; 2005 c.744 §24a; 2009 c.595 §1125; renumbered 414.842 in 2009]

735.723 Requirements for approval; rules. (1) The Administrator of the Office for Oregon Health Policy and Research shall adopt rules for the approval of one community-based health care initiative per community that meets the requirements under subsection (2) of this section and of a community-based health care improvement program that meets the requirements under subsection (3) of this section. The office may not approve community-based health care initiatives for more than three communities during the period beginning with June 23, 2009, and ending June 30, 2013.

(2) An approved community-based health care initiative shall:

(a) Be a nonprofit corporation governed by a board of directors that includes, but is not limited to, representatives of participating health care providers and qualified employers. At least 80 percent of the board

members must be residents of the community.

(b) Contract with health care providers that offer health care services in the community to provide services to enrollees in the program.

(c) Recruit qualified employers to enroll in the program.

(d) Establish an operational structure for:

(A) Assisting employees of qualified employers or their dependents to enroll in state medical assistance programs if appropriate;

(B) Enrolling qualified employees and their dependents in the community-based health care improvement program;

(C) Billing and collecting dues from qualified employers and qualified employees; and

(D) Reimbursing participating health care providers for services to enrollees.

(e) Establish a set of health care services that are covered in the community-based health care improvement program, cost-sharing requirements and incentives to encourage the utilization of primary care, wellness and chronic disease management services.

(f) Maintain a liquid reserve account in an amount sufficient to pay all claims that have been incurred but not yet charged for a period of at least two months.

(g) Provide to each qualified employee enrolled in the program a clear and concise written statement that describes the community-based health care improvement program and that includes:

(A) The health care services that are covered;

(B) Any exclusions or limitations on coverage of health care services, including any requirements for prior authorization;

(C) Copayments, coinsurance, deductibles and any other cost-sharing requirements;

(D) A list of participating health care providers;

(E) The complaint process described in subsection (3)(b) of this section; and

(F) The conditions under which the program or coverage through the program may be terminated.

(h) Comply with the requirements of ORS 735.725 and 735.727.

(3) An approved community-based health care improvement program shall:

(a) Reimburse the cost of the set of health care services established by the initiative and provided in the community to qualified employers, qualified employees and their dependents.

(b) Include an enrollee complaint process that ensures the resolution of complaints within 45 days.

(4) An individual who is a qualified employee and whose employment with a qualified employer terminates may elect to continue enrollment of the individual and the individual's dependents in an approved community-based health care improvement program for no more than 18 months by paying the required dues. The dues may not be greater than the amount that would be charged if the individual remained a qualified employee. An approved community-based health care initiative must notify an employee of the opportunity to continue coverage upon the individual's termination of coverage under the qualified employer's program. [2009 c.470 §2; 2013 c.69 §2]

Note: See note under 735.721.

735.724 [Formerly 653.810; 2003 c.128 §2; 2003 c.683 §1; 2005 c.238 §7; 2005 c.262 §7; 2005 c.727 §7; 2005 c.744 §25; renumbered 414.844 in 2009]

735.725 Enrollment requirements. (1) A community-based health care initiative may limit enrollment in a community-based health care improvement program. If enrollment is limited, the initiative must establish a waiting list.

(2) Except as provided in this section, an initiative may not restrict or deny enrollment in the program except for nonpayment of dues, fraud or misrepresentation.

(3) As a condition for enrolling a qualified employer and maintaining the employer's enrollment in the program, an initiative may require a minimum percentage of participation by qualified employees of an employer. [2009 c.470 §3]

Note: See note under 735.721.

735.726 [Formerly 653.815; 2005 c.744 §26; renumbered 414.846 in 2009]

735.727 Annual report to Legislative Assembly. A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research must report to the Legislative Assembly no later than October 1 of each year. The report must contain at a minimum the following information:

(1) The financial status of the community-based health care improvement program, including the dues, the costs per enrollee per month, the total amount of claims paid, the total amount of dues collected and the administrative expenses;

(2) A description of the set of health care services covered by the program and an analysis of service utilization;

(3) The number of qualified employers, qualified employees and dependents enrolled;

(4) The number and scope of practice of participating health care providers;

(5) Recommendations for improving the program and establishing programs in other geographical regions of the state; and

(6) Any other information requested by the administrator or the Legislative Assembly. [2009 c.470 §4]

Note: See note under 735.721.

OREGON REINSURANCE PROGRAM

Note: Sections 1, 2, 4, 4a and 42 (2), chapter 698, Oregon Laws 2013, provide:

Sec. 1. The Oregon Reinsurance Program is established in the Oregon Health Authority. The program shall be administered by the Oregon Medical Insurance Pool Board, created in ORS 735.610, for the purposes of stabilizing the rates and premiums for individual health benefit plans and providing greater financial certainty to consumers of health insurance in this state by providing state reinsurance payments to insurers from assessments described in section 2 of this 2013 Act. [2013 c.698 §1]

Sec. 2. (1) As used in this section, section 1, chapter 698, Oregon Laws 2013, and ORS 735.610:

(a) "Health benefit plan" has the meaning given that term in ORS 743.730.

(b) "Insurer" means an insurer described in ORS 735.605 (4)(a), (b) and (d).

(c) "Program" means the Oregon Reinsurance Program established in section 1, chapter 698, Oregon Laws 2013.

(d) "Reinsurance eligible health benefit plan" means a health benefit plan providing individual coverage that:

(A) Is delivered or issued for delivery in this state;

(B) Is not a grandfathered health plan as defined in ORS 743.730; and

(C) Meets the criteria prescribed by the Oregon Medical Insurance Pool Board under subsection (2) of this section.

(e) "Reinsurance eligible individual" means an individual who is insured on or before April 1, 2014, under a reinsurance eligible health benefit plan and who was:

(A) On December 31, 2013, enrolled in the Oregon Medical Insurance Pool created in ORS 735.610;

(B) On June 30, 2013, enrolled in the Temporary High Risk Pool Program established in section 1, chapter 47, Oregon Laws 2010;

(C) On December 31, 2013, insured under a portability health benefit plan as defined in ORS 743.760; or

(D) On December 31, 2013, reinsured under the reinsurance program for children's coverage described in ORS 735.614 (1)(b).

(2) The board shall prescribe by rule the criteria for a health benefit plan to qualify for reinsurance payments under the program. The criteria must be consistent with requirements for:

(a) Premium rates under 42 U.S.C. 300gg;

(b) Guaranteed availability under 42 U.S.C. 300gg-1;

(c) Guaranteed renewability under 42 U.S.C. 300gg-2;

(d) Coverage of essential health benefits under 42 U.S.C. 18022; and

(e) Using a single risk pool under 42 U.S.C. 18032(c).

(3) An issuer of a reinsurance eligible health benefit plan becomes eligible for a reinsurance payment when the claims costs for a reinsurance eligible individual's covered benefits in a calendar year exceed the attachment point. The amount of the payment shall be the product of the coinsurance rate and the issuer's claims costs for the reinsurance eligible individual's claims costs that exceed the attachment point, up to the reinsurance cap, as follows:

(a) For 2014:

(A) The attachment point is $30,000.

(B) The reinsurance cap is $300,000.

(C) Except as provided in paragraph (b) of this subsection, the coinsurance rate is:

(i) Ten percent for claims costs above $60,000 and up to and including $250,000; and

(ii) Ninety percent for claims costs from $30,000 and up to and including $60,000 and above $250,000.

(b) The board may lower the coinsurance rate if the reinsurance claims incurred exceed the total amount of the assessments collected under subsection (4) of this section.

(c) The board shall adopt by rule an attachment point, reinsurance cap and coinsurance rate for calendar years 2015 and 2016 that complement the federal reinsurance program requirements, so that the reinsurance claims do not exceed the total amount of the assessments collected under subsection (4) of this section. After the rules required under this paragraph are adopted for a calendar year, the board may not:

(A) Change the attachment point or the reinsurance cap adopted for that calendar year; or

(B) Increase the coinsurance rate adopted for that calendar year.

(4) The board shall impose an assessment on all insurers at a rate that is expected to produce an amount of funds sufficient to pay administrative expenses and to make reinsurance payments that are due to issuers of reinsurance eligible health benefit plans in a calendar year, but not greater than the rate that would be expected to produce funds totaling the lesser of:

(a) An amount per month multiplied by the number of insureds and certificate holders in this state who are insured or reinsured; or

(b) The total assessment set forth in subsection (5) of this section.

(5) The amount per month and total assessment on all insurers are as follows:

(a) For calendar year 2014, the amount per month is $4 and the total assessment is $72 million.

(b) For calendar year 2015, the amount per month is $3.50 and the total assessment is $63 million.

(c) For calendar year 2016, the amount per month is $2.20 and the total assessment is $40 million.

(6) In determining the number of insureds and certificate holders in this state who are insured or reinsured, the board shall exclude individuals with the following types of coverage:

(a) The medical assistance program under ORS chapter 414;

(b) Medicare;

(c) Disability income insurance;

(d) Hospital-only insurance;

(e) Dental-only insurance;

(f) Vision-only insurance;

(g) Accident-only insurance;

(h) Automobile insurance;

(i) Specific disease insurance;

(j) Medical supplemental plans;

(k) TRICARE;

(L) Prescription drug only plans;

(m) Long term care insurance; and

(n) Federal Employees Health Benefits Program.

(7) If the board collects assessments that exceed the amount necessary to pay administrative expenses and to make all of the reinsurance payments that are due to issuers of reinsurance eligible health benefit plans in calendar years 2014, 2015 and 2016, the board shall refund the excess, on a pro rata basis, to insurers who are subject to the assessment imposed by subsection (4) of this section.

(8) The board may not impose an assessment under subsection (4) of this section for calendar years beginning with 2017.

(9) All moneys received or collected by the board under this section shall be paid into the Oregon Medical Insurance Pool Account established in ORS 735.612.

(10) The board, in consultation with the Department of Consumer and Business Services, may adopt rules necessary to carry out the provisions of this section including, but not limited to, rules prescribing:

(a) The eligibility requirements for participation in the program by an issuer of a reinsurance eligible health benefit plan;

(b) The form and manner of issuing notices of assessment amounts;

(c) The amount, manner and frequency of the payment and collection of assessments;

(d) The amount, manner and frequency of reinsurance payments; and

(e) Reporting requirements for insurers subject to the assessment and for issuers of reinsurance eligible health benefit plans. [2013 c.698 §2; 2013 c.722 §32]

Sec. 4. (1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743.730.

(b) "Oregon Medical Insurance Pool Board" means the board created in ORS 735.610.

(c) "Oregon Reinsurance Program" means the program created in section 1 of this 2013 Act.

(d) "Reinsurance eligible individual" has the meaning given that term in section 2 of this 2013 Act.

(2) An insurer that offers a health benefit plan must report to the Oregon Medical Insurance Pool Board, in the form and manner prescribed by the board by rule, information about reinsurance eligible individuals insured by the health benefit plan, as necessary for the board to calculate reinsurance payments under the Oregon Reinsurance Program. [2013 c.698 §4]

Sec. 4a. In a rate filing under ORS 743.018, an insurer must identify the impact of:

(1) State reinsurance payments under section 2 of this 2013 Act and federal reinsurance payments on projected claims costs and in the development of rates; and

(2) Assessments imposed under section 2 of this 2013 Act on rates. [2013 c.698 §4a]

Sec. 42. (2) Sections 1, 2, 4 and 4a, chapter 698, Oregon Laws 2013, and ORS 735.600, 735.605, 735.610, 735.612, 735.615, 735.616, 735.620, 735.625, 735.630, 735.635, 735.645 and 735.650 are repealed July 1, 2017. [2013 c.698 §42(2); 2013 c.640 §20(2)]

735.728 [Formerly 653.820; 2005 c.744 §27; renumbered 414.848 in 2009]

735.730 [Formerly 653.825; 2005 c.744 §28; renumbered 414.851 in 2009]

735.731 [2003 c.683 §3; 2003 c.735 §12; 2005 c.744 §29; renumbered 414.852 in 2009]

735.732 [Formerly 653.830; 2005 c.744 §30; renumbered 414.854 in 2009]

735.733 [2003 c.684 §11; 2005 c.744 §31; renumbered 414.856 in 2009]

735.734 [Formerly 653.835; 2005 c.744 §32; 2009 c.595 §1126; renumbered 414.858 in 2009]

735.736 [Formerly 653.840; 2005 c.744 §33; renumbered 414.861 in 2009]

735.738 [Formerly 653.845; 2005 c.238 §8; 2005 c.727 §8; renumbered 414.862 in 2009]

735.740 [Formerly 653.850; 2003 c.684 §9; 2005 c.744 §34; 2007 c.71 §238; renumbered 414.864 in 2009]

735.750 [2003 c.684 §1; 2005 c.744 §35; renumbered 414.866 in 2009]

735.752 [2003 c.684 §2; renumbered 414.868 in 2009]

735.754 [2003 c.684 §3; 2005 c.744 §36; 2009 c.595 §1127; renumbered 414.870 in 2009]

735.756 [2003 c.684 §4; 2009 c.595 §1128; renumbered 414.872 in 2009]

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