

Chapter 750

1989 EDITION

Health Care Service Contractors; Legal Expense Organizations

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INSURANCE

**HEALTH CARE SERVICE
CONTRACTORS**

750.003 Purpose. The purpose of this section and ORS 750.005, 750.025 and 750.045 is to encourage and guarantee the development of health care service contractors by licensing and regulating their operation to insure that they provide high quality health care services through state licensed organizations meeting reasonable standards as to administration, services and financial soundness. [1985 c.747 §64]

750.005 Definitions. (1) "Doctor" means any person lawfully licensed or authorized by statute to render any health care services.

(2) "Health care service contractor" means:

(a) Any corporation that is sponsored by or otherwise intimately connected with a group of doctors licensed by this state, or by a group of hospitals licensed by this state, or both, under contracts with groups of doctors or hospitals which include conditions holding the subscriber harmless in the event of non-payment by the health care service contract as provided in ORS 750.095, and which accepts prepayment for health care services;

(b) Any person referred to in ORS 750.035; or

(c) Any for-profit or not for-profit corporation that accepts prepayment for ambulance and emergency medical service, or ambulance service only, but not for other health care services.

(3) "Health maintenance organization" means any health care service contractor operated on a for-profit or not for-profit basis which:

(a) Qualifies under Title XIII of the Public Health Service Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

- (i) Usual physician services;
 - (ii) Hospitalization;
 - (iii) Laboratory;
 - (iv) X-ray;
 - (v) Emergency and preventive services;
- and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis;

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such

organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis; and

(D) Employs the terms "health maintenance organization" or "HMO" in its name, contracts, literature or advertising media on or before July 13, 1985.

(4) "Health care services" means the furnishing of medicine, medical or surgical treatment, nursing, hospital service, ambulance service, dental service, optometrical service or any or all of the enumerated services or any other necessary services of like character, whether or not contingent upon sickness or personal injury, as well as the furnishing to any person of any and all other services and goods for the purpose of preventing, alleviating, curing, or healing human illness, physical disability or injury.

(5) "Claims" means any amount incurred by the insurer covering contracted benefits. [Formerly 742.010; 1973 c.515 §5; 1979 c.799 §1; 1985 c.747 §65, 1989 c.783 §4]

750.010 [Amended by 1957 c.301 §1; 1961 c.116 §1; 1967 c.359 §548; renumbered 744.305]

750.015 Management to include representatives of public. (1) Except as provided in subsection (2) of this section, not less than one-third of the group of persons vested with the management of the affairs of a health care service contractor, as defined in ORS 750.005 (2)(a), shall be representatives of the public who are not practicing doctors or employees or trustees of a participant hospital.

(2)(a) Notwithstanding subsection (1) of this section, the group of persons vested with the management of the affairs of a nonprofit private organization described in this subsection shall have at least two representatives of the public who are not practicing doctors, as defined in ORS 750.005, or employees or trustees of a participant hospital.

(b) This subsection applies to a nonprofit private organization that is a health maintenance organization, as defined in ORS 442.015, that is controlled by a single nonprofit hospital or by a group of nonprofit hospitals under common ownership and that operates in a county with a population of 200,000 or more. [Formerly 742.015; 1983 c.804 §1]

750.020 [Amended by 1961 c.116 §2; 1967 c.359 §549, renumbered 744.315]

750.025 Restricting distribution of income and representation as health maintenance organization. (1) A health care service contractor which is a not for-profit corporation, shall not distribute, upon liquidation or otherwise, any part of its income to its members, directors, trustees or officers except for the reasonable value of services rendered such contractor.

(2) An organization that does not meet the definition of health maintenance organization in ORS 750.005 shall not hold itself out to the public to be a health maintenance organization. [Formerly 742.025, 1985 c.747 §66]

750.030 [Repealed by 1967 c.359 §704]

750.035 Regulation of hospital care associations under prior law; exceptions. (1) Notwithstanding any other provision of law, except as provided in subsection (2) of this section, any persons doing a hospital association business, as defined in ORS 742.010 (1959 Replacement Part) in compliance with ORS chapter 742 (1959 Replacement Part) on August 12, 1965, may continue such business in compliance with ORS chapter 742 (1959 Replacement Part).

(2) Every person doing a hospital association business, as defined in ORS 742.010 (1959 Replacement Part), on August 12, 1965, shall comply with the provisions of ORS 750.045, 750.055, 750.085 and 750.095. [Formerly 742.035; 1989 c.783 §5]

750.040 [Amended by 1967 c.359 §552; renumbered 744.345]

750.045 Required capitalization; deposit of security; exemptions. (1) A health care service contractor which is a for-profit or not for-profit corporation shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than \$250,000 or an amount equal to 50 percent of the average claims as defined in ORS 750.005 (5) for the preceding 12-month period, whichever is greater, but in no case shall the required amount be more than \$500,000.

(2) A health care service contractor which is a for-profit or not for-profit corporation shall file a surety bond or such other bond or securities in the sum of \$250,000 as are authorized by the Insurance Code as a guarantee of the due execution of the policies to be entered into by such contractor in accordance with ORS 750.005 to 750.095. This subsection does not apply to a health care service contractor that has at least 75 percent of its assets invested in health care service facilities pursuant to ORS 733.700.

(3) Subsections (1) and (2) of this section do not apply to ambulance service, emergency medical service, dental service or optometrical service operated on a for-profit or not for-profit basis if:

(a) The services referred to in this subsection maintain capital or surplus, or any combination thereof, of not less than \$50,000 or an amount equal to 50 percent of the average claims as defined in ORS 750.005 (5) for the preceding 12-month period whichever is greater, but in no case shall the required amount be more than \$500,000.

(b) The services referred to in this subsection file a surety bond or other such bond or securities in the sum of \$50,000 as are authorized by the Insurance Code as a guarantee of the due execution of the policies to be entered into by such contractor in accordance with ORS 750.005 to 750.095. [Formerly 742.050, 1975 c.273 §1; 1977 c.402 §1, 1985 c.747 §67]

Note: Section 69, chapter 747, Oregon Laws 1985, as amended by section 21, chapter 784, Oregon Laws 1989, provides:

Sec. 69. (1) The provisions of ORS 750.045 as amended by section 67, chapter 747, Oregon Laws 1985, apply to

(a) Health care service contractors initially authorized under the provisions of the Insurance Code on or after July 13, 1985; and

(b) Health care service contractors initially authorized under the provisions of the Insurance Code before July 1, 1985, as provided in subsection (2) of this section.

(2) A health care service contractor initially authorized under the Insurance Code before July 1, 1985, must satisfy the following capital and surplus requirements:

(a) Except as provided in paragraph (b) of this subsection, such a health care service contractor.

(A) Must possess and thereafter maintain capital and surplus required under ORS 750.045 as amended by section 67, chapter 747, Oregon Laws 1985, not later than December 31, 1993.

(B) Until December 31, 1993, must possess and maintain at least the capital and surplus required under ORS 750.045 (1985 Replacement Part).

(b) A health care service contractor to which this subsection applies who reapplies for a certificate of authority after having its certificate of authority revoked for any cause shall not be issued a new certificate of authority unless the health care service contractor complies with ORS 750.045 as amended by section 67, chapter 747, Oregon Laws 1985. [1985 c.747 §69, 1989 c.784 §21]

750.050 [Amended by 1961 c.116 §3; 1967 c.359 §553, renumbered 744.355]

750.055 Other provisions applicable to health care service contractors. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.386, 731.390, 731.398 to 731.430, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.844 to 731.992 and 743.013.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325, 732.505 to 732.595 and 732.605 to 732.705.

(c)(A) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.700 to 733.780, apply to not for-profit health care service contractors.

(B) ORS chapter 733 applies to for-profit health care service contractors.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.061, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.412, 743.472, 743.492, 743.495, 743.498, 743.523 to 743.527, 473.529, 743.549 to 743.555, 743.556, 743.610 to 743.622, 743.650 to 743.656, 743.701, 743.704, 743.706 to 743.712, 743.715 (1), 743.721 and 743.722.

(f) ORS 743.522 and 743.528, except that individual policies may be issued to the persons or families insured in lieu of issuance of a single group policy as referred to in ORS 743.522. An individual policy issued under this paragraph shall be considered the statement of the essential features of the insurance coverage required under ORS 743.528 (2).

(g) The provisions of ORS chapter 744 relating to the regulation of agents.

(h) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(i) ORS 743.714, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(j) ORS 743.557 and 743.558 (1985 Replacement Parts) except that group practice or staff health maintenance organizations which are federally qualified pursuant to Title XIII of the Public Health Service Act shall be deemed to comply with the requirements of ORS 743.557 and 743.558.

(k) ORS 735.600 to 735.650.

(L) ORS 743.680 to 743.689.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state which is not governed by the insurance laws of such state, will be subject to all requirements of ORS chapter 732.

(4) The director may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions. [1967 c.359 §659; 1969 c.336 §18, 1971 c.231 §41; 1973 c.143 §5; 1973 c.515 §6; 1973 c.613 §4a; 1975 c.135 §3; 1975 c.338 §4a; 1975 c.689 §4, 1975 c.784 §13c, 1977 c.402 §6; 1979 c.268 §7; 1979 c.708 §11; 1979 c.785 §22a; 1979 c.797 §3a, 1981 c.254 §3; 1981 c.319 §3, 1981 c.422 §6, 1981 c.649 §22, 1981 c.752 §14; 1983 c.601 §9; 1985 c.747 §68; 1985 c.827 §3; 1987 c.411 §3; 1987 c.720 §3; 1987 c.739 §5; 1987 c.774 §62; 1987 c.838 §16; 1989 c.255 §13; 1989 c.425 §15; 1989 c.474 §4; 1989 c.701 §76; 1989 c.784 §14; 1989 c.832 §3; 1989 c.1022 §11]

750.059 Application of reimbursement requirement to group practice maintenance organizations for services by state hospital or state-approved program. ORS 743.701 does not apply to group practice maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act (42 U.S.C. 300e et seq.). [1981 c.422 §2; 1981 c.891 §3]

750.060 [Amended by 1967 c.359 §555; renumbered 744.375]

750.065 Reimbursement for services performed by optometrists. (1) Notwithstanding any provision of contract or agreement entered into by a corporation, association, society, firm, partnership or individual doing business as a hospital association or as a health care service contractor, whenever such contract or agreement provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such contract or agreement shall be entitled to reimbursement for such service, whether the said service is performed by a physician or duly licensed optometrist. Unless such contract or agreement shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto.

(2) Nothing in subsection (1) of this section shall apply to any contract or agreement limited to the furnishing of services to be performed exclusively by members of the association, society, group or partnership issuing such contract or agreement. [1971 c.97 §2]

750.070 [Repealed by 1967 c.359 §704]

750.075 Excess benefits contracts authorized for ambulance and emergency services contractors; notice to director. Contracts issued by a health care service contractor described in ORS 750.005 (2)(c) may provide that the benefits on behalf of the insured will be excess over benefits provided for the same service from other types of sources, if disclosure of this provision is adequately made, in the opinion of the director, to the insured. All forms relating to such disclosure shall be filed with the director and shall be subject to the procedures set forth in ORS 742.003 and 742.007. [1979 c.799 §3]

750.080 [Amended by 1967 c.359 §557; renumbered 744.396]

INSOLVENCY OF HEALTH CARE SERVICE CONTRACTOR

750.085 Offer of replacement coverage upon order of liquidation; procedure. (1) When a final order of liquidation with a finding of insolvency has been entered with respect to a health care service contractor

by a court of competent jurisdiction in the domicile of the health care service contractor, subscribers of the health care service contractor shall be offered replacement coverage as provided in this section.

(2) All insurers and health care service contractors that participated with the insolvent health care service contractor in the open enrollment process at the last regular open enrollment period for a group shall offer members of the group that are subscribers of the insolvent health care service contractor an open enrollment period of 30 days, commencing on the date on which the final order of liquidation with a finding of insolvency was entered. Each of the insurers and health care service contractors shall offer the subscribers of the insolvent health care service contractor the same coverages and rates that the insurer or health care service contractor had offered to members of the group at its last regular open enrollment period.

(3) If no other insurer or health care service contractor offered health insurance coverage to a group or groups whose members are enrolled with the insolvent health care service contractor, or if the other insurers and health care service contractors lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group subscribers of the insolvent health care service contractor, the director shall equitably allocate the contract or contracts for the group or groups among all health care service contractors that operate within a portion of the service area of the insolvent health care service contractor. The director shall take into consideration the health care delivery resources of each health care service contractor. Each health care service contractor to which a group or groups are so allocated shall offer to each such group the existing coverage of the health care service contractor, at rates determined by the health care service contractor in accordance with its existing rating methodology. Each health care service contractor to whom a group or groups are allocated may reevaluate the group or groups at the end of the contractual period or at the end of six months after the allocation, whichever occurs first, in order to determine the appropriate premium for each such group.

(4) The director shall equitably allocate the nongroup subscribers of the insolvent health care service contractor that are unable to obtain other coverage among all health care service contractors that operate within a portion of the service area of the insolvent health care service contractor. The director shall take into consideration the

health care delivery resources of each health care service contractor. Each health care service contractor to which nongroup subscribers are allocated shall offer its existing individual or conversion coverage to nongroup subscribers, at rates determined in accordance with its existing rating methodology. A health care service contractor that does not offer direct nongroup enrollment may aggregate all of the allocated nongroup subscribers into one group for rating and coverage purposes. [1989 c 783 §2]

750.090 [Amended by 1967 c 359 §558, renumbered 744 405]

750.095 Requirements of contract between provider and subscriber; content.

(1) For the purpose of this section only, and only in the event of a finding of impairment by the Director of the Department of Insurance and Finance or of a final order of liquidation, as described in ORS 750.085, any covered health care service furnished within the state by a provider to a subscriber of a health care service contractor shall be considered to have been furnished pursuant to a contract between the provider and the health care service contractor with whom the subscriber was enrolled when the services were furnished.

(2) Each contract between a health care service contractor and a provider of health care services shall provide that if the health care service contractor fails to pay for covered health care services as set forth in the subscriber's evidence of coverage or contract, the subscriber is not liable to the provider for any amounts owed by the health care service contractor.

(3) If the contract between the contracting provider and the health care service contractor has not been reduced to writing or fails to contain the provisions required by subsection (2) of this section, the subscriber is not liable to the contracting provider for any amounts owed by the health care service contractor.

(4) No contracting provider or agent, trustee or assignee of the contracting provider may maintain a civil action against a subscriber to collect any amounts owed by the health care service contractor for which the subscriber is not liable to the contracting provider under this section.

(5) Nothing in this section impairs the right of a provider to charge, collect from, attempt to collect from or maintain a civil action against a subscriber for any of the following:

(a) Deductible, copayment or coinsurance amounts.

(b) Health care services not covered by the health care service contractor.

(c) Health care services rendered after the termination of the contract between the health care service contractor and the provider, unless the health care services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract.

(6) Nothing in this section prohibits a subscriber from seeking noncovered health care services from a provider and accepting financial responsibility for these services.

(7) No health care service contractor shall limit the right of a provider of health care services to contract with the patient for payment of services not within the scope of the coverage offered by the health care service contractor. [1989 c.783 §3]

750.100 [Amended by 1967 c.359 §556, renumbered 744.385]

750.110 [Repealed by 1967 c.359 §704]

750.210 [Repealed by 1967 c.359 §704]

750.220 [Repealed by 1967 c.359 §704]

750.230 [Repealed by 1967 c.359 §704]

750.240 [Repealed by 1967 c.359 §704]

750.250 [Repealed by 1967 c.359 §704]

750.260 [Repealed by 1967 c.359 §704]

750.270 [Repealed by 1967 c.359 §704]

750.300 [1973 c.97 §3, repealed by 1989 c.331 §35]

750.310 [1973 c.97 §4, repealed by 1989 c.331 §35]

750.320 [1973 c.97 §5; repealed by 1989 c.331 §35]

750.330 [1973 c.97 §7; 1989 c.331 §26, renumbered 750.635 in 1989]

750.340 [1973 c.97 §6, 1975 c.769 §9; 1989 c.331 §27, renumbered 750.705 in 1989]

LEGAL EXPENSE ORGANIZATIONS

750.505 Definitions for ORS 750.505 to 750.715. As used in ORS 750.505 to 750.715:

(1) "Legal expense organization" or "organization" means any person or group of persons who provide or offer to provide a legal expense plan, including any person who acts as its administrator.

(2) "Legal expense plan" or "plan" means the agreement between an organization and a person or a group of persons whereby legal services are to be provided to the person or group of persons as members, or whereby the persons as members are to be reimbursed for charges incurred for legal services, in consideration of a specified payment.

(3) "Member" means a person who is eligible to receive legal services under a legal expense plan.

(4) "Membership agreement" means the written evidence of coverage of a member under a plan between an organization and members.

(5) "Provider agreement" means a written contract or agreement between an organization and a providing attorney for the rendering of legal services to a member or group of persons.

(6) "Providing attorney" means any attorney licensed and in good standing in this state who provides legal services pursuant to the membership agreement.

(7) "Sales or marketing representative" means any person who markets or solicits members for or on behalf of a plan. [1989 c.331 §2]

750.515 Certificate of registration required. A person shall not transact business as a legal expense organization or otherwise offer, provide, market or do business on behalf of a plan unless the person holds a valid certificate of registration as a legal expense organization. [1989 c.331 §3]

750.525 Inapplicability of ORS 750.505 to 750.715 to certain legal services. ORS 750.505 to 750.715 do not apply to the following arrangements:

(1) Retainer contracts made by an attorney or firm of attorneys with a specific individual, pursuant to which fees are based on reasonable estimates of the nature and amount of services to be provided, and similar contracts made by an attorney or firm of attorneys with a group of clients involved in the same or closely related legal matters.

(2) Any two-party agreement providing for the delivery of specified legal services in return for a specified payment including an administrative fee, whereby an arrangement is made between an attorney or firm of attorneys and a group of individuals who are all members of the same bona fide nonprofit membership organization or group of individuals who are all employed by the same employer, the primary purpose of which is other than the provision of legal services. Such groups of individuals may be but are not limited to churches, trade groups, credit unions or associations. Under such an arrangement no third party such as a legal expense organization or sales or marketing representative may be involved in receiving any of the specified payments or in overseeing the delivery of the specified legal services.

(3) Referral of individual clients to an attorney to the extent that such referral is provided by a nonprofit lawyer referral service or public corporation such as a state or local bar association, so long as there is no charge for such referral.

(4) Employee welfare benefit plans to the extent that state regulation is preempted by Section 514 of the federal Employee Retirement Income Security Act of 1974, or successor legislation.

(5) Legal assistance plans financed primarily by public funds, interest on lawyers trust accounts funds under the regulation of the Oregon State Bar or other public service funds.

(6) Authorized insurers offering legal expense insurance in this state. [1989 c.331 §4]

750.535 Registration requirements. An applicant for registration as a legal expense organization must do all of the following in order to obtain registration:

(1) Apply for the registration under ORS 750.545.

(2) File with the director in writing the address, including street and number, and mailing address, if different, of the organization's initial registered office and the name of its initial registered agent at that office.

(3) Meet the following qualifications:

(a) The applicant must be financially responsible and the organization able to meet its obligations to its members.

(b) The directors, officers or managers of the organization must be competent, trustworthy and experienced managerially, as determined by the director after investigation or upon receipt of reliable information. [1989 c.331 §5]

750.545 Application; fee. (1) An applicant for a certificate of registration shall apply to the director on a form prescribed by the director. The application shall be accompanied by a filing fee under ORS 731.804.

(2) An application shall include the following information:

(a) The applicant's name and the address of the principal office of the organization.

(b) Whether the applicant or any of its directors, officers or managers has ever been convicted of or is under indictment for a crime, has ever had a judgment entered against it or any of them for fraud, and whether any license to act as an insurance agent, broker or solicitor or in any other occupational or professional capacity has ever been refused, revoked or suspended in this or any other state with respect to the applicant or any of its directors, officers or managers.

(c) A statement of the financial condition of the applicant or of the organization. The statement must be in a form satisfactory to the director and verified by an official of the organization.

(d) Any other information required by the director. [1989 c.331 §6]

750.555 Issuance of certificate of registration. (1) If the director determines that an applicant has satisfied all requirements of ORS 750.535 and 750.545, the director shall

issue the certificate of registration to the applicant.

(2) If the director denies a registration application, the director shall so inform the applicant, stating the grounds for the denial. [1989 c.331 §7]

750.565 Duration of certificate; renewal; fee. (1) A certificate of registration of a legal expense organization is effective for one year from the date of issue.

(2) A legal expense organization may renew its certificate of registration by paying the director a renewal fee established pursuant to ORS 731.804. [1989 c.331 §8]

750.575 Grounds for suspension, revocation of certificate or refusal to issue or renew certificate. (1) The director may suspend, revoke, refuse to issue or refuse to renew a certificate of registration for any one or any combination of the following reasons:

(a) Fraud or deceit in obtaining or applying for the certificate.

(b) Dishonesty, fraud or gross negligence in the transaction of insurance.

(c) Conduct resulting in a conviction of a felony under the laws of any state or of the United States, to the extent that such conduct may be considered under ORS 670.280.

(d) Conviction of any crime, an essential element of which is dishonesty or fraud, under the laws of any state or of the United States.

(e) Refusal to renew or cancellation, revocation or suspension of authority to transact insurance or business as a legal expense organization or similar entity in another state.

(f) Failure to pay a civil penalty imposed by final order of the director.

(2) An organization holding a certificate that has not been renewed or has been revoked shall surrender the certificate to the director at the director's request.

(3) The director may suspend or refuse to renew a certificate immediately and without hearing pursuant to ORS 183.430 if the facts giving rise to such action demonstrate the organization to be a serious danger to the public's safety, or untrustworthy to maintain the certificate.

(4) Except as provided in subsection (3) of this section, the director may suspend, revoke, refuse to renew or refuse to issue a certificate of registration only after giving an opportunity for a hearing pursuant to ORS 183.310 to 183.550. [1989 c.331 §9]

750.585 Written provider agreement with providing attorney. An organization shall not operate or offer a plan in this state unless the organization first enters into a

written provider agreement with the providing attorney or attorneys. The following provisions apply to such an agreement:

(1) A provider agreement shall not contain any provision that allows the providing attorney to seek payment from a member, other than any copayments and deductibles scheduled in the agreement, in the event of nonpayment by the organization for any services that have been performed under the plan by the providing attorney; and

(2) A provider agreement shall contain a guarantee that the providing attorney will furnish plan services to plan members whether or not the providing attorney has been or will be paid under the plan. Provider agreements shall require providing attorneys to give plan members the full benefit of plan membership until the member leaves the plan or until the anniversary date of the date the plan member joined the plan, whichever comes first. [1989 c 331 §10]

750.595 Membership agreement. An organization must provide a membership agreement to each member of a group that is a party to a legal expense plan. Each membership agreement shall contain at least the following:

(1) A listing and clear description of the legal services promised or for which expenses are to be reimbursed and a clear explanation of the limits of the services.

(2) The copayments, deductibles or fees, if any, that the member is required to pay.

(3) The name and address of the principal place of business of the legal expense organization offering the plan.

(4) If the plan offers a limited choice of providing attorneys, a mechanism for providing the services of an alternate attorney in case representation by the designated providing attorney would be improper, unethical or impractical under the circumstances.

(5) A provision for review for settling disagreements about the grounds for demanding an alternative attorney or any benefit.

(6) All criteria by which a member may be denied renewal of membership. [1989 c 331 §11]

750.605 Unfair, discrimination or misleading provisions in agreements prohibited; record of transactions. (1) No provider agreement or membership agreement may contain provisions that are unfair, discriminatory or misleading, that encourage misrepresentation or misunderstandings of the agreement, that might endanger the solvency of the plan or legal expense organization or that are contrary to law.

(2) For the duration of each written membership and provider agreement and for six years following its termination, a legal expense organization shall maintain at its principal administrative office adequate books and records of all transactions between the plan and the providing attorneys, and adequate books and records of all transactions between the plan and members thereof. The director shall have reasonable access to the books and records so long as access does not violate or conflict with the attorney-client privilege recognized under the laws of the State of Oregon. [1989 c 331 §13]

750.615 Deposit to reimburse members for unearned premiums required. An organization shall deposit in an account that is maintained separately from operating funds an amount reasonably calculated to reimburse plan members for unearned premiums. The organization shall hold the amount in a fiduciary capacity. Records shall be kept of all deposits and receipts for a period of not less than six years. [1989 c 331 §14]

750.625 Paying providing attorney contingent on claims experience prohibited. Compensation paid to a providing attorney shall not be contingent on claims experience. This section does not prevent the compensation of a providing attorney from being based on membership fees collected or the number of claims paid or processed, nor does it prevent a providing attorney from sharing in a fund based on services performed. [1989 c 331 §15]

750.635 Registered agent and registered office in state required. (1) Each organization shall continuously maintain in this state a registered agent and registered office that may be, but need not be, the same as any of its places of business.

(2) A registered agent shall be:

(a) An individual who resides in this state and whose business office is identical to the registered office;

(b) A domestic corporation or nonprofit domestic corporation whose business office is identical to the registered office; or

(c) A foreign corporation or nonprofit foreign corporation authorized to transact business in this state whose business office is identical to the registered office.

(3) The director shall be an agent of an organization upon whom process may be served whenever the organization fails to appoint or maintain a registered agent in this state or whenever the registered agent of the organization cannot with reasonable diligence be found at the registered office. [1989 c.331 §16]

750.645 Annual report; content; names of sales and marketing representatives to be submitted. (1) Each organization shall provide annually to the director in as much detail as the director may require:

(a) A verified financial statement detailing the legal expense organization's assets, liabilities, unearned premium reserve, loss records and such other items as the director may require so long as such reporting does not violate or conflict with the attorney-client privilege recognized under the laws of the State of Oregon; and

(b) A list of the names and addresses of the organization's providing attorneys.

(2) Every legal expense organization shall submit to the director the names of its sales and marketing representatives and their addresses not later than January 1 and July 1 of each year. [1989 c 331 §§17, 18]

750.655 Filing schedule of legal service rates required. A legal expense organization shall file with the director all schedules and tables of premium rates for legal service to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables. [Formerly 750 §30]

750.675 Filing of provider and membership agreement with director. An organization shall file with the director a copy of the current membership agreement forms and the current provider agreement forms used by the organization, and a schedule of the rates charged its members. An organization shall file any material change in the provider agreement or membership agreement with the director prior to use. [1989 c 331 §12]

750.685 Indemnification insurance or bond required. (1) Except as otherwise provided in this section, no legal expense plan shall be issued, sold or offered for sale in this state unless the organization offering the plan is insured under an insurance contract that provides indemnification for the services under the plan, or reimbursement for services performed under a service contract, in the event of default of the organization. Any such insurance shall be issued only by an insurer authorized to do business in this state.

(2) Instead of holding insurance under subsection (1) of this section, an organization offering an access plan described in subsection (5) of this section may post a bond or provide evidence of deposit pursuant to this subsection. The bond or other deposit is to be held in trust to the director for the protection of members of the plan and other affected persons. The initial security bond or other deposit required for an access plan for at least the first full year of operation shall

be in the amount of \$10,000. The amount of deposit shall be adjusted annually and shall be in an amount equal to 10 percent of the gross written prepaid fees collected from plan members in the preceding calendar year, to a maximum of \$50,000. The bond or other deposit is to be held in a bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation or in a savings and loan association insured by the Federal Savings and Loan Insurance Corporation.

(3) Instead of holding insurance under subsection (1) of this section, an organization offering a comprehensive plan described in subsection (5) of this section may post a bond or provide evidence of deposit pursuant to this subsection. The bond or other deposit is to be held in trust to the director for the protection of members of the plan and other affected persons. The initial security bond or other deposit required for a comprehensive plan for at least the first full year of operation shall be in the amount of \$25,000. The amount of deposit shall be adjusted annually and shall be in an amount equal to 10 percent of the gross written prepaid fees collected from plan members in the preceding calendar year, to a maximum of \$100,000. The bond or other deposit is to be held in a bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation or in a savings and loan association insured by the Federal Savings and Loan Insurance Corporation.

(4) Property used as security shall be held in trust and shall remain unencumbered, and shall have at all times a market value of at least 95 percent of the amount specified. Any bond issued in lieu of security shall be cancelable only upon 30 days' advance written notice filed with the director. Securities or bonds deposited pursuant to this section shall be for the benefit of and subject to action thereon in the event of insolvency of the plan by any person sustaining actionable injury due to failure of the organization to faithfully perform its obligations to its members.

(5) For purposes of this section:

(a) "Access plan" means a plan that provides legal advice or consultation on legal matters that can be reasonably handled over the phone or by a limited review of routine legal documents.

(b) "Comprehensive plan" means a plan that provides legal advice and consultation regarding more complex or time-consuming matters and may include advice and representation in and regarding administrative and civil or criminal judicial proceedings. [1989 c.331 §19]

HEALTH CARE CONTRACTOR; LEGAL EXPENSE ORGANIZATION 750.715

750.695 ORS 750.505 to 750.715 not to affect regulation of practice of law; plan not subject to Insurance Code. (1) ORS 750.505 to 750.715 do not affect the regulation of the practice of law.

(2) Except as provided in ORS 750.505 to 750.715, legal expense plans are not subject to the Insurance Code. [1989 c 331 §20]

750.705 Application of Insurance Code.

(1) The following provisions of the Insurance Code shall apply to legal expense organizations to the extent so applicable and not inconsistent with the express provisions of ORS 750.505 to 750.715:

(a) ORS 731.004 to 731.026, 731.032 to 731.150, 731.158, 731.216 to 731.362, 731.386, 731.398 to 731.430, 731.450, 731.454, 731.504, 731.508, 731.512, 731.640 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.230, 732.245, 732.250, 732.320, 732.325 and 732.505 to 732.595.

(c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.710 to 733.780.

(d) ORS 737.205 to 737.225, 737.235 to 737.340 and 737.505.

(e) ORS 742.001 to 742.009, 742.061, 742.013 to 742.023 and 742.023 to 742.056.

(f) ORS 746.005 to 746.045, 746.065, 746.075, 746.100 to 746.130, 746.160 and 746.230 to 746.370.

(2) For the purposes of this section only, legal expense organizations shall be considered insurers. [Formerly 750.340]

750.715 Rulemaking authority of director. The director may make rules in order to carry out ORS 750.505 to 750.715. [1989 c 331 §21]

