Chapter 735

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Alternative Insurance

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ESSENTIAL PROPERTY INSURANCE

735.005 Definitions. 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, and insurance against the perils of vandalism and malicious mischief. "Essential property insurance" does not include automobile insurance or insurance on such types of manufacturing risks as may be excluded by the director.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

735.065 Required association functions. (1) The 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 paragraphs (a) and (b) of subsection (3) of this section, the assessment of each member insurer for a particular calendar year shall be in the proportion that the net direct written premiums of the member insurer for the second preceding calendar year bears to the net direct written premiums of all member insurers for the second preceding calendar year. Each member insurer shall be notified of an assessment not later than the 30th day before the day it is due. If the funds of the association do not provide in any one year an amount sufficient to pay the expenses of the association, the funds available shall be prorated among the expenses and the unpaid portion shall be paid as soon thereafter as funds become available. If an assessment would cause a member insurer's financial statement to reflect an amount of surplus less than the minimum amount required for a certificate of authority by any jurisdiction in which the member insured is authorized to transact insurance, the association may, in whole or in part, exempt the member insurer from payment of the assessment or defer payments.

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

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

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

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

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

735.075 Discretionary association functions. The association may:

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

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

(3) Sue or be sued.

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

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

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

735.085 Plan of operation; submission to director; approval of plan; compliance with plan. (1) The association shall submit to the director, 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 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.

(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 association is subject to regulation by the director 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 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 association or its employees or servicing facilities, any member of the board, or the director or the employees of the director for any action taken by them in carrying out ORS 735.005 to 735.145. [1971 c.321 §16]

MARKET ASSISTANCE PLANS; JOINT UNDERWRITING ASSOCIATIONS

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

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

(b) These businesses and service providers are essential to achieve goals such as increased work force 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 Insurance and Finance 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. [1987 c.774 §74]

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

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

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

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

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

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

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

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

735.220 Formation of joint underwriting association; funds. After finding under ORS 735.215 that there is a need in Oregon for a joint underwriting association, the director 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 shall approve rates filed by the joint underwriting association in accordance with ORS 737.310. All rates approved for the joint underwriting association shall be actuarially sound and calculated to be self-supporting. [1987 c.774 §79]

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

735.240 Annual statement. The joint underwriting association shall file an annual statement prepared by an independent certified public accountant containing a financial statement, a summary of its transactions and operations for the prior year and other information as prescribed by the director 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. 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 Insurance and Finance 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 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]

Note: Section 86, chapter 774, Oregon Laws 1987, provides:

Sec. 86. The director shall file a public report with the presiding officers of the Legislative Assembly detailing the operations, finances, claims and marketing experience of any joint underwriting association established under sections 74 to 85 of this Act [735.200 to 735.260]. The report shall be filed at the first session of the Legislative Assembly that occurs after an association has been in operation for at least one year. A copy of the report shall be given to each member of the Legislative Assembly. [1987 c.774 §86]

735.265 Liquor liability insurance risk and rate classifications. If a market assistance plan is formed under ORS 735.210, or a joint underwriting association is formed under ORS 735.220, the director 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 Insurance and Finance 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]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notice

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

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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]

735.320 Relationship to insurance guaranty fund and joint underwriting association. (1) No risk retention group shall be permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state. No risk retention group, or its insureds, shall receive

any benefit from any such fund for claims arising out of the operations of the risk retention group.

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

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

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

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

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

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

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

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

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

(a) That:

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

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

(b) That:

(A) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state; and

(B) On and after October 27, 1986, purchased insurance from an insurance carrier licensed in any state;

(c) That was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986, before October 27, 1986; and

(d) That does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Risk Retention Act of 1981, as in effect before October 27, 1986. [1987 c.774 §104]

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

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

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

735.350 Agent or broker; license. Any person acting or offering to act as an agent or broker for a risk retention group or purchasing group that solicits members, sells insurance coverage, purchases coverage for its members located within this state or otherwise does business in this state shall, be-

fore commencing any such activity, obtain a license as an agent from the director under ORS chapter 744. [1987 c.774 §108; 1989 c.701 §71]

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

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

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

SURPLUS LINES LAW

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

(1) Protecting persons seeking insurance in this state;

(2) Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state pursuant to ORS 735.400 to 735.495;

(3) Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state; and

(4) Protecting revenues of this state. [1987 c.774 §117]

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

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

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

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

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

(5) "Kind of insurance" means one of the types of insurance required to be reported in the annual statement which must be filed with the director by authorized insurers.

(6) "Nonadmitted insurer" means an insurer not authorized to do an insurance business in this state. This definition shall include insurance exchanges as authorized under the laws of various states.

(7) "Producing agent" means the individual agent dealing directly with the party seeking insurance.

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

(9) "Surplus lines licensee" means an agent licensed under ORS chapter 744 to place insurance on risks resident, located or to be performed in this state with nonadmitted insurers eligible to accept such insurance. [1987 c.774 §118; 1991 c.810 §25]

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

(1) The insurer is an eligible surplus lines insurer;

(2) The full amount or kind of insurance cannot be obtained from insurers who are admitted to do business in this state. Such full amount or kind of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular kind and class of insurance in this state; and

(3) All other requirements of ORS 735.400 to 735.495 are met. [1987 c.774 §119]

735.415 Qualifications for placement of coverage with nonadmitted insurer. No surplus lines licensee shall place any coverage with a nonadmitted insurer unless at the time of placement such nonadmitted insurer has:

(1) Established satisfactory evidence of good repute and financial integrity.

(2) Qualified under one of the following paragraphs:

(a) Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction, which equals:

(A) The minimum capital and surplus requirements under the laws of this state; or

(B) $3 million upon enactment, and $3.5 million three years after enactment, and $4.5 million five years after enactment, and $5 million six years after enactment, whichever is greater. After six years from enactment, the requirements of this subparagraph may be satisfied by an insurer possessing less than $5 million capital and surplus upon an affirmative finding of acceptability by the director. The finding shall be based upon such

factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends and company record and reputation within the industry. In no event shall the director make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than $3 million;

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

(c) In the case of an unincorporated group of alien individual insurers, maintains a trust fund of not less than $50 million as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group, and such trust shall likewise comply with the terms and conditions established in paragraph (b) of this subsection for alien insurers; or

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

(3) 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 which 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. [1987 c.774 §120]

735.420 Declaration of ineligibility of surplus lines insurer. (1) The director may declare a surplus lines insurer 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]

735.425 Filing by licensee after placement of surplus lines insurance. (1) Within 30 days after the placing of any surplus lines insurance, each surplus lines licensee shall file with the director:

(a) An affidavit, which shall be kept confidential, regarding the insurance, including the following:

(A) The name and address of the insured;

(B) The identity of the insurer or insurers;

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

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

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

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

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

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

(2) The director may direct that filings required under this section be made to the Surplus Lines Association of Oregon. [1987 c.774 §122]

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

(a) Facilitate and encourage compliance by its members with the laws of this state and the rules of the director relative to surplus lines insurance;

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

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

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

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

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

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

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

(c) A current list of members;

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

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

(f) A schedule of membership fees and charges.

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

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

(2) No surplus lines licensee shall issue or deliver any evidence of insurance or represent that insurance will be or has been written by any eligible surplus lines insurer, unless the licensee has authority from the insurer to cause the risk to be insured, or has received information from the insurer in the regular course of business that such insurance has been granted.

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

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

clauses, indorsements or any other material facts that would regularly be included in the policy.

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

(6) Every evidence of insurance negotiated, placed or procured under the provisions of ORS 735.400 to 735.495 issued by the surplus lines licensee shall bear the name of the licensee and the following legend in bold type: "This is evidence of insurance procured and developed under the Oregon surplus lines laws. It is NOT covered by the provisions of ORS 734.510 to 734.710 relating to the Oregon Insurance Guaranty Association. If the insurer issuing this insurance becomes insolvent, the Oregon Insurance Guaranty Association has no obligation to pay claims under this evidence of insurance." [1987 c.774 §124]

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

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

735.450 Requirements for surplus lines insurance agent license. (1) Except as provided in subsection (5) of this section, a person shall not procure any contract of surplus lines insurance with any nonadmitted insurer unless the person is licensed under ORS chapter 744 as a resident agent authorized to transact general lines insurance and is further authorized under the license to transact surplus lines insurance.

(2) The director may amend the license of a resident general lines agent to authorize the agent to transact insurance as a surplus lines agent if the agent:

(a) Has applied under ORS chapter 744 to have the class of surplus lines insurance added to the agent license and has satisfied all requirements therefor under ORS chapter 744; and

(b) Filed with the director a bond in favor of this state in the penal sum of $50,000 aggregate liability, with corporate sureties approved by the director.

(3) The bond required by subsection (2) of this section shall be conditioned that the surplus lines licensee will conduct business in accordance with the provisions of ORS 735.400 to 735.495 and will promptly remit the taxes as provided by law. The bond shall be maintained in force and unimpaired during the term of the license. No bond shall be terminated unless at least 30 days' prior written notice is given to the licensee and director.

(4) Subject to ORS 744.004, corporations, including foreign corporations, shall be eligible to be resident surplus lines licensees.

(5) The director may amend the license of a nonresident general lines agent to authorize the agent to transact insurance as a surplus lines agent solely for the purpose of complying with the provisions of ORS 735.300 to 735.365, the Oregon Liability Risk Retention Law. [1987 c.774 §127; 1989 c.288 §1; 1991 c.810 §26]

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

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

(a) Amount of the insurance and perils insured;

(b) Brief description of the property insured and its location;

(c) Gross premium charged;

(d) Any return premium paid;

(e) Rate of premium charged upon the several items of property;

(f) Effective date of the contract and the terms thereof;

(g) Name and address of the insured;

(h) Name and address of the insurer;

(i) Amount of tax and other sums to be collected from the insured; and

(j) Identity of the producing agent, any confirming correspondence from the insurer or its representative and the application.

(2) The record of each contract shall be kept open at all reasonable times to examination by the director without notice for a period not less than five years following termination of the contract. [1987 c.774 §129]

735.465 Monthly reports. On or before the end of each month, each surplus lines

licensee shall file with the director, on forms prescribed by the director, a verified report in duplicate of all surplus lines insurance transacted during the preceding month showing:

(1) Aggregate gross premiums written;

(2) Aggregate return premiums; and

(3) Amount of aggregate tax. [1987 c.774 §130]

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

(2) The surplus lines tax is due on the first day of April following the calendar year in which the premium is written. The tax shall be paid to and reported on forms prescribed by the director or upon the director's order paid to and reported on forms prescribed by the surplus lines association.

(3) Notwithstanding subsection (2) of this section, if a surplus lines license is terminated or nonrenewed for any reason, the taxes described in this section are due on the 30th day after the termination or nonrenewal. [1987 c.774 §131; 1989 c.288 §2]

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 against the surplus lines licensee and the surety on the bond filed under ORS 735.450. [1987 c.774 §132; 1989 c.288 §3]

735.480 Suspensions or revocation of license; refusal to renew; grounds. The director 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;

(2) Removal of the surplus lines licensee's office accounts and records from this state 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) Failure to maintain required bond;

(7) Violation of any provision of ORS 735.400 to 735.495; or

(8) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under ORS 744.013. [1987 c.774 §133; 1989 c.288 §4]

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

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

(3) The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers. [1987 c.774 §134; 1989 c.288 §5]

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

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

(3) The insurer shall have 40 days from the date of the service of the summons and

complaint upon such agent in which to plead, answer or defend any such cause.

(4) Upon service of summons and complaint upon such agent for such insurer, the court in which the action is begun shall be deemed to have duly acquired personal jurisdiction of the defendant insurer so served. [1987 c.774 §137]

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

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

MEDICAL INSURANCE POOL

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

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

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

(2) "Board" means the Oregon Medical Insurance Pool Board.

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

(4) "Insurer" means:

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

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

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

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

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

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

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

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

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

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

735.610 Oregon Medical Insurance Pool Board; plan of operation; authority. (1) There is created a state agency to be known as the Oregon Medical Insurance Pool Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.

(2) The board shall consist of nine individuals, eight of whom shall be appointed by the Governor. The Director of the Department of Insurance and Finance shall be a member of the board and shall also serve as the chair of the board or shall designate such

chair. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, one representative of reinsurers and two members of the general public who are not associated with the medical profession, a hospital or an insurer.

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

(4) The board shall submit to the director a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The director shall, after notice and hearing, approve the plan of operation provided the plan is determined to be suitable to assure the fair, reasonable and equitable administration of the pool. The plan of operation shall become effective upon approval in writing by the director. If the board fails to submit a suitable plan of operation within 180 days after July 26, 1989, or at any time thereafter fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt such rules as are necessary or advisable to effectuate the provisions of ORS 735.600 to 735.650. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the board and approved by the director.

(5) In its plan, the board shall:

(a) Establish procedures for the handling and accounting of assets and moneys of the pool;

(b) Select an administering insurer or insurers in accordance with ORS 735.600 to 735.650;

(c) Establish rules of procedures for the operation of the board; and

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan.

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

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

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

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

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

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

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

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

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

(i) Adopt rules for the purpose generally of carrying out ORS 735.600 to 735.650, as provided under ORS 183.310 to 183.550; and

(j) Employ such staff and consultants as may be necessary for the purpose of carrying out its responsibilities under ORS 735.600 to 735.650.

(7) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495. [1987 c.838 §4; 1989 c.838 §7]

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

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

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

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

(2) All moneys in the Oregon Medical Insurance Pool Account are continuously appropriated to the Oregon Medical Insurance Pool Board to carry out the provisions of ORS 735.600 to 735.650. [1989 c.838 §§2, 3]

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

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

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

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

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

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

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

(8) The board shall abate or defer assessments authorized by this section if a court orders that assessments cannot be made applicable to reinsurers. However, if a court orders that assessments cannot be made applicable to reinsurers, the board may continue to assess insurers to the end of the biennium in which the determination is made. [1989 c.838 §4; 1991 c.333 §1]

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

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made an adverse underwriting decision, as defined in ORS 746.600 (1), on medical insurance for health reasons while the person was a resident;

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

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

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

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

(a) The person is eligible for health care benefits under ORS chapter 414 or Medicare;

(b) The person has terminated coverage in the pool unless 12 months have lapsed since such termination;

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

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

(e) The person has, on the date of issue of coverage by the board, coverage under

health insurance or a self-insurance arrangement which is substantially equivalent to coverage under ORS 735.625.

(4) A person applying for coverage shall establish initial eligibility by such evidence as the plan of operation shall require. [1987 c.838 §5; 1989 c.838 §11]

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

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

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

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

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

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

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

(3) The administering insurer shall:

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

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

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

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

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

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

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

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

735.625 Coverage. (1) The board shall offer major medical expense coverage to every eligible person.

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

(3) In establishing the pool coverage, the board shall take into consideration the levels of medical insurance provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of, and commensurate with, medical insurance provided through a representative number of large employers in the state.

(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 standard risk rate by calculating the average individual rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be more than 150 percent of rates established as applicable for individual risks.

(d) The board shall annually determine adjusted benefits and premiums. Such adjustments will be in keeping with the purposes of ORS 735.600 to 735.650, subject to a limitation of keeping pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member

self-insurance arrangements. The board may determine the total number of persons that may be enrolled for coverage at any time and may permit and prohibit enrollment in order to maintain the number authorized. Nothing in this paragraph authorizes the board to prohibit enrollment for any reason other than to control the number of persons in the pool.

(5)(a) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition, if:

(A) The condition manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

(B) Medical advice, care or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage.

(b) The preexisting condition exclusions described in paragraph (a) of this subsection shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage which was involuntarily terminated if the application for pool coverage is made not later than 60 days following the involuntary termination. In such a case, coverage in the pool shall be effective from the date on which such prior coverage was terminated. The board may assess an additional premium of up to 10 percent for coverage provided under the plan in this manner, notwithstanding the premium limitations stated in ORS 735.600 to 735.650.

(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 Medicaid.

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

(7) Notwithstanding any other provision of law, 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]

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

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

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

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

735.650 Application of provisions of Insurance Code. (1) The pool shall be subject to examination and regulation by the Director of the Department of Insurance and Finance.

(2) 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, 733.010 to 733.050, 733.080, 742.003, 742.005, 742.023, 742.028, 742.038, 742.046, 742.051, 742.053, 742.056, 743.010, 743.018 to 743.028, 743.041, 743.050, 743.402 to 743.444, 743.447 to 743.480, 743.483 to 743.498, 743.703 to 743.714, 743.721, ORS chapter 744, ORS 746.005 to 746.370 and 746.600 to 746.690.

(3) For the purposes of this section only, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance and pool coverage contracts shall

be deemed policies. [1987 c.838 §14; 1989 c.701 §72; 1989 c.838 §18]

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