

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, 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 Part A, Part B and Part D 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; 2003 c.33 §4; 2005 c.634 §4]

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The Director of the Department of Consumer and Business Services shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650.

(7) In consultation with the board, the director shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650. [1987 c.838 §4; 1989 c.838 §7; 1993 c.744 §190; 1995 c.79 §361; 2001 c.356 §1; 2003 c.364 §95]

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

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

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

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

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

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

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

(2) Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of Oregon insureds and certificate holders insured or reinsured by each insurer, and the denominator of which equals the total of all Oregon insureds and certificate holders insured or reinsured by all insurers, all determined as of March 31 each year.

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

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

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

(6) Each insurer's proportion of participation in the pool shall be determined by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board. The board may use any reasonable method of estimating the number of

insureds and certificate holders of an insurer if the specific number is unknown. With respect to insurers that are reinsurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer.

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

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

(9) Subject to the approval of the Director of the Department of Consumer and Business Services, the board may develop a program for adjusting the assessment of an insurer in the individual health benefits market based on that insurer's contribution to reducing the enrollment in the Oregon Medical Insurance Pool. When developing the program, the board may consider, but is not limited to, the following factors:

- (a) The insurer's level of participation;
- (b) Level of health benefit plan coverage offered; and
- (c) Assumption of risk in the individual health benefits market. [1989 c.838 §4; 1991 c.333 §1; 1995 c.603 §28; 2005 c.304 §1; 2005 c.635 §1]

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

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made within a time frame established by the board an adverse underwriting decision, as defined in ORS 746.600 (1)(a)(A), (B), (D), (E) or (F), on individual medical insurance for health reasons while the person was a resident;

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

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

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

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

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

(a) Except as provided in ORS 735.625 (3)(c), the person is eligible to receive health services as defined in ORS 414.705 that meet or exceed those adopted by the board or is eligible for Medicare;

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

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

414.705; or

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

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

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

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

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

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

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

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

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

Note: The amendments to 735.615 by section 3, chapter 305, Oregon Laws 2005, become operative January 2, 2008. See section 4, chapter 305, Oregon Laws 2005. The text that is operative on and after January 2, 2008, is set forth for the user's convenience.

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

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made within a time frame established by the board an adverse underwriting decision, as defined in ORS 746.600 (1)(a)(A), (B) or (D), on individual medical insurance for health reasons while the person was a resident;

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

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

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

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

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

(a) Except as provided in ORS 735.625 (3)(c), the person is eligible to receive health services as defined in ORS 414.705 that meet or exceed those adopted by the board or is eligible for Medicare;

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

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

414.705; or

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

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

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

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

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

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

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

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

(6) The board may adopt rules to establish additional eligibility requirements for a person described in subsection (1)(d) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

(d) On or after January 1, 1998, an individual who meets the eligibility requirements of 42

U.S.C. 300gg-41, as amended and in effect on January 1, 1998, and does not otherwise qualify to obtain portability coverage from an Oregon group carrier in accordance with ORS 743.760.

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

(a) An eligible individual does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) At least one year prior to the expiration of each three-year period of service by an

administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(3) The administering insurer shall be responsible for one or more of the following:

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

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

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

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

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

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

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

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

(4) The board may contract with third party administrators or other vendors to provide services described in subsection (5) of this section that are in addition to or that replace services provided by the administering insurer.

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

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

(b) Disease case management.

(c) Direct provider or provider network contracts.

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

735.625 Coverage; rules. (1) Except as provided in subsection (3)(c) of this section, the Oregon Medical Insurance Pool Board shall offer major medical expense coverage to every eligible person.

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

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

(b) In establishing medical insurance coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the

board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to those found in the commercial group or employer-based medical insurance market.

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

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

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

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

(c) The board shall determine the applicable medical and portability risk rates either by calculating the average rate charged by insurers offering coverages in the state comparable to the pool coverage or by using reasonable actuarial techniques. The risk rates shall reflect anticipated experience and expenses for such coverage. Rates for pool coverage may not be more than 125 percent of rates established as applicable for medically eligible individuals or for persons eligible for pool coverage under ORS 735.615 (1)(d), or 100 percent of rates established as applicable for portability eligible individuals.

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

(5)(a) The board may apply:

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

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

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

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

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

(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers’ compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except the Medicaid portion of the Oregon Health Plan offering a level of health services described in ORS 414.707.

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

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

(8) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care. [1987 c.838 §8; 1989 c.838 §13; 1993 c.130 §2; 1995 c.603 §27; 1999 c.987 §2; 2001 c.356 §3; 2003 c.684 §5; 2005 c.634 §2; 2005 c.635 §5a]

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

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

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

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

735.650 Application of provisions of Insurance Code. (1) The following provisions of the Insurance Code shall apply to the pool to the extent applicable and not inconsistent with the express provisions of ORS 735.600 to 735.650: ORS 731.004 to 731.022, 731.052 to 731.146, 731.162, 731.216 to 731.328, 742.023, 742.028, 742.046, 742.051, 742.056, 743.024, 743.027, 743.028, 743.041, 743.050, 743.100 to 743.106, 743.402, 743.707, 743.721, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.834, 743.837, 743.839, 743.845, 746.005 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(2) For the purposes of this section only, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance and pool coverage contracts shall be deemed policies. [1987 c.838 §14; 1989 c.701 §72; 1989 c.838 §18; 1999 c.987 §3; 2001 c.356 §4; 2003 c.87 §20]