

# Chapter 284-16 WAC

## INSURERS

### WAC

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284-16-060 Disability insurance—Minimum reserve standards. [Order 282, filed 7/22/66.] Repealed by WSR 92-19-038 (Order R 92-8), filed 9/9/92, effective 10/10/92. Statutory Authority: RCW 48.02.060.  
284-16-100 Investments—Encumbrance—Interpretation of RCW 48.13.130. [Rule made 5/15/53, filed 3/22/60.] Repealed by WSR 17-19-026 (Matter No. R 2017-02),

filed 9/11/17, effective 10/12/17. Statutory Authority: RCW 48.02.060, 48.13.171(1) and chapter 48.13 RCW. F.H.A. mortgage loans and investments. [Order 1001, issued 10/2/47, filed 3/22/60.] Repealed by WSR 17-19-026 (Matter No. R 2017-02), filed 9/11/17, effective 10/12/17. Statutory Authority: RCW 48.02.060, 48.13.171(1) and chapter 48.13 RCW.

### TITLE INSURERS

**WAC 284-16-030 Title insurers—Defining "complete set of tract indexes."** (1) The phrase "a complete set of tract indexes," as used in RCW 48.29.020 and 48.29.040, is defined to mean a set of indexes from which the record ownership and condition of title to all land within the particular county can be traced and ascertained, such set of indexes to be complete from the inception of title from the United States of America.

(2) The basic component parts of such a set of indexes are:

(a) An index or indexes in which the reference is to geographic subdivisions of land, classified according to legal description (as distinguished from an index or indexes in which the reference is to the name of the title holder, commonly called a grantor-grantee index) wherein notations of or references to:

(i) All filed or recorded instruments affecting title to particularly described parcels of real property and which impart constructive notice under the recording laws; and

(ii) All judicial proceedings in the particular county affecting title to particularly described parcels of real property are posted, filed, entered or otherwise included in that part of the indexing system which designates the particular parcel of real property; provided, no reference need be made in such index to any judicial proceeding which is referred to or noted in the name index defined in subparagraph (b) below.

(b) A name index or indexes wherein notations of or references to all instruments, proceedings and other matters of record in the particular county which affect or may affect title to all real property (as distinguished from particularly described parcels of real property) of the person, partnership, corporation or other entity named therein and affected thereby, are posted, filed, entered or otherwise included in that part of the indexing system which designates that name.

(3) The indexes prescribed in numbered subsection (2) above, may be maintained in bound books, loose-leaf books, jackets or folders, on card files, or in any other form or system, whether manual, mechanical, electronic or otherwise; or in any combination of such forms or systems.

(4) The extent to which the prescribed indexes shall be subdivided or defined is dependent upon all relevant circumstances. The population of the particular county, the extent to which land within the particular county has been subdivided and passed into separate ownerships, and all other factors

which are reasonably related to the purpose of the statutory requirement, are entitled to consideration in such determination.

[Order 127, adopted 12/12/60, filed 12/14/60.]

### VALUATION OF STOCK OF SUBSIDIARY

**WAC 284-16-150 Purpose.** The purpose of this regulation, WAC 284-16-150 through 284-16-220, is to implement RCW 48.12.180(3) by establishing rules for the valuation of stock of a subsidiary of an insurer.

[Order R 76-7, § 284-16-150, filed 11/30/76.]

**WAC 284-16-160 Definitions.** For purpose of this regulation: (1) The term "subsidiary" shall have the same meaning given it by RCW 48.31A.010;

(2) The term "book value" shall mean that value determined by dividing the amount of its capital and surplus as shown in its last annual statement or subsequent report of examination (excluding from surplus, reserves required by statute and any portion of surplus properly allocable to policyholders, rather than stockholders) less the value (par of redemption value, whichever is the greater) of all of its preferred stock, if any, outstanding, by the number of shares of its common stock issued and outstanding.

[Order R 76-7, § 284-16-160, filed 11/30/76.]

**WAC 284-16-170 Usual valuation of stock of a subsidiary.** The common stock of any subsidiary of an insurer may always be valued on the basis of the value of only such of the assets of such subsidiary as would constitute lawful investments for the insurer if acquired or held directly by the insurer.

[Order R 76-7, § 284-16-170, filed 11/30/76.]

**WAC 284-16-180 Other methods of valuing stock of a subsidiary.** If sound business judgment of an insurer's management causes it to believe that a valuation of common stock of a subsidiary pursuant to WAC 284-16-170 is inappropriate, it may value such stock on one of the following bases:

(1) "Book value," provided, however, that the common of a noninsurance company may not be valued on the basis of this subsection, and further provided that an insurer may value its holdings of stock in a subsidiary insurer at acquisition cost if acquisition cost is less than market or book value.

(2) One of the following bases appropriate to each type of subsidiary owned by it, provided, however, that an insurer shall not be required to value the stock of all its subsidiaries on the same basis:

(a) Subject to the limitations imposed under WAC 284-16-190, the net worth of a noninsurance company determined in accordance with generally accepted accounting principles, as of the end of its most recent fiscal year, provided, subject to WAC 284-16-200, that the financial statements of the company for its most recent fiscal year have been audited by an independent certified public accountant in accordance with generally accepted auditing standards. The common stock of an insurance company may not be valued under this subsection.

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(b) Subject to the limitations imposed under WAC 284-16-190, a value equal to the cost of the common stock of the subsidiary, provided such value is determined and adjusted to reflect subsequent operating results, in the case of insurance companies in accordance with statutory accounting requirements, and for other than insurance companies in accordance with generally accepted accounting principles.

(c) The market value of the common stock of the subsidiary, if the stock is listed on a national securities exchange.

(d) The value, if any, placed on the common stock of such subsidiary by the National Association of Insurance Commissioners.

(e) Any other value which the insurer can substantiate to the satisfaction of the commissioner as being a reasonable value.

[Order R 76-7, § 284-16-180, filed 11/30/76.]

**WAC 284-16-190 Limitation on values.** (1) With respect to values determined under WAC 284-16-180 (2)(a) or (b), amounts attributable to "good will," and other intangibles shall not in the aggregate (of all direct and indirect subsidiaries) exceed (either initially on acquisition of a subsidiary, or thereafter), 10% of the capital and surplus of an insurer, as reported in its next preceding annual statement. Such amounts shall be written off over a period not in excess of ten years.

(2) For purposes of this section, "good will" shall be defined as the amount arising at a given point in time, resulting from an arm's-length transaction involving the transfer of a business, representing the difference between the value of the consideration given and the net asset value of the properties acquired on the books of the predecessor company.

(3) Where warranted in exceptional cases, the commissioner may require a more rapid write-off of good will than is otherwise provided in this section.

[Order R 76-7, § 284-16-190, filed 11/30/76.]

**WAC 284-16-200 Additional provisions.** (1) Within 90 days after the effective date of this regulation, a domestic insurer using a method of valuation permitted by WAC 284-16-180 shall file with the commissioner relevant information identifying, supporting and justifying the value of, and the basis of valuation used in accordance with the provisions of this regulation for each of its subsidiaries.

(2) Within 30 days after the acquisition of a subsidiary, a domestic insurer shall file with the commissioner relevant information identifying, supporting and justifying the value of, and the basis of valuation used in accordance with the provisions of this regulation for such subsidiary.

(3) A valuation basis used for a subsidiary shall thereafter be consistently used unless a change is substantiated as reasonable and on that basis is approved in writing by the commissioner.

(4) If a subsidiary is valued on the basis of WAC 284-16-180 (2)(a) and the books of the subsidiary are not audited at the time the valuation is included in the insurer's annual statement, the insurer shall thereafter report and explain the differences, if any, between the value of the subsidiary as reported in the annual statement and the value as determined by audit.

(9/11/17)

Such report and explanation shall be made as soon as possible following such audit.

(5) If any subsidiary, which is not itself an insurance company, is valued other than on the basis of market value, there shall be deducted from the otherwise determined value a sum equal to the value claimed for any of its assets which would not constitute admitted assets for the insurer if held directly by the insurer, if such assets:

(a) Are held by the subsidiary but used, under a lease arrangement or otherwise, significantly in the conduct of the insurer's business; or

(b) Were acquired from or purchased for the benefit or use of the insurer by the subsidiary under circumstances that, in the opinion of the commissioner, support a finding that the primary purpose of such acquisition or purchase was the evasion or avoidance of RCW 48.12.010 or 48.12.020.

[Order R 76-7, § 284-16-200, filed 11/30/76.]

**WAC 284-16-210 Adjustment procedure.** The commissioner may, after notice and opportunity to be heard, determine that the basis used for valuation of the stock of any subsidiary does not, under the specific circumstances of the case, reflect the value of the subsidiary and may order either an adjustment in valuation or the use of one of the other specified bases of valuation.

[Order R 76-7, § 284-16-210, filed 11/30/76.]

**WAC 284-16-220 Cumulative limitations.** Except as modified by this regulation, applicable cumulative limitations of chapter 48.13 RCW shall continue to apply.

[Order R 76-7, § 284-16-220, filed 11/30/76.]

## FINANCIALLY HAZARDOUS CONDITION

**WAC 284-16-300 Purpose.** (1) The purpose of this regulation, WAC 284-16-300 through 284-16-320 is to set forth the standards which the commissioner will use to identify insurers in such condition as to render the continuance of their business hazardous to their policyholders, creditors or to the general public.

(2) This regulation shall not be interpreted to limit the powers granted the commissioner by any laws or parts of laws of this state, nor shall this regulation be interpreted to supersede any laws or parts of laws of this state.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.44.050, and 48.46.200. WSR 09-24-053 (Matter No. R 2009-06), § 284-16-300, filed 11/24/09, effective 12/25/09. Statutory Authority: RCW 48.02.060. WSR 92-19-039 (Order R 92-9), § 284-16-300, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-310 Standards.** The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to its policyholders, creditors, or the general public. The commissioner may consider:

(1) Adverse findings reported in financial condition reports, market conduct examination reports, audit reports, or actuarial opinions, reports or summaries.

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(2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and reports.

(3) Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts.

(4) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

(5) Whether the insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders, is greater than fifty percent of such insurer's remaining surplus as regards policyholders in excess of the minimum required.

(6) Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required.

(7) Whether a reinsurer, obligor or any entity within the insurer's insurance holding company system is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation, and which in the opinion of the commissioner may affect the solvency of the insurer.

(8) Contingencies, pledges, or guaranties which either individually or collectively involve a total amount which in the opinion of the commissioner may affect the solvency of the insurer.

(9) Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer.

(10) The age and collectibility of receivables.

(11) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position.

(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false or misleading information concerning an inquiry.

(13) Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the commissioner.

(14) Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

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(15) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial or administrative capacity to meet its obligations in a timely manner.

(16) Whether the insurer has experienced or will experience in the foreseeable future, cash flow or liquidity problems.

(17) Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, or sound actuarial principles and standards of practice.

(18) Whether management persistently engages in material under reserving that results in adverse development.

(19) Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature.

(20) Any other factor determined by the commissioner to be hazardous to the insurer's policyholders, creditors or general public.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.44.050, and 48.46.200. WSR 09-24-053 (Matter No. R 2009-06), § 284-16-310, filed 11/24/09, effective 12/25/09. Statutory Authority: RCW 48.02.060. WSR 92-19-039 (Order R 92-9), § 284-16-310, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-320 Manner in which commissioner will exercise authority.** (1) For the purpose of making a determination of an insurer's financial condition under this regulation, the commissioner may:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(b) Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates consistent with the *NAIC Accounting Policies and Procedures Manual*, state laws or regulations;

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(d) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

(2) If the commissioner determines that the continued operation of the insurer authorized to transact business in this state may be hazardous to its policyholders, creditors or the general public, then the commissioner may, in conjunction with or in lieu of a notice required or permitted by RCW 48.05.150, issue an order requiring the insurer to:

(a) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(b) Reduce, suspend, or limit the volume of business being accepted or renewed;

(c) Reduce general insurance and commission expenses by specified methods;

(d) Increase the insurer's capital and surplus;

(e) Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;

(f) File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

(g) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

(h) Document the adequacy of premium rates in relation to the risks insured;

(i) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or in such format as promulgated by the commissioner;

(j) Correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the commissioner;

(k) Provide a business plan to the commissioner in order to continue to transact business in the state; or

(l) Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any nonlife insurance product written by the insurer that the commissioner considers necessary to improve the financial condition of the insurer.

If the insurer is a foreign insurer, the commissioner's order may be limited to the extent provided by statute.

(3) Any insurer subject to an order under subsection (2) of this section may make a written demand for a hearing, subject to the requirements of RCW 48.04.010, by specifying in what respects it is aggrieved and the grounds to be relied upon as basis for the relief to be demanded at the hearing.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.44.050, and 48.46.200. WSR 09-24-053 (Matter No. R 2009-06), § 284-16-320, filed 11/24/09, effective 12/25/09. Statutory Authority: RCW 48.02.060. WSR 92-19-039 (Order R 92-9), § 284-16-320, filed 9/9/92, effective 10/10/92.]

## MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP DISABILITY INSURANCE CONTRACTS

**WAC 284-16-400 Title and scope.** (1) This regulation, WAC 284-16-400 through 284-16-540, shall be known and may be cited as the "Washington minimum reserve standards for individual and group disability insurance contracts regulation."

(2) These standards apply to all individual and group disability insurance coverages except medicare supplement insurance as governed by WAC 284-66-210.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-400, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-410 Definitions.** For the purpose of this regulation, the following definitions shall apply:

(1) "Annual-claim cost" means the net annual cost per unit of benefit before the addition of expense including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a one hundred dollar monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age thirty-five, in a certain occupation might be twelve dollars, while the gross premium for this benefit might be eighteen dollars. The additional six dollars would cover expense and profit or contingencies.

(2) "Claims accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for accrued benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

(3) "Claims incurred" means that portion of a claim for which the insurer has become obligated to make payment, on or prior to the valuation date.

(4) "Claims reported" means those claims that have been incurred on or prior to the valuation date of which the insurer has been informed, on or prior to the valuation date. These claims are considered as reported claims for annual statement purposes.

(5) "Claims unaccrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made, which may or may not be discounted with interest, must be established.

(6) "Claims unreported" means those claims that have been incurred on or prior to the valuation date of which the insurer has not been informed, on or prior to the valuation date. These claims are considered as unreported claims for annual statement purposes.

(7) "Date of disablement" means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

(8) "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(9) "Gross premium" is the amount of premium charged by the insurer. It includes the net premium, based on claim-cost, for the risk, together with any loading for expenses, profit, or contingencies.

(10) "Group insurance" includes blanket disability insurance.

(11) "Level premium" means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during

the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

(12) "Long-term care insurance" means any insurance policy or benefit contract primarily advertised, marketed, offered, or designed to provide coverage or services over a prolonged period of time for either institutional or community-based convalescent, custodial, chronic, or terminally ill care. Long-term care insurance may be issued by insurers; fraternal benefit societies; health care service contractors; health maintenance organizations or any similar organization to the extent they are authorized. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, nor shall it include a contract between a continuing care retirement community and its residents.

(13) "Modal premium" means the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is one hundred dollars and if, instead, monthly premiums of nine dollars are paid then the modal premium is nine dollars.

(14) "Negative reserve" means a negative terminal reserve value. Negative reserves occur when the present value of future benefits is less than the present value of future valuation net premiums.

(15) "Preliminary term reserve method" means the method of valuation for which the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium, or stream of changing valuation premiums, becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(16) "Present value of amounts not yet due on claims" means the reserve for claims unaccrued which may be discounted at interest.

(17) "Reserve" includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits which result in:

(a) Claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

(b) Claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

(18) "Terminal reserve" means the reserve at the end of a contract year, which is the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

(19) "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to

the period of coverage extending beyond the valuation date. Thus if an annual premium of one hundred twenty dollars was paid on November 1, twenty dollars would be earned as of December 31 and the remaining one hundred dollars would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(20) "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-410, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-420 Reserves in excess of minimum reserve standards.** When an insurer determines that adequacy of its disability insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-420, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-430 Prospective gross premium valuation.** (1) With respect to any block of contracts, or with respect to an insurer's disability business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. The gross premium valuation shall take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date, adjusted for future premium increases reasonably expected to be put into effect, of:

- (a) All expected benefits unpaid;
- (b) All expected expenses unpaid; and
- (c) All unearned or expected premiums.

(2) The insurer shall perform gross premium valuation whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's disability business as a whole. In the event inadequacy is found to exist, the insurer shall make immediate loss recognition and restore the reserves to adequacy. The insurer shall hold adequate reserves, inclusive of claim, premium and contract reserves, if any, with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

(3) Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-430, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-440 General claim reserve requirements.** (1) Claim reserves are required for all incurred but unpaid claims on all disability insurance policies;

(2) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims; and

(3) All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-440, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-450 Minimum standards for claim reserves.** (1) For disability income:

(a) The maximum interest rate for claim reserves is specified in WAC 284-16-520.

(b) Minimum standards with respect to morbidity are those specified in WAC 284-16-500 and 284-16-510; except that, at the option of the insurer, for claims with a duration from date of disablement of less than two years, reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(c) For contracts with an elimination period, the insurer shall measure the duration of disablement as dating from the time that benefits would have begun to accrue had there been no elimination period.

(2) For all other benefits:

(a) The maximum interest rate for claim reserves is specified in WAC 284-16-520.

(b) The insurer shall base the reserve on the insurer's morbidity experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(c) General claim reserve methods are as follows:

(i) The insurer may use any generally accepted or reasonable actuarial method or combination of methods to estimate all claim liabilities.

(ii) The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. The insurer may also employ approximations based on groupings and averages. The insurer shall, however, determine adequacy of the claim reserves in the aggregate.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-450, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-460 Premium reserves.** (1) General premium reserve requirements are:

(a) Unearned premium reserves are required for all contracts, including credit insurance disability contracts, with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation;

(b) If premiums due and unpaid are carried as an asset, the insurer shall treat the premiums as premiums in force, subject to unearned premium reserve determination. The insurer shall carry as an offsetting liability the value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums; and

(c) Insurers may appropriately discount to the valuation date the gross premiums paid in advance for a period of cov-

erage commencing after the next premium due date which follows the date of valuation. The insurer shall hold this discounted premium either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

(2) Minimum standards for unearned premium reserves are as follows:

(a) The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:

(i) The valuation net modal premium on the contract reserve basis applying to the contract; or

(ii) The gross modal premium for the contract if no contract reserve applies.

(b) However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.

(3) General premium reserve methods are as follows: In computing premium reserves, the insurer may employ suitable approximations and estimates; including, but not limited to groupings, averages, and aggregate estimation. The insurer shall periodically test the approximations or estimates to determine their continuing adequacy and reliability.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-460, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-470 Contract reserves.** (1) General contract reserve requirements are:

(a) Contract reserves are required, unless otherwise specified in (b) of this subsection for:

(i) All individual and group contracts with which level premiums are used; or

(ii) All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The insurer shall determine the values specified in this item (ii) on the basis specified in subsection (2) of this section.

(b) Contracts not requiring a contract reserve are:

(i) Contracts which cannot be continued after one year from issue; or

(ii) Contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

(c) The contract reserve is in addition to claim reserves and premium reserves; and

(d) The insurer shall use methods and procedures for contract reserves that are consistent with those for claim reserves for any contract, or else shall make appropriate adjustment when necessary to assure provision for the aggregate liability. The insurer shall use the same definition of the date of incurral in both determinations.

(2) The basis for determining minimum standards for contract reserves are:

(a) Minimum standards with respect to morbidity are those set forth in WAC 284-16-500 and 284-16-510. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated. The insurer shall value contracts for which tabular morbidity standards are not specified in WAC 284-16-500 and 284-16-510 using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

(b) The maximum interest rate is specified in WAC 284-16-520.

(c) The insurer shall use termination rates in the computation of reserves on the basis of a mortality table as specified in WAC 284-16-530 except as noted in (d) of this subsection.

(d) Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard, the insurer may use total termination rates at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) Eighty percent of the total termination rate used in the calculation of the gross premiums; or

(ii) Eight percent.

(e) Where a morbidity standard specified in WAC 284-16-500 and 284-16-510 is on an aggregate basis, the insurer may adjust the morbidity standard to reflect the effect of insurer underwriting by policy duration. The adjustments shall be appropriate to the underwriting and be acceptable to the commissioner.

(f) Reserve method:

(i) For insurance, except long-term care and medicare supplement insurance, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(ii) For long-term care insurance and medicare supplemental insurance as governed by WAC 284-66-210 the minimum reserve is the reserve calculated on the one-year full preliminary term method.

(g) The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

(h) The insurer may offset negative reserves on any benefit against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(3) Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above; an insurer may use any reasonable assumptions as to interest rates, termination and/or mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following:

(a) The net level premium method;

- (b) The one-year full preliminary term method;
  - (c) Prospective valuation on the basis of actual gross premiums with reasonable allowances for future expenses;
  - (d) The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms;
  - (e) The computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and
  - (f) The use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.
- (4) Tests for adequacy and reasonableness of contract reserves.

(a) Annually, the insurer shall make an appropriate review of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of subsection (2) of this section.

(b) If an insurer has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, commissioner's regulation, or for some other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for such shortfalls in the aggregate.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-470, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-480 Determination of adequacy.** The insurer shall determine the adequacy of its disability insurance reserves on the basis of the claim reserves, premium reserves, and contract reserves combined. However, these standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-480, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-490 Reinsurance.** Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-490, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-500 Specific minimum morbidity standards for individual disability contracts.** (1) Disability income benefits due to accident or sickness.

- (a) Contract reserves for:
  - (i) Contracts issued on or after January 1, 1967, and prior to January 1, 1986: The 1964 Commissioners Disability Table (64 CDT).

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- (ii) Contracts issued on or after January 1, 1993: The 1985 Commissioners Individual Disability Tables A (85CIDA); or The 1985 Commissioners Individual Disability Tables B (85CIDB).

- (iii) Contracts issued during 1986 through December 31, 1992: Optional use of either the 1964 Table or the 1985 Tables.

- (iv) Each insurer shall elect, with respect to all individual contracts issued in any one statement year, either it will use Tables A or Tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(b) Claim reserves: The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred.

(2) Hospital benefits, surgical benefits and maternity benefits (scheduled benefits or fixed time period benefits only).

(a) Contract reserves for:

- (i) Contracts issued on or after January 1, 1967, and before January 1, 1986: The 1956 Intercompany Hospital-Surgical Tables.

- (ii) Contracts issued on or after January 1, 1993: The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

- (iii) Contracts issued during 1986 through December 31, 1992: Optional use of the 1974 Medical Expense Tables.

(b) Claim reserves: No specific standards. See subsection (5) of this section.

(3) Cancer expense benefits (scheduled benefits or fixed time period benefits only).

(a) Contract reserves for:

- (i) Contracts issued on or after January 1, 1993: The 1985 NAIC Cancer Claim Cost Tables.

- (ii) Contracts issued during 1986 through December 31, 1992: Optional use of the 1985 NAIC Cancer Claim Cost Tables.

(b) Claim reserves: No specific standard. See subsection (5) of this section.

(4) Accidental death benefits.

- (a) Contract reserves for contracts issued on or after January 1, 1967: The 1959 Accidental Death Benefits Table.

- (b) Claim reserves: Actual amount incurred.

(5) Other individual contract benefits.

- (a) Contract reserves: For all other individual contract benefits, morbidity assumptions are to be determined using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

- (b) Claim reserves: For all benefits other than disability, claim reserves are to be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-500, filed 9/9/92, effective 10/10/92.]

(9/11/17)



**WAC 284-16-510 Specific minimum morbidity standards for group disability contracts.** (1) Disability income benefits due to accident or sickness.

(a) Contract reserves for:

(i) Contracts issued prior to January 1, 1993: The same basis, if any, as that employed by the insurer as of December 31, 1992;

(ii) Contracts issued on or after January 1, 1993: The 1987 Commissioners Group Disability Income Table (87CGDT).

(b) Claim reserves for:

(i) Claims incurred on or after January 1, 1993: The 1987 Commissioners Group Disability Income Table (87CGDT);

(ii) Claims incurred prior to January 1, 1993: Optional use of either the 1964 Table or the 1987 Table.

(2) Other group contract benefits.

(a) Contract reserves: For all other group contract benefits, morbidity assumptions are to be determined using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

(b) Claim reserves: For all benefits other than disability, claim reserves are to be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-510, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-520 Specific standards for interest.** (1) For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of life insurance issued on the same date as the disability insurance contract.

(2) For claim reserves the maximum interest rate is the maximum rate permitted by law in the valuation of life insurance issued on the same date as the claim incurral date.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-520, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-530 Specific standards for mortality.** The mortality basis used shall be according to a table, but without use of selection factors, permitted by law for the valuation of whole life insurance issued on the same date as the disability insurance contract.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-530, filed 9/9/92, effective 10/10/92.]

**WAC 284-16-540 Reserves for waiver of premium.** (1) Waiver of premium reserves involve several special considerations. First, many disability valuation tables are based on exposures that include contracts on premium waiver as in-force contracts. Hence, contract reserves based on these tables are not reserves on "active lives" but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB Tables.

(2) Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

(a) Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

(9/11/17)

(b) Premium reserves should include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

(c) Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

(3) If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true "active life" basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

[Statutory Authority: RCW 48.02.060. WSR 92-19-038 (Order R 92-8), § 284-16-540, filed 9/9/92, effective 10/10/92.]

## ADMINISTRATIVE SUPERVISION OF INSURERS

**WAC 284-16-600 Purpose.** The purpose of this regulation, WAC 284-16-600 through 284-16-650, is to establish standards and procedures for the administrative supervision of insurers exceeding their powers or engaging in methods or practices that render the continuance of their business financially hazardous to their policyholders, creditors or the general public.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. WSR 09-23-022 (Matter No. R 2008-15), § 284-16-600, filed 11/9/09, effective 12/10/09.]

**WAC 284-16-610 Definitions.** The following definitions apply throughout this regulation unless the context clearly requires otherwise:

(1) The term "exceeded its powers" has the meaning set forth at RCW 48.31.020 (2)(a).

(2) The term "financially hazardous" means the standards set forth at WAC 284-16-310.

(3) "Insurer" has the meaning set forth at RCW 48.31.020(1) and 48.31.021.

(4) "Plan of correction" is an insurer's written plan to address or correct the commissioner's requirements to abate the findings and determination in the commissioner's order for administrative supervision.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. WSR 09-23-022 (Matter No. R 2008-15), § 284-16-610, filed 11/9/09, effective 12/10/09.]

**WAC 284-16-620 Process for establishing administrative supervision of an insurer.** (1) The commissioner may issue an order for administrative supervision and appoint an administrative supervisor if the commissioner makes a finding that:

(a) The insurer is in a condition which makes its continued operation financially hazardous to its policyholders, creditors or the general public; or

(b) The insurer has exceeded its powers.

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(2) In making a determination in subsection (1) of this section, the commissioner will consider:

(a) The conditions in RCW 48.31.020 (2)(a) to determine whether an insurer has exceeded its powers; or

(b) The findings in RCW 48.31.400(1), standards in WAC 284-16-310, and authorized actions in WAC 284-16-320(1) to determine whether an insurer is in financially hazardous condition.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. WSR 09-23-022 (Matter No. R 2008-15), § 284-16-620, filed 11/9/09, effective 12/10/09.]

**WAC 284-16-630 Plan of correction.** (1) This plan of correction must include one or more of the actions under WAC 284-16-320(2), and may include one or more prohibitions contained in the order.

(2) The contents of a plan of correction must address the specific facts and circumstances that led to the order. The plan of correction must include all of the following elements necessary to fully address the list of requirements contained in the administrative supervision order:

(a) An executive summary identifying the objective goals of the plan with key implementation dates and a projected date for full statutory compliance;

(b) A background description of the insurer describing its history, ownership structure, relationships with affiliates, management structure, key employees, and overall operating structure of its organization;

(c) The financial condition of the insurer summarizing its major categories of assets and liabilities, revenues and expenses, and debt and capital structure based on actual annual results for the previous two calendar years and monthly financial forecasts and assumptions for the next three year period to include any specific business plans by function from the date of the commissioner's order;

(d) The causes of the financially hazardous condition or exceeding its powers situation giving rise to supervision proceedings;

(e) The proposed corrective actions specifically identifying operational changes, contractual changes, management changes, and internal control structure changes;

(f) A proposal for monitoring and reporting systems to provide periodic reviews of progress and comparisons of actual results with the plan of correction objectives;

(g) An agreement that the insurer will provide a copy of any notice, request, or other communication from any other regulatory authority that is received by the insurer under administrative supervision to the administrative supervisor or designee within five business days after receipt by the insurer; and

(h) Any other element necessary to fully address a requirement contained in the administrative supervision order.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. WSR 09-23-022 (Matter No. R 2008-15), § 284-16-630, filed 11/9/09, effective 12/10/09.]

**WAC 284-16-640 Compliance with written requirements of commissioner—Noncompliance.** (1) Within fifteen days after receipt of the commissioner's order, the insurer under administrative supervision must submit its plan

of correction to address or correct the stated requirements in writing to the commissioner. The commissioner may extend the fifteen-day time period for submission of the plan of correction if the commissioner finds the insurer establishes good cause for the extension.

(2) If the commissioner and the insurer agree on the plan of correction, the commissioner will issue a written order to carry out the plan of correction. The insurer must not implement its plan of correction prior to receiving written approval by the commissioner.

(3) If the insurer fails to timely submit or the commissioner and the insurer are unable to agree to a plan of correction, the commissioner may enter an order requiring the insurer to take such corrective actions as may be reasonably necessary to remove the causes and conditions giving rise to the need for administrative supervision.

(4) Failure of the insurer to timely submit a plan of correction is a violation of the applicable provisions of Title 48 RCW.

(5) A copy of the commissioner's order approving the plan of correction or the order requiring the insurer to take corrective actions will be provided to the insurer and to the administrative supervisor.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. WSR 09-23-022 (Matter No. R 2008-15), § 284-16-640, filed 11/9/09, effective 12/10/09.]

#### **WAC 284-16-650 Administrative supervisor duties.**

(1) To the extent possible and consistent with the list of requirements referenced in RCW 48.31.400 (2)(b), the administrative supervisor will allow the insurer to continue its existing operations.

(2) The administrative supervisor will establish appropriate disbursement limits consistent with good internal control principles to facilitate prompt payment of claims and payables.

(3) Unless the processing of claims is an issue identified in the list of requirements referenced in RCW 48.31.400 (2)(b), the administrative supervisor will allow claims to be processed in the ordinary course of business.

(4) The administrative supervisor will promptly acknowledge every insurer's request for approval of actions identified in the administrative supervision order or plan of correction that requires approval. To the extent feasible, the administrative supervisor will act on an insurer's requests within five business days after receipt.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. WSR 09-23-022 (Matter No. R 2008-15), § 284-16-650, filed 11/9/09, effective 12/10/09.]

### **BUSINESS CONTINUITY PLANS**

**WAC 284-16-700 Definitions.** For purposes of this regulation, the following definitions apply:

(1) "Financially significant activities and applications" means computer software, including system programs and application programs, which are used to perform automated processing of a financially significant account balance or set of transactions. This includes financially significant e-business systems.

(2) "Regulatory reporting" includes filing of quarterly and annual statements, holding company filings, submission of financial payments for fees and taxes, rate and form filings and licensing appointments and renewals.

[Statutory Authority: RCW 48.02.060 and 48.07.205. WSR 10-22-076 (Matter No. R 2010-04), § 284-16-700, filed 11/1/10, effective 1/1/11.]

**WAC 284-16-710 Requirements for business continuity plan.** (1) Each domestic insurer must create and maintain a written business continuity plan identifying procedures relating to a local, state or national emergency or significant business disruption. Such procedures must be reasonably designed to:

(a) Enable the insurer to meet its existing obligations to insurance beneficiaries, policyholders, claimants, subscribers;

(b) Address the insurer's existing relationships with affiliates, third-party service providers, the National Association of Insurance Commissioners and the office of insurance commissioner; and

(c) Be made available upon request to the office of insurance commissioner.

(2) Each domestic insurer must update its business continuity plan in the event of any material change to the insurer's operations, structure, business or location.

(3) Each domestic insurer must conduct an annual review and test of its business continuity plan to determine whether modification is necessary in light of changes to the insurer's operations, structure, business or location.

(4) The elements that comprise a business continuity plan are flexible and may be tailored to the size and needs of an insurer. Each plan must at a minimum, address:

(a) Data back-up and recovery (hard copy and electronic);

(b) Information system disaster recovery (main site and alternate site);

(c) All financially significant activities and applications;

(d) Restoration priority based upon a business impact analysis;

(e) Alternate communications between policyholders or subscribers and the insurer;

(f) Alternate communications between the insurer, its employees and producers;

(g) Alternate physical location of employees;

(h) Regulatory reporting;

(i) Communications with regulators; and

(j) How the insurer will assure policyholders' prompt access to funds and securities due in the event that the insurer determines that it is unable to continue its business.

(5) If any of the categories in subsection (4) of this section are not applicable, the insurer's business continuity plan does not need to address the category but the insurer's business continuity plan must include the rationale for not including such category. If an insurer relies on an affiliate or third-party service provider for any of the categories in subsection (4) of this section or any financially significant system, application or activities, the insurer's business continuity plan must address this relationship.

(6) Each domestic insurer must clearly describe senior management roles and responsibilities associated with the

declaration of an emergency and implementation of the business continuity plan.

(7) Each domestic insurer must designate a member of senior management to approve the plan and he or she shall be responsible for conducting the required annual review and test.

[Statutory Authority: RCW 48.02.060 and 48.07.205. WSR 10-22-076 (Matter No. R 2010-04), § 284-16-710, filed 11/1/10, effective 1/1/11.]