



---

---

**Rules of**  
**Department of Insurance,**  
**Financial Institutions and**  
**Professional Registration**  
**Division 100—Insurer Conduct**  
**Chapter 8—Market Conduct Examination**

<b>Title</b>	<b>Page</b>
<b>20 CSR 100-8.010</b> Standards of Examination .....	3
<b>20 CSR 100-8.020</b> Sampling and Error Rates .....	3
<b>20 CSR 100-8.040</b> Insurer Record Retention .....	4



**Title 20—DEPARTMENT OF  
INSURANCE, FINANCIAL  
INSTITUTIONS AND  
PROFESSIONAL REGISTRATION  
Division 100—Insurer Conduct  
Chapter 8—Market Conduct Examination**

**20 CSR 100-8.010 Standards of Examination**

*PURPOSE: This rule sets out the scope of the rules in this chapter and provides definitions to aid in the interpretation of the rules in this chapter.*

(1) Examination Protocol. The director shall monitor the market conduct of insurers and producers transacting business in Missouri by using uniform standards of examination developed in consultation with members of the National Association of Insurance Commissioners (NAIC). Uniform state standards may be adopted by review and adoption of the *Market Conduct Examiners Handbook*, the *Market Regulation Handbook*, or other guides adopted by the director.

*AUTHORITY: section 374.045, RSMo 2000.\* Original rule filed Nov. 1, 2007, effective July 30, 2008.*

*\*Original authority: 374.045, RSMo 1967, amended 1993, 1995.*

**20 CSR 100-8.020 Sampling and Error Rates**

*PURPOSE: This rule effectuates and aids in the interpretation of sections 375.1007, 375.445 and 375.936(6), RSMo regarding detection of frequency to indicate a business practice under the Unfair Claims Settlement Practices Act or conducting business fraudulently, not in good faith or in a manner constituting misrepresentations or false advertising.*

(1) Unfair Claims Settlement Rates.

(A) As used in section (1), the terms and phrases mean as follows:

1. “Time error rate,” any one (1) of the following:

A. Acknowledgment time error rate, the percentage of claims in which the insurer has performed an act described in section 375.1007(2), RSMo or violated 20 CSR 100-1.030;

B. Investigation time error rate, the percentage of claims in which the insurer has performed an act described in section

375.1007(3), RSMo or violated 20 CSR 200-1.040; and

C. Determination time error rate, the percentage of claims in which the insurer has performed an act described in section 375.1007(7), RSMo or violated 20 CSR 200-1.050(1)(A).

2. “Unfair settlement rate,” the percentage of claims in which the insurer has performed an act described in section 375.1007(1), (5), (6), (8), (15), RSMo or violated 20 CSR 200-1.020 and 20 CSR 200-1.050(1)(B) or 20 CSR 200-1.050(2).

(B) The time error rates and unfair settlement rate will be important in determining whether the insurer has engaged in an unfair settlement practice as that phrase is used in section 375.1007, RSMo; however, other relevant factors will be considered in making the determinations. No attempt is made in this regulation to list other relevant factors because these factors depend on the facts of each case and no exhaustive or comprehensive list of other factors can be made.

(C) The time error rates and unfair settlement rate may be established by census or by an appropriate random sample. Whether a random sample was appropriate will be determined on a case-by-case basis.

(2) Unfair, Fraudulent, or Bad Faith Conduct in Claims Settlement.

(A) As used in section (2), the terms and phrases mean as follows:

1. “Insurance law,” any statutory provision in Chapters 354 or 374 through 385, RSMo or any regulation promulgated thereunder;

2. “Claims error rate,” the percentage of claims in which the insurer violated any insurance law, except section 375.1007, RSMo or 20 CSR 100-1.010, 20 CSR 100-1.020, 20 CSR 100-1.030, 20 CSR 100-1.040, 20 CSR 100-1.050, 20 CSR 100-1.100, section (1) of this rule and 20 CSR 300-2.100 or accepted or denied claims other than in accordance with the terms of an applicable policy, contract, certificate, endorsement or rider except where that acceptance or denial has already been included in the claims error rate as a violation of an insurance law;

3. “Cancelled, Non-Renewed, Declined (CND) error rate,” the percentage of cancelled and non-renewed policies and declined policy applications in which the insurer cancelled, non-renewed or declined in violation of any insurance law or the terms of the insurer’s policy, contract, certificate, endorsement or rider, or underwriting manuals or guidelines on file with the director;

4. “Post-claims underwriting index,” in life or accident or health insurance, means

the ratio which the contestable policies or certificates which are rescinded by an insurer after a claim has been made or in which a claim has been resisted on the grounds of misrepresentation as divided by the total contestable policies or certificates on which claims have been made bears to the applications for insurance declined or rejected by the insurer as divided by the total applications for insurance;

5. “Quotation error rate,” the percentage of personal lines property and casualty policies, contracts, certificates, endorsements or riders in which the premium quoted by the agent of the insurer is more than five dollars (\$5) different than the premium actually charged by the insurer, excluding policies, contracts, certificates, endorsements or riders in which the information relied on by the agent is substantially different than the information relied on by the insurer; and

6. “Rating error rate,” the percentage of policies, contracts, certificates, endorsements or riders in which the premium actually charged the insured is more than five dollars (\$5) different than the premium which should have been charged had the insurer calculated the premium in accordance with its policies, contracts, certificates, endorsements, riders and rating manuals or schedules on file with the director.

(B) The rates and index set forth in this regulation will be important in determining whether a violation of section 375.445, RSMo has occurred and the quotation error rate may also be considered in determining whether misrepresentations and false advertising of insurance policies within the meaning of section 375.936(6), RSMo has occurred. However, other relevant factors will be considered in making these determinations. No attempt is made in this regulation to list other relevant factors because other factors depend on the facts of each case and no exhaustive or comprehensive list of other relevant factors can be made.

(C) The rates or index may be established by census or by an appropriate random sample. Whether a random sample was appropriate will be determined on a case-by-case basis to ensure that the sample reflects a true random selection from the group as a whole and not so constricted by location, types, or time frame as to provide an inaccurate depiction of the overall group.

*AUTHORITY: sections 374.045, 375.948 and 375.1018, RSMo 2000.\* Original rule filed Nov. 1, 2007, effective July 30, 2008.*



*\*Original authority: 374.045, RSMo 1967, amended 1993, 1995; 375.948, RSMo 1959, amended 1978, 1991; and 375.1018, RSMo 1991.*

**20 CSR 100-8.040 Insurer Record Retention**

*PURPOSE: This rule describes the requirements for record keeping for insurers and related entities doing business in this state. This regulation was adopted pursuant to the provisions of section 374.045, RSMo and to implement sections 287.350, 354.190, 354.465, 374.190, 374.210, 375.158, 379.343 and 379.475, RSMo and 144.027, 354.149, 354.717, 375.022, 375.150, 375.151, 375.926, 375.932, 375.938, 375.1002 and 375.1009, RSMo.*

(1) As used in this rule, the terms and phrases mean as follows:

(A) "Application," any written or electronic application form, any enrollment form, any document used to add coverage under any existing policy, any questionnaire, telephone interview form, paramedical interview form, or any other document used to question or underwrite an applicant for any policy issued by an insurer or for any declination of coverage by an insurer. "Application" does not include documents, questionnaires or notes generated in response to a request for a premium quote which did not result in an application for coverage;

(B) "Business entity," as that term is defined in section 375.012.1(1), RSMo;

(C) "Claim," as that term is defined in section 20 CSR 100-1.010(1)(B);

(D) "Examiner," a market conduct examiner authorized by the director to conduct an examination pursuant to section 374.202.2(4), RSMo;

(E) "Inquiry," a specific question, criticism or request made in writing to an insurer by a market conduct examiner duly appointed by the director;

(F) "Insurer," as that term is defined in section 375.932 or 375.1002, RSMo; and

(G) "Policy," as that term is defined in section 375.932(5), RSMo. The term "policy" shall also include any evidence of coverage issued by a health maintenance organization to an enrollee.

(2) Records Required. Every insurer transacting business in this state shall maintain its books, records, documents and other business records in a manner so that the following practices of the insurer may be readily ascertained during market conduct examinations: claims handling and payment, com-

plaint handling, termination, rating, underwriting and marketing.

(3) Records to be Maintained. The following records shall be maintained:

(A) A Missouri policy record file shall be maintained for each Missouri policy issued, and shall be maintained for the duration of the current policy term plus two (2) calendar years. Missouri policy records shall be maintained so as to show clearly the policy period, basis for rating and any imposition of additional exclusions from or exceptions to coverage. Missouri policy records need not be segregated from the policy records of other states so long as they are readily available to Missouri market conduct examiners as required under this rule. Missouri policy records shall include the following:

1. The actual, completed application for each contract.

A. The application shall bear the signature of the applicant whenever the insurer intends to retain any right to contest any warranty, representation or condition contained in the application.

B. The application shall bear a clearly legible means by which an examiner can identify any insurance producer involved in the transaction. The examiners shall be provided with any information needed to determine the identity of said insurance producer;

2. Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, and any written or electronic correspondence to or from the insured pertaining to the coverage. If any of these records has already been filed with the department, a separate copy of the record need not be maintained in the individual policy files to which the record pertains, provided it is clear from the insurer's other records or systems that the record applies to a particular policy and that any data contained in the record relating to that policy can be retrieved or recreated;

3. Any binder with terms and conditions that differ from the terms and conditions of the policy subsequently issued; and

4. Any guidelines, manuals or other information necessary for the reconstruction of the rating and underwriting of the policy. The maintenance at the site of a market conduct examination of a single copy of each of the above shall satisfy this requirement. If any such rating or underwriting record is computer based, the records used to input the information into the computer system shall also be available to the examiners;

(B) A Missouri claim file shall be maintained for the calendar year in which the claim is closed plus three (3) years. The claim file shall be maintained so as to show clearly the inception, handling, and disposition of each claim. The claim file(s) shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed. A Missouri claim file(s) shall include the following:

1. Any notification of claim, proof of loss, claim form(s), proof of claim payment check/draft, notes, contract, declaration pages, certificates evidencing coverage under a group contract, endorsements or riders, work papers, any written communication, and any documented or recorded telephone communication related to the handling of a claim, including the investigation, payment and/or denial of the claim, and any claim manual(s) or other information necessary for reviewing the claim. Where a particular document pertains to more than one (1) file, insurers may satisfy the requirements of this paragraph by making available, at the site of a market conduct examination, a single copy of each document;

2. Documents in a claim file received from an insured, the insured's insurance producer, a claimant, the department or any other insurer shall bear the initial date of receipt date-stamped by the insurer in a legible form in ink or some other permanent manner. Unless the company provides the examiners with written procedures to the contrary, the earliest date stamped on a document will be considered the initial date of receipt;

3. In cases of a total loss on property claims for a motor vehicle, trailer, boat or outboard motor, the claim file shall contain a copy of the certification described in section 144.027, RSMo attesting to the amount of the insurance proceeds and any deductible obligation paid by the claimant regarding the loss. The certification shall contain a statement informing the claimant that the sales tax credit is valid for only one hundred eighty (180) days; and

4. If an insurer, as its regular business practice, places the responsibility for handling certain types of claims upon company personnel other than its claims personnel, the insurer need not duplicate its files for maintenance by claims personnel. These claims records must be maintained as part of the records of the insurer's operations and must be readily available to examiners. Notwithstanding the definition of "claim" at subsection 20 CSR 100-1.010(1)(B), the time requirements for the retention of records for policy files stated at section 374.205.2(2), RSMo, apply to



claims handled by the company's personnel who typically handle policy files;

(C) Records to be maintained relating to the insurer's compliance with Missouri's licensing requirements shall include the Missouri licensing records of each insurance producer associated with the insurer. Licensing records shall be maintained so as to show clearly the dates of the appointment and terminations of each insurance producer. In accordance with the provisions of section 375.158, RSMo, insurers must have procedures in place to request, review, and document current licenses of each insurance producer to whom a commission will be paid or to validate the producer's licensure status prior to the payment of this commission. Upon request by the director, insurers shall provide documentation that such license verification procedures were followed. The date of the receipt by the insurer of the copy of the license shall be indicated by a date-stamp placed on the license. Unless the company provides the examiners with written procedures to the contrary, the earliest date stamped on a document will be considered the initial date of receipt;

(D) The Missouri complaint records required to be maintained under section 375.936(3), RSMo shall include a complaint log or register in addition to the actual written complaints. The complaint log or register shall show clearly the total number of complaints for a period of not less than the immediately preceding three (3) years, the classification of each complaint by line of insurance, the nature of each complaint, and the disposition of each complaint. The complaint log or register shall also contain a reference to the location of the file to which each complaint corresponds. If the insurer maintains the file in a computer format, the reference in the complaint log or register for locating such documentation shall be an identifier such as the policy number or other code. Such codes shall be provided to the examiners at the time of an examination;

(E) The insurer shall retain declined underwriting files for a period of three (3) years from the date of declination. The term "declined underwriting file" shall mean all written or electronic records concerning a policy for which an application for insurance coverage has been completed and submitted to the insurer or its insurance producer but the insurer has made a determination not to issue a policy or not to add additional coverage when requested. A declined underwriting file shall include an application, any documentation substantiating the decision to decline an issuance of a policy, any binder issued without the insurer issuing a policy,

any documentation substantiating the decision not to add additional coverage when requested and, if required by law, any declination notification. Notes regarding requests for quotations which do not result in a completed application for coverage need not be maintained for purposes of this regulation; and

(F) The insurer shall retain claim files for a period of three (3) years from the date of the claim determination. These files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of these events can be reconstructed. Documentary material which is pertinent to the investigation and/or denial of a claim shall be legibly date stamped with the date of receipt whether it is from an insured, his/her agent, a claimant, the department or any other insurer.

#### (4) Form of Record.

(A) Any record required to be maintained by an insurer, may be in the form of paper; photograph; computer; magnetic, mechanical or electronic medium; or any process which accurately forms a durable reproduction of the record, so long as the record is capable of duplication to a hard copy that is as legible as the original document. Documents that require the signature(s) of the insured and/or insurer's insurance producer, shall be maintained in any format as listed above provided evidence of the signature(s) is preserved in that format.

(B) The maintenance of records in a computer-based format shall be archival in nature only, so as to preclude, to the extent reasonable, the alteration of the record after the initial transfer to a computer format. Upon request of an examiner all records shall be capable of duplication to a hard copy that is as legible as the original document. Such records shall be maintained according to written procedures developed and adhered to by the insurer. Said written procedures shall be made available to the department's market conduct examiners in accordance with section (6) below.

(C) Photographs, microfilms or other image-processing reproductions of records shall be equivalent to the originals and may be certified as the same in actions or proceedings before the department unless inconsistent with 20 CSR 800-1.100.

(5) Location of Files. All records required to be maintained under this rule shall be kept in a location which will allow the records to be produced for examination within the time period required under section (6) of this rule. When, under normal circumstances, some-

one other than the insurer maintains a required record or type of record, the other person's or entity's responsibility to maintain the records shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and shall be available to the examiners for purposes of examination.

#### (6) Time Limits to Provide Records and to Respond to Examiners.

(A) An insurer shall provide any record requested by any examiner within ten (10) calendar days. When the requested record is not or cannot be produced by the insurer within ten (10) calendar days, this nonproduction shall be deemed a violation of this rule, unless the insurer can demonstrate to the satisfaction of the director that the requested record cannot reasonably be provided within ten (10) calendar days of the request.

(B) As a means to facilitate the examination and to aid in the examination in accordance with section 374.205.2(2), RSMo, an insurer shall provide a written response to any inquiry submitted by any examiner within ten (10) calendar days. When the requested information is not provided by the insurer within ten (10) calendar days, a violation shall be deemed to have occurred, unless the insurer can demonstrate to the satisfaction of the director that the requested response cannot reasonably be provided within ten (10) calendar days of the inquiry.

(7) Examination Work Papers. Records required to be provided during a market conduct examination shall be returned to the insurer following the examination, unless such records relate to an inquiry made by a department examiner. Records related to an inquiry shall become a part of the work papers of the examination. Regulation 20 CSR 10-2.400 shall govern the public access to the work papers of the examination.

*AUTHORITY: sections 374.045 and 375.948, RSMo 2000.\* Original rule filed Nov. 1, 2007, effective July 30, 2008.*

*\*Original authority: 374.045, RSMo 1967, amended 1993, 1995 and 375.948, RSMo 1959, amended 1978, 1991.*