230-RICR-20-60-4

TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 – INSURANCE

SUBCHAPTER 60 – MISCELLANEOUS

Part 4 - Record Retention

4.1 Authority

This Part is promulgated in accordance with R.I. Gen. Laws Chapters 27-9.1, 27-13.1 and 27-29. Nothing herein shall be construed to create or imply a private cause of action for violation of this Act.

4.2 Purpose

This Part implements R.I. Gen. Laws Chapters 27-13.1 and 27-29 regarding the retention and maintenance of records required for market conduct purposes as contained in § 4.4 of this Part.

4.3 Definitions

A. All definitions contained in R.I. Gen. Laws §§ 27-13.1-2 and 27-29-2 are hereby incorporated by reference. In addition, for purposes of this Part:

1. "Application and accompanying records" means any written or electronic application form, any enrollment form, any document or record thereof, used to add coverage under any existing policy, 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.

2. "Claim file and accompanying records" means the file maintained so as to show clearly the inception, handling and disposition of each claim. The claim file shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed.

3. "Commissioner" means the Director of the Department of Business Regulation or his or her designee.

4. “Complaint” means a written communication primarily expressing a grievance.

5. “Declination” or “Declined underwriting file” means all written or electronic records concerning coverage for which an application has been completed and submitted to the insurer or its producer but the insurer has made a determination not to issue a policy or not to add additional coverage when requested.

6. “Examiner” means a market conduct examiner or any other examiner authorized or designated by the commissioner to conduct an examination pursuant to R.I. Gen. Laws Chapter 27-13.1.

7. “Grievance” for health insurance purposes, means a written complaint submitted by or on behalf of a covered person regarding the:

   a. Claims payment, handling or reimbursement for health care services; or

   b. Matters pertaining to the contractual relationship between a covered person and a health carrier.

8. “Inquiry” means a specific question, criticism or request made in writing to an insurer by an examiner.

9. “Related entity” means a person authorized to act on behalf of the insurer in connection with the business of insurance.

4.4 Records Required for Market Conduct Purposes

A. An insurer or related entity licensed to do business in this state shall maintain its books, records and documents in a manner so that the commissioner can readily ascertain during an examination the insurer’s compliance with state insurance laws and rules and with the standards outlined in the NAIC Market Regulation Handbook, including, but not limited to, company operations and management, policyholder service, marketing, producer licensing, underwriting, rating, complaint/grievance handling, and claims practices.

B. For a health insurer, the insurer or related entity shall maintain its books, records, and documents in a manner so that the practices of the insurer regarding network adequacy, utilization review, quality assessment and improvement and provider credentialing may be ascertained during a market conduct examination.

C. These records shall be retained for the current year plus four (4) years.

D. The producer of record shall maintain a file for each policy sold, and the file shall contain all work papers and written communications in his or her possession pertaining to the policy documented therein. These records shall be retained for the current year plus four (4) years.

E. During an examination of the insurer, the insurer shall provide a copy of the written contract entered into with each third party vendor or service provider as requested by an examiner within the time frames set forth in § 4.11 of this Part.

4.5. Policy Record File

A. A policy record file shall be maintained for each policy issued, and shall be maintained for the duration of the current policy term plus four (4) years, or for life insurance policies and annuity contracts, for the time the policy or contract is in force and four (4) years thereafter. 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. If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination and account records indicating a return of premiums, if any, shall also be maintained. Policy records need not be segregated from the policy records of other states so long as the records are readily available to market conduct examiners as required under this Part.

B. Policy records shall include the following:

1. Any application and accompanying records for each contract. The application shall bear a clearly legible means by which an examiner can identify a producer involved in the transaction. The examiners shall be provided with information clearly identitifying the producer involved in the transaction.

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, any termination notices, 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 commissioner, 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 the policy, as well as the actual policy issued to the insured, can be retrieved or recreated;

3. Any binder; and

4. Any guidelines, manuals or other information necessary for the reconstruction of the rating, underwriting, policy owner service and claims handling 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. These types of records include, but are not limited to, the application, the policy form including any amendments or endorsements, rating manuals, underwriting rules, credit reports or scores, claims history reports, previous insurance coverage reports (e.g., MIB), questionnaires, internal reports, and underwriting and rating notes.

C. A declined underwriting file shall be maintained and shall include 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 that do not result in a completed application for coverage need not be maintained for purposes of this Part. The insurer shall retain declined underwriting files for the current year plus four (4) years.

4.6 Claim File

A. A claim file and accompanying records shall be maintained for the calendar year in which the claim is closed plus four (4) years. The claim file shall be maintained so as to show clearly the inception, handling and disposition of each claim. The claim files shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed. A claim file shall, at a minimum, include the following items:

1. For property and casualty: the file or files containing the notice of claim, claim forms, proof of loss or other form of claim submission, settlement demands, accident reports, police reports, adjustors logs, claim investigation documentation, inspection reports, supporting bills, estimates and valuation worksheets, medical records, correspondence to and from insureds and claimants or their representatives, notes, contracts, declaration pages, certificates evidencing coverage under a group contract, endorsements or riders, work papers, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, payment or denial of the claim, copies of claim checks or drafts, or check numbers and amounts, releases, all applicable notices, correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, any other documentation created and maintained in a

paper or electronic format, necessary to support claim handling activity, and any claim manuals or other information necessary for reviewing the claim.

2. For life and annuity: the file or files containing the notice of claim, claim forms, proofs of loss, medical records, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, claim handling logs, copies of checks or drafts, check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.

3. For health: the file or files containing the notice of claim, claim forms, medical records, bills, electronically submitted bills, proofs of loss, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, health facility pre-admission certification or utilization review documentation, claim handling logs, copies of explanation of benefit statements, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, copies of checks or drafts, or check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.

B. Where a particular document pertains to more than one file, insurers may satisfy the requirements of this section by making available, at the site of an examination, a single copy of each document.

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

D. 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 shall be maintained as part of the

records of the insurer's operations and shall be readily available to examiners.

4.7 Licensing Records

Records to be maintained relating to the insurer's compliance with licensing requirements shall include the licensing records of each producer, adjuster or appraiser associated with the insurer. Licensing records shall be maintained so as to show clearly the licensing status of the producer, adjuster or appraiser at the time of solicitation, negotiation or procurement. It is incumbent upon the insurer to verify and keep track of the license expiration date and renew the license as required for each producer or adjuster associated with the insurer. A screenprint from the Producer Database (PDB) may serve to provide adequate proof only of a producer's current licensing status.

4.8 Complaint Records

The complaint records required to be maintained under R.I. Gen. Laws § 27-29-4(13) shall include a complaint log or register, or grievance log or register for health insurers, in addition to the actual written complaints. The complaint log or register shall show clearly the total number of complaints for the current year plus the immediately preceding four (4) years, the classification of each complaint by line of insurance and by complainant (i.e. insured, Division of Insurance, third party, etc.), the nature of each complaint, the insurer's disposition of each complaint, and the complaint number assigned by the Division of Insurance, if applicable. If the insurer maintains the file in a computer format, the reference in the complaint log or register for locating the documentation shall be an identifier such as the policy number or other code. The codes shall be provided to the examiners at the time of an examination.

4.9 Format of Records

A. Any record required to be maintained by an insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium; or any process that 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 are produced and sent to an insured by use of a template and an electronic mail list shall be considered to be sufficiently reproduced if the insurer can provide proof of mailing of the document and a copy of the template. Documents that require the signature of the insured or insurer's producer shall be maintained in any format listed above provided evidence of the signature is preserved in that format.

B. The maintenance of records in a computer-based format shall be archival in nature, so as to preclude 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. The records shall be maintained according to written procedures developed and adhered to by the insurer. The written procedures shall be made available to the commissioner during an examination.

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 commissioner unless inconsistent with R.I. Gen. Laws Chapter 42-35.

4.10 Location of Files

A. All records required to be maintained under this Part shall be kept in a location that will allow the records to be produced for examination within the time period required. When, under normal circumstances, someone other than the insurer maintains a required record or type of record, the other person'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.

B. If required by law or otherwise available, the insurer shall maintain disaster preparedness or disaster recovery procedures that include provisions for the maintenance or reconstruction of original or duplicate records at another location. These procedures shall be provided for review during the examination.

4.11 Time Limits to Provide Records and to Respond to Examiners

A. Initial data requests should be submitted to a company at least thirty (30) days prior to the commencement of the on-site examination, desk audit or other form of review to provide ample time for the company to prepare the materials requested by the examining state. §§ 4.11(B) and (C) of this Part below apply to requests for supplemental data and information not anticipated at the time of the initial request as specified in Subsection A. This section will not apply to any examination designated by the Department as an "emergency" examination.

B. As a means to facilitate the examination and to aid in the examination in accordance with R.I. Gen. Laws § 27-13.1-3 an insurer shall provide any requested document or written response to an inquiry submitted by an examiner within five (5) working days, or such other time period as mutually

agreed upon by the examiner and the insurer. When the requested document or response is not produced by the insurer within the specified time period, a violation shall be deemed to have occurred unless the insurer can demonstrate to the satisfaction of the commissioner that the requested record cannot reasonably be provided within the specified time period of the request.

C. The time period for when a response is due may be extended if that request consists of a data run, request for statistical information, or information that cannot logistically be obtained without additional time. Approval for such an extention must be obtained from the Division, in writing. That writing will then control the time period required for response.

D. Additional records requested by the commissioner shall be made available for the examination upon the date specified by the Examiner in Charge.

4.12 Confidential Materials

Original records required to be provided during a market conduct examination shall be returned to the insurer following the examination. If the records relate to an inquiry made by an examiner copies of the records shall become a part of the work papers of the examination. R.I. Gen. Laws §§ 27-13.1-5(f) and 38-2-2(4)(i)(W) shall govern the public access to the work papers of the examination.

4.13 Severability

If any provision of this Part or the application thereof to any person or circumstances is held invalid or unconstitutional, the invalidity or unconstitutionality shall not affect other provisions or applications of this Part which can be given effect without the invalid or unconstitutional provision or application, and to this end the provisions of this Part are severable.

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TITLE 230 - DEPARTMENT OF BUSINESS REGULATION (INCLUDES THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER)

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