DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

United Services Automobile Association – NAIC # 25941
USAA Casualty Insurance Company – NAIC # 25968
USAA General Indemnity Company – NAIC # 18600
Garrison Property and Casualty Insurance Company – NAIC # 21253

Examination Authority # 25941-15-PIP-703
Examination Authority # 25968-15-PIP-704
Examination Authority # 18600-15-PIP-705
Examination Authority # 21253-15-PIP-706

9800 Fredericksburg Road
San Antonio, TX 78288

As of

March 31, 2015

Karen Weldin Stewart, CIR-ML
Commissioner

Delaware Department of Insurance

I, Karen Weldin Stewart, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of March 31, 2015 on

United Services Automobile Association
USAA Casualty Insurance Company
USAA General Indemnity Company
Garrison Property and Casualty Insurance Company

is a true and correct copy of the document filed with this Department.

Attest By: _____

In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover.

_____
Karen Weldin Stewart, CIR-ML
Insurance Commissioner

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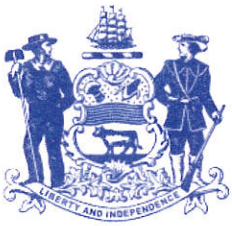
Karen Weldin Stewart, CIR-ML
Commissioner



Delaware Department of Insurance

REPORT ON EXAMINATION

OF THE

United Services Automobile Association
USAA Casualty Insurance Company
USAA General Indemnity Company
Garrison Property and Casualty Insurance Company

AS OF

March 31, 2015

The above-captioned Report was completed by examiners of the Delaware Department of Insurance.

Consideration has been duly given to the comments, conclusions and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted and filed as an official record of this Department.

Karen Weldin Stewart, CIR-ML
Insurance Commissioner

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Honorable Karen Weldin Stewart, CIR-ML
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Stewart:

In compliance with the instructions contained in Certificate of Examination Authority Numbers 25941-15-PIP-703, 25968-15-PIP-704, 18600-15-PIP-705 and 21253-15-PIP-706, and pursuant to statutory provisions including 18 Del. CODE §318-322, a market conduct examination has been conducted of the affairs and practices of:

United Services Automobile Association
USAA Casualty Insurance Company
USAA General Indemnity Company
Garrison Property and Casualty Insurance Company

The examination was performed as of March 31, 2015. USAA Companies hereinafter referred to as the "Company", were incorporated under the laws of Texas. The examination consisted of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

9800 Fredericksburg Road
San Antonio, TX

The off-site examination phase was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the "Department" or "DDOI," or other suitable locations.

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

United Services Automobile Association is a member-owned reciprocal inter-insurance exchange founded in 1922 to provide competitively priced insurance for its members. The USAA property & casualty group of insurers (USAA P&C) consists of United Services Automobile Association, USAA Casualty Insurance Company, USAA General Indemnity Company, and Garrison Property and Casualty Insurance Company. All are domiciled in Texas. All Companies herein will be referred to as USAA Companies.

On their 2014 annual statement filed with the Department, the USAA P & C group reported total private passenger premiums written for all states of $49,975,491 of which Delaware has a market share of 1.98% or approximately $989,761. The 2013 statement shows private passenger premiums of $45,401,840 of which Delaware's market share is 1.94% or approximately $880,770.

The examination focused on the Company's private passenger automobile business in the following areas of operation: Company Operations and Management, Complaint Handling and Claims.

The following exceptions were noted:

COMPLAINT HANDLING

2 Exceptions – 18 Del. C. §2304 (17) Unfair methods of competition and unfair or deceptive acts or practices defined

-For failure to maintain complete complaint logs

6 Exceptions – 18 Del. C. §2304 (26) Unfair methods of competition and unfair or deceptive acts or practices defined

-For failure to respond to an inquiry from the Department of Insurance within 21 days

2 Exceptions – 18 Del. Admin Code 902 §1.2.1.2 Prohibited unfair claim settlement practices

-For failure to respond to an inquiry with respect to an insured's claim within 15 working days One exception received an response to communication 49 days after receipt and the other received no response at all.

CLAIMS

14 Exceptions – 18 Del. Admin. Code 2304 §16(f) Unfair claim settlement practices

-For failure to abide by the provision of Delaware Insurance Department Bulletin #10 (excerpted within this document)

2 Exceptions – 18 Del. Admin Code 902 §1.2.1.2 Prohibited unfair claim settlement practices

-For failure to respond to an inquiry with respect to an insured's claim within 15 working days. One exception received a response 44 days after receipt of communication and the other was received 273 days after receipt.

1 Exception – 18 Del. Admin Code 902 §1.2.1.5 Prohibited unfair claim settlement practices

-For failure to advise in writing of a claim acceptance or denial within 30 days

1 Exception – 18 Del. Admin Code 903 §4 Prompt Payment of Settled Claims

-For failure to reimburse the remainder of deductible within 30 days

SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 18 Del. CODE §318-322 and covered the experience period of January 1, 2013 through March 31, 2015.

The examination was a target market conduct examination of the Company's private passenger automobile business in the following areas of operation: Company Operations and Management, Complaint Handling, and Claims with an emphasis on Personal Injury Protection.

The examination consisted of four companies being examined simultaneously with one sample per category. The Companies operate on the same platform rather than autonomous entities therefore allowing for sampling of files to be of combined universes.

METHODOLOGY

This examination was performed in accordance with Market Regulation standards established by the Department and examination procedures suggested by the NAIC. While the examiners' report on the errors found in individual files, the focus is also on general business practices of the Company.

The Company identified the universe of files for each segment of the review. Based on the universe sizes, random sampling was utilized to select the files reviewed during this examination.

Delaware Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. An exception is any instance of Company activity that does not comply with an insurance statute or regulation. Exceptions contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of exceptions identified during the examination and review written summaries provided on the exceptions found.

COMPANY HISTORY

United Services Automobile Association is a member-owned reciprocal inter-insurance exchange founded in 1922 to provide competitively priced insurance for its members. The USAA property & casualty group of insurers consists of United Services Automobile Association, USAA Casualty Insurance Company, USAA General Indemnity Company, and Garrison Property and Casualty Insurance Company. All are domiciled in Texas.

United Services Automobile Association is licensed in all states, District of Columbia, the U.S. Virgin Islands, Guam and Puerto Rico.

USAA Casualty Insurance Company and USAA General Indemnity Company are licensed in all states, the District of Columbia and the U.S. Virgin Islands. In addition, USAA General Indemnity Company is licensed in Puerto Rico.

Garrison is currently licensed in all states and the District of Columbia.

USAA Companies provides personal lines property and casualty insurance to its policyholders, which includes automobile, homeowners, renters, fire, (also referred to as rental property insurance, or RPI), umbrella, valuable personal property, and pleasure boat.

USAA Companies has claims operations in San Antonio, TX, Chesapeake, VA, Tampa, FL, Colorado Springs, CO, and Phoenix, AZ.

COMPLAINT HANDLING

All written complaints (including email) are forwarded to the CEO Member Relations Department. CEO Member Relations is responsible for the Enterprise Complaint Registry that facilitates the capture, resolution and reporting of all USAA Companies complaints. They provide oversight and approval of complaint resolutions to make sure they are addressed appropriately and to ensure legal or regulatory obligations are satisfied. They also oversee member, non-member and third party correspondence addressed to USAA.

The Company has written procedures on handling all types of complaints and grievances. USAA Companies had a total of 108 Complaints reported in Delaware during the examination period. They had 45 complaints in 2013, 56 complaints in 2014 and seven in the first quarter of 2015.

The complaint log was reviewed for compliance with 18 Del. C. §2304 (17). This section of the Code requires maintenance of a complete record of all complaints received since the date of its last examination. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with 18 Del. Admin. Code 902 §1.2.1.2.

The following exceptions were noted during the review.

2 Exceptions: 18 Del. C. §2304(17) *Unfair methods of competition and unfair or deceptive acts or practices defined – The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:*

(17) Failure to maintain complaint handling procedures. – Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination as otherwise required in this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.

The Company failed to include all complaints in its complaint log. There were two complaints included in Department records that were not included in the Company's complaint log.

Recommendation: The Company should review its complaint handling procedures and make necessary revisions to ensure that all consumer complaints are included in accordance with 18 Del. C. §2304(17).

6 Exceptions: 18 Del. C. §2304(26) *Unfair methods of competition and unfair or deceptive acts or practices defined. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:*
(26) Failure to respond to regulatory inquiries. – No person shall, with such frequency as to indicate a general business practice, fail to provide preliminary substantive responses to inquiries from the Department of Insurance regarding the denial of claims, cancellation, nonrenewal, or refusal of benefits, refusal to pre-authorize benefits, or violations of this title, with 21 calendar days of such inquiry. A response in compliance with this paragraph shall not preclude the provision of additional information responsive to the inquiry.

The Company failed to respond to inquiries from the Department of Insurance within 21 days. Two exceptions noted receipt of response 22 days after receipt of Department inquiry, one 23 days, one 26 days, one 27 days and one 74 days.

Recommendation: The Company should review its complaint handling procedures and make necessary revisions to ensure that all consumer complaints receive a response within 21 working days in accordance with 18 Del. C. §2304(26).

2 Exceptions: 18 Del. Admin Code 902 §1.2.1.2 *Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.*

The Company failed to issue a response within 15 working days regarding communications with respect to the insured's claim. One exception received an response to communication 49 days after receipt and the other received no response at all.

Recommendation: The Company shall review its claim handling procedures and make necessary revisions to ensure that upon receipt of a claim a response is communicated to an insured within 15 working days in accordance with 18 Del. Admin Code 902 §1.2.1.2.

CLAIMS

Personal Injury Protection – Paid and Claims Closed without Payment

USAA Companies reported 30,170 private passenger automobile policies in force in Delaware as of March 31, 2015. During the examination period, 32,687 private passenger automobile claims were submitted. Of those claims, approximately 6.06% had a Personal Injury Protection component.

Personal Injury Protection frequently initiates with a provider of medical or hospital services submitting a bill for consideration. The billing is reviewed for usual and customary charges by an independent third party vendor. The bill could be paid in full or adjusted according to either a Preferred Provider Organization agreement (if applicable) with the provider or according to a formula based on Medicare fee schedules. These adjustments could result in the provider receiving less than the billed amount and the provider may bill a policyholder for the remaining balance. This is commonly referred to as "Balance Billing".

According to Delaware Insurance Department Bulletin #10:

> *"Under the applicable law, 21 Delaware Code, Section 2118(a)(2), insurers are responsible for paying the "reasonable and necessary expenses" for PIP coverage. Some insurers are refusing to pay more than a portion of the medical, hospital, or other professional medical expenses on behalf of their insureds based upon what those carriers believe are "unreasonable" fees billed. In interpreting the relevant statute, it is the Commissioner's opinion that PIP carriers must pay all of an insured's PIP costs (less any applicable deductible) if those costs are reasonable and pertain to services that are necessarily required for the care of the insured. This does not apply when a provider of services and carrier have previously agreed on a price for a specified service. If a medical provider has charged in "unreasonable fee" for a necessary treatment, the unreasonableness of that fee does not render the treatment "unnecessary." That portion of the fee which is not in dispute shall be paid according to relevant law.*
>
> *A dispute over the remaining amount of such a fee should remain a dispute between the carrier and the provider. It is expected that carriers will make good faith efforts to resolve such disputes and not expose the insured party to harassment or legal action. However, if a claim is made or legal action is filed by the provider against the insured party for the amount of the fee in dispute, the carrier must provide a defense for its insured against that claim or legal action.*
>
> *Under the Delaware Unfair Practice Act, Title 18 Delaware Code, Section 2304(16), it is an unfair trade practice to attempt with such frequency as to indicate a general business practice to settle a claim for less than the insurance policy requires. The Department will vigorously enforce the rights of insured to receive the benefits to which they are contractually entitled. It will be considered a violation of 18 Delaware Code, Section 2304 if a carrier asserts that the provisions of this bulletin prohibit balance billing."*

The Company asserts that the amounts paid under the Personal Injury Protection coverage is "usual and reasonable". The Company has in place a procedure wherein they will assist the consumer should any balance billing be attempted by the provider. A letter is provided for the insured to sign and forward to the provider that indicates the amount paid by the Company has been reviewed and the difference between the amount submitted and the amount paid is reasonable and they will not be providing any

additional remuneration. The letter includes a caveat that "any additional documentation should be submitted to USAA for reconsideration". The provider is also advised of the steps needed if they wish to appeal the decision.

The Company advised that they have developed additional proactive steps to enhance their Personal Injury Protection claims procedures regarding balances billing from providers with implementation throughout 2016. The proposed process includes:

- Updating letters and forms to address both potential and actual balance billing and payment disputes. These updates will include clarification that USAA will work with the provider to resolve disputes and will indemnify and defend the insured as necessary. The updates will also instruct members to contact the adjuster if a provider or collection agent contacts them.

- Update procedures for the 1st party adjuster to ask a member at the 30-day status follow-up and throughout the life of the file when appropriate, whether there are any payment disputes or balance billing.

- Update procedures for the 1st party adjuster to advise an insured, at file closure, to contact USAA if they receive any contact from a provider or collection agency demanding payment or indicating that there is a payment dispute.

- Implement an additional manager review, when a Fee Methodology Letter has been sent to a provider. (A Fee Methodology letter is a letter sent to providers that explains how usual and customary fees are determined.) If a Fee Methodology Letter has been sent to a provider in connection with a PIP claim, a manager will review the file to ensure that no further action or follow-up is needed before closing the file.

- Provide adjuster with additional training about medical billing, to provide awareness to the adjuster of billing inaccuracies that can affect reimbursement of services based on how the provider billed. The steps planned include:
    - Providing more detailed information to adjusters on medical service billing and levels of service, or adjustments due to billing of a modifier; and
    - Reinforcing the range of options available to resolve disputes with providers, including negotiated settlements.
    - Ask DE providers to join the PPO network, to reduce the potential for billing disputes.

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The Company was asked to clarify what steps would be taken if the propose procedures are still met with exception by providers. The Company responded their obligation is to pay a reasonable fee for necessary services related to an auto accident. They believe that they have been consistently meeting this obligation. They also believe that the enhancements to

procedures will result in identifying potential balance billing issues earlier and give adjusters more tools to resolve balance billing issues before they affect insureds. Their goal is to avoid having providers "expose the insured party to harassment or legal action", as stated in Auto Bulletin No 10.

When asked what would happen if a provider refuses to join the PPO network and provides a Balance Billing to an insured, the Company advised it would treat this provider the same as any other provider that is not in the PPO network.

The Company was provided a list of all of the files involving a Bodily Injury component during the examination period. The Company provided a listing of 3,639 files from which the examiners filtered 1,981 Personal Injury Protection claims. The examiners selected and reviewed 105 Paid Claims and 83 Claims Closed without Pay. In addition, Contributory Negligence claims were reviewed for compliance with 18 Del. C. §2304 Unfair Practices in the Insurance Business.

In the sample of 105 Paid Claims, it was noted that 48 claims were paid 100%, 11 claims were paid under a PPO contract and the remaining 46, or 44%, had an adjustment for "reasonable" fees. Of the 46 claims with adjustments, the examiner found 14 (30%) cases in which the reasonable fee was contested by the provider.

The following exceptions were noted:

14 Exceptions: 18 Del. Admin. Code 2304 §16(f) *Unfair claim settlement practices. — No person shall commit or perform with such frequency as to indicate a general business practice any of the following: (f) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;*

The Company failed to abide by the provisions of Delaware Insurance Department #10 regarding Balance Billing by not taking a more pro-active approach to assist consumers.

Recommendation: The Company should take a more proactive approach to situations when the insured is balance billed. The Company should take full responsibility for the amount of reimbursement and advise the insured that they will take over all collection actions relative to the amount of the balance being billed in accordance with Delaware Insurance Department Bulletin #10. To assist with compliance of the DOI bulletin, the Company should fully implement the proposed enhanced procedures as described in the report.

2 Exceptions: 18 Del. Admin Code 902 §1.2.1.2 *Prohibited Unfair Claim Settlement Practices – Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.*

The Company failed to issue a response within 15 working days regarding communications with respect to the insured's claim. One exception received a response 44 days after receipt of communication and the other was received 273 days after receipt.

Recommendation: The Company shall update its claim procedures to ensure that all communications regarding claims by insureds are responded to within 15 working days in accordance with 18 Del. Admin Code 902 §1.2.1.2.

Claims with Contributory Negligence

The Company was requested to provide a list of all of the files involving Contributory Negligence received during the examination period. The Company provided a listing of 603 files from which the examiners selected and received 83 files for review. The Contributory Negligence claims were reviewed for compliance with 18 Del. C. §2304 Unfair Practices in the Insurance Business.

The following exceptions were noted.

1 Exception – 18 Del. Admin. Code 902 §1.2.1.5. *Failure to affirm or deny coverage or a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer.*

The Company failed to advise in writing the reason for delay within 30 days. Delay letter was sent 62 days after the date of notice of loss.

Recommendation: It is recommended that the Company ensure that all persons presenting claims are being advised in writing regarding the reason for delay to affirm or deny coverage or claim and that such communication is within 30 days in accordance with 18 Del. Admin Code 902 §1.2.1.5.

1 Exception – 18 Del. Admin Code 903 §4. *For the purpose of this regulation prompt payment is defined as remittance of the check within 30 days from: the date of agreement, memorialized in writing; final order by the court; or unappealed arbitration award.*

The Company failed to pay reminder of deductible within 30 days. The percentage of contributory negligence was amended and the Company failed to adjust the amount of deductible payable to the insured. The reimbursement was not made until the adjustment was brought to the attention of the Company and payment made on 7/29/2015.

Recommendation: It is recommended that the Company ensure, upon receipt of subrogation or arbitration, any additional deductible reimbursements as a result of a change in contributory negligence be paid with 30 days in accordance with 18 Del. Admin Code 903 §4.

Subrogation Claims

The Company was requested to provide a list of all of the files involving Subrogation received during the examination period. The Company provided a listing of 1,935 files from which the examiners selected and received 105 files for review. The Subrogation claims were reviewed for compliance with 18 Del. C. §2304 Unfair Practices in the Insurance Business.

No exceptions were noted.

Arbitration Claims

The Company was requested to provide a list of all of the files involving Arbitration received during the examination period. The Company provided a listing of 154 files from which the examiners selected and received 76 files for review. The Arbitration claims were reviewed for compliance with 18 Del. C. §2304 Unfair Practices in the Insurance Business.

No exceptions were noted.

CONCLUSION

The recommendations made below identify corrective measures the Department finds necessary as a result of the exceptions noted in the Report. Location in the Report is referenced in parenthesis.

1. The Company should review its complaint handling procedures and make necessary revisions to ensure that all consumer complaints are included in accordance with 18 Del. C. §2304(17). (Complaints)
2. The Company should review its complaint handling procedures and make necessary revisions to ensure that all consumer complaints receive a response within 21 working days in accordance with 18 Del. C. §2304(26). (Complaints)
3. The Company shall review its claim handling procedures and make necessary revisions to ensure that upon receipt of a claim a response is communicated to an insured within 15 working days in accordance with 18 Del. Admin Code 902 §1.2.1.2. (Complaints & Claims)
4. The Company should take a more pro-active approach to situations when the insured is balance billed. The Company should take full responsibility for the full amount of reimbursement and advise the insured that they will take over all collection actions relative to the amount of the balance be billed in accordance with Delaware Insurance Department Bulletin #10. To assist with compliance the Company should fully implement the proposed enhanced procedures, as described in the report. (Claims)
5. It is recommended that the Company ensure that all persons presenting claims are being advised in writing regarding the reason for delay to affirm or deny coverage or claim and that such communication is within 30 days in accordance with 18 Del. Admin Code 902 §1.2.1.5. (Claims)
6. It is recommended that the Company ensure, upon receipt of subrogation or arbitration, any additional deductible reimbursements as a result of a change in contributory negligence be paid with 30 days in accordance with 18 Del. Admin Code 903 §4. (Claims)

The examination conducted by Shelly Schuman, James Myers, Linda Armstrong and Steve Misenheimer is respectfully submitted.

James R Myers, AMCM
Examiner-in-Charge