STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF FINANCIAL SERVICES,	)	
Petitioner,	)	
vs.	)	Case No. 04-0718PL
BRADLEY W. BESHORE,	)	
Respondent.	)	

RECOMMENDED ORDER

On October 4 through 7, 2004, an administrative hearing in this case was held in Sarasota, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Philip M. Payne, Esquire
David J. Busch, Esquire
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STATEMENT OF THE ISSUE

The issues in the case are whether the allegations of the Second Administrative Complaint are correct, and, if so, what penalty, if any, should be imposed.

PRELIMINARY STATEMENT

On March 4, 2004, the Department of Financial Services (Petitioner) forwarded to the Division of Administrative Hearings (DOAH) a Petition for Formal Administrative Proceeding filed by Bradley W. Beshore (Respondent) challenging an Amended Administrative Complaint. (The initial Administrative Complaint was amended prior to the case being referred to DOAH.) Also enclosed with the Petition for Hearing was Respondent's Motion to Dismiss the Amended Complaint. Petitioner filed a Response to the Motion to Dismiss on March 5, 2004.

By Notice of Hearing dated March 15, 2004, the case was scheduled for hearing commencing on June 28, 2004.

On May 18, 2004, hearing was held on Respondent's Motion to Dismiss Amended Administrative Complaint.

On May 28, 2004, Petitioner filed a six-count Second Amended Administrative Complaint. On June 10, 2004, Respondent filed a Response to, and a Renewed Motion to Dismiss, the Second Amended Administrative Complaint. Petitioner filed a Response to the Renewed Motion to Dismiss on June 21, 2004.

On June 25, 2004, a hearing was held on Respondent's Renewed Motion to Dismiss the Second Amended Administrative Complaint. By Order entered June 25, 2004, both pending Motions to Dismiss were denied. By Notice of Hearing dated June 25, 2004, the hearing was continued and rescheduled for October 4 through 8, 11, and 12, 2004.

On September 20, 2004, the parties filed a Prehearing Stipulation wherein Petitioner dismissed the allegations set forth in paragraph number four of the Second Amended Administrative Complaint.

The case was transferred to the undersigned Administrative Law Judge on September 28, 2004. The hearing commenced on October 4, 2004.

At the hearing, Petitioner presented the testimony of nine witnesses. The following Petitioner's exhibits were admitted into evidence: Exhibits numbered 1; 2A; 3 (parts A, B, and C); 5 (parts B, C, D, E, F, I, M, N, P, Q, and R); 7 (parts B, C, D, E, F, G, H, I, J, K, M, N, P, Q, and S); 8 (parts C, D, E, F, G, I, K, L, N, and P); 9 (parts D, E, F, G, H, I, J, K, L, M, and N); 10 (parts B and C); 11 (parts B, D, E, F, G, H, I, J, and N); 12B; 13 (parts C, D, E, F, G, H, I, K, N, L, and O); and 17A.

Respondent testified on his own behalf and had Exhibits numbered 1 through 3 admitted into evidence.

The five-volume Transcript of the hearing was filed November 4, 2004. Pursuant to an agreement between the parties, Proposed Recommended Orders were filed on January 28, 2005.

On February 3, 2005, Respondent filed Respondent's Motion to Strike Portions of Petitioner's Proposed Recommended Order (Motion to Strike) and attachments thereto. On February 18, 2004, Petitioner filed a response to the Motion to Strike.

Upon review of the motion and response, Respondent's Motion to Strike is granted as to Appendices 1, 2, 4 through 9, and 12. Respondent's Motion to Strike is otherwise denied.

FINDINGS OF FACT

1. At all times material to this case, Respondent was an insurance agent, holding Florida license number A020887, and was licensed as a Resident Life, Health & Variable Annuity (2-15); Life (20-16); Life & Health (2-18); General Lines, Property & Casualty Insurance (2-20); and Health (2-40) agent.

2. Respondent has been licensed in Florida since February 14, 1994, and has consistently met all continuing education requirements applicable to his licensure.

3. At all times material to this case, Respondent was employed as an account executive by HRH of Southwest Florida, Inc. HRH of Southwest Florida, Inc., is a subsidiary of HRH, Inc., a large provider of insurance agency services. Respondent

is not and has never been an officer, director, manager, or shareholder of HRH of Southwest Florida, Inc.

4. HRH of Southwest Florida, Inc., provided insurance and risk management services to businesses. Insofar as is relevant to this case, HRH of Southwest Florida, Inc., offered to its clients both fully insured health benefit plans and partially self-funded health benefit plans.

5. Fully insured health benefit plans are those in which an employer pays a premium (sometimes with an employee contribution) to an insurer, and health benefit insurance coverage is provided to participants in the plan. Petitioner has the responsibility for regulating fully insured health benefit plans sold in the State of Florida.

6. Partially self-funded health benefit plans include those where an employer's funds (again sometimes with an employee contribution) are used to cover health expenses of plan participants. The employer's funds are collected by a third-party administrator responsible for paying claims out of the employer's funds, and for obtaining stop-loss insurance to cover claims in excess of the funds available from the employer. Properly created, partially self-funded health benefit plans may be exempt from regulation by state authorities under the provisions of the federal Employee Retirement Income Security Act (ERISA).

7. In the April 2001, HRH of Southwest Florida, Inc., began offering to clients in Lee, Manatee, and Sarasota Counties, a health benefit product made available by Meridian Benefit, Inc. (MBI).

8. MBI had no authorization to operate as an insurer in the State of Florida.

9. Based on information provided to HRH of Southwest Florida, Inc., MBI was operating as a third-party administrator for partially self-funded health benefit plans. The information provided to HRH of Southwest Florida, Inc., initially came from Thomas Mestmaker and Associates, a managing general agency representing MBI, and was confirmed through information subsequently provided by MBI. The plans were presumed by Respondent to be exempt from regulation by Petitioner under the provisions of ERISA based on the information provided by MBI.

10. According to the information provided to Respondent and to HRH of Southwest Florida, Inc., the MBI plan included establishment of a single employer trust (SET) on behalf of each business. Health claims from each business' employees would be paid from the funds contributed to the trust by the employer. "Stop-loss" insurance would be obtained to cover claims in excess of an employer's contribution.

11. The information provided by Respondent to his clients was provided to Respondent or to HRH of Southwest Florida, Inc.,

by MBI and affiliated other sources. Based on such information, Respondent presumed that MBI was a stable organization and that the stop-loss coverage was in place.

12. Respondent had no specific training related to ERISA-qualification of health benefit plans. He has sold other plans that he believed were ERISA-qualified plans to other employers in Florida.

13. Typically, a business owner would initially contact HRH of Southwest Florida, Inc., seeking health benefits for employees. A representative of HRH of Southwest Florida, Inc., such as Respondent, would research a variety of options for the business owner and then present the options to the client.

14. The evidence establishes that the MBI health benefit plan was one of several options (including both fully-insured and partially self-funded plans) presented to clients. A client was free to choose the MBI plan, another plan presented, or no plan at all. Clients generally reviewed health benefit plans on an annual basis, at which point the process of presenting various options was repeated.

15. Respondent eventually sold the MBI plan to ten or twelve business clients seeking to provide health benefits to employees.

16. Clients choosing to obtain health benefits through the MBI plan submitted information related to the client's employees

through Respondent and HRH of Southwest Florida, Inc., to MBI, which would respond with a preliminary rate proposal. After a client chose to accept the rate proposal, representatives from HRH of Southwest Florida, Inc., including Respondent, would assist client employees in completing applications. The applications were submitted to MBI, which in turn established actual rates and communicated the actual rate directly to the client.

17. Clients who chose to accept the final rate proposal then executed documents purportedly establishing an SET. The documents apparently were created by MBI, and were delivered to clients through representatives of HRH of Southwest Florida, Inc., including Petitioner. After execution by the clients, the documents were returned to MBI.

18. Some clients received a general document on MBI letterhead titled "Technical Aspects of SET SINGLE EMPLOYER TRUST" wherein clients were advised that the SET was an "Employee Welfare Benefit Plan" that was "designed to conform to the Employee Retirement Income Security Act of 1974, as amended." The document described the process of establishing rates and advised that MBI was the plan administrator. The document also referenced a trust document and stated that the trust custodian was First Union National Bank. The document stated as follows:

> At First Union an account will be established for each single employer trust into which all contributions received by the trust from the employer group will be deposited. Any income earned from funds deposited in that account will be credited to that account and any fees charged by the bank will be charged to that account.

19. Some clients received a disclosure document from "Hilb, Rogal and Hamilton of Sarasota" specifically applicable to the client, which provided that the client "intends to establish a SINGLE EMPLOYER TRUST Employee Welfare Benefit Plan," that client contributions would be made to a trust, and that "all benefits funded by the Plan will be paid out of the assets of the Trust." The document further provided that "[I]n its discretion, the Trust may purchase stop-loss insurance to pay any claims in excess of the amounts held in the Trust."

20. Clients were provided with a document titled "DIRECTIVE TO ESTABLISH A HEALTH AND WELFARE BENEFIT PLAN UNDER ERISA" wherein each client provided information, including the number of total and participating employees and the plan coverage sought. The document required the signature of a client's representative and authorized MBI to establish a "Health and Welfare Benefit Plan under ERISA."

21. Clients were provided with a document titled "HEALTH AND WELFARE PLAN - PLAN DOCUMENT," a lengthy document that set

forth the specific health care benefits provided to each client under the selected benefit plan.

22. Each client was provided with a document titled "HEALTH AND WELFARE PLAN SUMMARY" which essentially summarized the plan being provided to the client, identified as the "Plan Sponsor." The document identified MBI as the plan administrator and the claim administrator.

23. The document provided as follows:

> The Plan conforms to and is governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan is not a policy of insurance. Neither the Plan Sponsor, nor any trust established to fund the benefits hereunder, is an insurance company.

24. At various times, clients were provided with a document titled "WELFARE BENEFIT PLAN TRUST." In some instances, the document purported to be a trust agreement between the client and First Union, the designated custodian. In other instances, the "WELFARE BENEFIT PLAN TRUST" document did not identify the name of the trust custodian. In all cases, the document identified the plan administrator as MBI, and provided that MBI could "elect such financial institution as it deems appropriate to serve as the custodian with respect to the Trust. . . ." The document further provided that the plan administrator could "remove the Custodian at any time upon sixty (60) days notice in writing to the Custodian . . ." and that the

custodian could resign with like notice to the plan administrator. In the agreements where First Union was designated the custodian, removal of the custodian required the client to designate a replacement custodian. In the agreements where no designation was made, the document provided that the plan administrator would designate the replacement custodian.

25. Once the documents were executed and returned to MBI, MBI directly invoiced clients for payment of funds, and clients paid such funds directly to MBI. There is no evidence that Respondent was involved in handling funds transferred from the client to MBI. There is no evidence that Respondent received any information related to any trust accounts that may or may not have been established under the agreement between the client, a trust custodian, and MBI. There is no evidence that Respondent received cancelled checks or copies of account statements.

26. There is no credible evidence that custodial accounts were established by MBI or that contributions submitted to MBI by employers were deposited into custodial accounts. Some checks from multiple employers appear to have been deposited into a single account at First Union. Some checks were deposited into the PNC Bank. There is no credible evidence as to the distribution of the deposited funds.

27. Although under the terms of the trust agreement not all clients were required to approve substitute custodians, there is no evidence that any client required to approve a substitute custodian was ever asked to do so. There is no evidence that the plan administrator complied with the trust document language related to removal of the custodian.

28. At some point in 2002, questions arose about the source of funds available to pay claims in excess of employer contributions. The information initially provided to clients by Respondent was that stop-loss insurance was in place to cover such claims. However, according to a letter on MBI letterhead dated February 25, 2002, to Thomas E. Mestmaker and Associates, "MBI is responsible for any amounts due under adjudicated claims in excess of the contribution amount of its client, assuming that all payments, obligations and bills submitted to the client are timely paid, and the Plan is in good standing with MBI." The letter further states, "MBI is responsible for any excess, subject to the terms and conditions of the initial Directive together with the Plan Trust Agreement, as applicable."

29. There were apparently concerns regarding the soundness of MBI and their ability to handle losses. In March of 2002, information available to Respondent indicated that the stop-loss coverage MBI had supposedly obtained would not be renewed.

Respondent began to prepare to move his MBI clients to other benefit plans.

30. A letter to Respondent dated April 11, 2002, on MBI letterhead and purportedly from the Controller of MBI states in part as follows:

> Meridian Benefit Inc. has acted as an administrator for ERISA-based health plans that it has developed for years. Meridian Benefit Inc. has credibly sufficient contributions and reserves necessary to pay claims for these plans. Moreover, the finances of Meridian Benefit Inc. have been and continue to be sound.
> Since Meridian Benefit Inc. is a privately held company, we cannot share our detailed financial data, however through management and underwriting Meridian Benefit Inc. has been able to control claims and group losses.

31. MBI then advised Respondent and others that the stop-loss insurance was in place via a statement dated June 19, 2002, indicating that "reinsurance" was being provided by American National Life Insurance Company effective July 1, 2002.

32. As MBI or affiliated entities issued statements regarding the soundness of the MBI plan and the availability of stop-loss coverage, Respondent made the information, including the aforementioned letters, available to clients.

33. The parties have stipulated that American National Life Insurance Company did not provide "reinsurance" or

stop-loss insurance relative to any health and welfare benefit plan with MBI as plan administrator.

34. There is no credible evidence that any stop-loss insurance was actually ever obtained by MBI on behalf of employers.

35. In early 2003, MBI informed employers that the employers would be responsible for payment of claims in excess of contributions. By letter dated February 19, 2003, MBI issued a letter to clients which indicated that if a client's claims exceeded contributions, MBI would "advance funds" against the employer's account and then would "approach the employer for repayment of the deficit." The letter further provided that if MBI and the employer "cannot successfully negotiate repayment for the advance, MBI will unfortunately, be forced to stop payment on any existing or future claims."

36. The February 19 letter clearly contradicted earlier affirmations that stop-loss insurance was in place to cover claims in excess of contributions.

37. The evidence fails to establish from where funds "advanced" by MBI would have come. Respondent testified that he did not know the source of the funds.

38. The evidence establishes that Respondent made no independent effort to review MBI or the MBI plan being offered to clients, to determine whether or not stop-loss insurance was

actually in place by contacting the insurer identified by MBI as the stop-loss insurer, or to determine whether client funds were being deposited into custodial accounts.

39. By letters dated February 20, 2003 (the day after notifying employers that they would be required to reimburse MBI for funds "advanced"), MBI advised employers of account deficits and directed the employers to pay the deficits.

40. On or about May 15, 2003, MBI filed for Chapter 7 bankruptcy in the United States District Court in New Jersey.

41. MBI had an agreement with Healthcare Sarasota, a local employer organization with an existing network of healthcare providers (a preferred provider organization or "PPO"), to permit MBI plan participants to utilize the Healthcare Sarasota provider network.

42. Client benefit claims were handled between the PPO and MBI. On occasion, representatives of HRH of Southwest Florida, Inc., including Petitioner, became involved in resolving claim issues at the request of clients, but Petitioner had no direct involvement in paying claims.

43. Prior to and by the time MBI filed for bankruptcy, there were numerous unpaid health benefits claims incurred by employees of the employers who became involved with the MBI plan through Respondent. Some employers have paid the claims and are seeking restitution from various parties. Other claims remain

unpaid. Although the evidence fails to clearly establish the amount of the remaining unpaid claims, it is clear that at the time of the hearing, thousands of dollars in health benefit claims remain unpaid by any responsible party. Some employees of businesses that participated in the MBI plan have had unpaid claims forwarded by health providers to debt collection agencies.

44. Petitioner has disseminated information to the public and to licensed agents about potential difficulties that may result from participating in health benefit plans that are not subject to state regulation. There is no evidence that licensed agents are required to read the information disseminated by Petitioner, and there is no evidence that Respondent did so.

Child Development Center

45. In mid-2001, Respondent met with a representative of the Child Development Center (CDC) to present various options for health benefit coverage for CDC employees. CDC chose to provide health benefits through the MBI plan.

46. A CDC representative executed the document titled "DIRECTIVE TO ESTABLISH A HEALTH & WELFARE BENEFIT PLAN UNDER ERISA." The document was dated June 21, 2001, with an effective date of July 1, 2001, and signed by Respondent, identified as the "Benefit Consultant."

47. A CDC representative executed the document titled "WELFARE BENEFIT PLAN TRUST." The document provided an effective date of July 1, 2001, but was executed on September 19, 2001. The document stated that the trust custodian would be First Union. Nothing on the document indicated that First Union had agreed to be the custodian.

48. Included with the information provided by Respondent to CDC was the letter dated February 25, 2002, from MBI to Thomas Mestmaker and Associates stating that MBI was responsible for amounts due under adjudicated claims in excess of the employer's contribution.

49. By July 2002, there were no apparent problems with coverage or claims paid, and CDC renewed its participation in the MBI plan.

50. By January 2003, problems with CDC claims payments were occurring and CDC representatives requested from Respondent an accounting of claims paid. The accounting was not immediately made available, although at some subsequent and unidentified time CDC received the information.

51. In March 2003, an employee of CDC located information on the internet indicating that the States of Colorado and North Carolina had issued "cease and desist" orders against MBI. The CDC representative forwarded the information to "Tyla Heatherly"

an employee at HRH of Southwest Florida, Inc., and asked that it be provided to Respondent.

52. Respondent thereafter advised the CDC representative that the problems in other states were related to the type of plans that were being offered in those states, and that the CDC plan was an ERISA-qualified SET.

53. By letter from MBI to CDC dated May 5, 2003, MBI advised CDC that MBI was "experiencing severe financial problems and is in the process of winding-down its business." The letter advised CDC to "make immediate arrangements" to obtain either a different third party administrator or to obtain other health benefit coverage.

54. Beginning June 20, 2001, CDC paid funds by check to MBI pursuant to the invoices that MBI delivered directly to CDC. Although the CDC checks to MBI were deposited, the evidence fails to establish that the CDC funds were deposited into a custodial trust account for the benefit of CDC.

Family Counseling Center of Sarasota, Inc.

55. At some point in 2001, Respondent met with a representative of the Family Counseling Center of Sarasota, Inc. (FCCS), to present various options for health benefit coverage for FCCS employees. FCCS chose to provide health benefits through the MBI plan.

56. An FCCS representative executed the document titled "DIRECTIVE TO ESTABLISH A HEALTH & WELFARE BENEFIT PLAN UNDER ERISA" dated October 31, 2001, and signed by Respondent, as the "Benefit Consultant."

57. By his signature, an FCCS representative acknowledged receipt of the "HEALTH AND WELFARE PLAN SUMMARY" document indicating an effective date of December 1, 2001, which was also signed by Respondent.

58. An FCCS representative executed the document titled "WELFARE BENEFIT PLAN TRUST." The document has an effective date of December 1, 2001, but the date of execution was January 3, 2002. The document stated that the trust custodian would be First Union. Nothing on the document indicated that First Union had agreed to be the custodian.

59. Included with the information provided by Respondent to FCCS was the letter dated February 25, 2002, from MBI to Thomas Mestmaker and Associates stating that MBI was responsible for amounts due under adjudicated claims in excess of the employer's contribution. Respondent provided to FCCS the MBI letter to Respondent dated April 11, 2002, advising that MBI had sufficient contributions and reserves necessary to pay claims and was in sound condition. Respondent provided to FCCS the document on MBI letterhead dated June 19, 2002, stating that

American National Life Insurance Company was providing "reinsurance."

60. Towards the end of the first year of the MBI plan, FCCS learned that renewal of the MBI plan would involve a substantial cost increase. FCCS initially intended to change benefit plans due to the cost increase, but Respondent apparently negotiated with MBI to reduce the price increase to 40 percent over the initial year cost. FCCS renewed the MBI plan because even with the rate increase the MBI plan was still less expensive than other available benefit plans.

61. FCCS received the MBI letter dated February 19, 2003, stating that if a client's claims exceeded contributions, MBI would "advance funds" against the client's account and then would "approach the employer for repayment of the deficit." The evidence fails to establish whether the letter was provided to FCCS by Respondent or by MBI.

62. By letter from MBI to FCCS dated February 20, 2003, MBI advised FCCS that the client needed to submit "a one-time payment of $163,670.75 to bring your account into a positive position or an increase in your contribution of 200% effective 5/1/2003."

63. The letters of February 19 and 20, 2003, contradicted the assurances by Respondent to FCCS that stop-loss coverage was

in place to address claims in excess of employer contributions. FCCS contacted Respondent to advise him of the situation.

64. By letter from FCCS to the chief executive officer of HRH of Southwest Florida, Inc., dated April 25, 2003, FCCS advised that MBI was not paying claims and that some of the staff were having accounts turned over to collection agencies for non-payment.

65. By letter from MBI to FCCS dated May 5, 2003, MBI advised FCCS that MBI was "experiencing severe financial problems and is in the process of winding-down its business." The letter advised FCCS to "make immediate arrangements" to obtain either a different third party administrator or to obtain other health benefit coverage.

66. FCCS paid funds by check to MBI pursuant to the invoices that MBI delivered directly to FCCS. Although the FCCS checks to MBI were deposited, the evidence fails to establish that the FCCS funds were deposited into a custodial account for the benefit of FCCS.

<u>Sarasota Land Services</u>

67. In the beginning of 2002, Respondent met with a representative of Sarasota Land Services (SLS) to present various options for health benefit coverage for SLS employees. SLS chose to provide health benefits though the MBI plan.

68. An SLS representative executed the document titled "DIRECTIVE TO ESTABLISH A HEALTH & WELFARE BENEFIT PLAN UNDER ERISA." The document was executed on February 11, 2002, with an effective date of March 1, 2002, and was signed by Respondent, as the "Benefit Consultant."

69. By her signature, the SLS representative acknowledged receipt of the "HEALTH AND WELFARE PLAN SUMMARY" document indicating an effective date of March 1, 2002, which was also signed by Respondent.

70. An SLS representative executed the document titled "WELFARE BENEFIT PLAN TRUST." The document indicates the agreement was executed on February 11, 2002, and was effective as of March 1, 2002, but the SLS representative's signature was dated September 10, 2002. The document did not identify the name of the trust custodian, but provided that MBI could "elect such financial institution as it deems appropriate to serve as the custodian with respect to the Trust. . . ."

71. SLS received the disclosure document from "Hilb, Rogal and Hamilton of Sarasota" titled "DISCLOSURE AND ACKNOWLEDGEMENT REGARDING THE SARASOTA LAND SERVICES BENEFIT PLAN" dated March 1, 2002. The SLS representative's signature on the disclosure form is dated September 10, 2002.

72. By letter from MBI to SLS dated February 20, 2003, MBI advised SLS that the claims history required an increase in

SLS's contribution of 100 percent effective March 1, 2003. Upon receipt of the letter, the SLS representative contacted Respondent and discussed the situation. The discussion included references to the stop-loss insurance coverage that the SLS representative expected to cover claims in excess of contributions.

73. SLS did not renew its participation in the MBI plan.

74. Beginning February 12, 2002, SLS paid funds by check to MBI pursuant to the invoices that MBI delivered directly to SLS. Although the SLS checks to MBI were deposited, the evidence fails to establish that the SLS funds were deposited into a custodial account for the benefit of SLS.

75. SLS also paid an administrative fee directly to HRH of Southwest Florida, Inc. The evidence does not establish what, if any, of the administrative fee was paid to Respondent.

Center For Sight

76. In the fall of 2001, the Center For Sight (CFS) entered into an agreement with MBI to obtain health benefit services for CFS employees. CFS was already participating in the MBI plan in March 2002, at the time the CFS representative who testified at the hearing became employed at CFS.

77. A CFS representative executed on July 17, 2001, the document titled "DIRECTIVE TO ESTABLISH A HEALTH & WELFARE BENEFIT PLAN UNDER ERISA." The document indicated an effective

date of August 1, 2001, and was signed by Respondent, as the "Benefit Consultant."

78. By their signatures, CFS representatives acknowledged receipt of the "HEALTH AND WELFARE PLAN SUMMARY" document indicating an effective date of August 1, 2001.

79. CFS representatives executed the document titled "WELFARE BENEFIT PLAN TRUST" with an effective date of August 1, 2001, although the document was executed on September 1, 2001. The document indicated that the trust custodian would be First Union. Nothing on the document indicated that First Union had agreed to be the custodian.

80. The CFS representative who testified at the hearing was the chief operating officer for CFS. He reviewed the MBI plan upon beginning his employment. He testified that claims payment problems began "instantaneously," but stated that Respondent was helpful in getting claims processed and paid. He testified that he had no problems with Respondent.

81. The CFS representative had concerns about the provision of stop-loss insurance and asked Respondent to obtain a copy of a policy, but the policy was never provided to CFS. However, prior to renewal in July 2002, Respondent provided to CFS the MBI document dated June 19, 2002, stating that American National Life Insurance Company was providing "reinsurance."

82. At the end of the first year, Respondent presented various health benefit options to CFS, but despite the claims payment problems, CFS renewed the MBI plan in July 2002 because the MBI plan was substantially less expensive than other benefit plans.

83. At some subsequent time, Sarasota Memorial Hospital and other local providers began to refuse services to CFS employees covered under the MBI plan, apparently because claims were not being paid.

84. CFS received the MBI letter dated February 19, 2003, stating that if a client's claims exceeded contributions, MBI would "advance funds" against the client's account and then would "approach the employer for repayment of the deficit."

85. By letter from MBI to CFS dated February 20, 2003, MBI advised FCCS that the client needed to submit "a one-time payment of $5,471.66 to bring your account into a positive position or an increase in your contribution of 15% effective 4/1/2003."

86. By letter dated April 18, 2003, to MBI and copied to Respondent, CFS set forth a list of concerns related to claims which were unpaid or had been denied and to "high administrative cost" and asked that there be a resolution to the problems.

87. Eventually CFS paid approximately $300,000 in pending employee claims using CFS funds and sought health benefits from another source.

88. Beginning July 19, 2001, CFS paid funds by check to MBI pursuant to the invoices that MBI delivered directly to CFS. Although CFS checks to MBI were deposited, the evidence fails to establish that the CFS funds were deposited into a custodial account for the benefit of CFS.

Michael's Gourmet Group

89. Prior to 2002, Respondent had an existing relationship with Michael's Gourmet Group (MGG) and had previously assisted MGG in obtaining health benefits from various sources. In March of 2002, Respondent met with a representative of MGG to present various options for health benefit coverage for MGG employees. MGG chose to provide health benefits through the MBI plan.

90. As he did in presenting available health benefit options to clients, Respondent informed MGG that the MBI plan was a partially self-funded plan and that stop-loss insurance would cover claims in excess of the MGG contributions.

91. An MGG representative executed the document titled "DIRECTIVE TO ESTABLISH A HEALTH & WELFARE BENEFIT PLAN UNDER ERISA." The document was executed on February 27, 2002, with an

effective date of March 1, 2002, and was signed by Respondent, as the "Benefit Consultant."

92. Although the evidence includes a "HEALTH AND WELFARE PLAN SUMMARY" document applicable to MGG and indicating an effective date of March 1, 2002, there are no signatures on the document.

93. An MGG representative executed the document titled "WELFARE BENEFIT PLAN TRUST" with an effective date of March 1, 2002, although the document was executed July 24, 2002. The document did not identify the name of the trust custodian, but provided that MBI may "elect such financial institution as it deems appropriate to serve as the custodian with respect to the Trust. . . ."

94. MGG received a document from "Hilb, Rogal and Hamilton of Sarasota" titled "DISCLOSURE AND ACKNOWLEDGEMENT REGARDING THE SARASOTA LAND SERVICES BENEFIT PLAN" dated March 15, 2002. The MGG representative's signature on the disclosure form is dated July 24, 2002.

95. MGG received the MBI letter dated February 19, 2003, which stated that if a client's claims exceeded contributions, MBI would "advance funds" against the client's account and then would "approach the employer for repayment of the deficit."

96. By letter from MBI to MGG dated February 20, 2003, MBI advised MGG that the claims history required an increase in MGG's contribution of 300 percent effective March 1, 2003.

97. Subsequent to receipt of the two letters, MGG discontinued its participation in the MBI plan.

98. Beginning February 27, 2002, MGG paid funds by check to MBI pursuant to the invoices that MBI delivered directly to MGG. Although MGG's checks to MBI were deposited, the evidence fails to establish that MGG's funds were deposited into a custodial account for the benefit of MGG.

99. MGG also paid an administrative fee directly to HRH of Southwest Florida, Inc. The evidence does not establish what, if any, of the administrative fee was paid to Respondent.

Cheddar's Casual Cafe

100. In September 2001, Respondent met with a representative of a restaurant chain known as Cheddar's Casual Cafe (Cheddar's). Respondent presented various options for health benefits to Cheddar's, and the Cheddar's representative chose to provide health benefits through the MBI plan.

101. A Cheddar's representative executed the document titled "DIRECTIVE TO ESTABLISH A HEALTH & WELFARE BENEFIT PLAN UNDER ERISA" dated December 18, 2001, and signed by Respondent, as the "Benefit Consultant."

102. By his signature, the Cheddar's representative acknowledged receipt of the "HEALTH AND WELFARE PLAN SUMMARY" document indicating an effective date of January 1, 2002.

103. By his signature, the Cheddar's representative on January 14, 2002, executed the document titled "WELFARE BENEFIT PLAN TRUST" with an effective date of January 1, 2002. The document indicated that the trust custodian would be First Union. Nothing on the document indicated that First Union had agreed to be the custodian.

104. Beginning February 5, 2002, Cheddar's paid funds by check to MBI pursuant to the invoices that MBI delivered directly to Cheddar's. Although Cheddar's checks to MBI were deposited, the evidence fails to establish that Cheddar's funds were deposited into a custodial account for the benefit of Cheddar's.

105. Cheddar's also paid an administrative fee directly to HRH of Southwest Florida, Inc. The evidence does not establish what, if any, of the administrative fee was paid to Respondent.

106. Cheddar's representative inquired as to the stability of MBI and was advised by Respondent that MBI was stable. The Cheddar's representative relied on Respondent's representation when the Cheddar's health benefit plan came up for renewal towards the end of 2002. Although Respondent presented health benefit plans from several companies, Cheddar's renewed the MBI

plan, even though some employees had experienced late claims payments.

107. By claim denial dated February 28, 2003, MBI denied the hospital claim for a Cheddar's employee because the claim was over 120 days old, but there is no evidence that Respondent was advised of the denied claim.

108. By letter dated April 29, 2003, to MBI, Cheddar's cancelled coverage as of April 1, 2003. The letter states that "there are a substantial number of unpaid claims from calendar years 2002 and 2003" and asserts that MBI has been unresponsive to complaints about the problems.

109. A copy of the April 29, 2003, letter was sent to Respondent with a cover letter expressing dissatisfaction with the MBI plan, with the MBI operation, and with Respondent's representation of MBI.

CONCLUSIONS OF LAW

110. The Division of Administrative Hearings has jurisdiction over the parties to and subject matter of this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2003).[1]

111. The Division has jurisdiction over the determination of whether the MBI plan met the requirements for ERISA-qualification. The Board of Trustees of Diversified Industrial Group v. Tom Gallagher, Case No. CV 91-0641SVW(Ex), U.S. District Court, Central District of California, April 22, 1991.

112. Petitioner has the burden of establishing the allegations of the Administrative Complaint by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987). Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932, 935 (Fla. 1996). Clear and convincing evidence is that which is credible, precise, explicit, and lacking confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact the firm belief of conviction, without hesitancy, as to the truth of the allegations. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

113. Section 624.02, Florida Statutes, provides as follows:

> "Insurance" defined.--"Insurance" is a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies.

114. Section 624.03, Florida Statutes, provides as follows:

> "Insurer" defined.--"Insurer" includes every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

115. The plan of health benefits offered by Respondent to the clients referenced herein meets the definition of insurance. The evidence in this case establishes that the insurance benefits were provided to employees of clients participating in the MBI plan, and that MBI, responsible for payment of benefit claims,

was acting as an insurer. MBI was not authorized to transact insurance business in the State of Florida.

116. Respondent asserts that the MBI health benefit plan is exempt from state regulation because the documents executed by the employers created ERISA-qualified SET health benefit plans.

117. Respondent has the burden of establishing that the MBI health benefit plan met ERISA requirements and that state regulation of the plan is preempted. Department of Financial Services v. Clifford Eugene Kiefer, DOAH Case No. 03-2041PL, Recommended Order entered April 2, 2004, Final Order issued April 28, 2004, stating at page 36 as follows:

> Any intent by Respondent to rely upon the doctrine of preemption, in the assertion that the health plans purchased by Respondent's customers from TRG were ERISA plans, is a form of defense and the burden to prove facts necessary to establish that defense resides with Respondent. The proof necessary concerns questions of fact when examining whether the subject plan is "an employee welfare benefit plan" sponsored by a single employer or union, recognized under ERISA and preempted from state regulation. See Metropolitan Life Insurance Co. v. Taylor, 481 U.S. 58, 107 S. Ct. 1542, 95 L.Ed. 2d 55 (1987); and Kanne v. Connecticut General Life Ins. Co., 867 F.2d 489 (9th Cir. 1988), cert. denied 492 U.S. 906, 109 S. Ct. 3216, 106 L.Ed. 2d 566 (1989). See also Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977).

118. Respondent has failed to meet the burden. There is no apparent disagreement that a validly created SET providing health

benefits to employees of a single employer, and funded solely from the contributions from said employees and employer, could constitute a legitimate ERISA plan.

119. Although the MBI documents provided by Respondent to his clients stated that the plan was an ERISA-qualified SET, the evidence fails to establish that the operation of the MBI plan complied with the framework set forth in the documents. An employer's decision to extend benefits does not constitute, in and of itself, the establishment of an ERISA plan. Wells v. General Motors Corp., 881 F.2d 166 (5th Cir. 1989), cert. denied, 495 U.S. 923 (1990). The existence of an ERISA plan is a question of fact, to be answered in the light of all the surrounding circumstances from the point of view of a reasonable person. Kanne v. Connecticut General Life Ins. Co., 867 F.2d 489 (9th Cir. 1988); Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co., 809 F.2d 617 (9th Cir. 1987); Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982).

120. MBI's documents and Respondent's representations to his clients provided that an employer's contributions would be placed into custodial trust accounts used to fund the payment of claims and that stop-loss insurance would be utilized to cover claims in excess of contributions. The MBI plan was clearly not operated in accordance with the documents provided to employers by Respondent. In reality, employer contributions were not

segregated into trust accounts, claims were paid from commingled funds contributed by various employers, and MBI obtained no stop-loss insurance and was responsible for paying the claims.

121. There is no credible evidence that MBI created separate custodial trust accounts on behalf of the individual employers or that employer funds were properly deposited into such accounts. Federal law requires that the employer contributions to an ERISA-qualified health benefit plan must be held in trust. See 29 U.S.C. § 1103(a).

122. The evidence establishes that employers often remitted contributions to MBI, and benefit plans became effective, before employers executed trust documents. Common sense would suggest that prior to the execution of the trust agreement documents, MBI would have had no authorization from clients to establish trust accounts. At least some of the contributions from various employers were deposited into a common account at First Union, and there is no credible evidence that any individual trust accounts existed from which to pay claims.

123. As early as February of 2002, MBI's managing general agent acknowledged that MBI was "responsible for any amounts due under adjudicated claims in excess of the contribution amount" assuming a client was current in making its contribution. Although MBI could have obtained stop-loss insurance to cover

claims in excess of contributions, there is no evidence that it did so.

124. The evidence suggests that the commingling of funds continued after clients executed trust documents. In the letter of February 19, 2003, MBI advised employers that MBI would advance funds to cover claims in excess of contributions. Assuming an employer had insufficient funds in a segregated SET account to pay excess claims, and absent any information related to MBI's assets, it is reasonable to presume that the funds MBI proposed to advance in the letter would have come from pooled funds.

125. Because the evidence fails to establish that the MBI plan met applicable ERISA requirements, it is unnecessary to determine whether, as asserted by Respondent, federal law would have preempted state-regulation of the MBI plan in Florida.

126. The Second Amended Administrative Complaint alleges that Respondent has violated Subsections 626.611(8), 626.621(2) and (6), and 626.901(1), Florida Statutes.

127. Subsection 626.611(8), Florida Statutes, provides as follows:

> Grounds for compulsory refusal, suspension, or revocation of agent's, title agency's, adjuster's, customer representative's, service representative's, or managing general agent's license or appointment.--The department or office shall deny an application for, suspend, revoke, or refuse

> to renew or continue the license or appointment of any applicant, agent, title agency, adjuster, customer representative, service representative, or managing general agent, and it shall suspend or revoke the eligibility to hold a license or appointment of any such person, if it finds that as to the applicant, licensee, or appointee any one or more of the following applicable grounds exist:
>
> * * *
>
> (8) Demonstrated lack of reasonably adequate knowledge and technical competence to engage in the transactions authorized by the license or appointment.

128. The evidence establishes that Respondent has violated Subsection 626.611(8), Florida Statutes. The MBI plan was clearly not operated in accordance with the plan documents. As stated earlier, trust agreements were often not executed until after employers were already making contributions to MBI. No trust accounts could have existed prior to execution of the trust agreements, and there is no credible evidence that any trust accounts were created and funded. Respondent delivered plan documents to employers and signed some of them. It is reasonable to assume that Respondent read and understood the documents he presented to his clients. In representing the MBI plan to his clients, Respondent demonstrated a lack of reasonably adequate knowledge and technical competence to engage in the transactions at issue in this case.

129. Subsections 626.621(2) and (6), Florida Statutes, provide as follows:

> Grounds for discretionary refusal, suspension, or revocation of agent's, adjuster's, customer representative's, service representative's, or managing general agent's license or appointment.--The department or office may, in its discretion, deny an application for, suspend, revoke, or refuse to renew or continue the license or appointment of any applicant, agent, adjuster, customer representative, service representative, or managing general agent, and it may suspend or revoke the eligibility to hold a license or appointment of any such person, if it finds that as to the applicant, licensee, or appointee any one or more of the following applicable grounds exist under circumstances for which such denial, suspension, revocation, or refusal is not mandatory under s. 626.621:
>
> * * *
>
> (2) Violation of any provision of this code or of any other law applicable to the business of insurance in the course of dealing under the license or appointment.
>
> * * *
>
> (6) In the conduct of business under the license or appointment, engaging in unfair methods of competition or in unfair or deceptive acts or practices, as prohibited under part IX of this chapter, or having otherwise shown himself or herself to be a source of injury or loss to the public or detrimental to the public interest.

130. Other than as specifically addressed herein, there are no violations of the insurance code or other applicable law; accordingly, there is no violation of Subsection 626.621(2), Florida Statutes.

131. The evidence establishes that Respondent has violated Subsection 626.621(6), Florida Statutes, as "a source of injury or loss to the public or detrimental to the public interest."

132. A substantial amount of unpaid health benefit claims remained at the time of the hearing. Such claims were to have been paid by employer contributions deposited into trust accounts on behalf of employees. There is no credible evidence that such accounts were created. Stop-loss insurance was to have been available to cover claims in excess of contributions. There is no credible evidence that MBI ever obtained such stop-loss insurance.

133. There is no evidence that Respondent made any attempts to verify the existence of trust accounts. There is no credible evidence that Respondent made any attempts beyond telephone calls to MBI to verify the existence of stop-loss insurance on behalf of his clients. Respondent made no serious effort to obtain any information related to the operation of the MBI plan beyond the materials provided to him by MBI.

134. Subsection 626.901(1), Florida Statutes, provides as follows:

> 626.901 Representing or aiding unauthorized insurer prohibited.--
> (1) No person shall, from offices or by personnel or facilities located in this state, or in any other state or country, directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, any insurer not then authorized to transact such insurance in this state in:
> (a) The solicitation, negotiation, procurement, or effectuation of insurance or annuity contracts, or renewals thereof;

> (b) The dissemination of information as to coverage or rates;
> (c) The forwarding of applications;
> (d) The delivery of policies or contracts;
> (e) The inspection of risks;
> (f) The fixing of rates;
> (g) The investigation or adjustment of claims or losses; or
> (h) The collection or forwarding of premiums;
>
> or in any other manner represent or assist such an insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state. . . .

135. MBI had no authorization to transact insurance in the State of Florida. By representing the MBI plan to clients in Florida, Respondent acted in violation of Subsection 626.901(1), Florida Statutes.

136. Respondent asserts that Subsection 626.901(1), Florida Statutes, requires Petitioner to establish that the offending agent had or should have had knowledge that the unauthorized entity was acting improperly. Respondent asserts that according to documentation and representations by MBI as to the product being marketed, the MBI plan was an ERISA-qualified SET pre-empted from regulation by Petitioner. Respondent testified that he had no knowledge of any problems with MBI's operation and had no reason to believe that the representations were incorrect or untrue.

137. Subsection 626.901(1), Florida Statutes, does not require evidence of an offender's knowledge. Had the Legislature intended to impose such a limitation on prosecution of a licensee representing an unauthorized insurer, it could have done so. The Legislature did as much in Subsection 626.901(2), Florida Statutes, which provides civil liability for an agent who "knew or reasonably should have known" that an insurance contract was placed with an unauthorized insurer. Subsection 626.901(1), Florida Statutes, contains an unqualified prohibition against representing an unauthorized insurer. MBI was an unauthorized insurer. Respondent has failed to establish that the MBI plan was exempt from regulation by Petitioner.

138. Florida Administrative Code Chapter 69B-231 sets forth penalty guidelines relevant to the statutory violations alleged in the Second Amended Administrative Complaint. Florida Administrative Code Rule 69B-231.080 provides a penalty of a six-month suspension for a violation of Subsection 626.611(8), Florida Statutes. Florida Administrative Code Rule 69B-231.090 provides a penalty of a six-month suspension for a violation of Subsection 626.621(6), Florida Statutes. Florida Administrative Code Rule 69B-231.110 provides a penalty of a six-month suspension for a violation of Subsection 626.901(1), Florida Statutes.

139. Florida Administrative Code Rule 69B-231.040 provides as follows:

> 69B-231.040 Calculating Penalty.
> (1) Penalty Per Count.
> (a) The Department is authorized to find that multiple grounds exist under Sections 626.611 and 626.621, F.S., for disciplinary action against the licensee based upon a single count in an administrative complaint based upon a single act of misconduct by a licensee. However, for the purpose of this rule chapter, only the violation specifying the highest stated penalty will be considered for that count. The highest stated penalty thus established for each count is referred to as the "penalty per count."
> (b) The requirement for a single highest stated penalty for each count in an administrative complaint shall be applicable regardless of the number or nature of the violations established in a single count of an administrative complaint.
> (2) Total Penalty. Each penalty per count shall be added together and the sum shall be referred to as the "total penalty."
> (3) Final Penalty. The final penalty which will be imposed against a licensee under these rules shall be the total penalty, as adjusted to take into consideration any aggravating or mitigating factors, provided however the Department shall convert the total penalty to an administrative fine and probation in the absence of a violation of Section 626.611, F.S., if warranted upon the Department's consideration of the factors set forth in rule subsection 69B-231.160(1), F.A.C.

140. The maximum penalty per count in this case related to the charged violations of Sections 626.611 and 626.621, Florida Statutes, is a six-month suspension. The penalty for a violation

of Section 626.901, Florida Statutes, is an additional six-month suspension. The combined suspension period is 12 months per count. There are six counts to the Administrative Complaint. The total penalty is a suspension period of 78 months.

141. Determination of the final penalty requires consideration of the total penalty as well as any aggravating or mitigating factors. Florida Administrative Code Rule 69B-231.160 provides in part as follows:

> 69B-231.160 Aggravating/Mitigating Factors. The Department shall consider the following aggravating and mitigating factors and apply them to the total penalty in reaching the final penalty assessed against a licensee under this rule chapter. After consideration and application of these factors, the Department shall, if warranted by the Department's consideration of the factors, either decrease or increase the penalty to any penalty authorized by law.
> (1) For penalties other than those assessed under Rule 69B-231.150, F.A.C.:
> (a) Willfulness of licensee’s conduct;
> (b) Degree of actual injury to victim;
> (c) Degree of potential injury to victim;
> (d) Age or capacity of victim;
> (e) Timely restitution;
> (f) Motivation of agent;
> (g) Financial gain or loss to agent;
> (h) Cooperation with the Department;
> (i) Vicarious or personal responsibility;
> (j) Related criminal charge; disposition;
> (k) Existence of secondary violations in counts;
> (l) Previous disciplinary orders or prior warning by the Department; and
> (m) Other relevant factors.

142. In this case, there are no aggravating or mitigating circumstances sufficient to warrant increasing or decreasing the applicable penalty. There is no evidence that Respondent intentionally participated in the marketing of the MBI plan for financial gain; in fact, Respondent testified without contradiction, that commissions on the MBI plan were less than other health benefit plans proposed to employers. Although health claims remain unpaid, such claims payment is apparently the subject of on-going litigation, and the degree of actual injury to victims is unknown at this time. There is no evidence as to previous disciplinary action against Respondent. On the other hand, there is no evidence that Respondent made any serious effort to review the MBI product he offered to his clients. The fact that Respondent was marketing a benefit plan approved by his employer does not offer reason to mitigate the penalty.

143. Petitioner has the ability to access an administrative fine in lieu of suspension under the provisions of Subsection 626.681, Florida Statutes, or to place Respondent on probation for a period not to exceed two years pursuant to Section 626.691, Florida Statutes. Based on the evidence presented during the hearing, the final penalty of a 78-month suspension is warranted.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Department of Financial Services enter a final order suspending the insurance licensure of Bradley W. Beshore for a period of 78 months.

DONE AND ENTERED this 10th day of March, 2005, in Tallahassee, Leon County, Florida.

William F. Quattlebaum

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 10th day of March, 2005.

ENDNOTE

1/ All citations are to Florida Statutes (2003) unless otherwise indicated.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.