STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF FINANACIAL SERVICES, Petitioner, vs. MICHAEL D. CARLL and JAMES W. CRAIN, JR., Respondents.	)	Case Nos. 06-2096PL 06-2097PL

RECOMMENDED ORDER

Administrative Law Judge (ALJ) Daniel Manry conducted the formal hearing of these consolidated cases on October 10 through 12, 2006, in Sarasota, Florida, for the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Philip M. Payne, Esquire
David J. Busch, Esquire
Division of Legal Services
Department of Financial Services
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Tallahassee, Florida 32399

For Respondent Crain: Marc S. Nurik, Esquire
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For Respondent Carll: Joan H. Donnelly, Esquire
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STATEMENT OF THE ISSUES

The issues are whether the alleged actions of the respondents demonstrate a lack of fitness or trustworthiness to engage in the business of insurance within the meaning of Subsection 626.611(7), Florida Statutes (2004), and, if so, what penalty should be imposed. (All statutory references are to Florida Statutes (2004) unless otherwise stated.)

PRELIMINARY STATEMENT

Petitioner filed an administrative complaint against each respondent on May 22, 2006. Each requested a formal hearing. Petitioner referred the requests to DOAH, and the ALJ consolidated the requests with the agreement of the parties.

At the hearing, Petitioner presented the testimony of five witnesses and submitted 12 exhibits for admission into evidence. The respondents testified, called two other witnesses, and submitted 11 joint exhibits.

Respondent Carll submitted one additional exhibit, and Respondent Crain submitted two additional exhibits. None of the parties called expert witnesses.

The identity of the witnesses and exhibits and the rulings regarding each are reported in the six-volume Transcript of the hearing filed with DOAH on November 27, 2006. Pursuant to the

agreement of the parties at the conclusion of the hearing, Petitioner timely filed its Proposed Recommended Order (PRO) on December 26, 2006. Mr. Carll and Mr. Crain timely filed their respective PROs on December 22 and 27, 2006.

FINDINGS OF FACT

1. Petitioner is the state agency responsible for regulating insurance agents in Florida. The respondents, Crain and Carll, are licensed as Life and Health insurance agents pursuant to respective license numbers A056967 and A040734.

2. The respondents have known each other for approximately 13 years. During that time, the two engaged in the business of selling health insurance. Mr. Carll was an independent contractor, but Mr. Crain was Mr. Carll's only boss.

3. Mr. Crain wholly owns two Florida corporations that he operates as insurance agencies. The two corporations are identified in the record as International Life and Health Services of Manatee County, Inc. (Manatee), and International Life and Health Services of Sarasota County, Inc. (Sarasota).

4. Mr. Crain owns two other Florida corporations. They are identified in the record as Independent Living Home Care Agency, Inc. (Home Care Agency), and Independent Living Home Care Membership Association, Inc. (Home Care).

5. Home Care promises in a plan written by Mr. Crain to provide plan purchasers with access to discounted in-home care

(the plan). Approximately 44 Florida residents purchased the plan in 2005 and 2006 from insurance agents, including Mr. Carll, who, as agents for Mr. Crain, Manatee, or Sarasota, previously sold health insurance to some of the plan purchasers.

6. Mr. Crain is personally and fully liable for the acts of the selling insurance agents within the meaning of Section 626.839. Mr. Crain is a health insurance agent who is the president and sole shareholder of a health insurance agency.

7. Mr. Crain directly supervised and controlled the insurance agents who sold the plan in Florida. Mr. Crain wrote the plan and trained the insurance agents in the content of the plan, sales techniques, how to exclude impaired customers, and how to determine whether a customer was an appropriate candidate to purchase a plan. Mr. Crain did not obtain a legal opinion concerning his final version of the plan.

8. The plan satisfies the statutory definition of insurance. However, the plan is not health insurance that the legislature has expressed its intent to regulate.[1]

9. The plan promises Home Care will provide a purchaser of a membership with access to in-home care from a third-party provider, denominated as a "caregiver," at a cost substantially less than the market rate caregivers normally charge for such services (discounted home care services). The plan promises to

refund 120 percent of the membership fee if Home Care were unable to provide access to discounted home care services.

10. The plan excludes medical care from the definition of home care services. Home care services include companion and homemaker services; housekeeping and laundry services; transportation services for doctor visits, groceries, and visits with friends; meal preparation; assistance with dressing and undressing; organizing files and bills; not burdening loved ones; protecting assets and heir's inheritance; gaining respect; and preserving one's legacy while gaining respect and dignity.

11. The plan offers memberships for four, six, and eight years. Only four and six-year memberships are pertinent to this proceeding.

12. The respective cost for each four and six-year membership is $2,475 and $3,475. Home Care promises each member will have access to discounted home care services for respective benefit periods of 1.5 and 2.5 years. The cost of membership does not apply toward the cost of discounted home care services.

13. Services are not available at the discounted rate for the first 90 days after the date a purchaser requests services (the elimination period).[2] The elimination period is 180 days "for pre-existing conditions".[3]

14. An additional payment of $1,395 reduces the normal elimination period from 90 to 60 days, extends the membership

period an additional two years, and extends the respective benefit periods by one year. The plan charges an additional 25 percent if a purchaser elects installment payments.

15. The plan promises home care services at substantial discounts below the market rate. The discounted plan rates are $94 for 24 hours of service; $72 for eight hours of service; and $36 for four hours of service. Market rates in the community range from $204 to $480 for 24 hours of service and from $16 to $18 an hour for shorter periods.[4]

16. The 44 plans sold in Florida generated approximately $192,000 in membership fees for Home Care. Mr. Crain deposited the fees into a bank account he created for Home Care and for which Mr. Crain is the sole authorized signatory. Home Care paid commissions to insurance agents ranging from 50 and 60 percent of the sale proceeds.

17. The allegations in this proceeding pertain to four of the 44 plan purchasers. Ms. Janet McClurkin purchased the plan in April 2005 in two installments totaling $2,112. Ms. Ruth Frakes purchased the plan in February 2005 in two installments totaling $4,870. Ms. Carin Clareus purchased the plan in February 2005 for one payment of $1,953. Ms. Eva Muller purchased the plan in March 2005 for one payment of $3,475.[5]

18. A finding of guilt requires proof of one or more of five essential allegations, the first of which alleges the four

plan purchasers are elderly women who, at the time of purchase, were "disabled" and suffered from "diminished mental capacity." The four sales allegedly violated the plan prohibition against sales to anyone "not of sound mind or body."

19. The four plan purchasers are clearly elderly women. At the time of the hearing, Ms. McClurkin was 94 years old.[6] Ms. McClurkin is Canadian, has been widowed for approximately 35 years, has no children or nearby family, and lives alone. Her nephew had power of attorney at the time of the hearing.

20. Ms. McClurkin suffered from hearing and memory loss. She had worn two hearing aids for about a year, was recovering from surgery for breast cancer two years earlier, and had functioned for over 15 years with two artificial hips.

21. Ms. Frakes was 90 years old at the time of the hearing.[7] Ms. Frakes had been widowed for approximately 26 years and had no children and no surviving relatives. Ms. Frakes wore a Life Alert alarm, had been wearing two hearing aids for approximately seven years, had been reading through a magnifying glass for approximately five years, was taking medication for high blood pressure, and suffered from arthritis.

22. Ms. Clareus was 97 years old at the time of the hearing and resided in a community of about 200 senior citizens.[8] She immigrated to the United States in 1928, had been widowed for approximately four years at the time of the hearing, and had

no children and no nearby relatives. Ms. Clareus had been legally blind for approximately eight years but was able to read through an assistive device in her residence.

23. Ms. Muller was approximately 85 years old at the time of the hearing. She immigrated from Germany and then became a U.S. citizen, all in a time frame not disclosed in the record.

24. Ms. Muller had been divorced early in her life and lived alone in a mobile home community. She had no nearby relatives and experienced memory problems. Ms. Muller owns an automobile but does not drive. Friends drive for her. After purchasing the plan, Ms. Muller executed a power of attorney naming Ms. Ingrid Eglsaer as her general power of attorney.

25. At the time of the hearing, the four witnesses demonstrated confusion and difficulty in recalling specific facts. However, their confusion and impaired memory at the hearing was not clear and convincing evidence that the witnesses were incompetent when they purchased the plan.

26. The allegation of incompetence at the time of purchase may be supported by inference or surmise, but inference and surmise do not satisfy the requirement for clear and convincing evidence.[9] Petitioner submitted no expert testimony concerning the mental capacity of a purchaser at the time of the purchase.

27. Petitioner next alleges the respondents misrepresented that Home Care would provide home care services and home medical

care without further charge. Each Administrative Complaint admits the alleged misrepresentation conflicts with the terms of the plan.[10] The plan promises access to discounted home care services and states that the membership fee does not apply toward charges for discounted home care services.[11]

28. The evidence is less than clear and convincing that the respondents misrepresented the contents of the plan in a manner that led purchasers to believe they would receive home care services or home medical care without additional charge. Testimony of the four purchasers concerning verbal representations by insurance agents during sales transactions is confused, is not precise and explicit, and is less than clear and convincing.

29. Each purchaser may have inferred that she was purchasing insurance for either home care services or home medical care without an additional charge. Some purchasers had previously purchased such insurance from the same insurance agent. Each sale included a consultation in which the insurance agent reviewed other insurance held by the purchaser.

30. The plan included terms that sounded to elderly women like familiar insurance terms. For example, the plan requires the purchaser to apply for coverage and employs terms such as "Eligible Persons," "Effective Date," "Elimination Period," "Limitations and Exclusions," and "Benefit Discount Period."

31. The plan extends the elimination period when "pre-existing conditions" exist, describes home care providers as "caregivers," and discusses "co-payments." The plan includes a disclosure form and a medical release form.

32. The evidence is less than clear and convincing that the respondents made promises or representations, other than those in the plan, to induce a purchaser to infer that the plan entitled her to discounted home care or medical care at no additional charge. Rather, the terms of the plan were purposefully confusing and induced the four elderly women to draw the desired inference.

33. Petitioner also alleges the respondents made false and worthless promises that defrauded the purchasers. However, it is unnecessary to resolve the allegations of fraud in this case.[12]

34. This case can be resolved if the evidence supports one of two remaining allegations. First, the respondents allegedly misrepresented the access to discounted caregiver services that a purchaser acquired upon payment of a membership fee. Second, the promises of access to discounted caregiver services that the respondents made to each of the four plan purchasers were false and worthless.[13]

35. The plan misrepresented the access to caregivers that a purchaser acquired upon payment of a membership fee. The plan provides, in relevant part:

> If a member joins the association they are guaranteed the homecare discounts provided for in the contractual agreement.

Respondent Crain, Exhibit 1, at 4.

36. The plan does not name or otherwise identify a caregiver responsible for supplying the discounted caregiver services "guaranteed" in the plan. In that regard, the plan is factually distinguishable from a home care plan that passed judicial scrutiny in an unrelated proceeding.[14]

37. Neither Mr. Crain nor Home Care possessed a legal right to require a caregiver to provide discounted services in accordance with the terms of the plan. Neither Mr. Crain nor Home Care possessed the practical ability to ensure that a caregiver would provide home care services at any price, much less the discounted prices promised in the plan.[15]

38. The absence of either a legally enforceable right or practical ability to ensure that a caregiver would provide the discounted home care services promised in the plan were material facts that Mr. Crain did not disclose to purchasers. The failure to disclose material facts was willful and misrepresented the access to discounted caregiver services that a purchaser acquired upon payment of a membership fee.

39. Testimony from Mr. Crain concerning his practical ability to ensure delivery of discounted caregiver services was neither credible nor persuasive to the fact-finder. Mr. Crain discussed home care services with a number of caregivers. Based on those conversations, Mr. Crain developed a list of caregivers he said he could call in the future to request discounted caregiver services promised in the plan if and when one of the 44 purchasers requested services (the list).[16]

40. The list evolved between January 2005 and September 2006. Mr. Crain advertised for caregivers in local newspapers. The collective responses numbered between 100 and 200.

41. Mr. Crain or a staff-member collected the contact information for each responder and questioned each responder concerning, among other things, their qualifications and experience. The final list identified 15 caregivers.

42. Mr. Crain described the list of 15 in answers to questions from the fact-finder:

> [Q] Well, I want to make sure I understand clearly. So, you ran an ad. People called in, you took down their contact information, and did you run [abuse registry] screens on these people?
>
> [A] Yes, I did.
>
> [Q] Okay. You mentioned earlier 200 responded. Did all 200 make the list?
>
> [A] The list? . . .

[Q] . . . The list I'm referring to is the list referred to in testimony of . . . [insurance] agents of yours that said you maintained a list of contract individuals . . . Did you maintain a list?

[A] I had a list of potential caregivers from the original ad, yes.

* * *

[Q] So you ran two ads. You had some responses to the first ad, and overwhelming responses to the second ad, and when you talked to the person, what did [you] do . . . ?

[A] They call in -- I briefly qualify them.

* * *

[Q] And what kind of information do you collect?

[A] Name, address, phone number, work history, educational history . . . . ethical behavior . . . . [and abuse] screening . . . . [I]f the agency they work for currently or in the past could not fax me a copy of . . . screening . . . by AHCA [Agency for Health Care Administration], then I could then screen them myself.

[Q] [H]ow many of these people did you actually either screen or get faxes of their screen?

[A] About seven.

[Q] Out of how many?

[A] Altogether, I had spoken to no less than a hundred people.

[Q] From both ads?

[A] Correct. . . .

> [Q] How many of the seven did you screen yourself?
>
> [A] Three. . . .
>
> [Q] Okay. Now, you talked to a hundred. Did you compile a resource list?
>
> [A] Yes, I did.
>
> [Q] And how many . . . , of the hundred, made the resource list?
>
> [A] I had at least 15 potentially eligible people that could work for me, but I had seven that could go at any moment. Or not at any moment but that were available, already screened with experience and ready to go. Or around seven.

Transcript (TR) at 581-585.

43. Mr. Crain did not bond or insure any of the 15 potentially eligible caregivers. Mr. Crain explained the bonding procedure in the following testimony:

> [Q] [The plan] . . . talks about having people bonded, insured, and fully screened, correct?
>
> [A] Yes.
>
> [Q] Now, we've already talked about screening. How would you make arrangements to bond and insure someone?
>
> [A] If they were employed, to bond a person is a one-page form . . . [y]ou . . . deliver to this insurance agency . . . down the road from my office . . . and putting a hundred dollars for every ten thousand dollars of bonding you want. . . .
>
> [Q] So, when in the process would you bond and insure someone?

> [A] The day or the day before they went out to the actual care.
>
> [Q] So actually, prior to having a request for services and actually arranging for somebody to go out, you wouldn't have gone through the trouble or expense of bonding or insuring, correct?
>
> [A] Correct.
>
> [Q] Who actually bears the expense of bonding and insuring?
>
> [A] The provider.
>
> [Q] You mean the worker?
>
> [A] Yeah. . . .

TR at 585-586.

44. The plan promised that access to discounted services included a guaranteed refund equal to 120 percent of membership if Home Care were unable to provide access to the discounted caregiver services promised in the plan. Mr. Crain wrote the refund language to state:

> 17. 120% money back guarantee. If [Home Care] cannot provide homemaker and companion services at the discounted rate as governed by this contract, the company shall pay the member all the fees paid plus an additional 20%. Due to severe, unprecedented, skyrocketing costs for caregivers, or an unforeseen increase in the demand for personnel, the company will make this refund. [Home Care] has a big responsibility to provide quality home care services to all of it's [sic] members. Even though management owners and outside professionals have thoroughly though [sic] out almost every variable in making this

> contract both beneficial to the customers and profitable for [Home Care], no one can predict the future. Therefore it is agreed by both parties that by entering into this contract that the legal remedy for [Home Care's] possible inability to provide the service at the discounted rate, is for [Home Care] to refund 120% of the member's fee after reviewing the case with legal counsel as provided for by [Home Care] regarding the unusual circumstances of the said member.

Respondent Crain, Exhibit 1, at 7.

45. The promise that access to discounted caregiver services includes a guaranteed refund of 120 percent of the membership fee is a false promise. The promise is not conditioned on any discernable legal standard or any other standard capable of objective measurement. Rather, the applicable standard is a subjective standard to be interpreted at the sole discretion of Mr. Crain.

46. Mr. Crain willfully included the false refund promise in the plan. As Mr. Crain explained:

> [A] The right to get a refund? After five days, they don't have a right to get a refund.
>
> [Q] Do you or have you, on behalf of the company, given refunds to persons beyond the five-day period?
>
> [A] Yes.
>
> [Q] Is that at your discretion?
>
> [A] Yes.

> [Q] Is there any particular policy or plan regarding when and how to give a refund and how much?
>
> [A] No.

TR at 614.

47. Mr. Crain is the sole arbiter of the entitlement to a refund and the amount of the refund to be paid. For example, Mr. Crain paid Ms. Muller 120 percent of her membership fee but paid only a prorated amount to Ms. Clareus.[17]

48. The promise to refund 120 percent of the membership fee is worthless. Mr. Crain willfully included the worthless promise in the plan.

49. The refund obligation is owed solely by Home Care, and Home Care has not retained sufficient reserves to fund its contractual obligation.[18] Mr. Crain withdrew virtually all of the $192,000 in membership fees to pay commissions, operating costs, and similar expenses.

50. On June 19, 2006, Home Care had $946 in its bank account. The last refund obligation Home Care owes to the two unpaid purchasers in this proceeding will not expire until sometime in 2011. The corporate promise to refund 120 percent of the membership fee is worthless because it is an unfunded obligation to pay refunds from non-existent reserves.

51. Mr. Carll did not exercise ordinary diligence, much less the reasonable skill and diligence required of an insurance

agent, to examine the plan for misrepresentations and false promises. Mr. Carll willfully failed to independently examine the plan. As Mr. Carll explained during his testimony:

> Jim was constantly on the phone interviewing people, prospective caregivers, talking to -- even to home health care agencies that provide homemaker services, and it's my understanding that he had compiled a list of people who could be called in the event if someone requested for [sic] service.
>
> * * *
>
> [Q] When you had meetings with Mr. Crain, did you ask him questions?
>
> [A] Yes.
>
> [Q] What questions did you ask about the plan?
>
> [A] Oh, how does the elimination period work. You know, when do services begin? What do people have to do to get services? Questions of that nature.
>
> [Q] Anything else?
>
> [A] Just questions about, you know, well how to talk to these people and, you know, what to look for when you walk into a house.
>
> [Q] Did you ask Mr. Crain what ability he had to ensure that these third party contractors would provide their services for the fees he guaranteed in the plan?
>
> [A] Yes.
>
> [Q] Okay. What did you ask him?
>
> [A] I said, Well, how can we be sure that these people will get the services that they need when they ask for them?

> [Q] And?
>
> [A] He said that he had interviewed numerous people. He had a list of people that he could call . . . to provide [discounted services]. . . .
>
> [Q] Did you ask Mr. Crain what ability he had to . . . enforce that representation from them if, at some future time, he asked them to provide that service, and they said they no longer would?
>
> [A] I didn't ask him that question.
>
> [Q] So you didn't ask him if he had these people under legal contract for the term of the plan?
>
> [A] No. . . . I have a lot of faith in Jim Crain.

TR at 358 and 422-424.

52. Mr. Carll knew, or should have known, that the plan he sold included misrepresentations. Mr. Carll knew, or should have known, from the language of the plan that the refund promise is false.

53. Each of the respondents is an insurance agent who enjoyed a fiduciary relationship which arose from previous sales of health insurance. Mr. Carll also enjoyed a fiduciary relationship that arose during the previously discussed consultative role he performed when he reviewed with plan purchasers their existing insurance. As Mr. Carll explained during his testimony:

[A] Well, a lot them, some of them were referrals, some of them were people we already knew.

[Q] How did you know them?

[A] That they had purchased insurance with us before. You know, a lot of them called the office.

[Q] For what purpose did they call?

[A] Well, they called the office looking for the agent that sold them insurance.

TR at 360-361.

CONCLUSIONS OF LAW

54. DOAH has jurisdiction over the subject matter and parties in this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2006); §§ 626.611(7) and 626.839. DOAH provided the parties with adequate notice of the formal hearing.

55. The burden of proof is on Petitioner. Petitioner must show by clear and convincing evidence that: the respondents committed the acts alleged in the administrative complaints; the acts violated the statutes charged in the complaints; and the proposed penalty is reasonable. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996).

56. The evidence is clear and convincing that Mr. Crain wrote the plan to: misrepresent the promised access to caregivers; and to make false and worthless promises of either

access to caregivers or a refund equal to 120 percent of the membership fee. It is equally clear that Mr. Carll knew, or should have known, the plan he sold included misrepresentations and false promises. The evidence is of sufficient weight to convince the fact-finder, without hesitancy, as to the truth of the specific allegations against each respondent. Inquiry Concerning a Judge No. 93-62, 645 So. 2d 398, 404 (Fla. 1994); Lee County v. Sunbelt Equities, II, Limited Partnership, 619 So. 2d 996, 1006 n. 13 (Fla. 2d DCA 1993); Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

57. Insurance agents enjoy the benefit of public trust and stand in a fiduciary relationship with their customers. Natelson v. Department of Insurance, 454 So. 2d 31, 32 (Fla. 1st DCA 1984). A person acting in a fiduciary capacity generally has a duty to make a full and fair disclosure of material facts to the person reposing confidence in the fiduciary. Federal Deposit Insurance Corporation v. Martin, et al., 801 F. Supp. 617, 620 (Fla. Mid. Dist. 1992) (citations omitted).

58. It is clear and convincing to the trier of fact that the acts committed by the respondents were willful. Willfulness is an issue of fact to be determined by the trier of fact. Roche Security and Casualty Company, Inc. v. Department of Financial Services, Office of Insurance Regulation, 895 So. 2d 1139, 1141 (Fla. 2d DCA 2005).

59. The fact-finder is not persuaded by testimony from Mr. Carll that he had "a lot of faith" in the representations and assurances he received from Mr. Crain. Mr. Carll, as an insurance agent, is required to disclose to a purchaser material facts Mr. Carll knew or should have known concerning misrepresentations and false promises in the plan. Cf. Forgione v. Dennis Pirtle Agency, Inc., 701 So. 2d 557, 560 (Fla. 1997) (insurance agent is required to use reasonable skill and diligence in obtaining appropriate insurance coverage), distinguished on other grounds, Cowan Liebowitz & Latman, P.C. v. Kaplan, 902 So. 2d 755, 762 (Fla. 2005) (qualifying ruling in Forgione that claims for legal malpractice are not assignable); Moss v. Appel, 718 So. 2d 199, 201 (Fla. 4th DCA 1998) (fiduciary relationship of insurance broker arises from consulting relationship, and broker has duty to disclose to insured material facts concerning insurer); Randolph v. Mitchell, 677 So. 2d 976, 978 (Fla. 5th DCA 1996) (insurance agent has obligation to disclose to insured material facts known to agent); State Farm Life Insurance Company v. Bass, 605 So. 2d 908, 910 (Fla. 3d DCA 1992)(reliance of putative insured on insurance agent's undertaking is sufficient to trigger duty upon agent to exercise reasonable skill and care to obtain appropriate coverage).

60. Mr. Carll did not use reasonable skill and diligence to determine that the plan he sold included misrepresentations and false promises. Nor did Mr. Carll exercise ordinary diligence, which would have disclosed the misrepresentations and false promises in the plan. Mr. Carll's testimony that he trusted the representations made to him by Mr. Crain does not satisfy the requirement for Mr. Carll to exercise ordinary diligence. Cf. Ramel v. Chasebrook Construction Company, Inc., 135 So. 2d 876, 881 (Fla. 2d DCA 1961) (a "representee" is charged with knowledge of those facts he could have discovered through ordinary diligence).

61. The disposition of this case does not depend on a finding that Mr. Crain, as principal, is liable for alleged misrepresentations of the plan by Mr. Carll, as agent. Rather, each respondent individually made willful misrepresentations and false or worthless promises by respectively writing and selling the plan.

62. Once Petitioner shows the respondents misrepresented material facts and made false or worthless promises, Petitioner is entitled to interpret the relevant statute to mean that such acts demonstrate a lack of fitness or trustworthiness to engage in the business of insurance. An agency's interpretation of a statute it is charged with enforcing is entitled to great

deference. Mack v. Department of Financial Services, 914 So. 2d 986, 989 (Fla. 1st DCA 2005).

63. Petitioner articulated technical reasons for deference to agency expertise. Johnston, M.D. v. Department of Professional Regulation, Board of Medical Examiners, 456 So. 2d 939, 943-944 (Fla. 1st DCA 1984). The plan written by Mr. Crain and sold by Mr. Carll contains contractual provisions that have a "public interest" insurance element. Protection of the public from "schemes, deceptions, and insolvencies of third parties" is a valid policy reason for the statutory interpretation adopted by Petitioner. Cf. Liberty Care Plan, 710 So. 2d at 207 (approving the cited principle but reversing declaratory statement that home care plan was health insurance).

64. The plan Mr. Crain wrote is similar to a home care plan that was judicially determined in an unrelated proceeding to be insurance. However, home care plans do not satisfy the statutory definition of health insurance and are not regulated by the legislature. Liberty Care Plan, 710 So. 2d at 205-206.

65. A determination that the plan does not satisfy the statutory definition of insurance would not change the disposition of this case. Courts have held that a licensee may demonstrate a lack of fitness or trustworthiness to engage in the business of insurance by acts unrelated to the insurance business. Compare Paisley v. Department of Insurance, 526 So.

2d 167 (Fla. 1st DCA 1988), and Natelson, 454 So. 2d at 32 (lack of fitness demonstrated by felony convictions unrelated to insurance), with Mack, 914 So. 2d at 988-989, and Ganter v. Department of Insurance, 620 So. 2d 202 (Fla. 1st DCA 1993) (sale of auto club memberships are ancillary products).

66. The statutory penalty for a violation of Subsection 626.611(7), is mandatory suspension for a period prescribed in Florida Administrative Code Rule 69B-231.080(7). The Rule prescribes a suspension of six months for each offense but does not authorize revocation. Deviation from a valid, existing rule is grounds for remand by a reviewing court. § 120.68(7)(e)2., Fla. Stat. (2006). Compare Dyer v. Department of Insurance and Treasurer, 585 So. 2d 1009 (Fla. 1st DCA 1991) (agency cannot impose penalty not authorized by statute), with Roche Surety and Casualty Company, Inc. v. Department of Financial Services, Office of Insurance Regulation, 895 So. 2d 1139 (Fla. 2d DCA 2005), and Cottrill v. Department of Insurance, 685 So. 2d 1371 (Fla. 1st DCA 1996) (penal statutes are strictly construed).

67. Each respondent committed four separate violations of Subsection 626.611(7), punishable by a license suspension of six months. Several mitigating and aggravating factors must be considered. Mr. Crain repaid some membership fees received by Home Care. However, the respondents traded on their fiduciary relationships for financial gain, which was substantial, as was

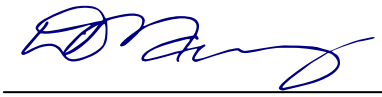
the financial loss to three of the purchasers. Each purchaser is elderly and vulnerable.

RECOMMENDATION

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

RECOMMENDED that Petitioner enter a final order finding the respondents guilty of violating Subsection 626.611(7), for the reasons stated herein, and suspending their licenses for 24 months from the date the proposed agency action becomes final.

DONE AND ENTERED this 31st day of January, 2007, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 31st day of January, 2007.

ENDNOTES

1/ See Liberty Care Plan v. Department of Insurance, 710 So. 2d 202, 205-206 (Fla. 1st DCA 1998).

2/ It is unclear to the trier of fact whether the 1.5 and 2.5-year benefit periods begins to run from the date of the request for services and, therefore, includes the elimination period, or begins to run on the first day after the expiration of the elimination period.

3/ Paragraph 11 of the Plan identified in the record as Respondent, Crain's Exhibit 1 (RN-1).

4/ The plan also offers a prescription discount benefit that is not material to the disposition of this case.

5/ Mr. Carll and another selling agent were both involved in the sale to Ms. McClurkin. The relative involvement of each agent is not material to the disposition of the allegations against Mr. Carll.

6/ Ms. McClurkin turned 95 on January 12, 2007.

7/ Ms. Frakes turned 90 on October 16, 2006.

8/ Ms. Clareus turned 97 on September 17, 2006.

9/ Bowling v. Department of Insurance, 394 So. 2d 165, 172 (Fla. 1st DCA 1981).

10/ For example, paragraphs 8 and 10 of the administrative complaints against Mr. Carll and Mr. Crain respectively allege that the respondents:

> . . . led the elderly consumer to believe that they would receive both discount homemaker/companion services and home medical care services. . . . However, upon closer reading, the Home Care membership plan, despite its cost, only purports to provide access to discount homemaker service providers and does not provide the actual homemaker or home medical care services.

11/ The plan actually misrepresents that it is not insurance, but the administrative complaints do not include that allegation

as a ground for discipline. Rather, the administrative complaints allege, inter alia, that the respondents misrepresented the plan as insurance for home care services or home medical care and collected "premiums" even though the plan was not insurance and merely provided access to discounted home care services. The issue of whether the plan satisfied the statutory definition of insurance is not material to the disposition of this case.

12/ The elements of fraud are not material to the disposition of this case. For reasons stated hereinafter, the trier of fact finds that insurance agents who make false and worthless promises to purchasers demonstrate a lack of fitness and trustworthiness to engage in the business of insurance, within the meaning of Section 626.611(7), irrespective of whether such actions satisfy the elements of fraud.

13/ The relevant allegations against Mr. Crain appear in the Administrative Complaint in paragraphs 25, 27, 32, 34, 40, 42, 48, and 50. The pertinent allegations against Mr. Carll appear in the Administrative Complaint in paragraphs 23, 25, 30, 32, 38, 40, 46, and 48.

14/ Liberty Care Plan, 710 So. 2d at 205-206.

15/ It is unnecessary to resolve the factual dispute concerning the economic feasibility of the discounts promised in the plan.

16/ The parties devoted a substantial amount of hearing time to the efforts of one purchaser to obtain services after she broke her arm. The details of the ordeal are not relevant to the disposition of this case.

17/ Home Care made refunds to approximately ten purchasers. Home care refunded membership fees to Ms. McClurkin and Ms. Calreus. The remaining refunds were limited to what Mr. Crain testified were "premium" overpayments or miscalculations. TR at 616-617.

18/ The expiration dates for the unused portion of the membership fees at issue in this proceeding range between February 2009 and March 2011.

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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.