

2002

Gerald G. Ide v. Utah Insurance Department : Brief of Appellant

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

GERALD G. IDE,

Petitioner,

vs.

UTAH INSURANCE DEPARTMENT,

Respondent.

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Appeal No. 20020981-CA

BRIEF OF PETITIONER

Petition for Review From Order Revoking Insurance License
Before the Insurance Commissioner of the State of Utah

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FILED
Utah Court of Appeals

APR

LIST OF PARTIES

The caption to this brief has the names of all parties.

GERALD G. IDE,

vs.

Respondent.

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Appeal No. 20020981-CA

Petition for Review From Order Revoking Insurance License Before the Insurance Commissioner of the State of Utah

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JURISDICTION

The Court of Appeals has jurisdiction over this Petition for Review under § 78-2a-3(2)(a) of the Utah Code as Petitioner seeks review of final orders resulting from formal adjudicative proceedings of the Utah Insurance Department, an agency of the State of Utah.

STATEMENT OF ISSUES PRESENTED

A. ISSUES PRESENTED.

The following issues are presented by this Petition for Review:

1. Did the Insurance Department deny due process of law to the Petitioner when it shifted the burden of proof at trial to him to defend his license?

This issue was presented by the Petitioner to the agency at R. at 298.

2. Was the Presiding Officer decision not supported by substantial evidence where the findings that Petitioner sold unauthorized insurance are based solely on unsupported opinion testimony and not on substantive law or agency rules?

This issue was presented by the Petitioner to the agency at R. at 298.

B. STANDARD OF REVIEW.

“Judicial review of final agency actions is governed by the Utah Administrative Procedures Act.” *Viktron/Lika Utah v. Labor Comm’n*, 2001 UT App 8, ¶ 5, 18 P.3d 519. With regard to the issues in this case, under § 63-46b-16(4) of the Utah Code, relief may be granted only if, based on the agency’s record, the Court determines that a party seeking

review was substantially prejudiced because the agency action was unconstitutional, or was “based on a determination of fact that is not supported by substantial evidence when viewed in light of the whole record before the court.” Utah Code Ann. § 63-46b-16(4)(a), (g) (1953 as amended).

Whether an agency action is unconstitutional is a general law question, and because questions of general law are reviewed under a correction of error standard, *Savage Indus. v. Tax Comm'n*, 811 P.2d 664, 669-70 (Utah 1991), constitutional challenges to agency action would be likewise be subject to correction of error review. *See Questar Pipeline v. Tax Comm'n*, 817 P.2d 316, 318 (Utah 1991). Further, in applying the substantial evidence test to determine whether the Agency correctly determined the factual basis for revocation of the license, the Court reviews the whole record before it. *See Grey Sterling Company v. Board of Review*, 776 P.2d 63 (Utah App. 1989). The Petitioner must marshal all of the evidence supporting the findings and show that despite the supporting facts, and in light of the conflicting or contradictory evidence, the Agency’s findings are not supported by substantial evidence. *See Intermountain Healthcare, Inc. v. Board of Review*, 839 P.2d 841 (Utah App. 1992).

DETERMINATIVE LAW

The resolution of the appeal is controlled by the Due Process Clauses of the United States and Utah Constitutions, found at Addendum F. Statutes and rules of central

importance include U.C.A. §§ 31A-1-301(63) and (125), U.C.A. § 58-59-305 and R590-160-5(10) of the Utah Administrative Code. See Addenda C, D, and E.

STATEMENT OF THE CASE

A. NATURE OF THE CASE.

Petitioner was a licensed insurance agent whose license was revoked by the Utah Department of Insurance. Petitioner seeks here judicial review of the proceedings which resulted in the revocation of his license.

B. COURSE OF PROCEEDINGS.

On February 6, 2002, the Utah Department of Insurance gave Ide notice of formal adjudicative proceeding and pre-hearing conference. (R. at 6). There were some pre-hearing motions and scheduling matters that were resolved and a hearing was held on April 24, 2002 before Mark E. Kleinfield, Administrative Law Judge. (R. at 108). The Presiding Officer, Mr. Kleinfield, issued an order/decision on that hearing dated April 30, 2002. (R. at 102). Mr. Ide then brought an agency Petition for Review as provided by § 63-46b-13 of the Utah Code. That review resulted in affirming the decision of the Presiding Officer in an Order dated October 31, 2002. (R. at 382).

On November 22, 2002, Ide filed a Petition for Review with this Court.

C. STATEMENT OF FACTS.

Gerald Ide was originally licensed to sell insurance in 1976. (R. at 403, 115). No license action had ever been taken against him prior to the current circumstances. (R. at 403, 115). Ide concentrated his insurance sales through a firm known as National Care Marketing offering products of health and life insurance. (R. at 403, 116).

In December, 2001, the Insurance Commissioner issued a cease and desist order against Ide and others for assisting an unauthorized insurance business in Utah. (R. at 128). Ide did not resist the cease and desist order and believed himself to also be a victim of the circumstances that led to the order, as he had enrolled his own daughter in the program that turned out to be unauthorized insurance. (R. at 403, 117-123). Ide was surprised by this legal problem and voluntarily contacted the few policy holders to whom he had sold the product and personally paid their health insurance claims that had arisen. The payments were made out of his own pocket and he unwound the few policies he had sold. (R. at 403, 121-122).

Toward the end of December, 2001, Ide began promoting the sale of a product known as "Privilege Care". (R. at 403, 123). Two Insurance Department investigators, Hansen and Taylor, visited Ide on January 24, 2002. Hansen testified Ide was told in that meeting that Privilege Care was not going to be approved and that it was unauthorized insurance. (R. at 403, 23). Ide disputes that representation. (R. at 403, 158).

Ide did market Privilege Care after meeting with the investigators but did it with the understanding that he was selling a healthcare plan under a Professional Employer's Organization (PEO) which is not an insurance product and, thus, is regulated outside of the insurance code. (R. at 403, 128-138).

The Utah Insurance Commissioner brought this action for license revocation against Ide for marketing Privilege Care as an unauthorized insurance product. Ide argued at his license revocation hearing and here that the Privilege Care product has never been shown to be insurance, and the ruling was based on the Presiding Officer requiring him to prove that Privilege Care was not insurance instead of placing the burden of proof on the state to prove that he was selling unauthorized insurance contrary to law.

SUMMARY OF ARGUMENTS

Petitioner Ide shows the Court in this brief that he was denied due process in his license revocation hearing in that rather than requiring the Department of Insurance to show that unauthorized insurance had been sold, the Presiding Officer found that Ide had failed to show the Privilege Care product was outside insurance regulation, thereby shifting the burden of proof to him to defend his license.

Ide also shows in this brief that the decision is not supported by substantial evidence. Rather than affirmatively prove that the Privilege Care product was unauthorized insurance sold contrary to law, the Presiding Officer based his decision to revoke the insurance license

on the opinion of potential consumers and two department investigators that had done no study of the structure of the product to see if it met the definition of insurance. While one may correctly state that there was evidence to support the decision, a close look at that evidence shows that it consists entirely of unsupported opinion. By contrast, Ide presented affirmative testimony that the product he sold was an unregulated PEO product.

ARGUMENT

A. INTRODUCTION.

The insurance agent license of Gerald Ide was revoked because the Presiding Officer found that Ide had engaged in the sale of unauthorized insurance. Ide's defense was that the product he was selling was participation in a Professional Employer's Organization or PEO. A good understanding of the difference between insurance and a PEO is important to understanding why the Presiding Officer decided the case incorrectly.

The Utah Code provides insurance-related definitions in § 31A-1-301. The full text is given in Addendum D to this brief, but insurance is defined in § 31A-1-301(63) as an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons or for a distribution of risk among a group of persons. Subsection (125)(a) defines an unauthorized insurer as one not holding a valid certificate of authority to do insurance business in the state or transacting business not authorized by a Certificate of Authority. *See* Addendum D.

The Utah Code also provides for the existence of Professional Employer Organizations under the Professional Employer Organization Licensing Act found at Title 58, Chapter 59 of the Utah Code. Of particular importance in this appeal is § 58-59-305 which specifically provides that a PEO not domiciled in this state and employing less than 25 employees within the state is exempt from licensing. *See Addendum E.*

This brief demonstrates that the burden of proof for showing cause for revocation of Ide's license for the sale of unauthorized insurance is on the insurance department. Ide presented *prima facie* evidence that he was selling PEO memberships. That evidence remains un rebutted. The Insurance Department never established by competent proof that the Privilege Care program was unauthorized insurance within the definition of the Utah Code. Instead, the court will observe from what is explained herein, that the Presiding Officer held that Ide failed to prove he was marketing a PEO product and, therefore, it had to be unauthorized insurance. That analytical framework, not supported by substantial evidence, constitutes a denial of due process by shifting the burden of proof to Ide.

B. DUE PROCESS WAS DENIED BY SHIFTING THE BURDEN OF PROOF TO IDE.

An appellate court, in reviewing an agency action, shall grant relief if, based on the agency's record, the agency action is unconstitutional. U.C.A. § 63-46b-16(4)(a). The agency's action in revoking Mr. Ide's insurance license in this case amounts to a deprivation

of a constitutionally-protected property interest without due process of law, under both the Utah and the Federal Constitutions. U.S. Const. amend. XIV, § 1; Utah Const., art. I, § 7. The due process clause of the Utah Constitution provides that “[n]o person shall be deprived of life, liberty or property, without due process of law.” *See id.* The Utah Supreme Court held, in *Untermeyer v. State Tax Commission*, 129 P.2d 881, 885 (Utah 1942), that Utah’s constitutional due process guarantee is “substantially the same” as the due process guaranteed by the Fifth and Fourteenth amendments to the United States Constitution.

Procedural due process is available only to parties that can establish the existence of a recognized property or liberty interest. *See Stidham v. Peace Officer Standards and Training*, 265 F.3d 1144, 1149-50 (10th Cir. 2001), (citing *Setliff v. Mem’l Hosp.*, 850 F.2d 1384, 1394 (10th Cir. 1988) (citations omitted)); *see also Wells Fargo Armored Service v. Georgia Public Service Comm’n*, 547 F.2d 938, 941 (5th Cir. 1977) (Due Process Clause protects only against a deprivation of liberty or property interests). In this case, Mr. Ide’s insurance license is a recognized property interest, and revocation of that license may not be had without affording Mr. Ide due process of law. The Presiding Officer, however, denied Mr. Ide his procedural due process rights by improperly shifting the burden of proof, thus requiring that Mr. Ide prove there was no violation of the Insurance Code.

1. An Insurance License Is A Constitutionally-Protected Property Interest.

A license to practice one's calling or profession is a protected property right. *See Bell v. Burson*, 402 U.S. 535, 539 (1971). In *Bell*, the Court found that once a license is issued, its continued possession may become essential to the pursuit of one's livelihood. *See id.* Suspension of a license, according to the Court, involves state action and may not be had absent the procedural due process required by the Fourteenth Amendment. *See id.* at 539.

The Utah Supreme Court, *In Re Worthen*, 926 P.2d 853, 877 (Utah 1996), acknowledged that a professional license constituted a property right. There, the Court remarked that Utah courts never hesitate to consider allegations of due process violations "when professionals risk losing their professional license or means of employment through the action of a public disciplinary body." *Worthen*, 926 P.2d at 877.

The insurance license held by Petitioner, Gerald Ide, then, is a constitutionally-protected property interest. Mr. Ide has been licensed to sell insurance since 1976. (R. at 403, 115). Prior to the incidents giving rise to the current circumstances, no action had ever been taken against his license. (R. at 403, 115). Continued possession of his insurance license is essential to the pursuit of his livelihood. (R. at 403, 64). (*See also*, R. at 403, 142). Therefore, Mr. Ide's insurance license is a constitutionally-protected property interest, deprivation of which may not be had absent due process.

2. Procedural Requirements of a License Revocation Hearing.

Proceedings to revoke an existing license are formal adjudicative proceedings conducted pursuant to the provisions of § 63-46b-8 of the Utah Code. Utah Admin. Code R590-160-4(2) (2002). *See* Addendum C. In these formal proceedings, the Presiding Officer regulates the course of the hearing so as to obtain full disclosure of relevant facts, and to afford the parties reasonable opportunity to present their positions. U.C.A. § 63-46b-8(1)(a). All parties to a formal proceeding must be afforded the opportunity to present evidence, argue, respond, cross-examine witnesses, and submit rebuttal evidence. U.C.A. § 63-46b-8(1)(c). Before an insurance license may be suspended or revoked in such a proceeding, the Department of Insurance must prove, by a preponderance of the evidence, all issues of fact—in this case, that the Privilege Care program was unauthorized insurance. *See* Addendum C.

3. Due Process Was Denied by Improperly Shifting the Burden of Proof to Petitioner.

The Due Process Clause prevents a state from depriving a party of a protected property interest without a fair trial in a fair tribunal. *See Bunnell v. Industrial Comm'n*, 740 P.2d 1331, 1333 (Utah 1987); *Stivers v. Pierce*, 71 F.3d 732, 741 (9th Cir. 1995) (citing *In re Murchison*, 349 U.S. 133, 136 (1955)). This fairness requirement applies not just to the courts, but to state administrative agencies charged with applying eligibility criteria for

licenses as well. *See id.*; *see also Gibson v. Berryhill*, 411 U.S. 564, 578-79 (1973). The hearing that ended in revocation of Mr. Ide's insurance license was not a fair hearing. The Presiding Officer unfairly shifted the burden of proof from the Insurance Department to Mr. Ide, thereby denying him the procedural safeguards of "a fair trial in a fair tribunal," which are guaranteed by the Due Process Clauses of both the Utah and Federal Constitutions.

Here, the Department of Insurance had the burden of proving, by a preponderance of the evidence, that each element of insurance, under the Utah Code, was present in the Privilege Care program. *See* Addendum C. In other words the Department of Insurance had to prove that the Privilege Care program sold by Mr. Ide was unauthorized insurance, and not a PEO. Instead, however, the Presiding Officer shifted the burden back to Mr. Ide, and required him to prove that Privilege Care was *not* insurance. (R. at 120, ¶ 9). By improperly shifting the burden, the Presiding Officer denied Mr. Ide procedural due process, which resulted in a deprivation of his constitutionally-protected property interest in his insurance license. *See Nelson v. Jacobsen*, 660 P.2d 1207, 1212 (Utah 1983); *Appleman, Insurance Law and Practice* § 10413 (1982) (there must exist circumstances upon which to base conclusions), citing *Sterling Ins. Co. v. Commonwealth*, 78 S.E. 2d 691 (1953).

Due process was denied here because the Order and the logic contained therein bases a substantial portion of the decision on the failure of Mr. Ide to establish ERISA exemption for the Privilege Care product. (R. at 120, ¶ 9). The hearing officer, in his Order, incorrectly

maintains that at the hearing Mr. Ide argued for an ERISA exemption. Faced with the nearly-impossible task of proving a negative, one can search the entire trial transcript and identify not a single place where Mr. Ide presented evidence or argument that placed any import whatsoever on ERISA. This conclusion is completely without evidentiary support, and exposes the hearing officer's presupposition that Mr. Ide need address concerns about ERISA.

Put succinctly: (1) Mr. Ide presented evidence that he became involved in a PEO program; (2) Mr. Ide had a very limited understanding of what the PEO program was; and (3) at no time did Mr. Ide understand the PEO program to be insurance. Nothing in Title 58, Chapter 59, which governs PEO programs, would seem to suggest that one must show that a particular PEO program is ERISA-related. In fact, according to § 58-59-305, a PEO with less than 25 employees that is not domiciled in the state need not meet any licensing requirements. *See* Addendum E.

For the Presiding Officer to then turn around and require Mr. Ide to show ERISA compliance is, in effect, to create a new PEO requirement not found in § 58-59-305. *See Nelson*, 669 P.2d at 1212 (to satisfy due process, parties must be adequately informed of the specific issues they must be prepared to meet); *see also, Mangone v. U-Haul International, Inc.*, 7 P.3d 189 (Colo. App. 2000) (holding that when a regulatory statute imposes a sanction, due process requires the statute to be reasonably clear as to what conduct lies within

its scope); *Appleman* at § 10413 (statutory provisions are mandatory; commissioner has no discretion to impose any other requirements as a condition precedent). In other words, a PEO in Utah need not meet the licensing requirements if it has less than 25 employees in the state; a PEO is exempt from regulation by the Department of Insurance. Therefore, ERISA has no relevance to this proceeding.

The obligation of the Insurance Department in lifting Mr. Ide's license was: (1) to show that Privilege Care was an insurance program; and (2) to procedurally rebut the affirmative statements of the Privilege Care executive's testimony that it was a PEO. The Insurance Department clearly failed to meet its burden. The hearing officer reached the conclusion that the program was not an exempt PEO simply by saying that Mr. Ide failed to prove ERISA qualification. That is not an element in Title 58, Chapter 59. The decision assumes that if Privilege Care is not a PEO, then it *must be* insurance. By shifting the burden to Mr. Ide to prove a negative, the agency abandoned all procedural safeguards, thus depriving Mr. Ide of his constitutionally-protected property interest in his insurance license, without due process of law. In revoking Mr. Ide's insurance license, then, the agency action was unconstitutional as applied in this case.

C. REVOCATION IS NOT SUPPORTED BY SUBSTANTIAL EVIDENCE.

1. The Legal Standard.

Central to the revocation of Ide's insurance agent license was the factual determination that he had engaged in the sale of unauthorized insurance. The sale of unauthorized insurance is a factual determination which must be supported by substantial evidence as required by U.C.A. § 63-46b-16(4)(g). This Court has earlier defined substantial evidence as that quantum and quality of relevant evidence that is adequate to convince a reasonable mind to support a conclusion. *See Caster v. West Valley City*, 2001 Ut. App. 212, 20 P.3d 22.

The determination of whether substantial evidence exists includes looking at the factual determination in light of the whole record before the court, including evidence contrary to the decision. *See Westside Dixon Associates, LLC v. Utah Power & Light*, 2002 Ut. 31, 44 P.3d 775. However, the appealing party challenging the findings of fact must marshal all of the evidence supporting the findings and show they do not measure up to substantial evidence. *See Whitear v. Labor Commission*, 973 P.2d 982 (Utah App. 1998).

What follows is a marshaling of the facts and a showing that those facts do not constitute substantial evidence to reach the conclusion that unauthorized insurance was being sold to justify the revocation of Ide's livelihood.

2. Marshaled Facts.

The ultimate fact at issue in this appeal is whether Gerald Ide sold unauthorized insurance. The findings of fact of the Presiding Officer assist in marshaling the evidence as they form the factual basis upon which a conclusion was made that Ide violated the law. Petitioner presents the following facts with reference to the record as required:

1. Five Star Marketing was included in the cease and desist order of December 6, 2001 and Privilege Care had administrators that were involved in Five Star Marketing. (R. at 108-09).

2. Ide contacted Karen Wilburg of Santaquin, Utah on January 8, 2002 for the purpose of marketing Privilege Care, and took money from her as an initial payment. She believed she was buying health insurance. (R. at 109, ¶ 15).

3. Ide was told by investigators Taylor and Hansen on or about January 24, 2002 that they believed Privilege Care was not underwritten by the Union Labor Life Insurance Company as it claimed and Privilege Care was an unauthorized insurer. (R. at 109, ¶ 16).

4. On January 25, 2002, Ide contacted Kirk Miller and marketed the Privilege Care program to him; Miller believed it was health insurance. (R. at 109, ¶ 17).

5. On January 29, 2002, Ide contacted insurance agent Doug Milne and provided him the application form and information about Privilege Care to enroll a client of

Mr. Milne. This client had previously been written an Employer's Mutual, LLC policy, the organization that was ordered to cease and desist under the prior order. (R. at 109, ¶ 18).

6. Privilege Care claimed to be underwritten by the Union Labor Life Insurance Company but was, in fact, not. (R. at 109, ¶ 19).

7. Included as evidence was the contractual agreement for Privilege Care which the Presiding Officer interpreted to be insurance. (*See* Order on Hearing at fn. 3, p. 21 at R. 122).

8. State investigators Taylor and Hansen reviewed some Privilege Care literature and were of the opinion the Privilege Care program was an insurance program. (R. at 403, 32, 66).

3. Substantial Evidence Does Not Exist Here.

Before looking at the problems associated with each individual fact relied upon by the Presiding Officer, there are some significant general problems with the agency finding a sale of unauthorized insurance. First, the agency has no rules defining unauthorized insurance. One has to look to the definition of insurance contained in U.C.A. §§ 31A-1-301(63) and (125) to find what facts are needed to support a revocation of the agent license. *See* Addendum D.

Looking at the definitions of "insurance" and "unauthorized insurer," it becomes readily apparent that the insurance department needed to prove that Ide was selling an

arrangement, contract, or plan that transferred risk, and that product came from someone who was required to have an insurance certificate of authority. An examination of the marshaled facts shows that not only do the facts not support a finding of sale of unauthorized insurance, but they ignore the requirement that these elements be shown in order to revoke the insurance license.

Turning to the marshaled facts viewed in light of the entire record, the evidence is far below substantial. First, one of the primary grounds recited for supporting the decision is that the persons to whom the Privilege Care program was marketed believed they were buying health insurance. (R. at 122, n. 3). Nothing in the Utah Code or in case law suggests that because a consumer believes they are purchasing health insurance that the product at issue becomes health insurance. (R. at 403, 31-37). Such reasoning strains all logic, yet that is what the Presiding Officer did here. Insurance has a specific defined meaning in the Utah Code, and the opinion of any consumer is not part of that definition. Either there was a program that shifted risk within the meaning of insurance and which was outside the PEO statutes, or there was not. This supposed supporting fact of consumer opinion is actually meaningless and has no weight in finding substantial evidence.

Next, considerable weight was given to the opinions of the two investigators in testifying that the PEO product was unauthorized insurance. Cross-examination of those witnesses, found at R. at 403, 29, 42, 48, 64, 74, makes very clear that the opinions were

founded on virtually nothing beyond the fact that the investigators did not like the Privilege Care product. They had no standard at all by which to gauge what constitutes insurance beyond the defining statute. The investigators admitted that the department did not have a position on the particular product and denied that they spoke for the Insurance Department in defining an insurance product. (R. at 403, 32). The investigators also admit on cross-examination that while they looked at some literature, they made no study of Privilege Care. They did not look at the contract of sale to determine if it was an insurance policy. (R. at 403, 70-72). They did not look at the corporate organization, nor did they interview anybody associated with Privilege Care to determine whether the product met the definition of allocating risk so as to constitute insurance. A reading of their entire testimony shows that the investigators simply opined that Privilege Care looks like insurance to them without any factual basis behind that opinion. (R. at 403, 16-46, 56-75).

What is needed by the insurance department to sustain this decision is a specific finding that the Privilege Care product allocates risk as defined by the insurance code. Otherwise, the body of evidence is to have an un rebutted defense that the product is a PEO as established by the testimony of Michael Garnett. (R. at 403, 91-97). Mr. Garnett testified that he is the senior vice president for regulatory compliance with Privilege Care. He testified affirmatively that Privilege Care is a PEO. He explained how the PEO works. (R. at 403, 91-97). Nothing of evidence countered that beyond the opinion of consumers and

investigators that did not study the structure of the Privilege Care product. The Presiding Officer, in his order on hearing, simply begs the question of whether the product meets the statutory definition of insurance and calls Privilege Care insurance without any evidence of risk allocation having been presented. *See*, for example, Finding No. 15 at R. at 109 wherein Privilege Care is labeled “healthcare insurance” with virtually nothing but the opinion of a lay consumer to establish that vital fact.

4. Summary.

Applying the substantial evidence test of whether this opinion evidence constitutes the quantum and quality of evidence adequate to convince a reasonable mind to support a conclusion, the decision of the Presiding Officer cannot be upheld.

What supports the license revocation as to whether unauthorized insurance was marketed is merely the opinion of a couple of consumers and the opinion of two investigators who made no study to determine whether the program was, in fact, insurance under Utah law. The investigators admitted they did not have authority to speak for the Insurance Commission in labeling a particular product insurance.

The Presiding Officer found, at Fact No. 17, that Ide was not a good agent and was “out of his element” in marketing Privilege Care with probably an incomplete understanding of how those kinds of products work. (R. at 122). Ide’s understanding or lack of understanding of what he was marketing does not make a non-insurance product insurance,

and certainly does not constitute evidence of what is insurance. Absent specific affirmative proof that an insurance product was marketed, it can never be said that the core conclusion that Privilege Care was unauthorized insurance is supported by substantial evidence. Giving Ide the administrative death penalty under such circumstances cannot be sustained.

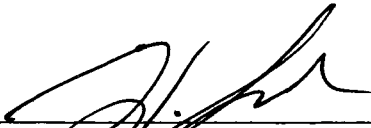
On the other hand, the Michael Garnett testimony was an affirmative direct explanation that Privilege Care was a PEO not subject to insurance licensing under Utah law. The Presiding Officer chose to simply disregard that testimony without the presentation of any evidence whatsoever that what was said by Garnett was untrue. It is not as if the Presiding Officer made a factual choice between conflicting evidence. He made his choice based on the opinion of investigators that had studied practically nothing about how Privilege Care was organized and how its product worked, and a senior corporate official of Privilege Care that explained the program in some detail as a PEO.

CONCLUSION

This Court should reverse the Insurance Department decision to revoke the Insurance Agent License of Gerald Ide and order its reinstatement for the reasons stated herein.

DATED this 14th day of ~~March~~ ^{April}, 2003.

KIPP AND CHRISTIAN, P.C.



Gregory J. Sanders
Margaret R. Wakeham
Attorneys for Petitioner

ADDENDUM

A.	Order on Hearing	A-1
B.	Order on Review	A-31
C.	R590-160-4(2) of the Utah Administrative Code R590-160-5(10) of the Utah Administrative Code	A-41
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ADDENDUM “A”

Order on Hearing

**BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF UTAH**

COMPLAINANT:

UTAH INSURANCE DEPARTMENT

RESPONDENT:

GERALD G. IDE

111 East 5600 South, Suite 208
Murray, UT 84107

ORDER ON HEARING
(Formal Hearing)

DOCKET No. 2002-007-HL

Mark E. Kleinfield,
Presiding Officer

FILE COPY

License No. 51030

STATEMENT OF THE CASE

THIS MATTER, concerning whether Respondent's insurance agent license should be revoked based on Respondent's alleged assistance in *doing of an unauthorized insurance business*, came on to be heard before the Commissioner of the Utah State Insurance Department ("*Department*") on the 24th day of April, 2002 at 9:00 o'clock A. M. Mountain Time, with Mark E. Kleinfield, *Administrative Law Judge*, serving as designated *Presiding Officer*.

Said hearing being held at the Department's offices located at the Utah State Office Building, Room 3110, Salt Lake City, Utah 84114, having been convened at the designated time of 9:00 A. M., April 24th, 2002 and adjourned at 1:47 P. M. on said same day.

Appearances:

M. Gale Lemmon, *Enforcement Counsel*, Attorney for Complainant, Utah State Insurance Department, State Office Building, Room 3110, Salt Lake City, Utah 84114.

Gregory J. Sanders, Kipp & Christian, P. C., *Attorney for Respondent*, 10 Exchange Place, 4th Floor, Salt Lake City, Utah 84111.

By the Presiding Officer:

Pursuant to a March 20th, 2002 *Pre-Hearing Conference Order* a hearing was conducted on April 24th, 2002 in the above-entitled proceeding. The Respondent was present at that time.

The hearing was convened and conducted as a **formal hearing** in accordance with Utah Code Ann. Sections 63-46b-6, 63-46b-7, 63-46b-8, 63-46b-9 and 63-46b-10 and Administrative Rule R590-160-6.

ISSUE, BURDEN and "STANDARD OF PROOF"

1. The basic issue(s) in this case is (are):

a. Whether the Respondent violated the terms of the Commissioner's December 6th, 2001 *Cease and Desist Order* and or Section 31A-15-102, U. C. A., 1953, as amended, by assisting in the *doing of an unauthorized insurance business?*; and

b. And if so is revocation of Respondent's license or a lesser penalty the appropriate penalty?

(SEE also Paragraph 2 under DISCUSSION-ANALYSIS.)

2. The "*burden of proof*" or "*burden of going forward*" in this case as to the above issue(s) is on the Complainant Department.

3. As per Utah Administrative Code Rule, R590-160-5.J as to the above and foregoing "issue(s)" or "question(s)" to be answered the "*standard of proof*" as to issues of fact is to be proven by a "*preponderance of the evidence*".

The Complainant offered an opening statement. The Respondent waived opening statement.

Thereafter, evidence was offered and received.

SUMMARY OF THE EVIDENCE

Witnesses:

For the Complainant Department:

1. Doug Milne, *Insurance Agent*, 9583 Shoshone Circle, Sandy, Utah 84092.

2. Brian Hansen, *Market Conduct Examiner*, Utah Insurance Department, State Office Building, Room 3110, Salt Lake City, Utah 84114.

3. Kirk C. Miller, *Insured Consumer*, 1601 Pony Express Way, Centerville, Utah 84014.

4. Joe Taylor, *Market Conduct Examiner*, Utah Insurance Department, State Office Building, Room 3110, Salt Lake City, Utah 84114.

5. Karen Wilbert, *Insured Consumer*, 516 East 450 South, Santaquin, Utah 84655. Ms. Wilbert testified via telephone ((801) 754-5045).

For the Respondent:

1. Michael E. Garnett, *Senior Vice-president, Privilege Care PEO*, 110 Monte Aveue, Suite 209, Moorestown, New Jersey 08057. Mr. Garnett testified via telephone ((609) 685-6122).

2. Gerald G. Ide, *Respondent*, 111 East 5600 South, Suite 708, Murray, Utah 84107.

All of whom were sworn and testified.

Exhibits:

The Complainant Department offered the following exhibits:

1. **Complainant's Exhibit No. 1**, consisting of seven (7) type written or printed pages, being a copy of a December 6th, 2001 *Cease and Desist Order* issued in Docket No. 2001-242-HL, Utah Insurance Department, Complainant, Employers Mutual, LLC, et al, including "JERRY IDE, License No. 51030, 111 E. 5600 S., Suite 208 Murray, UT 84107".

2. **Complainant's Exhibit No. 2**, consisting of one (1) type written or printed page, being a copy of a January 7, 2002 *letter* from Five Star Marketing, 1113 Edgefield Drive, Plano, Texas 75075 to Consultants & Managers.

3 **Complainant's Exhibit No. 3**, consisting of sixteen (16) type written or printed pages, being a copy of *various documents* regarding Privilege Care and Five Star Marketing, including application form, contractual agreement, new business turn-in form, medical questionnaire, etc.

4. **Complainant's Exhibit No. 4**, consisting of two (2) type written or printed pages, being a copy of (page 1) a February 5, 2002 *letter* from Gerald G. Ide to Brian Hansen, Utah State Insurance Department, Salt Lake City, Utah regarding Fax to Five Star Marketing, and a copy of (page 2) a February 4, 2002 *letter* from Gerald G. Ide to Five

Star Marketing, 1113 Edgefield Drive, Plano, Texas 75075 regarding termination of contract.

5. **Complainant's Exhibit No. 5**, consisting of two (2) type written or printed pages, being a copy of an UNDATED, UNSIGNED *application-enrollment of one Karen K. Wilbert* as regards Privilege Care. Second page indicates a hand-written receipt for \$424.00 to the said Karen K. Wilbert from one Jerry Ide.

6. **Complainant's Exhibit No. 6**, consisting of two (2) type written or printed pages, being a copy of an UNDATED, UNSIGNED *application-enrollment of one Kirk C. Miller* as regards Privilege Care. Second page is a blank copy of a Privilege Care Inc. PEO Contractual Agreement.

7. **Complainant's Exhibit No. 7**, consisting of one (1) type written or printed page, being a copy of an UNDATED, UNSIGNED *letter* from one Doug Milne to a Mr. Taylor regarding Jerry Ide and a "new program that replaced ERISA". Top of letter shows a Fax date of February 4, 2002.

8. **Complainant's Exhibit No. 8**, consisting of seventeen (17) type written or printed pages, being a copy of a 1992 U. S. Department of Labor, Pension and Welfare benefits Administration publication entitled: "*MEWAs Multiple Employer Welfare Arrangements Under the Employee Retirement and Income Security Act: A Guide to Federal and State Regulation*".

9. **Complainant's Exhibit No. 9**, consisting of fifteen (15) type written or printed pages, being a copy of a March 24, 1990 National Association of Insurance Commissioners publication entitled: "*ERISA*" by John Keene, U. S. Department of Labor, Pension and Welfare Benefits Administration.

10. **Complainant's Exhibit No. 10**, consisting of sixteen (16) type written or printed pages, being a copies of four (4) separate *newsletters* of the Utah Department of Insurance, each containing four (4) pages, being the respective January 1990, January 1992, Winter 1993/94 and Summer 1994 issues. Each issue containing an article concerning ERISA and or unauthorized insurers, amongst other articles.

(No objection being made all of which Complainant's exhibits were accepted and entered, except for Complainant's Exhibit No. 2 which was not formally offered by the Complainant.)

The Respondent offered the following exhibits:

1. **Respondent's Exhibit No. 1**, consisting of one (1) page of typed and or printed materials, being a copy of an (UNSIGNED) January 9, 2002 *letter* from as testified to by Gerald G. Ide, Respondent, from Five Star Marketing to Consultants & Managers, regarding Employers Mutual plan and "New Companies to Market".

2. **Respondent's Exhibit No. 2**, consisting of one (1) page of typed and or printed materials, being a copy of an (UNSIGNED) March 25, 2002 *letter* as testified to by Gerald G. Ide, Respondent, from Privilege Care to "whom it may concern", regarding Gerald G. Ide and his relationship with Privilege Care.

3. **Respondent's Exhibit No. 3**, consisting of one (1) page of typed and or printed materials, being a copy of a February 24, 2002 *affidavit-letter* from Don R. Smith, Five Star Marketing, 1113 Edgefield Drive, Plano, Texas 75075 to "Whom it may concern" regarding Gerald G. Ide and his relationship with Five Star Marketing.

4. **Respondent's Exhibit No. 4**, consisting of one (1) page of typed and or printed materials, being a copy of a February 22, 2002 *letter* from James M. Doyle, President, Privilege Care Marketing Group, P. O. Box 177, Moorestown, New Jersey 08057 to "whom it may concern" regarding Gerald Ide and his relationship with Privilege Care Marketing Group.

5. **Respondent's Exhibit No. 5**, consisting of two (2) pages of typed and or printed materials, being a copy of a January 22, 2002 *Fax* from Darene (NO LAST NAME), Five Star Marketing, 1113 Edgefield Drive, Plano, Texas 75075 to Nathan Clark regarding Privilege Care New Business Procedures effective 02-01-02.

6. **Respondent's Exhibit No. 6**, consisting of twenty-two (22) pages of typed and or printed materials, being copies of twenty-two (22) separate individuals with various dates being "*letters of support and character*" as regards Gerald G. Ide.

(No objection being made which exhibits were accepted and entered, except for Respondent's Exhibit No. 2 which was accepted and entered over objection of the Complainant, and Respondent's Exhibit No. 5 which was withdrawn by the Respondent.)

Argument followed.

The Presiding Officer being fully advised in the premises and taking administrative notice of the files and records of the Department, now enters his *Findings of Fact, Conclusions of Law, and Order*, on behalf of the Department:

FINDINGS OF FACT

I, find by a preponderance of the evidence, the following facts:

Preliminary-Procedural Facts (Paragraphs 1-11)

1. The Utah Insurance Department ("*Department*") is a governmental entity of the State of Utah. The Department as per Utah Code Ann. Section 31A-2-101 is empowered to administer the *Insurance Code*, Title 31A, Utah Code Ann., 1953, as amended.

2. The Respondent, GERALD G. IDE, is:

a. a licensed insurance agent having obtained and maintained present License No. 51030 since on or about December 29, 1983, currently suspended as per *Emergency Proceeding Suspension of License Order* under date of February 6th, 2002; and

b. presently maintains a principal business address of 111 East 5600 South, Suite 208, Murray, Utah 84107.

3. a. The Commissioner of the Utah Insurance Department issued his *Cease and Desist Order* under date of December 6th, 2001 directed to the Respondent amongst others in regards to the assisting of an unauthorized insurance business, namely *Employers Mutual, LLC* as allegedly exempt from the laws of the State of Utah as per the federal *Employers Retirement Income Security Act of 1974* and allegedly marketed by *Five Star Marketing*, in the State of Utah, in violation of Section 31A-15-102, U. C. A., 1953, as amended; and

b. The Commissioner of the Utah Insurance Department issued his *Cease and Desist Order* under date of December 6th, 2001 directed to the Respondent amongst others in to "immediately Cease and Desist any assistance to any person doing an unauthorized insurance business in the State of Utah, including soliciting, marketing, or proposing to make an insurance contract, taking receiving or forwarding an application for insurance, collecting or receiving, in full or in part, any insurance premium, issuing or delivering an insurance policy or other evidence of an insurance contract, publishing or disseminating any advertisement or information for insurance, for any unauthorized insurer." (Paragraph 2, Page 6, December 6th, 2002 Cease and Desist Order, **Docket 2001-242-HL**). (EMPHASIS ADDED).

4. The Department on or about February 6th, 2002 filed its *Complaint* alleging those violations as set forth in Paragraph 1 of *Issue, Burden and Standard of Proof*, above, and issued a *Notice of Formal Proceeding Adjudicative Proceeding and Pre-Hearing Conference*, being **Docket No. 2002-007-HL**, to the Respondent. A copy of said Notice being mailed to the Respondent at his referenced business address on or about February 6th, 2002.

5. The Respondent filed his *Answer* on March 6th, 2002.

6. The Complainant filed its *Motion for Summary Judgment* on March 7th, 2002.
7. A *Pre-Hearing Conference* was scheduled for March 13th, 2002 at 10:00 A. M..
8. As per a March 13th, 2002 *Notice of Continuance of Hearing* the March 13th, 2002 Pre-Hearing Conference was continued to March 20th, 2002 at 10:00 A. M..
9. The Respondent filed his *Motion for Leave to Amend Answer* and tendered his proposed *Amended Answer* on March 19th, 2002.
10. a. A *Pre-Hearing Conference* was held on March 20th, 2002 at 10:00 A. M. and a *Pre-Hearing Conference Order* issued on March 20th, 2002 setting said matter for hearing on April 24th, 2002 at 9:00 o'clock A. M.;
- b. The Complainant's *Motion for Summary Judgment* was denied at said *Pre-Hearing Conference*.
- b. The Respondent with leave of the Court filed his *Amended Answer* at said *Pre-Hearing Conference* on March 20th, 2002.
11. That based on the preliminary facts as set forth in paragraphs 1 through 10, immediately above, a hearing was held on April 24th, 2002 at 9:00 o'clock A. M..

Operative Facts
(Paragraphs 12-20)

12. The Department on or about December 6th, 2001 issued a *Cease and Desist Order*, being **Docket No. 2001-242-HL**, ordering the Respondent, along with others, to "*immediately cease and desist any assistance to any person doing an unauthorized insurance business in the State of Utah, including soliciting, marketing, or proposing to make an insurance contract ... publishing or disseminating any advertisement or information for insurance, for any unauthorized insurer*". (EMPHASIS ADDED).

13. a.i. Included as a Co-Respondent, amongst twenty-seven (27) total Respondents, in such December 6th, 2001 Cease and Desist Order was an entity located in the State of Texas known as *Five Star Marketing*, 1113 Edgefield Drive, Plano, Texas 75075 which was promoting and marketing unauthorized insurance, namely *Employers Mutual, LLC*, through agents in various states, including the present Respondent in the State of Utah; and

ii. Included as a Co-Respondent, amongst twenty-seven (27) total Respondents, in such December 6th, 2001 Cease and Desist Order was one *Don R. Smith*, 1113 Edgefield Drive, Plano, Texas 75075, an officer and or employee of said *Five Star Marketing*; and

b.i. Included as a Co-Respondent, amongst twenty-seven (27) total Respondents, in such December 6th, 2001 Cease and Desist Order was an entity located in the State of

New Jersey known as *American Benefit Society*, 141 Ganttown Road, Suite E, Turnersville, New Jersey 08012 which was operating as a third party administrator for said Employers Mutual, LLC; and

ii. Included as a Co-Respondent, amongst twenty-seven (27) total Respondents, in such December 6th, 2001 Cease and Desist Order was one *Jim Doyle*, 141 Ganttown Road, Suite E, Turnersville, New Jersey 08012, an officer and or employee of said American Benefit Society.

14. Since the issuance of such December 6th, 2001 Cease and Desist Order, Respondent has continued to assist Five Star Marketing and or others, including one Don R. Smith, and one Jim Doyle, both named in said December 6th, 2001 Cease and Desist Order, in promoting and soliciting the sale of another unauthorized insurance, namely Privilege Care, in the State of Utah, in violation of the December 6th, 2001 Cease and Desist Order.

15. On or about January 8th, 2002, Respondent contacted a resident of the State of Utah, one Karen Wilbert, Santaquin, Utah and solicited health care insurance known as *Privilege Care*, which Respondent claimed was underwritten by *Union Labor Life Insurance Company*. On or about January 10th, 2002, Respondent took an application from such person and collected premium in the amount of \$424.00.

16. The Respondent was advised in person by representatives of the Department on or about January 24th, 2002, that the Privilege Care program was not underwritten by the Union Labor Life Insurance Company, and that Five Star Marketing was not to do any business in the State of Utah, and that Privilege Care was an unauthorized insurer.

17. On or about January 25th, 2002, Respondent contacted another resident of the State of Utah, one Kirk C. Miller, Centerville, Utah and solicited health care insurance through Privilege Care.

18. On or about January 29th, 2002, Respondent contacted a licensed agent, Doug Milne, in the State of Utah, and provided such agent information and application forms to deliver to a Mr. Milne's client, a resident of the State of Utah, to *enroll* such person in Privilege Care in place of a previously written Employers Mutual, LLC policy.

19. Privilege Care is being promoted by Five Star Marketing and Privilege Care Marketing Group, Inc., which claims that it is/was underwritten by the Union Labor Life Insurance Company. The Union Labor Life Insurance Company has denied that it is/was underwriting any program known as Privilege Care and denies any knowledge of such program.

20. Privilege Care is/was not authorized to be in the insurance business in the State of Utah.

DISCUSSION-ANALYSIS

(Paragraphs 1 - 21)

1. a. Both the Respondent and the Department in large measure while advocating **clearly** different characterizations or interpretations of the above referenced operative facts in substance concurred as to the basic *chronology* and **core** facts.

b. The record now being complete sets forth competent and credible evidence for the entry of the following analysis.

2. **The question(s) presented is:**

a. "Whether the Respondent's actions are violative the Commissioner's December 6th, 2001 *Cease and Desist Order* and or of Utah Code Ann. Section 31A-15-102?"; and

b. "If the Respondent has so violated both or either of said Commissioner's December 6th, 2001 *Cease and Desist Order* or said cited statutory section what, if any, is the appropriate penalty to be imposed"; and

c. Whether as per Utah Administrative Code Rule, R590-160-5.J as to each of the above and foregoing "issue(s)" or "question(s)" to be answered the "*standard of proof*" as to issues of fact have been proven by a "*preponderance of the evidence*"?

3. **Applicable Pertinent Statutes and Administrative Rules** are as follows (although others may be otherwise specifically cited within the body of this "*Order on Hearing*");

a. i. Section 31A-1-104 states:

31A-1-104. Authorization to do insurance business.

A person may not engage in the following without complying with this title:

- (1) do an insurance business as defined under Section 31A-1-301;
- (2) act as an insurance agent, broker, or consultant as defined under Section 31A-1-301; or
- (3) engage in insurance adjusting as defined under Section 31A-26-102.

ii. Subsection 31A-1-301(64) states:

31A-1-301. Definitions.

"As used in this title, unless otherwise specified:

(64) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance, as defined in Subsection (51), by organizations that are or should be licensed under this title;

(b) providing benefits to employees in the event of contingencies not within the control of the employees, in which the employees are entitled to the benefits as a right, which benefits may be provided either:

(i) by single employers or by multiple employer groups; or

(ii) through trusts, associations, or other entities;

(c) providing annuities, including those issued in return for gifts, except those provided by persons specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of motor clubs as outlined in Subsection (77);

(e) providing other persons with insurance as defined in Subsection (59);

(f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or surety, any contract or policy of title insurance;

(g) transacting or proposing to transact any phase of title insurance, including solicitation, negotiation preliminary to execution, execution of a contract of title insurance, insuring, and transacting matters subsequent to the execution of the contract and arising out of it, including reinsurance; and

(h) doing, or proposing to do, any business in substance equivalent to Subsections (64)(a) through (g) in a manner designed to evade the provisions of this title.

b. i. Section 31A-1-105 states:

31A-1-105. Presumption of jurisdiction.

(1) Any insurer, including the Workers' Compensation Fund created under Chapter 33, that provides coverage of a resident of this state, property located in this state, or a business activity conducted in this state, or that engages in any activity described in Subsections 31A-15-102(2)(a) through (h), is:

(a) doing an insurance business in this state; and

(b) subject to the jurisdiction of the insurance commissioner and the courts of this state under Sections 31A-2-309 and 31A-2-310 to the extent of that coverage or activity.

(2) Any person doing or purporting to do an insurance business in this state as defined in Section 31A-1-301 is subject to the jurisdiction of the insurance commissioner and this title, **unless the insurer can establish** that the exemptions of Section 31A-1-103 apply.

(3) This section does not limit the jurisdiction of the courts of this state under other applicable law.

(EMPHASIS ADDED).

ii. Subsection 31A-1-103(3)(a) states:

31A-1-103. Scope and applicability of title.

“(3) Except as otherwise expressly provided, this title does not apply to:
(a) those activities of an insurer where state jurisdiction is preempted by Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended;”

c. Subsection 31A-2-201(4)(a) states:

31A-2-201. General duties and powers.

“(4)(a) The commissioner shall issue prohibitory, mandatory, and other orders necessary to secure compliance with this title. An order by the commissioner is not effective unless the order:
(i) is in writing; and
(ii) is signed by the commissioner or under the commissioner’s authority.”

d. Subsection 31A-2-308(1)(a) and (b) states:

31A-2-308. Enforcement penalties and procedures.

“(1) (a) A person who violates any insurance statute or rule or any order issued under Subsection 31A-2-201(4) shall forfeit to the state twice the amount of any profit gained from the violation, in addition to any other forfeiture or penalty imposed.

(b) (i) The commissioner may order an individual agent, broker, adjuster, or insurance consultant who violates an insurance statute or rule to forfeit to the state not more than \$2,500 for each violation.

(ii) The commissioner may order any other person who violates an insurance statute or rule to forfeit to the state not more than \$5,000 for each violation.”

(EMPHASIS ADDED).

e. Subsection 31A-2-308(10) states:

31A-2-308. Enforcement penalties and procedures.

“(10) (a) After a hearing, the commissioner may, in whole or in part, revoke, suspend, place on probation, limit, or refuse to renew the licensee's license or certificate of authority:

(i) when a licensee of the department, other than a domestic insurer:

(A) persistently or substantially violates the insurance law; or

(B) violates an order of the commissioner under Subsection 31A-2-201(4);

(ii) if there are grounds for delinquency proceedings against the licensee under Section 31A-27-301 or Section 31A-27-307; or

(iii) if the licensee's methods and practices in the conduct of the licensee's business endanger, or the licensee's financial resources are inadequate to safeguard, the legitimate interests of the licensee's customers and the public.

(b) Additional license termination or probation provisions for licensees other than insurers are set forth in Sections 31A-19a-303, 31A-19a-304, 31A-23-216, 31A-23-217, 31A-25-208, 31A-25-209, 31A-26-213, 31A-26-214, 31A-35-501, and 31A-35-503."

(EMPHASIS ADDED).

f. Section 31A-4-106 states:

31A-4-106. Provision of health care.

(1) As used in this section, "health care provider" has the same definition as in Section 78-14-3.

(2) Except under Subsection (3) or (4), a person may not directly or indirectly provide health care, or arrange for, manage, or administer the provision or arrangement of, collect advance payments for, or compensate providers of health care unless authorized to do so or employed by someone authorized to do so under Chapter 5, 7, 8, 9, or 14.

(3) Subsection (2) does not apply to:

(a) a natural person or professional corporation that alone or with others professionally associated with the natural person or professional corporation, and without receiving consideration for services in advance of the need for a particular service, provides the service personally with the aid of nonprofessional assistants;

(b) a health care facility as defined in Section 26-21-2 which:

(i) is licensed or exempt from licensing under Title 26, Chapter 21; and

(ii) does not engage in health care insurance as defined under Section 31A-1-301;

(c) **a person who files with the commissioner under Section 31A-1-105 a certificate from the United States Department of Labor, or other evidence satisfactory to the commissioner, showing that the laws of Utah are preempted under Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law;**

(d) a person licensed under Chapter 23 who:

(i) has arranged for the insurance of all services under:

(A) Subsection (2) by an insurer authorized to do business in Utah;

(B) Section 31A-15-103; or

(C) works for an uninsured employer that complies with Chapter 13; or

(e) an employer that self-funds its obligations to provide health care services or indemnity for its employees if the employer complies with Chapter 13.

(4) A person may not provide administrative or management services for any other person subject to Subsection (2) and not exempt under Subsection (3) unless the person is an authorized insurer under Chapter 5, 7, 8, 9, or 14, or complies with Chapter 25.

(5) It is unlawful for any insurer or person providing, administering, or managing health care insurance under Chapter 5, 7, 8, 9, or 14 to enter into a contract that limits a health care provider's ability to advise the health care provider's patients or clients fully about treatment options or other issues that affect the health care of the health care provider's patients or clients.

(EMPHASIS ADDED).

g. Section 31A-15-102 states:

31A-15-102. Assisting unauthorized insurers.

(1) No person may do any act enumerated under Subsection (2) who knows or should know that the act may assist in the illegal placement of insurance with an unauthorized insurer or the subsequent servicing of an insurance policy illegally placed with an unauthorized insurer.

(2) An act performed by mail is performed both at the place of mailing and at the place of delivery. Any of the following acts, whether performed by mail or otherwise, fall within the prohibition of Subsection (1):

(a) soliciting, making, or proposing to make an insurance contract;

(b) taking, receiving, or forwarding an application for insurance;

(c) collecting or receiving, in full or in part, an insurance premium;

(d) issuing or delivering an insurance policy or other evidence of an insurance contract except as a messenger not employed by the insurer, an insurance agent, or a broker;

(e) doing any of the following in connection with the solicitation, negotiation, procuring, or effectuation of insurance coverage for another: inspecting risks, setting rates, advertising, disseminating information, or advising on risk management;

(f) publishing or disseminating any advertisement encouraging the placement or servicing of insurance that would violate Subsection (1); however this provision does not apply to publication or dissemination to an audience primarily outside Utah that also reaches persons in Utah unless the extension to persons inside Utah can be conveniently avoided without substantial expense other than loss of revenue; nor does it apply to

regional or national network programs on radio or television unless they originate in Utah;

(g) investigating, settling, adjusting, or litigating claims; or

(h) representing or assisting any person to do an unauthorized insurance business or to procure insurance from an unauthorized insurer.

(3) Subsection (1) does not prohibit:

(a) an attorney acting for a client;

(b) a full-time salaried employee of an insured acting in the capacity of an insurance buyer or manager; or

(c) insurance activities described under Section 31A-15-103.

(4) Any act performed in Utah which is prohibited under this section constitutes appointment of the commissioner or the lieutenant governor as agent for service of process under Sections 31A-2-309 and 31A-2-310.

(EMPHASIS ADDED).

h. Section 31A-23-216 states *in part*:

31A-23-216. Termination of license.

“(1) A license issued under this chapter remains in force until:

(a) revoked, suspended, or limited under Subsection (2);

(b) lapsed under Subsection (3);

(c) surrendered to and accepted by the commissioner; or

(d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons or Part 4, Protection of Property of Persons Under Disability and Minors.

(2) (a) If the commissioner makes a finding under Subsection (2)(b), after an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may:

(i) revoke a license of an agent, broker, surplus lines broker, or consultant;

(ii) suspend for a specified period of 12 months or less a license of an agent, broker, surplus lines broker, or consultant; or

(iii) limit in whole or in part the license of any agent, broker, surplus lines broker, or consultant.

(b) The commissioner may take an action described in Subsection (2)(a) if the commissioner finds that the licensee:

- (i) is unqualified for a license under Section 31A-23-203;
- (ii) has violated:
 - (A) an insurance statute;
 - (B) a rule that is valid under Subsection 31A-2-201(3); or
 - (C) an order that is valid under Subsection 31A-2-201(4);”

i. Section 31A-23-405 states:

31A-23-405. Services performed for unauthorized insurers.

(1) A person licensed under Chapter 23 may not perform any act that assists any person not authorized as an insurer to act as an insurer.

(2) It is a violation of this section to assist any person purporting to be exempt from state insurance regulation under Section 514 of the Employee Retirement Income Security Act of 1974, unless that person has rebutted the presumption of jurisdiction under Section 31A-1-105.

(3) It is not a violation of this section:

- (a) to assist persons engaged in self insurance as defined under Section 31A-1-301; or
- (b) for a surplus lines broker to engage in the placement of insurance under Section 31A-15-103.

(EMPHASIS ADDED).

j. Section 514 of the federal *Employee Retirement Income Security Act of 1974* reads in part:

29 U. S. C. 1144. - Other laws (ERISA sec. 514)

(a) **Supersedure; effective date.** Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application.

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. Sec. 393-1 through 393-51).

(B)

(C)

(6)(A) Notwithstanding any other provision of this section -

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides -

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders , qualified medical child support orders to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action -

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act .. .

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) **Definitions.** For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) **Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited.** Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

(EMPHASIS ADDED).

4. a. i. Without extensive elaboration of the Respondent's actions which the Court will dispense with such can be said to be **clearly** in assistance to one *doing an insurance-like business*.¹

ii. Whether application forms were or were not handed-in or whether money was collected and was or was not handed-in or whether policies were or were not delivered is in so many words *irrelevant*.

iii. The activities referenced in Subsection 31A-15-102(2)(a) through (h) are fairly encompassing. One could venture to say that the Respondent in one form or another took part to a greater or lesser extent in all of such.²

b.i. The *heart* or determinative issue is whether or not both of or either of the two (2) companies the Respondent represented and solicited on behalf of and thus assisted were or were not exempt from the jurisdiction of the Utah Insurance Code.

ii. (A) If within the jurisdiction of the Code such companies should be registered with the Department and absent such registration such companies are *doing an unauthorized insurance business* and the Respondent's assistance thereof would be in violation of the December 6th, 2001 *Cease and Desist Order* as well as Section 31A-15-102, U. C. A., 1953, as amended; or

(B) If exempt from the coverage of the Code such companies need not be registered and whatever the Respondent's assistance thereof such would not be in violation of the December 6th, 2001 *Cease and Desist Order* as well as Section 31A-15-102, U. C. A., 1953, as amended.

¹ It is clear from the testimony of Ms. Wilbert and Mr. Miller they thought that the Respondent was selling and that they were buying health care insurance.

² Absent Subsection 31A-15-102(2)(d) "issuing or delivering an insurance policy" which is one of the problems with the Respondent and the companies he represented --- policies and coverage were promised, but were never delivered and coverage never extended. Suffice it to say the Respondent "assisted" and advanced both of the named entities' interests by Respondent's actions irrespective if money did or did not change hands from Ms. Wilbert and or Mr. Miller and or Mr. Milne's unnamed client to either of the named "insurers". **SEE "Findings of Fact"** No.s 15, 17 and 18, above.

5. a. Section 31A-1-105 creates a “*presumption of jurisdiction*” “unless the insurer can establish that the exemptions of Section 31A-1-103 apply.

b. The one relevant possible exemption in Section 31A-1-103 is found in Subsection 31A-1-103(3)(a) wherein it states: “(3) Except as otherwise expressly provided this title does not apply to: (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of the federal Employee Income Security Act of 1974, as amended”, commonly called “ERISA”.

c. i. Section 31A-4-106(3) establishes a mechanism whereby a purported ERISA entity providing “health care benefits” may “rebut” such presumption of jurisdiction and prove its exemption status.

ii. “[A] person (or entity) person who files with the commissioner under Section 31A-1-105 a certificate from the United States Department of Labor, or other evidence satisfactory to the commissioner, showing that the laws of Utah are preempted under Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law” is exempted.

6. While there was testimony from Mr. Garnett to the effect “*that Privilege Care PEO has everything in order with [L]abor*” the record is *devoid* of any certificate from the United States Department of Labor regarding either Employers Mutual, LLC and or Privilege Care PEO.

7. Such lack of a certificate from the United States Department of Labor leads the Court to review and weigh as per Subsection 31A-4-106(3) what “*other evidence*”, if any, “*satisfactory to the commissioner*” is in the record “*showing that the laws of Utah are preempted*”.

8. a. Respondent through counsel argued that both Employers Mutual, LLC and Privilege Care PEO are “*employee leasing companies*” or “*professional employer organizations*” (“PEO”) offering and administering “ERISA” sanctioned health benefits programs to small employer groups. SEE Chapter 59 of Title 58, “Professional Employer Organization Licensing Act”.

b. It would appear that PEOs can qualify as ERISA sanctioned entities.

9. While counsel for the Respondent argued that Employers Mutual, LLC was a PEO and an ERISA program there is no definitive nor conclusive testimonial or documentary evidence in the record in the Court’s mind to sustain such. Accordingly the Court finds that Employers Mutual, LLC is not a PEO offering an ERISA sanctioned program or otherwise.

10.a. As to Privilege Care PEO there was testimony from Mr. Garnett and “self-proving” documentary exhibits that Privilege Care PEO is a “professional employer organization.

b.i. Privilege Care PEO though is not registered with the Utah Department of Commerce which has specific jurisdiction over PEOs.

ii. As advanced by counsel for the Respondent and per Mr. Garnett’s testimony as per Section 58-59-305(2) “a professional employer organization, which is not domiciled in this state, and which employs less than 25 employees working within this state” is exempt from licensure under Chapter 59 of Title 58. Privilege Care PEO is not domiciled in Utah nor does it have 25 or more employees working within this state.

iii. Privilege Care PEO need not be licensed as a PEO.

11. While Respondent’s and Privilege Care PEO’s evidentiary proof can be said to be “self-proving or “self-serving” *arguendo* assuming Privilege Care PEO is a PEO is the health benefits program it offers to “employers” amongst other PEO benefits such as to be ERISA sanctioned and pre-empted from the laws of the State of Utah and the jurisdiction of the Utah Insurance Department?

12. a. As per Paragraph 6, above, “[W]hile there was testimony from Mr. Garnett to the effect “that Privilege Care PEO has everything in order with [L]abor” the record is again devoid of any certificate from the United States Department of Labor regarding Privilege Care PEO” or anything other than such statement in the record.

b. The testimony of Mr. Garnett and the advanced documentary evidence as to Privilege Care PEO being an ERISA sanctioned benefits program is “self-proving” and “self-serving”.

c. No literature other than some token letters lacking even a letterhead in some instances was presented. No articles of incorporation nor the arguably determinative “*agreement*” with the labor union repeatedly spoken of by Mr. Garnett were presented.

13. The “burden” of proving such exemption to the satisfaction of the Commissioner is on the entity tendering such. Here Privilege Care PEO itself has not made an “application for exemption”, but such has been advanced by the Respondent as a defense. The burden accordingly in such circumstance is on the Respondent. The Respondent has failed to prove such exemption.

14. The Respondent has violated the December 6th, 2001 *Cease and Desist Order and Utah Code Ann. Section 31A-15-102* based on Respondent's assistance to Privilege Care PEO *doing an unauthorized insurance business* in the State of Utah.³

15. The Court having determined that neither Employers Mutual, LLC nor Privilege Care PEO for purposes of the present proceeding are ERISA sanctioned programs and that as such the Respondent's actions in marketing such were in violation as alleged by the Complainant the question now becomes what is the appropriate penalty?

16. a. No evidence of previous similar violations or other major problems with the Respondent's license were presented.

b. i. As per Respondent's Exhibit No. 6 at least twenty-two (22) separate persons have advanced letters of support for the Respondent. Some apparently being former or present co-workers or agents as well as consumers for whom the Respondent has served as an agent.

ii. Such letters speak glowingly of the Respondent as a person. And the Court in viewing the Respondent's testimony does not doubt that he is basically a sincere and good person.

17. a. That said the evidence is also abundantly clear that the Respondent was not a good agent and has done a great disservice to the particular consumers to whom he marketed in the present instance.

b. i. It is clear that the Respondent was for want of a better phrase "*out of his element*".

ii. The Respondent had no idea what ERISA was and even at the hearing the Court questions if the Respondent even now has any real idea of what an ERISA program is.

c. To market any product on the say so of non-letterhead marketing "*rah-rah*" as presented by Five Star Marketing as to Employers Mutual, LL in the first place raises serious questions in the Court's mind.

³ Counsel for Respondent makes much ado that Privilege Care PEO's program and actions are not insurance. Ms. Wilbert's and Mr. Miller's testimony clearly indicated that they believed it was insurance. From the Court's review of Complainant Exhibit No. 3, which is the only real printed literature about the companies advanced, consisting of sixteen (16) pages while there is present the "*contractual agreement*" spoken of by Mr. Garnett and some other references to "*multiemployer trusts*" (ERISA language, etc.) the bulk of the apparent Privilege Care PEO/Privilege Care Marketing Group, Inc. information presents itself as health insurance marketing materials. The average person looking at such (especially the "*self-employed*" targets) like Ms. Wilbert and Mr. Miller as they testified would as does the Court view such as "health care insurance". Calling a horse a cow does not make it moo. Just simply calling health care insurance an ERISA sanctioned program does not make it so. Neigh (sic) this is/was insurance which the marketers hoped to ride on the backs of consumers to the finish line of the consumers pocketbook. While the Respondent may not have been the trainer or jockey he was one of the stable exercise boys assisting in preparing for the race.

d. i. To then even after the issuance of the December 6th, 2001 Cease and Desist Order wherein it clearly stated that Respondent “shall immediately Cease and Desist any assistance to any person doing an unauthorized insurance business in the State of Utah” to market Privilege Care PEO or any other product on the mere further non-letterheaded printed material say so or verbal thoughts of one (James M. Doyle) who states “we’re not named in the C & D so go ahead” or words to such effect borders on *incredulity*.

ii. It is especially disturbing that **red flags** didn’t go up to the Respondent when such statement was made by a James M. Doyle, President, Privilege Care Marketing Group, Inc., P. O. Box 177, Moorestown, New Jersey 08057, when one of the named Respondents in the December 6th, 2001 Cease and Desist was a Jim Doyle, 141 Ganttown Road, Suite E, Turnersville, New Jersey 08012. Such in itself let alone the other issues rampant in the program(s) raised the necessity of extensive “*due diligence*” on the Respondent’s part.

e. The Respondent argues he did due diligence. In so many words the Respondent’s due diligence was taking on face value what the marketers told him or faxed him. This sounds much like the *Emperor’s New Clothes*. For like the “two swindlers [who] came to this city; they made people believe that they were weavers and declared they could manufacture the finest cloth to be imagined(.)” and that “[t]heir colours and patterns, they said, were not only exceptionally beautiful, but the clothes made of their material possessed the wonderful quality of being invisible to any man who was unfit for his office or unpardonably stupid(.)”, so too were “*weavers*” Don R. Smith and Jim Doyle strangers to this (Salt Lake) city.⁴ The Respondent did little if anything to look behind the promotional materials and search out what ERISA is/was or inquire of the alleged underwriter other than one or two token phone calls. As testified to by Mr. Taylor, Department Market Conduct Examiner, “*if its sounds too good to be true,*”

18. a. That the Respondent would on January 25th, 2002 after having been told less than twenty-four (24) hours prior on January 24th, 2002 by Department representatives that Privilege Care PEO was at the least questionable and as testified to by both Mr. Hansen and Mr. Taylor told that it was an unauthorized insurer go ahead and market such to Mr. Miller surpasses incredulity and approaches *ludicrous* behavior.

b. And beyond the January 25th, 2002 Miller circumstance further on January 29th, 2002 the Respondent approached Mr. Milne, a fellow agent, as to marketing Privilege Care.

c. While arguendo misguided and confused prior to the January 24th, 2002 face to face warning from Department representatives the Respondent’s actions on January 25th and 29th, 2002 raise in the Court’s mind questions of not only the Respondent’s arguable competence as an agent, but whether Respondent is a rationale functioning adult as well.

⁴ *The Emperor’s New Suit*, Hans Christian Andersen (1837).

19. The Respondent presents that no one was harmed. That he has made whole the instant consumers. Such speaks well of the Respondent yet the Court gets the impression such was done not so much out of empathy for the consumer and what the Respondent did to place the consumer “*in harms way*”, but apprehension of what might befall the Respondent.

20. Counsel for the Complainant has aptly labeled the Respondent’s actions in assisting in doing of an unauthorized insurance business as the “*second greatest sin*” that an agent could commit. Second only to an agent taking premiums and not delivering them to an insurer or of embezzlement of insurance proceeds. Counsel is correct in his analysis.

21. a. The Respondent’s testimony at hearing reminds one of the Emperor’s actions when he heard the little child exclaim amongst others “*But he has nothing on at all*”. For as the fable states: “*That made a deep impression upon the emperor, for it seemed to him that they were right; but he thought to himself, ‘Now I must bear up to the end’. And the chamberlains walked with still greater dignity, as they carried the train which did not exist.*”⁵

b. The Court accordingly feels that anything short of revocation of the Respondent’s license at this time would not serve the interest of the general public nor protect the potential consumers the Respondent might come in contact with would he be permitted to retain his agent license for like the Emperor he is “*unfit for his office*”.

BASED ON THE ABOVE AND FOREGOING FINDINGS OF FACT and discussion-analysis the Presiding Officer enters the following:

CONCLUSIONS OF LAW

1. The [Commissioner’s] *Cease and Desist Order* under date of December 6th, 2001 was promulgated in accordance with Section 31A-2-201(4) and was an “*order[s as] necessary to secure compliance with this title (Title 31A).*”

2. a. The Respondent assisted at least two (2) persons and or entities doing an *unauthorized insurance business* in the State of Utah, namely *Employers Mutual, LLC* and *Privilege Care PEO*.

b. The Respondent violated the December 6th, 2001 *Cease and Desist Order* and Utah Code Ann. Section 31A-15-102 based on Respondent’s assistance to a person(s) *doing an unauthorized insurance business* in the State of Utah.

⁵ *The Emperor’s New Suit*, Hans Christian Andersen (1837).

3. The imposition of a \$2,500.00 administrative forfeiture in accordance with Section 31A-2-308(1)(b)(i) is within the statutory authority of the Department to impose for a violation as herein proven by the Complainant Department.

4. The “*forfeit(ing) to the state twice the amount of any profit gained from the violation, in addition to any other forfeiture or penalty imposed*” in accordance with Section 31A-2-308(1)(a) is within the statutory authority of the Department to impose for a violation as herein proved by the Complainant Department.

5. The revocation of an agent’s license in accordance with Sections 31A-2-308(10) and 31A-23-216 is within the statutory authority of the Department to impose for a violation as herein proven by the Complainant Department.

AND BASED ON THE ABOVE AND FOREGOING CONCLUSIONS OF LAW
the Presiding Officer enters the following:

ORDER

WHEREFORE, IT IS ORDERED that:

1. The Respondent being in violation of the December 6th, 2001 *Cease and Desist Order and Utah Code Ann.* Section 31A-15-102 in accordance with Section 31A-2-308(1)(b)(i) is hereby assessed an administrative forfeiture of \$2,500.00.

2. The Respondent being in violation of the December 6th, 2001 *Cease and Desist Order and Utah Code Ann.* Section 31A-15-102 in accordance with Section 31A-2-308(1)(a) “*shall forfeit to the state twice the amount of any profit gained from the violation*” once such profit, if any, is determined after examination of the Respondent’s financial records by Department representatives.

3. The Respondent being in violation of the December 6th, 2001 *Cease and Desist Order and Utah Code Ann.* Section 31A-15-102 in accordance with Sections 31A-2-308(10) and 31A-23-216 the Respondent’s insurance agent license is hereby revoked immediately upon entry of this order.

DATED and ENTERED this 30th day of April, 2002.

MERWIN U. STEWART,
INSURANCE COMMISSIONER



MARK E. KLEINFELD
ADMINISTRATIVE LAW JUDGE and
PRESIDING OFFICER

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114
Telephone: (801) 537-9246
Facsimile: (801) 538-3829
Email: MKleinfeld@utah.gov

ADMINISTRATIVE AGENCY REVIEW

Administrative Agency Review of this Order may be obtained by filing a Petition for Review with the Commissioner of the Utah Insurance Department within thirty (30) days of the date of entry of said Order consistent with Utah Code Ann. Section 63-46b-12 and Administrative Rule R590-160-8.

Failure to seek agency review shall be considered a failure to exhaust administrative remedies.

(R590-160-8 and Section 63-46b-14)

JUDICIAL REVIEW

As an "Formal Hearing" after agency review judicial review of this Order may be obtained by filing a petition for such review consistent with Utah Code Ann. Section 63-46b-16.

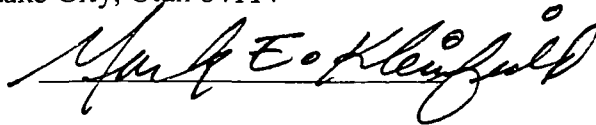
CERTIFICATE OF MAILING

I hereby certify that on the 30 day of April, 2002 a true and correct copy of the above and foregoing *ORDER ON HEARING (Formal Hearing)* was sent certified mail, return receipt requested, and first class mail, both postage prepaid to the following:

Gregory J. Sanders
Kipp & Christian, P. C.
Attorney for Respondent
10 Exchange Place, 4th Floor
Salt Lake City, Utah 84111

and a true and correct copy hand-delivered to the following:

M. Gale Lemmon
Enforcement Counsel
Attorney for Complainant
Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114



**Exhibits are omitted. They may be found
in the record, pages 128 through 251.**

ADDENDUM “B”

Order on Review

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF UTAH

COMPLAINANT:

UTAH STATE INSURANCE DEPARTMENT

RESPONDENT:

GERALD G. IDE
License No. 51030

:
:
:
:
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:
:

ORDER ON REVIEW

Docket No. 2002-007-HL

Gerald G. Ide (also referred to as "Respondent") filed a request for Agency Review pursuant to Utah Code Ann. (U.C.A.) Section 63-46b-12 and Utah Administrative Code (U.A.C.) Rule, R590-160-8. Respondent did not request oral argument.

STATEMENT OF FACTS

This case began as an emergency proceeding to suspend the Respondent's license. The Utah Insurance Department (also referred to as "Complainant") issued an Emergency Proceeding Suspension of License on February 6, 2002. The Order suspended the Respondent's producer's license as of February 6, 2002 for a period of 12 months from the date of the order; ordered the Respondent to cease doing any insurance business in the State of Utah; and ordered the Complainant to commence a formal adjudicative proceeding against the Respondent for the revocation of Respondent's license pursuant to the provisions of U.C.A Section 63-46b-1, *et seq.*

The Complainant issued a Notice of Formal Adjudicative Proceeding and Pre-Hearing Conference on February 6, 2002. A pre-hearing conference was set for March 13, 2002. The notice included a copy of the Complaint alleging that the Respondent had engaged in conduct that violated an Order of the Commissioner and provisions of the Utah Insurance Code. The Complaint demanded that a hearing be set in the matter; that Respondent's license be revoked; and such other relief as the presiding officer deems just.

On March 6, 2002, the Complainant received Respondent's answer to the Complaint issued February 6, 2002. In this answer, Respondent requested that his license be reinstated and the complaint dismissed. On March 7, 2002, the Complainant made a Motion for Summary Judgment to be heard at the Pre-Hearing Conference scheduled for March 13, 2002. The Pre-Hearing Conference was continued to March 20, 2002.

On March 19, 2002, Respondent filed a Memorandum Opposing Motion for Summary Judgment and a Motion to Amend Answer. On March 20, 2002, following the pre-hearing conference, a Pre-Hearing Conference Order was issued granting the Complainant's motion to withdraw its Motion for Summary Judgment; granting the Respondent's Motion to Amend Answer; setting April 24, 2002 as the date for a formal administrative hearing; setting forth the rules for discovery; setting a cut-off date for motions; setting dates for statements of facts and statements of issue(s); setting a date for the exchanging of witness lists and exhibit lists; and setting a date for filing of pre-hearing memorandum.

The formal hearing was conducted on April 24, 2002. Exhibits, witness testimony, and testimony from the Respondent and the Complainant were presented during the hearing. On April 30, 2002, the presiding officer issued his Order on Hearing. That order assessed an administrative forfeiture of \$2,500.00, assessed a forfeiture of twice the amount of profit gained from the violation, and immediately revoked the Respondent's producer's license. The order paperwork also included instructions for seeking administrative agency review and judicial review.

Respondent filed a Petition for Review on May 24, 2002. The Petition requested review on the following grounds: (1) the discipline imposed by the Order is disproportionate to the offense alleged; and (2) the decision process explained in the Order shifts the burden of proof from the Complainant to the Respondent and thereby inappropriately concludes as a matter of fact and as a matter of law that Respondent's license should be revoked. Also on May 24, 2002, Respondent requested that the tapes from the hearing be provided for the purpose of having a transcript of the hearing prepared. On June 11, 2002, Complainant filed Complainant's Response to Respondent's Petition for Review. Complainant received a copy of the transcript of the proceedings on August 2, 2002. On August 13, 2002, Respondent filed a Memorandum in Support of Petition for Review. On August 26, Complainant filed Complainant's Response to Respondent's Memorandum in Support of Petition for Review. On September 15, Respondent filed a Reply Memorandum of Respondent in Support of Petition for Review. On September 26, 2002, the insurance commissioner designated the undersigned, as provided in U.C.A. Section 63-46b-12(2) and U.A.C. Rule R590-160-8C, to handle Respondent's request for agency review.

STANDARD OF REVIEW

The standards for agency review correspond to the standards for judicial review of formal adjudicative proceedings, as set forth in U.C.A. Subsection 63-46b-16(4). The applicable standards in this review are

- (d) the agency has erroneously interpreted or applied the law; [and]
- (g) the agency action is based upon a determination of fact, made or implied by the agency that is not supported by substantial evidence when viewed in light of the whole record before the court;

Substantial evidence is that quantum and quality of relevant evidence that is adequate to convince a reasonable mind to support a conclusion.

STATEMENT OF ISSUES

Should the order issued by the presiding officer be set aside because he made incorrect findings of fact and conclusions of law? Specifically, the respondent alleges in his Petition for Review that the presiding officer's order be set-aside on any of the following grounds:

1. The discipline imposed is disproportionate to the offense alleged.
2. Standard of proof language used by presiding officer is unknown as the standard is not in rule cited.
3. Burden is on Complainant to prove that product sold was unauthorized insurance, not on Respondent to prove that product sold was exempted from Complainant regulation.
4. Complainant's declarations of fact are not supported by substantial evidence.
 - a. Complainant's declaration that product sold was unauthorized insurance is not supported by substantial evidence;
 - b. Complainant's declaration that Respondent knew or should have known that product sold was unauthorized insurance not supported by substantial evidence; and
 - c. Complainant's declaration that product sold was insurance not supported by substantial evidence.

DISCUSSION OF FACTS AND ISSUES

Issue 1: The discipline imposed is disproportionate to the offense alleged.

The selling of unauthorized insurance is a very serious allegation because the purchaser has no recourse to the normal consumer protections available to the purchaser of an authorized product or a product exempt from regulation. Respondent was named in a Cease and Desist Order issued December 6, 2001, against an unauthorized insurer and was specifically enjoined to immediately cease and desist any assistance to any person doing an unauthorized insurance business in the State of Utah. Any assistance was defined as soliciting, marketing, or proposing to make an insurance contract, taking, receiving or forwarding an application for insurance, collecting or receiving, in full or in part, any insurance premium, issuing or delivering an insurance policy or other evidence of an insurance contract, or publishing or disseminating any advertisement or information for insurance for any unauthorized insurer. In January and February of 2002, in violation of the December 6, 2001 cease and desist order, the Respondent assisted another unauthorized insurer to do business in the State of Utah by soliciting, marketing, taking and forwarding applications for insurance, and receiving insurance premium.

Issue 2: Standard of proof language used by presiding officer is unknown as the standard is not in rule cited.

The presiding officer incorrectly cited the 1999 version of the rule. The paragraph cited is identical to the appropriate paragraph in the 2000 version of the rule.

R590-160-5. Rules Applicable to All Proceedings – effective February 3, 1994; notice of continuation January 1, 1999

J. Standard of Proof. All issues of fact in administrative proceedings before the commissioner shall be decided upon the basis of a preponderance of the evidence standard.

R590-160-5. Rules Applicable to All Proceedings – effective November 14, 2000

(10) Standard of Proof. All issues of fact in administrative proceedings before the commissioner shall be decided upon the basis of a preponderance of the evidence standard.

Issue 3: Burden is on Complainant to prove that product sold was unauthorized insurance, not on Respondent to prove that product sold was exempted from Complainant regulation.

Producers marketing insurance products in this state are expected to understand the laws and rules regulating the business of insurance in Utah. U.C.A. Section 31A-4-106 states a prohibition to arranging health insurance not authorized under Chapters 5, 7, 8, 9, or 14 and provides a methodology to obtain a preemption from regulation under Section 514 of the Employment Retirement Income Security Act of 1974 (ERISA) or other federal law. U.C.A. Section 31A-15-102 prohibits persons from assisting in the illegal placement of insurance with an unauthorized insurer. U.C.A. Section 31A-23-405 prohibits assisting any person purporting to be exempt from state insurance regulation under Section 514 of ERISA unless that person has rebutted the presumption of jurisdiction under U.C.A. Section 31A-1-105.

The Complainant stated in its original Complaint that the health insurance offered by Respondent was unauthorized insurance. The Complainant, in its Emergency Proceeding Suspension of License, identified Privilege Care as the unauthorized insurer that the Respondent had assisted. The Complainant also stated in testimony during Respondent's hearing that Privilege Care was conducting business as an unauthorized insurer. Respondent offered no evidence, other than testimony that the health insurance marketed by Respondent was a benefit provided through membership in a professional employer organization (PEO), to refute the Complainant's finding that the health insurance offered through the PEO was unauthorized insurance. The fact that the health insurance was being marketed through a PEO does not exempt the health insurance from having to comply with state insurance laws and regulations or qualify for a Section 514 of ERISA exemption. All health insurance offered in this state, no matter in what context it is marketed, must comply with state insurance laws and regulations or qualify for a Section 514 of ERISA exemption.

Issue 4a: Complainant's declaration that product sold was unauthorized insurance is not supported by substantial evidence.

Respondent correctly stated that the Complainant does not have jurisdiction over professional employer organizations. Privilege Care PEO as a PEO is not under the jurisdiction of the Complainant. However, the health insurance offered by Privilege Care PEO is subject to the Complainant's jurisdiction unless Privilege Care PEO perfects a preemption of jurisdiction under Section 514 of ERISA. Respondent did not present evidence Privilege Care PEO had a preemption of jurisdiction. Complainant presented substantial evidence that Privilege Care PEO was offering health insurance and the health insurance offered was not underwritten by an admitted health insurer.

Issue 4b: Complainant's declaration that Respondent knew or should have known that product sold was unauthorized insurance not supported by substantial evidence.

Respondent is an experienced life and health insurance producer as evidenced by his having been licensed for twenty-seven years. He admits to not knowing much about ERISA or unauthorized insurance. On December 6, 2001, Respondent was named in a Cease and Desist order because of his involvement with assisting an unauthorized insurer. The cease and desist order should have indicated to the Respondent that he did not know what constituted assisting an unauthorized insurer and heightened his need to learn what constituted unauthorized insurance to protect himself and his clients. Producers have an obligation to understand what constitutes assisting an unauthorized insurer and to understand what constitutes unauthorized insurance. Producers, therefore, must do any necessary research to determine that any insurance they choose to present to their clients is either issued by an insurer authorized to do the business of insurance in this state or is preempted from state insurance regulation.

Shortly after the December 6, 2001 Cease and Desist Order was effective, Respondent was solicited by persons named with him in the December 6, 2001 Cease and Desist Order to market health insurance to replace the health insurance issued by the unauthorized insurer named in the Cease and Desist Order. Respondent testified that he did not understand the replacement product he was selling and that he relied on information supplied by the same persons that had assured him that the previous health insurance had been authorized health insurance when in fact it was not. Respondent testified that he did not do independent research to determine if Privilege Care PEO was offering health insurance provided by an authorized insurer or health insurance preempted from Complaint's regulation under Section 514 of ERISA until after the Complainant indicated to him that Privilege Care PEO was not an authorized insurer. Evidence presented in the record clearly shows that sufficient indicators were present to alert Respondent that the health insurance offered through Privilege Care PEO was not authorized insurance. Respondent failed to learn what constituted unauthorized insurance and to do the necessary research to ensure the replacement health insurance offered through Privilege Care PEO was not being issued by an unauthorized insurer. Ignorance of the law is not an excuse for violating the law.

Issue 4c: Complainant's declaration that product sold was insurance not supported by substantial evidence.

Respondent's clients testified that they understood they were being offered health insurance to replace the health insurance previously sold to them by the Respondent. Materials from Privilege Care PEO introduced into evidence and used by the Respondent in his presentations to his clients clearly indicate that the product includes health insurance. The completed forms introduced into evidence as completed by the Respondent at the time of presentation to his clients were health insurance forms.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The order by the presiding officer should not be set aside because he made incorrect findings of fact and conclusions of law.

a. The discipline imposed is not disproportionate to the offense alleged.

(1) Respondent, by assisting an unauthorized insurer, placed his clients at substantial financial risk because health insurance issued by unauthorized insurers is not protected by the consumer protections provided for health insurance issued by an authorized insurer.

(2) Placing clients at substantial financial risk is a very serious violation of a producer's obligations to his clients.

(3) Respondent was named in a Cease and Desist Order issued December 6, 2001, against an unauthorized insurer and was specifically enjoined to immediately cease and desist any assistance to any person doing an unauthorized insurance business in the State of Utah.

(4) Respondent assisted another unauthorized insurer to do business in the State of Utah by soliciting, marketing, taking and forwarding applications for insurance, and receiving insurance premium during January and February of 2002.

(5) Respondent violated the terms of the commissioner's December 2001 Cease and Desist Order by assisting an unauthorized insurer during January and February 2002.

(6) Violation of a commissioner's order is a very serious breach of a producer's responsibilities.

(8) Respondent is an experienced insurance producer as evidenced by his having been licensed for twenty-seven years.

(7) The penalty imposed by the presiding officer was not disproportionate based on the Respondent's experience as an insurance producer, the very serious violation of his obligations to his clients, and the very serious breach of his responsibilities as a producer.

b. Standard of proof language cited by the presiding officer does not set an unknown standard.

(1) The presiding officer incorrectly cited the 1999 version of the rule.

(2) The standard of proof language in the 2000 version of the rule is identical to the standard of proof language in the 1999 version of the rule.

(3) The incorrect rule citation by the presiding officer did not impose a different standard of proof so the Respondent's statement that the standard of proof is unknown and thereby sets an unknown standard is incorrect.

c. The order by the presiding officer should not be set aside because burden is on Complainant to prove that product sold was unauthorized insurance, not on Respondent to prove that product sold was exempted from Complainant regulation.

(1) The Complainant stated in its original complaint that the product offered by Respondent was unauthorized insurance.

(2) The Complainant, in its Emergency Proceeding Suspension of License, specifically identified Privilege Care as the unauthorized insurer that the Respondent had assisted.

(3) A defense against the Complainant's allegation of assisting an unauthorized insurer is to prove incorrect the Complainant's declaration that the insurer being assisted by the Respondent is an unauthorized insurer.

(4) The burden of proof was rightly placed on the Respondent.

d. Complainant's declarations of fact are supported by substantial evidence.

(1) Complainant's declaration that the health insurance marketed by the Respondent was unauthorized insurance is supported by substantial evidence.

(i) Respondent did not present evidence that Privilege Care PEO had a preemption of jurisdiction under Section 514 of ERISA or that the health insurance offered through Privilege Care PEO was issued by an authorized insurer.

(ii) Complainant presented substantial evidence that Privilege Care PEO was offering health insurance and the health insurance offered was not issued by an authorized health insurer.

(iii) The Complainant's declaration that the health insurance marketed by the Respondent was unauthorized insurance is supported by substantial evidence.

(2) Complainant's declaration that Respondent knew or should have known that health insurance marketed by the Respondent was unauthorized insurance is supported by substantial evidence.

(i) Respondent is an experienced health and life insurance producer as evidenced by his having been licensed for twenty-seven years.

(ii) As an experienced health and life producer, Respondent has an obligation to understand what constitutes assisting an unauthorized insurer and what constitutes unauthorized insurance.

(iii) Evidence presented in the record clearly shows that sufficient indicators were present to alert Respondent that the health insurance offered through Privilege Care PEO was unauthorized insurance.

(iv) Respondent failed to learn what constitutes assisting an unauthorized insurer and to do the necessary research to ensure the health insurance offered through Privilege Care PEO was authorized insurance.

(v) Complainant's declaration that Respondent knew or should have known that health insurance marketed by the Respondent was unauthorized insurance is supported by substantial evidence.

(3) Complainant's declaration that health insurance marketed by the Respondent was insurance is supported by substantial evidence.

(i) Respondent's clients testified that they understood they were being offered health insurance to replace the health insurance previously sold to them by the Respondent.

(ii) Materials from Privilege Care PEO introduced into evidence and used by the Respondent in his presentations to his clients clearly indicate that the product includes health insurance.

(iii) The completed forms introduced into evidence as completed by the Respondent at the time of presentation to his clients were health insurance forms.

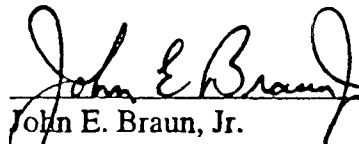
(iv) Complainant's declaration that health insurance marketed by the Respondent was insurance is supported by substantial evidence.

ORDER ON REVIEW

Based on the above Findings of Fact and Conclusion of Law and a review of the record in the matter, Respondent's request to set aside the presiding officer's Order on Hearing is hereby denied.

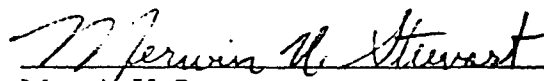
This order constitutes a final order of the Commissioner in the proceeding and any party aggrieved by the order may seek judicial review by filing a petition for judicial review with appropriate appellate court within thirty days after the date the order is issued.

Dated this 31st day of October 2002.



John E. Braun, Jr.
Assistant Insurance Commissioner
Designee of the Commissioner

I hereby adopt the analysis, findings of fact and conclusions of law, and the order of the designee as my Findings of Fact and Conclusions of Law and Order on Review in this matter.



Merwin U. Stewart
Insurance Commissioner

ADDENDUM “C”

R590-160-4(2) of the Utah Administrative Code
R590-160-5(10) of the Utah Administrative Code

R590-160-4. Designations of Proceedings.

(1) All actions pursuant to initial determinations upon applications for a license or a certificate of authority or any petition to remove an existing disability are designated as informal adjudicative proceedings.

(2) All actions that seek to suspend or revoke or limit an existing license, other than placing a license on probation, are formal adjudicative proceedings.

(3) All other agency actions are informal.

(4) Any proceeding may be converted from a formal proceeding to an informal proceeding or from an informal proceeding to a formal proceeding upon motion of a party or sua sponte by the presiding officer, subject to the provisions of Subsection 63-46b-4(3).

(10) Standard of Proof. All issues of fact in administrative proceedings before the commissioner shall be decided upon the basis of a preponderance of the evidence standard.

ADDENDUM “D”

U.C.A. § 31A-1-301(63) and (125)

(63) (a) "Insurance" means:

- (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons; or
- (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

(b) "Insurance" includes:

- (i) risk distributing arrangements providing for compensation or replacement for damages or loss through the provision of services or benefits in kind;
- (ii) contracts of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and
- (iii) plans in which the risk does not rest upon the person who makes the arrangements, but with a class of persons who have agreed to share it.

- (125) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:
- (i) not holding a valid certificate of authority to do an insurance business in this state; or
 - (ii) transacting business not authorized by a valid certificate.
- (b) "Admitted insurer" or "authorized insurer" means an insurer:
- (i) holding a valid certificate of authority to do an insurance business in this state; and
 - (ii) transacting business as authorized by a valid certificate.

ADDENDUM “E”

U.C.A. Title 58, Chapter 59

58-59-101. Short title.

This chapter is known as the "Professional Employer Organization Licensing Act."

58-59-102. Definitions.

In addition to the definitions in Section 58-1-102, as used in this chapter:

(1) "Adjusted net worth" means stockholder's equity determined in accordance with generally accepted accounting principles, increased by the amount of obligations subordinated to claims of general creditors with a remaining term to maturity in excess of three years, and mandatory redeemable preferred stock with a remaining term to redemption in excess

of three years and decreased by assets shown on the balance sheet in the form of receivables, loans, advances or similar types of assets receivable from owners, shareholders, partners or officers of the company and decreased by intangible assets not acquired in an arm's length transaction. The owners of the PEO may provide personal or corporate financial statements together with personal or corporate guaranty agreements to supplement the "Adjusted Net Worth" of the PEO.

(2) "Board" means the Professional Employer Organization Board created in Section 58-59-201.

(3) "Change in life count" means the percentage change in the number of lives on a health plan from the beginning to the end of the run-out period.

(4) "Client" or "client company" means a person or entity that leases any or all of its regular employees from a professional employer organization.

(5) "Coemployee" means a person who is an employee of a professional employer organization and of a client company.

(6) "Employment agreement" means the written agreement between a professional employer organization and each of its employees who are employed for the purpose of being coemployees to client companies.

(7) "Engage in practice as a professional employer organization" means to hold oneself out as a professional employer organization, to coemploy an employee with another person, or to receive any consideration for providing professional employer services or to expect payment of any consideration for providing professional employer services.

(8) "Excess Reserves" means assets of a health benefit plan less all liabilities including accrued liabilities of the health benefit plan as shown on a financial statement of the plan prepared according to generally accepted accounting practices.

(9) "Medical trend" means the medical component of the most current Consumer Price Index (CPI) 12 month change as of the last month that the run-out is calculated.

(10) "Professional employer agreement" means the written agreement between a professional employer organization and a client company in accordance with which the professional employer organization establishes the basis for a coemployment relationship with the client company's employees.

(11) (a) "Professional employer organization" or "PEO" means an organization who by contract agrees to employ a majority of a client's workforce where employer responsibilities for those employees are in fact allocated between or shared by the professional employer organization and the client.

(b) The employer responsibilities are considered to be allocated between or shared by the professional employer organization and the client whenever the agreement between the client and the professional employer organization expressly provides for such allocation or

(c) The term "professional employer organization arrangement" shall be liberally construed so as to include any and all arrangements meeting the criteria for professional employer organizations regardless of the term used.

(d) The following arrangements are not professional employer organization arrangements for purposes of this chapter:

(i) arrangements wherein a person, whose principal business activity is not entering into professional employer organization arrangements, shares employees with a commonly owned company within the meaning of Sections 414(b) and (c) of the Internal Revenue Code of 1986, as amended, and which does not hold itself out as a professional employer organization;

(ii) arrangements by which a person assumes responsibility for the product produced or service performed by that person or his agents and retains and exercises primary direction and control over the work performed by the individuals whose services are supplied under the arrangements;

(iii) a temporary help arrangement, whereby an organization hires its own employees and assigns them to a client to support or supplement the client's workforce in special work situations such as employee absences, temporary skill shortages, seasonal workloads, and special assignments and projects; provided, however, that the temporary help arrangement excludes arrangements where the majority of the client's work force has been assigned by a temporary help organization for a period of more than 12 consecutive months; and

(iv) any person otherwise subject to licensure under this chapter if, during any fiscal year of the person, the total gross wages paid to employees employed by the person in this state during such period under one or more professional employer organization arrangements do not exceed 5% of the total gross wages paid to all employees employed by the person during the same period, and provided further, that the person does not advertise or hold itself out to the public as providing arrangements denominated as "professional employer" or "employee leasing" in this state.

(12) "Represent oneself as a professional employer organization" means to hold oneself out by any means as a professional employer organization.

(13) "Run-out" means claims paid during the six-month period at the fiscal year end of the PEO for dates of service prior to that same six-month period, less amounts reimbursed or to be reimbursed by a reinsurance carrier or reimbursements from any other source for such claims.

(14) "Temporary employee," as may be further defined by rule, means an individual who is an employee of, registered for temporary assignment by, or otherwise associated with a temporary help company that engages in the assignment of individuals as temporary full-time or part-time personnel to fill assignments with a finite ending date to another independent entity.

(15) "Temporary help company," as may be further defined by rule, means a person or entity that provides temporary employees to fill assignments with a finite ending date to another independent entity in special, unusual, seasonal, or temporary skill shortage situations.

(16) "Total adjusted liabilities" means total liabilities as stated in an audited financial statement less obligations subordinated to claims of general creditors with a remaining term to maturity in excess of three

(17) "Unlawful conduct" is as defined in Sections 58-1-501 and 58-59-501.

(18) "Unprofessional conduct" is as defined in Sections 58-1-501 and 58-59-502.

PART 2

PROFESSIONAL EMPLOYER ORGANIZATION BOARD

58-59-201. Board.

(1) There is created the Professional Employer Organization Board consisting of:

(a) three members who are owners or officers of separate licensed professional employer organizations within this state;

(b) one member who is an owner or officer of a client company; and

(c) one member from the general public.

(2) The board shall be appointed and serve in accordance with Section 58-1-201.

(3) (a) The duties and responsibilities of the board shall be in accordance with Sections 58-1-201 through 58-1-203.

(b) The board shall designate one of its members on a permanent or rotating basis to:

(i) assist the division in reviewing complaints concerning the unlawful or unprofessional conduct of a licensee; and

(ii) advise the division in its investigation of these complaints.

(c) A board member who has, under Subsection (3)(b), reviewed a complaint or advised in its investigation is disqualified from participating with the board when the board serves as a presiding officer in an adjudicative proceeding concerning the complaint.

58-59-301. License required — License issuance.

(1) A license is required to engage in practice as a professional employer organization, except as specifically provided in Section 58-1-307 or 58-59-305.

(2) The division shall issue to persons qualified under the provision of this chapter a license as a professional employer organization.

58-59-302. Qualifications for licensure.

Each applicant for licensure as a professional employer organization shall:

- (1) submit an application in a form prescribed by the division;
- (2) pay a fee as determined by the department under Section 63-38-3.2;
- (3) provide documentation that the applicant is properly registered with:
 - (a) the Division of Corporations and Commercial Code;
 - (b) the Department of Workforce Services, for the purposes of Title 35A, Chapter 4, Employment Security Act;
 - (c) the State Tax Commission; and
 - (d) the Internal Revenue Service;
- (4) submit to the division a certified audit performed by an independent certified public accountant showing at least an adjusted net worth of \$50,000 or 5% of total adjusted liabilities, whichever is greater;
- (5) for the purpose of having criminal background checks, provide to the division, the names of:
 - (a) all individuals who have control of or a controlling interest in, as defined in Section 16-10a-102, the professional employer organization;
 - (b) all officers and directors of the professional employer organization; and
 - (c) all other individuals who have signatory authority over fiduciary funds held by the professional employer organization; and
- (6) provide evidence that the responsible managers of the professional employer organization have education and experience in the conduct of business that demonstrate a reasonable expectation that the professional employer organization will be managed with the skill and expertise necessary to protect the interests of its employees, client companies, and the public.

58-59-303. Term of license — Expiration — Renewal.

(1) The division shall issue each license under this chapter in accordance with a one-year renewal cycle established by rule. The division may by rule extend or shorten a renewal period by as much as six months to stagger the renewal cycles it administers.

(2) At the time of renewal the licensee shall show satisfactory documentation of compliance with Subsections 58-59-302(1) through (4) and Sections 58-59-306 and 58-59-310.

(3) Each license automatically expires on the expiration date shown on the license unless renewed by the licensee in accordance with Section 58-1-308.

58-59-304. Repealed.

58-59-305. Exemptions from licensure.

In addition to the exemptions from licensure in Section 58-1-307 the following are exempt from licensure under this chapter:

(1) related companies under common ownership that are not individually considered professional employer organizations under this chapter which combine employees of one commonly owned company with employees of another commonly owned company on either a temporary or regular basis; and

(2) a professional employer organization, which is not domiciled in this state, and which employs less than 25 employees working within this state.

58-59-306. Financial filing requirements.

(1) A professional employer organization shall submit to the division:

(a) on a quarterly basis, a statement from an independent certified public accountant, that all federal, state, and local withholding taxes, unemployment taxes, FICA taxes, workers' compensation premiums, and employee benefit plan premiums have been paid; and

(b) on an annual basis, audited financial statements prepared by an independent certified public accountant, in accordance with generally accepted accounting practices, that include a review of the payment of all federal, state, and local withholding taxes, unemployment taxes, FICA taxes, workers' compensation premiums, and employee benefit plan premiums.

(2) The audited financial statements required by Subsection (1) shall be adequate for the state and its political subdivisions as long as:

(a) there are no qualifications given in the opinion that the CPA considers material enough to question the stability of the PEO as a going concern; and

(b) the PEO complies with Subsection 58-59-302(4).

58-59-307. Records and reports protected.

Notwithstanding Title 63, Chapter 2, Government Records Access and Management Act, financial information submitted to the division by or at the request and direction of an applicant or licensee for the purpose of supporting a representation of financial responsibility is confidential, is not for public inspection, and is not subject to discovery in civil or administrative proceedings.

58-59-308. No guarantee.

By licensing and regulating professional employer organizations under this chapter, the state:

(1) does not guarantee any right, claim, or defense of any professional employer organization, client company, coemployee, or other person;

(2) does not guarantee the financial responsibility or solvency of any professional employer organization; and

(3) does not waive any right, claim, or defense of immunity that it may have under Title 63, Chapter 30, Utah Governmental Immunity Act, or other law.

58-59-309. State licensing provisions not exempted.

(1) Nothing in this chapter exempts a client of a PEO, nor a coemployee, from any state, local, or federal license or registration requirement.

(2) Any individual who must be licensed, registered, or certified according to law and who is a coemployee of a PEO and a client is considered an employee of the client for purposes of that license, registration, or certification.

(3) A PEO does not engage in an occupation, trade, or profession that is licensed, certified, or otherwise regulated by a governmental entity solely by entering into a professional employer arrangement with a client company or a coemployee.

58-59-310. Health benefit plans.

If a PEO offers any self-funded or partially self-funded health benefit plan, the PEO shall:

(1) use a third-party administrator licensed by the Utah State Insurance Department;

(2) hold all self-funded or partially self-funded plan assets, including participant contributions, in a trust account;

(3) provide to the division a list of the trustees of the plan;

(4) provide to the division a statement from a certified actuary that:

(a) the plan maintains stop loss insurance that:

(i) has an aggregate stop loss provision; and

(ii) has a specific attachment point on an individual person, per plan year, in an amount not greater than \$60,000 if the plan has 500 covered coemployees, \$90,000 if the plan has between 501 and 1000 covered coemployees, \$125,000 if the plan has over 1000 covered coemployees, and \$250,000 if the plan has more than 1000 covered coemployees and the plan has in reserves 100% of the statutory liability, except that the limits of the attachment points shall increase annually by twice the percentage of the medical trend beginning with the licenses given or renewed in the year 2004; and

(b) the plan has at least 50% of its statutory liability held in the plan trust within two months of the license renewal date where the

plan's statutory liability is calculated as the run-out multiplied by the change in life count multiplied by the medical trend;

(5) provide to the division a statement from a certified actuary indicating the run-out, the change in life count, the medical trend, and the statutory liability of the plan, where the plan's statutory liability is the run-out increased by the change in life count, then increased by the medical trend; and

(6) provide an audited financial statement evidencing that the PEO's plan has excess reserves of at least 50% of its statutory liability held in the plan trust as of the end of the fiscal year of the PEO, and if the excess reserves are not met, the PEO may supplement the proof that it has come into compliance with the requirement.

PART 4

DENIAL OF LICENSURE

58-59-401. Grounds for denial of license or renewal — Disciplinary proceedings.

(1) If at the time of renewal, a PEO fails to comply with the requirements of licensure for any reason, the division may put the PEO on probation until such time as the PEO comes into compliance with the licensure requirements or 90 days from the license renewal date, whichever comes first. If the PEO fails to cure any default within 90 days of the license renewal date, the division may refuse to renew the license of a licensee.

(2) The division may refuse to issue a license to an applicant, revoke, suspend, restrict, or place on probation the license of a licensee, issue a public or private reprimand to a licensee, and issue cease and desist orders in accordance with Section 58-1-401.

58-59-402. Court intervention.

If a professional employer organization is operating without a license, the division may file a complaint in district court asking for injunctive relief or any other remedy considered appropriate by the court.

PART 5

UNLAWFUL AND UNPROFESSIONAL CONDUCT — PENALTIES

58-59-501. Unlawful conduct.

Unlawful conduct includes:

- (1) engaging in practice as a professional employer organization without a license;
- (2) offering an employee a self-funded medical program, unless:
 - (a) the program provides its benefits under an employee benefit plan that complies with 29 U.S.C. Sec. 1143 et seq.; and
 - (b) the program is maintained for the sole benefit of participating coemployees;
- (3) misrepresenting that any self-funded medical program it offers is other than self-funded;
- (4) offering to its employees any self-funded or partially self-funded medical plan without delivering to each plan participant a summary plan description that accurately describes terms of the plan, including disclosure that the plan is self-funded or partially self-funded;
- (5) providing coemployees to any client company under any provision, term, or condition that is not contained in a clearly written agreement between the professional employer organization and client company;
- (6) any willful, fraudulent, or deceitful act by a licensee, caused by a licensee, or at a licensee's direction, that causes material injury to a client company or coemployee of a client company;
- (7) failing to maintain or ensure that client companies maintain in full force and effect required workers' compensation insurance on all coemployees in accordance with Utah law pursuant to Section 34A-2-103;
- (8) failing to pay in a timely manner any federal or state income tax withholding, FICA, unemployment tax, employee insurance benefit premium, workers' compensation premium, or other obligation due and payable directly as a result of engaging in business as a professional employer organization; and
- (9) failing to comply with federal law regarding any employee benefit offered to an employee.

58-59-502. Unprofessional conduct.

Unprofessional conduct includes:

(1) failing to maintain current lease agreements and employment agreements in appropriate form and content as required under this chapter;

(2) failing to inform the division of a change in ownership, in the address of its owners or officers, or in its principal business address or change in any responsible manager of the professional employer organization who has signatory authority over company funds within ten days after the change;

(3) failing within ten days to notify the division of the failure to pay when due an amount exceeding \$5,000 of any of the following obligations: any federal or state income tax, withholding tax, FICA, unemployment tax, employee insurance benefit premium, or worker compensation premium; and

(4) any of the following events unless the licensee first obtains written approval from the division for that event:

(a) the sale or transfer of a majority of the professional employer contracts of the licensee;

(b) the sale or transfer of a majority of the physical assets of the licensee;

(c) the sale or transfer of more than 25% of the ownership interest of a licensee by any means including the sale, transfer, or issuance of a member interest in a limited liability company, the sale, transfer, or issuance of a member interest in a partnership, the sale, transfer, or issuance of a ownership interest in a licensee in any other manner other than the sale or transfer of publicly traded shares of a corporation affected through a public exchange or market; and

(d) entering into one or more contracts, other than professional employer agreements with clients, which commits the licensee to make future payments to any person or persons in amounts which in total exceed the equity of the business for payment of service provided to or for the licensee.

58-59-503. Penalty for unlawful conduct.

(1) Any person who violates Subsections 58-59-501(1) through (4) is guilty of a third degree felony.

(2) Any person who violates Subsections 58-59-501 (5) through (9) is guilty of a class A misdemeanor.

(3) Any person who has engaged in unlawful conduct may be assessed the costs associated with the investigations, disciplinary proceedings, court proceedings, or other actions to enforce the provisions of this act.

ADDENDUM “F”

Due Process Clauses

Section 1. [Citizenship — Due process of law — Equal protection.]

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Sec. 7. [Due process of law.]

No person shall be deprived of life, liberty or property,
without due process of law.

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CERTIFICATE OF SERVICE

I hereby certify that I caused to be hand-delivered, this 14th day of April, 2003, two true and correct copies of the foregoing, **BRIEF OF PETITIONER** to the following:

M. Gale Lemmon
Enforcement Counsel
Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

