BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the Suspension Order Against: STUART IRA CHESLER, Respondent.	No. 09-0494 OAH No. 2010040159

DECISION

The attached Proposed Decision of the Administrative Law Judge of the Office of Administrative Hearings, dated October 18, 2010, is hereby adopted by the Department of Managed Health Care as its Decision in the above-entitled manner with the following technical and minor changes pursuant to Government Code Section 11571(c)(2)(C).

1. Revise the last name of [redacted] from [redacted] to [redacted] on page 2, paragraphs 5, 6, and 7; page 3, paragraphs 9, 10, 12, 13, 14, and 15; page 10, paragraph 47 continuing from page 9, quoted paragraphs 50, 51, and 52; and page 12, paragraph 11.
2. Revise "allegqation" to "allegation" on page 4, paragraph 20.
3. Revise "[redacted]" to "[redacted]" on page 7, paragraph 33.
4. Revise "advantage" to "Advantage" on page 9, paragraph 46.
5. Revise "plan" to "plans" on page 10, quoted paragraph 56.
6. Revise "Knox- Keene Act" to "Knox-Keene Act" on page 11, paragraph 2.
7. Revise "section 1342, subdivision (b)" to "section 1342 subdivision (c)" on page 12, paragraph 9.

This Decision shall become effective November 15, 2010.

IT IS SO ORDERED November 15, 2010.

By Lucinda A. Ehnes
Lucinda A. Ehnes
Director
Department of Managed Health Care

BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the Suspension Order Against: STUART IRA CHESLER, Respondent.	Dept. Enforcement Matter No. 09-494 OAH No. 2010040159

PROPOSED DECISION

This matter came on regularly for hearing before David B. Rosenman, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, on September 1, 2010, at Los Angeles, California. Complainant Amy L. Dobberteen, Assistant Deputy Director of the Department of Managed Health Care (DMHC), was represented at the hearing by Erin Weber, Staff Counsel. Respondent Stuart Chesler was present and represented himself.

Before the hearing, Complainant filed a joinder in a motion by Steve Poizner, Insurance Commissioner, to consolidate Respondent's appeal of the DMHC Suspension Order with an Accusation filed by Commissioner Poizner seeking the imposition of discipline against Respondent's insurance licenses (Department of Insurance file no. DISP-2010-00136; OAH no. 2010061273). By order in the Telephonic Trial Setting Conference Order dated August 13, 2009, the matters were consolidated for hearing. At the hearing, Commissioner Poizner and the Department of Insurance were represented by Denise L. Yuponce, Senior Staff Counsel. Separate Proposed Decisions will be prepared. By agreement of the parties, the exhibits will be forwarded to DMHC with the Proposed Decision.

Evidence was received, the record was closed, and the matter was submitted for decision on September 1, 2010.

FACTUAL FINDINGS

The Administrative Law Judge makes the following factual findings:

1. Amy L. Dobberteen filed the Suspension Order in her official capacity as Assistant Deputy Director of DMHC and as designee of the Director of DMHC.

2. Respondent is an insurance agent licensed by the Department of Insurance as a Life-Only Agent and an Accident and Health Agent, License Number 0B82766. There was

no evidence of any prior discipline against the license. Respondent filed a request for a hearing to appeal the Suspension Order.

3. In the Suspension Order (Exhibit 1, paragraph 9), Complainant makes allegations about Medicare Advantage plans, but submitted little, and possibly no, direct evidence to support those allegations. What little evidence submitted was intermingled with Respondent's testimony about the plans he was offering. Although the ALJ has reviewed notes of the testimony and the approximately 250 pages of documents in the exhibits, most of the allegations in this paragraph are not substantiated by the evidence.

4. During 2008 and 2009, Respondent solicited consumers to enroll in Medicare Advantage plans offered by [redacted] including two plans known as [redacted]) and [redacted]

5. [redacted] is an [redacted]-year-old female who is eligible for both Medicare and Medi-Cal. Her husband, [redacted], is a [redacted]-year-old male who is also eligible for both Medicare and Medi-Cal. During relevant times referenced herein, Mr. and Mrs. [redacted] were cared for by their [redacted], who resides with them.

6. Prior to their contact with Respondent, Mr. and Mrs. [redacted] received health care benefits through a [redacted] Medicare Advantage plan. [redacted]'s primary care physician for a number of years was Dr. [redacted] had been under the care of his primary care physician, Dr. [redacted], for at least two years. [redacted] was also receiving medical treatment for [redacted] from Dr. [redacted]. In addition, Mr. and Mrs. [redacted] were receiving care from a [redacted]

7. Complainant alleges that, prior to June 18, 2008, Respondent made an unsolicited telephone call to Mrs. [redacted]; falsely represented to [redacted] that he was from Medi-Cal; told her that since she was eligible for Medi-Cal she needed to sign up for a [redacted] Medicare Advantage plan and, that in reliance upon Respondent's representation, [redacted] agreed to allow Respondent to come to her home to discuss enrolling in a [redacted] Medicare Advantage plan.

8. Respondent credibly testified that he did not make phone calls to set up initial appointments. He was familiar with [redacted]'s procedure, which was to make calls in response to postcards sent from people indicating they wanted more information on [redacted] products. These phone operators would set up appointments for salesmen such as Respondent to visit these consumers in their homes.

9. Therefore, the allegations attributing statements to Respondent in the initial phone call contacting were not established by the evidence.

10. On or about June 18, 2008, Respondent came to the home of Mr. and Mrs. Their was not present for this meeting. During Respondent's presentation, Mr. and Mrs. told Respondent they wished to continue receiving care from their current doctors because these doctors were close to the home and they had been treating the for a long time. Respondent expressly told Mr. and Mrs. that all of their doctors were covered under the plan. In reliance upon Respondent's representations, Mr. and Mrs. enrolled in

11. Respondent credibly testified that, in order for him to fill in the portion of the applications (Exhibits 7 and 8) regarding medical group and primary care physician name and identification numbers, he called a number for salesmen to use for this purpose and learned that Dr. and his medical group were listed as providers. He used the identification numbers given to him on the phone to complete this portion of the applications.

12. Both applications list Dr. as the primary care physician. Each application was signed by the applicant below an acknowledgement that the enrollee had read and understood the information included. There was no evidence to explain why signed an application that listed Dr. and not Dr. as his primary care physician.

13. Despite Respondent's representations to the contrary, Mr. and Mrs. doctors were not in the network of contracted providers, nor were said doctors covered under the plan. Mr. and Mrs were unaware that their doctors were not covered by the plan for approximately three months following their enrollments in . In the meantime, they continued to see their doctors and incurred non-covered medical expenses that totaled over $4,500.

14. Approximately three months after enrolling in had an appointment with Dr. . At that office visit, Dr. staff informed Mrs. that Dr. was not contracted with and she would be solely responsible for the cost of services rendered by Dr.

15. Upon realizing that their doctors were not included in the plan, Mr. and Mrs. sought to cancel their enrollments ir . During the one month that it took to cancel their enrollments in and re-enroll in a plan that would permit them to continue treatment by their long-standing physicians, Mr. And Mrs. , suffered stress. Although it was not alleged that they also suffered financial harm in the form of non-covered medical expenses as a result of Respondent's misrepresentations, the evidence established

that, with the help of [redacted] and various advisors, the problems and bills were resolved.

[redacted]

16. [redacted] is an [redacted] year-old male who is eligible for Medicare. He is a frail elderly gentleman who is hard of hearing and can only hear if a person speaks clearly and slowly.

17. Prior to his contact with Respondent, Mr. [redacted] received health care benefits through a [redacted] Medicare Advantage plan. One of the [redacted] benefits that Mr. [redacted] received was home care, wherein an individual came to his home one day every week for four hours and performed certain household chores, such as making his bed, changing his bed linens, doing laundry, cleaning up the kitchen, and vacuuming. For this service, Mr. [redacted] paid $15 per week. Since he requires assistance with his activities of daily living, this home care benefit was extremely important to Mr. [redacted]

18. On or about August 28, 2008, Respondent made a visit to Mr. [redacted] home to market the [redacted] benefit plan. The allegation that the visit was unsolicited was countered by Respondent's testimony of the process to set the appointment (see Finding 8), and by Mr. [redacted] testimony that he received a phone call and set up an appointment. In an effort to induce Mr. [redacted] to enroll, Respondent assured Mr. [redacted] that, under [redacted] he would not have any co-payments for physician or hospital services and he would receive his heart medications for free.

19. Complainant alleges (Suspension Order, paragraphs 23 and 24) Respondent represented that the home health benefit was being eliminated by [redacted] and that this representation was false. Mr. [redacted] and his [redacted] testified Respondent said that [redacted] was going to stop the benefit. In an interview on January 26, 2010, with Julie Lowrie, an investigator for DMHC, summarized in Exhibit 4, Mr. [redacted] made no mention of any representation by Respondent on this subject. On this record, there was sufficient evidence to establish that Respondent made the representation that [redacted] would stop the benefit. However, Mr. [redacted] later learned that [redacted] would stop the benefit for new enrollees but not for existing customers. On this record, it was not established that Respondent made a false representation

20. Complainant alleges (Suspension Order, paragraph 25) Respondent represented that there was no time allowed to think about enrolling and the decision had to be made that day. There was no mention of these statements in any testimony, in the interview with Ms. Lowrie, or in the complaint made to [redacted] (Exhibit 16). This allegqation was not proven.

21. Based upon Respondent's representations and insistence that [redacted] was a superior plan, Mr. [redacted] felt pressured to enroll in [redacted] and he completed and signed the application.

22. After Respondent had left his home, Mr. [redacted] had second thoughts about his enrollment in [redacted] and the resultant loss of his home care services. Mr. [redacted] telephoned Respondent to inform him that he did not want to enroll in [redacted] and instructed Respondent to not submit his enrollment form to [redacted] Respondent assured Mr. [redacted] that he would cancel his enrollment. Respondent also told Mr. [redacted] that he would stop by to pick up a file he had left behind at the home.

23. The remaining allegations against Respondent concerning Mr. [redacted] application were that Respondent used high pressure tactics to convince Mr. [redacted] to sign the application, that Mr. [redacted] called Respondent the same day of the appointment and asked that the application be cancelled, but it was not, and that Respondent told Mr. [redacted] that his application had not been submitted.

24. The evidence in support of these allegations was not sufficient. First, Mr. [redacted] testified that he signed the application a few hours after first meeting Respondent, who "sort of pressured me" into signing. Mr. [redacted] said he didn't have time to stop and think about it. There was no other specific evidence of the nature of that pressure, other than Respondent's comment that the home care service was going to end. However, Mr. [redacted] testified that it would only end for new enrollees to [redacted] and would continue for existing enrollees like him. It was not clear if Mr. [redacted] learned that information from Respondent or from his later phone call to [redacted] or both. Respondent told Mr. [redacted] that under [redacted] there were fewer co-pays for physician services and certain medication prescriptions were free. There was no evidence to contradict these statements. While the evidence established that Respondent was a salesman using tools and techniques to sell his product, it was not established that those tools and techniques were unfair or deceptive as to Mr. [redacted]

25. As to the phone call to cancel the [redacted] application, Mr. [redacted] testified that the call was made the same day he signed the application. However, his [redacted] who was there during the appointment, was not sure if the call was the same day or the next day. In the interview on January 26, 2010, with Ms. Lowrie, summarized in Exhibit 4, Mr. [redacted] stated that he first called Respondent the day after he signed the application. Respondent testified credibly that he received the call from Mr. [redacted] the day after meeting him at his home. It is unknown whether Mr. [redacted] recollection of these events from August 2008 was fresher when he gave the phone interview in January 2010 or when he testified in September 2010.

26. Respondent testified credibly that it was his practice, and a requirement of [redacted] for enrollment applications to be sent to [redacted] the same day they were signed. Respondent also believed he was required to do this by law.

27. Mr. [redacted] did not testify to any comments made by Respondent to the effect that the application had been cancelled. Rather, he said Respondent told him it would be OK. In the interview with Ms. Lowrie, Mr. [redacted] said he was told that Respondent "would cancel" the application. The complaint to [redacted] (Exhibit 16) states that Respondent told Mr. [redacted] he would withdraw the application and he would handle everything.

28. Respondent returned to Mr. [redacted] home on August 29, 2008, to retrieve the file he had left. During this visit, Respondent again attempted to convince Mr. [redacted] to enroll in [redacted] Mr. [redacted] told Respondent that he did not want to enroll in [redacted] and that he wanted his application cancelled. It was not established, as alleged, that Respondent told Mr [redacted] that he had not yet submitted the enrollment form to [redacted]

29. Respondent had submitted the application and Mr [redacted] was enrolled in [redacted] When Mr. [redacted] discovered this, he immediately began attempts to cancel the transaction and to reinstate his enrollment in [redacted] After approximately one month, Mr. [redacted] was successful in canceling his [redacted] enrollment and was reinstated with [redacted] During this one month period, Mr. [redacted] suffered stress and worried that he would not be able to reinstate his [redacted] membership, thereby losing his valuable home care services. However, he was able to maintain this service.

30. [redacted] is an [redacted] year-old female who is eligible for Medicare. She is [redacted] and suffers from [redacted] all of which impact her daily activities.

31. Prior to her contact with Respondent, Ms. [redacted] had received health care benefits through a [redacted] Medicare Advantage plan. She was very satisfied with the [redacted] plan, in part because it provided vouchers for [redacted] transportation trips to doctor appointments per year, and she had approximately [redacted] doctor appointments per month.

32. Sometime prior to June 10, 2009, Ms. [redacted] received a telephone call from a female caller who sought to interest her in a [redacted] plan. Because the caller stated that there were no co-pays to see doctors and some medication prescriptions with no co-pays, Ms. [redacted] agreed to meet with Respondent because she wanted to hear more, even though she had no intention at that time of switching health plans.

33. On or about June 10, 2009, Respondent came to Ms. [redacted] home and promoted the [redacted] plan. Respondent told Ms. [redacted] that [redacted] would be the best medical program she would ever get. Respondent said that she would not have to pay for her doctor visits or her [redacted] medications. To confirm that her medications were covered, Ms. [redacted] told Respondent that she took the following: [redacted], and a [redacted]. She then asked him whether [redacted] covered those [redacted] medications. Respondent repeated that Ms. [redacted] would not have to pay for her [redacted] medications. Ms. [redacted] believed that [redacted] would cover the [redacted] medications she listed with no co-pays.

34. Ms. [redacted] told Respondent that she was happy with her coverage under [redacted] particularly the transportation benefit. Respondent told her that [redacted] was going to discontinue transportation benefits. Complainant alleges that Respondent's representation that [redacted] was going to discontinue Ms. [redacted] transportation benefit was false and a scare tactic to persuade her to enroll in [redacted].

35. Respondent denied that he told Ms. [redacted] that her transportation benefit would end. Ms. [redacted] told Investigator Lowrie in a phone conversation on January 27, 2010, summarized in Exhibit 5, that she learned from [redacted] that there was a question of whether [redacted] could afford to continue the transportation benefit for the following year. Therefore, it was not established that Respondent made any false statement to Ms. [redacted] about termination of benefits under [redacted] when they met in June 2009. Ms. [redacted] learned from [redacted] in 2010 that, if she re-enrolled, they would again provide her with the transportation benefits.

36. Although Complainant alleges that Ms. [redacted] signed the enrollment application only because she was intimidated by Respondent and was relying on his statements that certain [redacted] benefits would be discontinued, Ms. [redacted] testified credibly that she also relied upon the advice of a friend who had a [redacted] plan and was satisfied with it.

37. After enrolling in [redacted] discovered that all of her [redacted] medications were not free under the plan. For instance, Ms. [redacted] has co-payment obligations for [redacted] Further, her co-payment obligations for these medications are higher under [redacted] than they were under [redacted] although this conclusion is complicated by the fact that Ms. [redacted] changed pharmacies and it is possible that some of the cost differential she testified to is due to this change. As a result of Respondent's misrepresentations, Ms. [redacted] suffered stress.

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38. [redacted] is [redacted]-year-old female [redacted] who is eligible for Medicare.

39. Prior to her contact with Respondent, Ms. [redacted] was an enrollee of a [redacted] Medicare Advantage plan, which paid for all of Ms. [redacted] prescription medications, minus a small co-payment, up to a limit of $4,600 per year. This benefit was extremely important to Ms. [redacted] as one of her medications cost her $973 for a three month supply, and in 2007, the total amount of her prescriptions cost approximately $4,000.

40. On or about January 28, 2009, Ms. [redacted] received a telephone call from an individual who sought to interest her in a [redacted] Medicare Advantage plan. The caller informed her that [redacted] had a new program that would pay for all of her medications. Based upon the caller's representations, Ms [redacted] agreed to an appointment with Respondent.

41. On or about January 29, 2009, Respondent arrived at Ms. [redacted] home. Respondent told Ms. [redacted] that [redacted] was much better than the [redacted] plan. Respondent told her that under [redacted], she would not have any co-payments for certain medications. In reliance upon Respondent's representations, Ms. [redacted] agreed to enroll in [redacted]

42. After Respondent left her home, Ms. [redacted] reviewed the plan documents and realized that the [redacted] plan had a $2,600 annual prescription drug limit. After realizing that she would likely incur increased costs under the [redacted] plan, Ms. [redacted] immediately called Respondent and told him that she wanted to cancel the enrollment application. Respondent agreed to cancel the enrollment application.

43. Ms. [redacted] was consistent in her testimony and her telephone interview with Investigator Lowrie on February 10, 2010, summarized in Exhibit 6, that the phone call to cancel the enrollment was the same day as her meeting with Respondent. Respondent denied that the call was the same day, stating that he had faxed the enrollment application to [redacted] the day it was signed and that Ms [redacted] called him a few days later. In her telephone interview, Ms. [redacted] stated that, after she later received a packet of new enrollee information from [redacted], she called Respondent, who stated that his office made a mistake. This is construed as an admission by Respondent that the application should not have been sent to

44. Approximately one week after signing the enrollment form, Ms. [redacted] received documents from [redacted]. Upon receiving these documents, Ms. [redacted] realized that Respondent had submitted her enrollment form to [redacted] without her consent.

called Respondent to discuss the issue. Respondent told her that his office had accidentally submitted her enrollment form to [redacted], but that he had canceled her application. On this record, there was sufficient evidence to find that Ms. [redacted] called Respondent to cancel the application on the same day she had signed it. Respondent told Ms. [redacted] to simply throw the [redacted] materials in the garbage because her enrollment had been cancelled.

45. After speaking with Respondent, Ms. [redacted] telephoned [redacted] who informed her that her enrollment had not been cancelled. As a result of Respondent's misrepresentations, Ms. [redacted] suffered stress.

46. Respondent is 67 years old and, when he went on Medicare at age 65, decided to sell Medicare advantage policies as well as the policies for life insurance, annuities and long term care that he was already selling. In those two years, he sold approximately 400 Medicare advantage policies, and he is aware of complaints from only these five customers. He presented himself at the hearing as sincere in his beliefs of the advantages of the Medicare advantage policies he sold. In his recollection, the calls from these customers to cancel their enrollments did not occur on the same dates as the applications were signed, and he helped the customers by obtaining cancellation letters from them to forward to the insurers.

47. The Suspension Order includes the following findings by the Director of DMHC:

"45. Mr. Chesler enrolled Mr. [redacted] and Ms. [redacted] in [redacted] without their consent and such action constitutes misleading solicitation as well as fraud or dishonest dealing or unfair competition. (Health and Saf. Code § 1360 and 1388(b)(3).) By enrolling Mr. [redacted] and Ms. [redacted] without their consent, Mr. Chesler exposed Mr. [redacted] to a substantial risk in violation of Health and Safety Code section 1388(b)(1).

"46. Mr. Chesler misrepresented to Mr. [redacted] and Ms. [redacted] that Mr. Chesler would not enroll either individual in [redacted] As a result, Mr. [redacted] and Ms. [redacted] were misled and deceived by Mr. Chesler within the meaning of Health and Safety Code sections 1360 and 1388.

"47. Mr. Chesler misrepresented to Mr. [redacted] and Ms. [redacted] that Mr. Chesler would cancel their enrollment applications for [redacted] As a result, Mr. [redacted] and Ms. [redacted] were misled and deceived by Mr. Chesler within the meaning of Health and Safety Code sections 1360 and 1388.

"48. Mr. Chesler misrepresented to Mr. [redacted] that [redacted] was going to eliminate its home health care benefit. As a result, Mr. [redacted] was misled and deceived by Mr. Chesler within the meaning of Health and Safety Code sections 1360 and 1388.

"49. Mr. Chesler pressured Mr. [redacted] into enrolling in [redacted]. Such conduct constitutes dishonest dealing with the meaning of Health and Safety Code section 1388(b)(3).

"50. Mr. Chesler misrepresented to Mr. and Mrs. [redacted] that he was from Medi-Cal. As a result, Mr. and Mrs. [redacted] were misled and deceived by Mr. Chesler within the meaning of Health and Safety Code section 1360.

"51. Mr. Chesler misrepresented to Mr. and Mrs. [redacted] that their physicians were [redacted] network providers. As a result, Mr. and Mrs. [redacted] were misled and deceived by Mr. Chesler within the meaning of Health and Safety Code section 1360.

"52. Mr. Chesler misrepresented to Mr. and Mrs. [redacted] that because they were eligible for Medi-Cal they were required to enroll in a [redacted] Medicare Advantage plan.

"53. Mr. Chesler misrepresented to Ms. [redacted] that she would receive all of her heart medications for free under [redacted]. As a result, Ms. [redacted] was misled and deceived by Mr. Chesler within the meaning of Health and Safety Code section 1360.

"54. Mr. Chesler misrepresented to Ms. [redacted] that [redacted] was going to eliminate her transportation benefit. As a result, Ms. [redacted] was misled and deceived by Mr. Chesler within the meaning of Health and Safety Code section 1360.

"55. Mr. Chesler pressured Ms. [redacted] into enrolling in [redacted]. Such conduct constitutes dishonest dealing with the meaning of Health and Safety Code section 1388(b)(3).

"56. Mr. Chesler has engaged in a sustained pattern and practice of soliciting individuals for Medicare Advantage plans through deception, lies, and misleading promises in violation of Health and Safety Code sections 1360 and 1388. He has also engaged in a continuous pattern and practice of utilizing high-pressure tactics to convince individuals to enroll in Medicare Advantage plan in violation of Health and Safety Code section 1388(b)(3)."

48. As noted in the individual Factual Findings above, some of the Director's findings in the Suspension Order were supported by the evidence, and some were not. More specifically:

a. Director's findings 45 and 46 were established as to Ms. [redacted] but not as to Mr. [redacted]

b. Director's findings 47, 51, 53 and 56 were established by the evidence.

c. Director's findings 48, 49, 50, 52, 54 and 55 were not established by the evidence.

CONCLUSIONS OF LAW AND DISCUSSION

Based on the foregoing factual findings, the Administrative Law Judge makes the following conclusions of law:

1. No statute or case specifies the standard of proof to be applied in a proceeding of this type. Complainant asserts that the standard should be preponderance of the evidence. The usual standard of proof in civil proceedings is preponderance of the evidence. (Evidence Code, section 115.) In this matter, there is no license at stake. Therefore, under the analysis of *San Benito Foods v. Veneman* (1996) 50 Cal.App.4th 1889, it is determined that the standard of proof in this matter is preponderance of the evidence.

"Preponderance of the evidence means evidence that has more convincing force than that opposed to it.' (citations omitted) . . . . The sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is on the *quality* of the evidence. The *quantity* of evidence presented by each side is irrelevant." (*Glage v. Hawes Firearms Company* (1990) 226 Cal.App.3d 314, 324-325.) (Emphasis in original.) In meeting the burden of proof by a preponderance of the evidence, the Department "must produce substantial evidence, contradicted or uncontradicted, which supports the finding." (*In re Shelley J.* (1998) 68 Cal.App.4th 322 at p. 329.)

2. Complainant seeks to suspend for one year Respondent's ability to act as a solicitor or a solicitor firm offering Medicare Advantage plans to individuals eligible for Medicare. This action is taken under the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox- Keene Act), Health and Safety Code section 1340 et seq.[1]

3. The Director's powers include prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices, which are inimical to the general purpose of enabling a rational choice of health plans for the consumer public. (Health & Saf. Code, § 1342, subd. (c).)

4. The Knox-Keene Act prohibits deceptive solicitations by solicitors. No solicitor, solicitor firm, or representative shall use, or permit the use of, any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. (Health & Saf. Code, § 1360.)

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[1] All statutory references are to the Health and Safety Code unless indicated.

5. The Director may, after appropriate notice and opportunity for hearing, by order, censure, suspend, or penalize a solicitor if the Director determines that the person has committed any of the acts or omissions constituting grounds for disciplinary action. (Health & Saf. Code, § 1388.)

6. Grounds for disciplinary action against a solicitor exist when a solicitor operates in a manner that may constitute a substantial risk to a plan or subscribers and enrollees. (Health & Saf. Code, § 1388, subd. (b)(1).)

7. Grounds for disciplinary action against a solicitor exist when a solicitor has violated or attempted to violate any provision of the Knox-Keene Act or any rule or regulation adopted by the Director pursuant to her authority under the Knox-Keene Act. (Health & Saf. Code, § 1388, subd. (b)(2).)

8. Grounds for disciplinary action against a solicitor exist when a solicitor has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by section 17200 of the Business and Professions Code. (Health & Saf. Code, § 1388, subd. (b)(3).)

9. Cause exists to suspend for one year Respondent's ability to act as a solicitor or a solicitor firm offering Medicare Advantage plans to individuals eligible for Medicare pursuant to section 1342, subdivision (b), section 1360, section 1388 and section 1388, subdivisions (b)(1), (b)(2) and (b)(3). This conclusion is based on Factual Findings 2-48 and Legal Conclusions 1-8. Respondent's violations are based upon the Director's findings as supported by the evidence, more specifically set forth in Factual Findings 47 and 48.

10. Complainant has not proven some of her allegations against Respondent, and what has been proven paints a less dramatic picture than set forth in the Suspension Order. Respondent is a skilled and zealous salesman. He convinced some consumers to enroll in the plans he was selling. Except for the specific violations found above, it was not established that his tactics were unfair, overbearing or illegal.

11. It is troubling that there was no evidence as to why Respondent prepared, and Mr. signed, an application that did not list his regular physician. However, this act was not charged in the Suspension Order and, therefore, it would be a denial of due process to Respondent to base any disciplinary action upon it.

12. Respondent has not engaged in some of the improper conduct that was alleged, but clearly violated the applicable laws as noted above. In the companion matter, the Proposed Decision, if adopted by the Insurance Commissioner, includes an Order that all of Respondent's insurance licenses and licensing rights are revoked; however, the revocation is

stayed, and Respondent shall be issued a restricted license for two (2) years on terms and conditions. In this matter, Complainant requests that Respondent's ability to offer or sell Medicare Advantage plans be suspended for one year.

In consideration of all of the circumstances, the public safety and welfare will be adequately protected by enforcing the Suspension Order. Therefore, it is appropriate to grant Complainant's request.

ORDER

The appeal of Respondent Stuart Ira Chesler from the Suspension Order is denied.

DATED: October 18, 2010.

DAVID B. ROSENMAN
Administrative Law Judge
Office of Administrative Hearings