SUPERIOR COURT OF CALIFORNIA, COUNTY OF FRESNO

CENTRAL DIVISION

AGRICULTURAL CONTRACTING SERVICES ASS'N., INC. et al, Petitioner, vs. ADMINISTRATIVE HEARING BUREAU OF THE CALIFORNIA DEPARTMENT OF INSURANCE, Respondent.	Case No. 18CECG00446 ORDER DENYING WRIT OF MANDATE ON CEASE AND DESIST ORDER, REMANDING ON PENALTY ORDER, AND STATEMENT OI DECISION

Having heard oral argument on this matter on January 31, 2020 and having considered the papers of the parties and the administrative record lodged with the Court, the Court denies the petition for writ of mandate and other relief as to the Cease and Desist Order, and remands the Penalty order for consideration of the ability of respondents to pay, for the reasons below.

I.

Introduction

This writ proceeding challenges the result of an administrative hearing upholding a Cease and Desist Order issued by respondent California Department of Insurance. The Order found petitioners violated three sections of the Insurance Code by virtue of their marketing and sale of workers compensation

coverage to California employers. Petitioners assert that the Department of Insurance had no jurisdiction because California insurance law on the issues involved are preempted by the Employee Retirement and Income Security Act of 1974 (ERISA).

Petitioners also challenge the fairness and regularity of the proceedings below. The Court finds that petitioners have failed to carry their burden of proof, and therefore denies the petition for writ of mandate.

II.

Discussion

A. Cease and Desist Order

1. Standard of Review

When the trial court reviews an administrative decision pursuant to a petition for writ of mandate, it determines "whether the respondent has proceeded without, or in excess of, jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion." (Code Civ. Proc., § 1094.5, subd. (b).)

2. Respondent Had Jurisdiction Over Petitioners

a. Petitioners Bore the Burden of Proof on Their ERISA Defense

Section 514 of ERISA provides for federal preemption of state laws that relate to employee health benefit plans. Section 514 contains three interrelated concepts, which are referred to as (1) the "preemption" clause, (2) the "insurance savings" clause, and (3) the "deemer" clause. Taken together, these three clauses delineate those activities that through preemption require uniform federal treatment under ERISA or that remain within the regulatory

purview of the states. "The burden is on defendants to prove facts necessary to establish the defense of ERISA preemption." (*Marshall v. Bankers Life* (1992) 2 Cal.4th 1045, 1052.) This comports with the "rule of convenience."

"The rule of convenience 'emerged from a long line of decisions which operate to impose on a defendant the burden of proving an exonerating fact if its existence is 'peculiarly' within his personal knowledge and proof of its *non*existence, by the prosecution, would be relatively difficult or inconvenient … When there are facts peculiarly and clearly within the knowledge of the defendant, and the defendant can show the evidence without the least inconvenience, then the defendant is required to offer this proof." (*In re Shawnn F.* (1995) 34 Cal.App.4th 184, 197.)

This doctrine is also referred to as the "rule of convenience and necessity." (See *People v. Fish* (2018) 29 Cal.App.5th 462, 469-470, citing *People v. Salas* (2006) 37 Cal.4th 967 "The defendant who asserts that a security is actually exempt raises an affirmative defense and has the burden of presenting evidence to raise a reasonable doubt; it is reasonable that a defendant asserting a good faith belief that a security is exempt should bear the same burden."].)

The rule of convenience and necessity exists in federal common law as well. "Where the facts with regard to an issue lie peculiarly within the knowledge of a party, that a party is best situated to bear the burden of proof." (*Smith v. U.S.* (2013) 568 U.S. 106, 112.). Finally, the federal regulation by which an entity can seek a finding from the US Secretary of Labor as to whether it qualifies for an exemption from the definition of a

multiple employer welfare association, and may assert ERISA preemption, also imposes the burden of proof on the entity seeking to avoid state regulation. (29 C.F.R. part 2570.157.)

b. ERISA Does Not Apply to Workers Compensation Coverage

The Cease and Desist Order concerns petitioner's solicitation, marketing, and sale of purported workers compensation coverage. It asserts that petitioners issued "Certificates of Insurance" to California employers which falsely stated workers compensation coverage was provided for them through licensed insurance companies such as Travelers Casualty & Surety Company or National Union Fire Insurance Company. (AR 9-10, paragraph 13.)

29 U.S.C section 1003(b)(3) states, in relevant part: "[t]he provision of this subchapter shall not apply to any employee benefit plan if … (3) such plan is maintained solely for the purpose complying with applicable workman's compensation laws …" Because petitioners' plan included benefits in addition to worker's compensation insurance, petitioners claim this exception does not apply. This is not the law. As the United States Supreme Court held in *Shaw v. Delta Airlines, Inc.* (1983) 463 U.S. 85, multi-benefit plans are not exempt from state regulation of worker's compensation, unemployment compensation, and disability insurance.

> "Congress surely did not intend, at the same time it preserved the role of state disability laws, to make enforcement of those laws impossible. A State may require an employer to maintain a disability plan complying with state law as a separate administrative unit. Such a plan would be exempt under § 4(b)(3). The fact that state law permits employers to meet their state-law obligations by including disability insurance benefits in a multi-benefit ERISA plan, see N.Y.Work.Comp.Law App. §

> 355.6 (McKinney Supp.1982-1983), does not make the state law wholly unenforceable as to employers who choose that option.
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> "In other words, while the State may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan. If the State is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply."

(*Id.* at p. 108.)

In *Employee Staffing Services, Inc. v. Aubry* (9th Cir. 1994) 20 F.3d 103 (cited by the DOI), the Court confirmed that ERISA did not preempt California's state workers compensation laws even where workers compensation benefits were provided as part of an employee welfare benefit plan. "The premise of the complaint in this case is that ERISA opened a loophole so that employers could avoid buying workers' compensation insurance. It does not. The obligations of California workers' compensation insurance cannot be avoided by substituting an ERISA plan's coverage for work-related injuries." (*Id.* at p. 1039.)

> "Syntactically, the preemption of 'laws' and exemption of 'plans' might be construed to place the power to exempt in the employer's hands, when it adopts a plan, instead of the state legislature's hands, when it promulgates laws. But a construction which attributes a rational purpose to Congress makes this locus of power unlikely, because it would accidentally allow employers to avoid the century-old system of workers' compensation. *Shaw* removes any ambiguity which might be found in the ERISA statute on this issue. We see no reason to distinguish workers' compensation plans from disability plans, since both are controlled by identical language in the same subsection of the ERISA statute, and the same reasons apply to both."

(*Id.* at p. 1041.)

California Labor Code section 3700 permits workers compensation coverage to be offered in one of two forms: an insurance policy, or a self-funded plan approved by the State as meeting state requirements. Thus, "the California workers' compensation statutes require employers to maintain 'separately administered" workers' compensation insurance or self-insurance programs 'distinct from all other types of insurance,' so the plans required by the state must necessarily fall within the ERISA exemption for plans 'maintained solely for the purpose of complying with applicable workers' compensation laws." (*Employee Staffing Services, supra*, 20 F.3d at 1041[1]; see also *Fuller v. Norton* (10th Cir. 1996) 86 F.3d 1016 [state workers compensation laws pertaining to self-insured plans were not preempted by ERISA]; *Contract Services Employee Trust v. Davis* (10th Cir. 1995) 55 F.3d 533 [accord]; *Combined Management, Inc. v. Super. Of Ins. Bureau of Maine* (1st Cir. 1993) 22 F.3d 1 (*cert. denied*).)

As California requires an employer obtain workers compensation coverage only from an admitted insurer or a state-approved self-insured plan, ERISA cannot apply to workers compensation coverage held by a California employer. Thus, arguments regarding the savings clause and deemer clause for plans to which ERISA ***does*** apply (found at 29 U.S.C. § 1144, subd. (b)) are irrelevant. Similarly, issues relating to multiple employer welfare arrangements and collective bargaining agreements are relevant only to plans governed by ERISA.

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[1] That distinguishes California's law from the statute at issue in *District of Columbia v. Greater Wash. Bd. Of Trade* (1992) 506 U.S. 125, which required that the health insurance benefits under the employee welfare benefits be extended to cover workers out due to job injuries.

Petitioners' federal preemption defense fails as to the workers compensation coverage listed in the cease and desist order; the Department of Insurance had jurisdiction over petitioners' workers compensation insurance activities.

c. Petitioners' Provision of Other Coverage and Preemption

The Cease and Desist Order bars petitioners from acting as insurance agents, producers, etc. without a license or certification of authority. (AR 12). This bar is not limited to workers compensation coverage, and petitioners assert that because they offer additional employee benefits, including health coverage, which are subject to ERISA, respondent's Order is nonetheless preempted. An ERISA plan can exist where benefits provided by a group of employers, known as a multiple employer welfare arrangement or MEWA. (29 U.S.C. § 1002, subd. (40)(A).)

ERISA, however, permits state insurance regulations of MEWAs. Nonetheless, ERISA defines a MEWA to exclude plans that are established or maintained "under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements." (29 U.S.C. § 1002, subd. (40)(A).) Requirements for "bona fide collective bargaining agreement" are found in 29 C.F.R. part 2510.3-40. 29 C.F.R part 2570, subpart H, sets forth a procedure whereby an entity claiming exemption (ECE) can seek the required finding from the Secretary. (29 C.F.R. 2570.150, et seq.) While petitioners were not required to seek such a ruling, their failure to do so means that they are not a valid ECE.

(*Virginia Beach Policemen's Benev. Ass'n. v. Reich* (E.D.Va.1995) 881 F.Supp. 1058, 1070 (*affirmed* at 965 F. 3d 1440.)[2]

Further, entities may not claim "ECE" status where the welfare plan at issue is self-funded in whole or in part and marketed by "an individual who … has failed to obtain a license as an insurance producer to the extent that the individual engages in an activity for which such license is required ..." (29 C.F.R. 2510.3-40(c)(1)(ii).) "Self-funded" means self-insured," in that no insurance company issues a policy. "'Marketing' does includes the marketing of union membership that carries with it plan participation by virtue of such membership …" (29 C.F.R. 2510.3-40(c)(iv)(A).)

Because the workers compensation coverage at issue was self-funded and sold by petitioners without a license, this iteration of petitioners' federal preemption defense also fails.

Finally, petitioners also raise preemption under the "deemer clause" of ERISA, (29 U.S.C. § 1144, subd. (b)(2)(B)), which provides that self-funded employee welfare plans cannot be "deemed" to be "insurance companies." The deemer clause is irrelevant to whether or not an entity providing coverage is considered a MEWA under ERISA, as the definition of a MEWA is governed by 29 U.S.C. section 1002, subdivision (40) and 29 C.F.R. part 2510.3.

3. Fair Trial Claims

The issue of whether petitioners received a fair trial in their administrative hearing, is determined by this Court based on

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[2] The Department of Labor has cited this decision in opinions issued on MEWA status. See ERISA Op. Letter No. 2011-01A (February 1, 2011) at footnote 5. There was a discussion of this case and the history of the collective bargaining exception in recent National Association of Insurance

its own independent review of the administrative record and additional evidence permitted by Code of Civil Procedure section 1094.5, subsection (e). (*Pomona Valley Hospital Medical Center v. Superior Court* (1997) 55 Cal.App.4th 93, 101.)

Petitioners assert the trial was not fair because the burden of proof was improperly shifted to them to prove the California statutes underlying the Cease and Desist Order were preempted by ERISA. As noted above, such preemption is a defense, and under both state and federal law the burden of proof rests squarely on petitioners.

Petitioners also argue that the ALJ's request for additional evidence regarding their ERSIA defense was improper and done to repair the deficits of in the Commissioner's case. However, it was always petitioners' burden to prove that defense; the ALJ's call for additional evidence addressed the deficiencies in petitioners' presentation and provided petitioners with an additional chance to support their defense, particularly with regard to whether their business qualified as a MEWA or was the result of a bona fide collective bargaining relationship.

Petitioners further object to the consideration of a February, 2017 letter addressed to petitioner Asay from the Department of Labor, which indicated that the Office of Labor Management Standards had determined that petitioner did not qualify as a labor organization, on several grounds. (AR 73).

The technical rules of evidence do not apply to administrative hearings. (*Big Boy Liquors, Ltd. V. Alcoholic Beverage Control Appeals Board* (1969) 71 Cal.2d 1226, 1230; Gov.

Commissioners ("NAIC"). See 2019 NAIC Proc. 1st Quarter (April 6, 2019) at page *3-82. NAIC noted an ongoing problem with fraudulent claims of ECE status to avoid state regulation.

Code § 11513, subd. (c).) However, where a timely objection made, evidence which would be objectionable in a civil trial cannot be sufficient in and of itself to support an administrative finding. (Gov. Code § 11513, subd (d).) The letter was appended to the government's closing brief, and petitioners promptly objected. (AR 75 - 80.)

The ALJ found the letter to be highly relevant, though not dispositive on the issue of the exemption from MEWA status, because the letter contradicted testimony by Mr. Asay. The administrative record shows a careful consideration of the authenticity of the letter. Government Code section 11515 permits consideration of technical matter within an agency's special field, as well as of facts which can be judicially noticed - "either before or after submission of the case" - so long as the parties are given the opportunity to address the information to be considered.

Judicial notice of the letter was permissible, pursuant to Evidence Code section 452, subdivision (c), as the letter evidenced an "official act" of a legislative, executive, or judicial department of the United States. (*Wolski v. Fremont Investment & Loan* (2005) 127 Cal.App.4th 347, 355-356; *Booth v. Robinson* (1983) 147 Cal.App.3d 371, 374.) It was one piece of evidence among many considered on the question of whether the plan at issue was established or maintained pursuant to a "bona fide collective bargaining relationship," including prior communications to and from the author, Larry King. (AR 35, 73, 85, 117-177.)

Petitioners claim bias in the ALJ's comments that petitioners' asserted inability to provide evidence as to precise location and employers of petitioners' own members, did not accord with the fact it issued certificates of workers compensation coverage to the employers of those workers. Experience ratings necessary to determine the cost of workers compensation coverage are dependent on the accurate report of payroll, jobs classifications, and claims incurred. (*Allied Interstate, Inc. v. Sessions Payroll Management, Inc.* (2012) 203 Cal.App.4th 808.) In fact, an employer's failure to accurately report this information to an entity furnishing worker's compensation coverage itself constitutes a failure to obtain workers compensation coverage under California law. (*Wright v. Issak* (2007) 149 Cal.App.4th 1116.)

Communications from petitioners to various employers charge a separate fee for the rating process, discuss the "rating period," the state "rating bureau," claim petitioners filed their "rating plan," and assert that petitioners followed rules issued by the Workers Compensation Insurance Rating Bureau. (AR 275 [rating fee of $5,000], 795-797, 801-805, 809-810, 860, and 1051.) Testimony indicated that petitioners submitted payroll amounts to the WCIRB on occasion, obtained payroll information from employers, based their fees on data including, payroll, number of employees, and classifications of the employees. Thus, petitioners had the necessary information to submit to the WCIRB. (AR 1001:10-1002:14, 1020:8-22.) The observation that providing workers compensation coverage necessarily required knowledge of employee classifications and worksites is warranted, and no bias is shown.

Petitioners' other claims of impropriety relate to the weight, or lack thereof of evidence to support certain findings. Accordingly, they are addressed in the discussion of whether an abuse of discretion occurred.

4. Abuse of Discretion

a. No Vested or Fundament Right

When an administrative order or decision does not involve or substantially affect a fundamental vested right of the person challenging that decision or order, the substantial evidence test is applied by the trial court in a section 1094.5 review. (*Antelope Valley Press v. Poizner* (2008) 162 Cal.App.4th 839, 850.) Petitioners claim that the Cease and Desist Order effects fundamental vested rights and is subject to independent review by this Court.

Determination whether a right is fundamental and vested is made on a case-by-case basis. (*Antelope Valley Press, supra*, 162 Cal.App.4th at p. 850.)

A vested right can be found to be fundamental, and thus require a trial court's independent judgment review, on the basis of one or both of the following factors: "(1) the character and quality of its economic aspect; (2) the character and quality of its human aspect." (*Interstate Brands v. Unemployment Ins. Appeals Bd.* (1980) 26 Cal.3d 770, 780.) As a general rule, when a case involves or affects purely economic interests, courts are far less likely to find a right to be of the fundamental vested character. [Citations.]" (*JKH Enterprises, Inc. v. Department of Industrial Relations* (2006) 142 Cal.App.4th 1046, 1060.) Thus, " '[a]dministrative decisions which result in restricting a property

owner's return on his property, increasing the cost of doing business, or reducing profits are considered impacts on economic interests, rather than on fundamental vested rights.' " (*Id.* at p. 1061.)

In particular, "the continued operation of a business in a manner that violates the applicable regulatory scheme governing all employers is not a fundamental vested right or one that was legitimately acquired." (Ibid.) In *Coldwell Banker & Co. v. Department of Insurance* (1980) 102 Cal.App.3d 381, 407, the appellate court found that the right of Coldwell Banker, a real estate broker, to form Guardian Title and have the latter apply for a permit to issue stock and a license to engage in the underwritten title company business, was neither "fundamental" nor "vested." Transacting insurance in California without a license is not a fundamental vested right and does not trigger this court's independent review.

Petitioners also argue the rights of employers to workers compensation coverage will be affected. There is no right on the part of an employer to fail to provide statutorily-qualified workers compensation insurance; failure to have such coverage is a crime. (Labor Code § 3700.5.) If an employee is injured while working for an employer without such coverage, penalties of up to $100,000 can be imposed. (Labor Code § 3722, subds. (d) & (f).) Again, a labor contractor who lacks the required insurance cannot recover for work done because his contracting license is automatically suspended if he or she lacks valid workers compensation insurance. The elevated standard of review for vested rights does not apply in this case.

b. Basis of Cease and Desist Order

The insurance commissioner may "[i]ssue a cease and desist order to a person who has acted in a capacity for which a license, registration, or certificate of authority from the commissioner was required but not possessed." (Ins. Code, § 12921.8.) The Amended Cease & Desist Order alleged petitioners violated three sections of the insurance Code: 700, 742.23, and 1631. Insurance Code section 700, subdivision (a) provides, in relevant part:

> "A person shall not transact any class of insurance business in this state without first being admitted for that class. …. admission is secured by procuring a certificate of authority from the commissioner. The certificate shall not be granted until the applicant conforms to the requirements of this code and of the laws of this state prerequisite to its issue."

Insurance Code section 742.23, subdivision (a), provides, in relevant part:

> "After December 31, 1995, a self-funded or partially self-funded multiple employer welfare arrangement shall not provide any benefits for any resident of this state without first obtaining a certificate of compliance pursuant to this article …"

Insurance Code section 1631 provides, in relevant part:

> "Unless exempt by the provisions of this article, a person shall not solicit, negotiate, or effect contracts of insurance, or act in any of the capacities defined in Article 1 (commencing with Section 1621) unless the person holds a valid license from the commissioner authorizing the person to act in that capacity."

c. Violations of Insurance Code §§ 700 & 1631 Established

"Insurance" is defined as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." (Ins. Code, § 22.) "Transact" as applied to insurance includes any of the following: solicitation; negotiations preliminary to execution; execution of

a contract of insurance; and transaction of matters subsequent to execution of the contract and arising out of it. (Ins. Code, § 35.)

Self-insurance is a type of insurance for workers compensation benefits. (*Denny's Inc. v. WCAB* (2003) 104 Cal.App.4th 1433.) A group of self-insured employers must each sign a contract agreeing to indemnify the other members for their claims if they cannot pay due to insolvency. (8 C.C.R. § 15479.) This type of indemnity agreement meets the definition of "insurance" under Insurance Code section 22. Petitioners also meet the definition of "insurer," as a "person who undertakes to indemnify another by insurance is the insurer, and the person indemnified is the insured." (Ins. Code, § 23.)

Respondent had only to prove that petitioners "acted in a capacity for which a license, registration, or certificate of authority from the commissioner was required but not possessed." (Ins. Code, § 12921.8.) The administrative record contains substantial evidence that petitioners transacted the business of workers' compensation insurance in California by soliciting and marketing coverage, and issuing Certificates of Liability Insurance ("COLIs") and policy declarations to its employer members purporting to provide workers' compensation coverage in compliance with California law. There is also evidence in the record that petitioners claimed to be providing insurance with Travelers Casualty & Surety Company or National Union Fire Insurance Company. (AR 224-226, 247-248, 275, 787-793, 795-813, 809-810, 821-829, 860, 1001-1002, 1020, 1051.) This evidence is sufficient to establish the violations at issue.

Petitioners do not dispute that they hold no licenses, only that one was required for any of their activities.

d. Violation of Insurance Code § 742.23(a) Established

Insurance Code section 742.23, subdivision (c) requires MEWAs to register with the Department of Insurance before selling insurance to Californians. As noted above, it does not apply to workers compensation insurance, but might apply to other benefits purportedly offered by petitioners. Although petitioners contend they fall within an exception to the definition of a MEWA for plans established and maintained "under or pursuant to one or more agreements which the Secretary [of Labor] finds to be collective bargaining agreements" pursuant to 29 U.S.C. 1002, subdivision (40)(A)(i), they failed to meet their burden to prove that the plan falls within that exception. Petitioners do not dispute that they did not register with the Department, only whether ERISA preempted California law. The evidence proffered did not support their defense on the issue of such preemption.

Accordingly, petitioners have failed to demonstrate an abuse of discretion, in that substantial evidence supports respondent's Cease and Desist Order.

B. The Penalty Order

i. Standard of Review

> "Penalties may not be disturbed unless there is an arbitrary, capricious or patently abusive exercise of discretion by the administrative agency. Neither a trial court nor an appellate court is free to substitute its own discretion as to the matter. There is no abuse of discretion if the weight of the evidence supports the Commissioner's findings. We review de novo whether the agency's imposition of a particular penalty on the petitioner constituted an abuse of discretion by the agency."

(*Mercury Ins. Co. v. Lara* (2019) 35 Cal.App.5th 82, 104, internal citations and quotations omitted.)

ii. Overview of Regulatory Concerns

The current version of the penalty statute, Insurance Code section 12921.8, was enacted in 2005 upon report from the Department that:

> "Companies that transact insurance in negligent, reckless, or intentional disregard of the license requirement usually are equally cavalier about complying with other insurance law requirements in the areas of marketing, sales, underwriting, solvency and claims. Thus, such companies often use unlicensed, dishonest and/or uniformed sales representatives, misleading advertising, and unfairly discriminatory underwriting practices. They frequently have highly restrictive, if not completely illusory, policies. They use unfair claim settlement practices, if they pay claims at all. They have inadequate, if any, reserves to pay claims.
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> "In addition to harming consumers, such companies compete unfairly with licensed companies selling similar coverage that comply with the Code. Unlicensed companies typically steal business from licensed companies by charging less, but they charge less because they offer less coverage and/or pay fewer claims."

(Sen. Bill No. 706 (2005-2006 Reg. Sess.) California Bill Analysis, Senate Floor, July 12, 2005.) These dangers echo those discussed by governmental entities and officials arising out of MEWAS.

The August, 2013 revision of "MEWAs Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation," by the U.S.

Department of Labor, Employee Benefits Security Administration[3] has several comments on "sham" operations used to avoid state regulation with false ERISA preemption claims. See, e.g., page 60, where a commentator talks of "some MEWA operators who, through the use of sham unions and collective bargaining agreements, market fraudulent insurance schemes under the guise of collectively bargained welfare plans exempt from state insurance regulation."

See also page 65: "It is the view of the Department that the uncertainty created by the lack of clear criteria for distinguishing collectively bargained plans from MEWAs has encouraged unscrupulous operators of sham MEWAs in attempts to escape or delay state regulatory efforts by asserting that states lack jurisdiction to regulate such entities because they are excluded from the definition of MEWA by reason of the exception for collectively bargained plans."

"In addition, certain promoters set up arrangements that they claim are not MEWAs subject to state insurance regulation, because they are established pursuant to collective bargaining agreements. Often, however, these collective bargaining agreements are nothing more than shams designed to avoid state insurance regulation." (*Id.* at s 92-93.) "Entities may, however, claim the exemption on their own accord and sometimes do so incorrectly, including as part of an insurance fraud scheme using sham unions and collective bargaining agreements to market health coverage to small employers. The Secretary remains concerned about MEWA

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[3] Found at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

operators who avoid State insurance regulation by making false assertions that the arrangement is pursuant to a collective bargaining agreement." (*Id.* at 108.)

Such problems have existed for decades. See the presentation by Congressman Ney such problems to the House of Representatives, as found in the Congressional Record Volume 141, Number 31, pages E360-E361, "Extensions of Remarks," dated February 16, 1995:

> "An Empire of Scams. William Loeb set up a phony labor union to sell health insurance from Empire Blue Cross/Blue Shield in 1988. When Empire terminated the insurance contract two years later, the union moved the policies to bogus insurers. More than 8,000 consumers lost $43 million in premiums on worthless policies. Total unpaid claims could be as much as $24 million. Insurers for more than 600 agents named as defendants in the case have agreed to pay out more than $8 million to settle unpaid claims. More settlements may come in March. Loeb is serving seven years in jail."[4]

Federal courts have also taken a dim view of those attempting to avoid insurance regulations for a long time. In *Atlantic Health Care Benefits Trust v. Foster* (M.D.Pa.1992) 809 F. Supp. 365. The Court described the federal preemption defense thus: "Plaintiffs are trying to weasel themselves into the ERISA domain by creatively labeling their enterprise."

iii. Constitutionality

a. Specific Standard of Review

"The standard of review of constitutional questions is independent judgment, but with deference to underlying factual findings, which we review for substantial evidence, viewing the record in the light most favorable to the ruling. A statute is

[4] Found at https://www.congress.gov/crec/1995/02/16/CREC-1995-02-16-pt1-PgE360.pdf

presumed to be constitutional and ... it must be upheld unless its unconstitutionality clearly, positively and unmistakably appears." (*People v. Bill Lockyer v. Fremont Life Insurance* (2002) 104 Cal.App.4th 508, 514, internal quotations and citations omitted)("*Fremont*").

That requires consideration of the statutory language and the application of the statute to the facts in the specific case. (*Hale v. Morgan* (1978) 22 Cal.3d 388.)

b. Excessive Penalty

Petitioners also urge that the penalty imposed was an excessive fine under the U.S. Constitution, contending that the connection between the harm done and the penalty are "tenuous at best."[5] The harmful effect of unlawful insurance schemes on consumers, employers, employees, and companies acting within the law are laid out in the discussions above on the part of governmental entities charged with special expertise in this area. For a period of several year, petitioners collected money from business and their workers but left them without the protection promised, in danger of catastrophic loss of business licenses, businesses themselves, the jobs those businesses offered, and possible impoverishment of injured workers.

Warnings by a governmental agency which are not heeded are evidence of willful conduct supporting penalties. (*Apollo Estates, Inc. v. Department of Real Estate* (1985) 174 Cal.App.3d 625, 639.) Continued and repeated violations are another appropriate factor. (*Id.* 641.)

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[5] Petitioner's opening brief on the penalty issue at 11:6-8.

In *Fremont*, the insurer was told that its policy language had been disapproved, yet it continued to sell policies with the problem surrender charge for two years. The trial court imposed a penalty of $2,543,000 on the insurer, finding over 9,000 individual violations, which was upheld on appeal due to opportunity for gain in addition to actual profits shown. (*Fremont, supra,* 104 Cal.App.4th at 528.)

The statute in *Fremont* called for consideration of the payee's net worth. The statute here does not. Petitioners cite *People ex rel. Lockyer v. R.J. Reynolds Tobacco Co.* (2005) 37 Cal.4th 707, 728 as requiring a showing ability to pay.[6] There, the fine was imposed at the same time as the finding of violation.

Fines and even imprisonment for refusing to obey a lawful order are different. Such concern "the power of courts to impose conditional imprisonment for the purpose of compelling a person to obey a valid order. Such coercion, where the defendant carries the keys to freedom in his willingness to comply with the court's directive, is essentially a civil remedy designed for the benefit of other parties and has quite properly been exercised for centuries to secure compliance with judicial decrees." For that reasons, such coercion is not a subject address by the Eighth Amendment. (*Uphaus v. Wyman* (1959) 360 U.S. 72, 81, upholding a

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[6] That case also called for consideration of subjective belief in a good faith compliance with the law. The penalty in that matter was imposed by a court at the same time it found a violation, for that same violation. Here, the existence of a violation was first determined, an order made, and the penalty imposed only after petitioners refused to obey to the order. There is

contempt citation for refusal to obey a subpoena.) Such was cited in support of finding an order to register as a sex offender was not a punishment for purpose of the Eighth Amendment. (*In re Alva* (2004) 33 Cal.4th 254, 282.)

Insurance Code section 12921.8 does not limit its penalty provisions to acts done in violation of a cease and desist order, either in general or in this case. Where a penalty is imposed as a punishment, consideration of ability to pay now or in the future is required. (*People v. Aviles* (2019) 29 Cal.App.5th 1055, 1063.) Petitioners raised this argument below; it is not waived. (Penalty AR 86.) The statute as written and as followed in this case fails to impose such requirement. Evidence of petitioners' ability to pay the particular amount imposed cannot be inferred from the administrative record, and no specific findings on this subject were made. As the statute does not compel imposition of a penalty in the absence of finding an inability to pay, the statute is not unconstitutional. But the imposition of such in this case without a finding of ability to pay was an abuse of discretion.

If the program was legitimate, an ability to pay should not be an issue. Petitioners contend they offer workers compensation benefits through a self-insured group of employers (SIG) which they administered.

In 2012, S.B. 863, changed the language of Labor Code section 3701 to require said deposit to be increased to an amount equal to

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no "good faith" defense to a decision to ignore an order issued by an agency charged with determining violations.

essentially the maximum probable value of all current and future claims costs. A self-insured plan SIG had prove it possessed reserves and assets worth twice the amount all future claims might cost. The SIG also had to have an actuary review the records every year to make sure that it was solvent and ready to pay all future claims. See 8 California Code of Regulations, section 15481. As petitioners cannot lawfully provide insurance benefits in California, the funds and assets appear likely to be sufficient. But evidence is required.

Remand is necessary to permit production and consideration of evidence on the issue of petitioners' ability to pay the amount required by the statute before the penalty may be imposed.

c. Due Process

i. Notice

Petitioners contend that the order to show cause failed to provide them with adequate notice of the penalty that might be imposed. The OSC sets forth the penalty provision in the statute. The OSC further listed a March 30, 2016 certificate of insurance as the earliest date that petitioners acted without the license, registration, or certificate required. The Department sought penalties from that date to "the date of this order to show cause," that being January 31, 2018. The penalty was imposed for the period of March 30, 2016 to the date the order imposing a penalty was issued, the latest date for which petitioners failed to provide evidence they had ceased their activities.

The fact that penalties would continue to accrue until the conduct was ended is disclosed by the statute, and the beginning date from which they were imposed was also disclosed. Petitioners had sufficient notice of the remedies and an opportunity to be heard on when they should cease.

ii. Burden of Proof and Support of Findings Made

Insurance Code section 12921.8(c) places the burden on petitioners to demonstrate if and when they ceased the violations found. "In the absence of contrary evidence, it shall be presumed that a person continuously acted in a capacity for which a license, registration, or certificate of authority was required on each day from the date of the earliest such act until the date those acts were discontinued, as proven by the person at a hearing."

Evidence Code section 520 states: "The party claiming that a person is guilty of crime or wrongdoing has the burden of proof on that issue." The meaning of this rule was discussed in *Gong v. Firemen's Ins. Co. of Newark, N.J.* (1962) 202 Cal.App.2d 686, 691:

> "It has long been settled in California that the presumption of innocence obtains in civil cases where the commission of a crime becomes a collateral issue . . . In the present case, the affirmative defenses charged the plaintiff with criminal acts, and the plaintiff entered upon the trial clothed with the presumption of innocence. That presumption is evidence in favor of plaintiff and may outweigh positive evidence adduced against it."

The presumption is not so broad as petitioners would have it. No collateral criminal issues are presented; this presumption has not been shown applicable.

The order imposing the penalty is replete with specific reference to evidence showing that petitioners and their personnel continued their insurance activities with some shifts in names and a deceitful filing with federal authorities.

For example, a witness interviewed on February 22, 2018 stated his clients had workers compensation coverage with ALA, and were told by ALA that those clients had to sign membership cards for Omega. ALA also told the witness that the Department found no wrongdoing on its part. Payments were still being made to CompOne as well. (Penalty AR 96-97.)

The record showed Omega was incorporated by Marcus Asay on July 24, 2017, after the cease and desist order was issued. The purpose was stated to be to "build a national community labor union." (Penalty AR 101-102.) Marcus Asay was listed as the "contact" and affixed his signature as "Chair of Trustees [sic]" on a certification of insurance issued for a Compass Pilot policy period 3/1/2017 to 3/1/2018 issued by Omega. (Penalty AR 11.)

Omnis Benefit Plan Administrators, LLC (Penalty AR 305) corporate documents showed company and agent addresses which matched ALA's old address of 2491 Alluvial Ave. in Clovis for ALA. (Penalty AR 102, 104, 105; AR 753.)

Omega tried for an MEWA/ECE designation as well with the US Department of Labor, listing an address for an administrator in Sacramento with a (559) area code number. (Penalty AR 107 and 109). Question 16a on that filing asked if any litigation by any state agency had been instituted during the past five years against any "trustee, director, owners, partner, senior manager, or officer" of the sponsoring entity. It was answered "no." (Penalty AR 110.) The document was signed by Antonio Gastelum on April 26, 2018 as the "administrator" under penalty of perjury. (Penalty AR 116.)

Gastelum was listed as the Chief Financial Officer and Chief Operating Officer of ALA (AR 30, 52, 1003, 1007.) ALA's Chief Benefits Officer was Harold Zapata. Humberto Avila was on its Board of Trustees. (AR 748, 750, 755.) Mr. Avila showed up as an officer of Omega in the March 6, 2018 filing. (Penalty AR 103.) Harold Zapata was Omega's CEO in November of 2017, at the ALA address. (Penalty AR 104.)

The ALJ issued an order for additional evidence after the hearing. Petitioners were ordered to produce any and all documents filed with the California Agricultural Labor Board, filings with the Secretary of State for World Workforce International, Omnis Benefit Plan, Omega Community Labor Union, a file stamped copy of any M-1 forms filed with the US Department of Labor for Omega, a list of all of Omega's employees with contact and employer business description, a list of all employers

enrolled in Compass Pilot workers' compensation benefit plan, as well as all documents used to transition employers or members from ALA to Omega, or from CompOne USA to Compass Pilot. (Penalty AR 74- 75.)

Petitioners said they would produce only such documents as were part of the public record. They did not state they did not possess such documents, but instead that they lacked "the right or authorization to provide any non-public documents belonging to Omega Community Labor Union,", "Omnis Benefit Plan," "Compass Pilot," etc. They also claimed the materials were "trade secret" and "otherwise confidential." (Penalty AR 99 - 101). This was true although ALA/Omega officer Gastelum apparently possessed the "right" or "authorization" to provide oral testimony about the contents of such documents and other facts petitioners wanted to disclose to argue ALA and Omega were separate. (Penalty AR 216-225).

Evidence Code section 412 states: "If weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger and more satisfactory evidence, the evidence offered should be viewed with distrust." And Evidence Code section 413 states: "In determining what inferences to draw from the evidence or facts in the case against a party, the trier of fact may consider, among other things, the party's failure to explain or to deny by his testimony such evidence or facts in the

case against him, or his willful suppression of evidence relating thereto, if such be the case."

There is substantial evidence in the record that petitioners continued their course of conduct throughout the period for which the penalty was imposed, using different names and comingling funds. Petitioners were provided with an additional opportunity after the hearing to provided rebuttal evidence, and declined to do so. In light of the evidence in the record for this matter, requiring that petitioners show when and if they ceased engaging such conduct involved no due process violation.

iii. Adequate Notice and Evidence on Alter Ego Issue

Petitioners also take issue which the finding of that the old companies and the post-cease and desist companies were one enterpriser, contending they had insufficient of this issue or time to address it. This argument fails, as the order to show cause itself attached a certificate of insurance involving the new entities as a basis for seeking penalties. As noted above, an officer of ALA and of Omega testified about the alleged separate nature of the two under questioning by petitioners' counsel, while declining to produce ordered documentation to support that testimony.

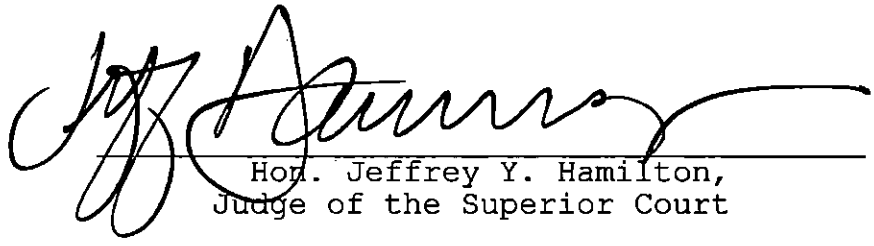
Petitioners were on notice of the issue of alter ego, presented evidence to rebut it, refused other evidence to rebut, and no denial of due process appears.

IV.

Disposition

Accordingly, the petition for writ of mandate as to the finding of violations of the Insurance Code is denied. The petition for writ of mandate as to the penalty is granted, but only as so as to allowed the ALJ to make findings on whether petitioners are able to pay the penalty posed, and the exercise of her discretion to refuse to impose a penalty if such ability is not found.

DATED this 23rd day of April, 2020



Hon. Jeffrey Y. Hamilton,
Judge of the Superior Court

COUNTY OF FRESNO
Fresno, CA