2013 IL App (3d) 120169-U

Order filed May 10, 2013

IN THE

APPELLATE COURT OF ILLINOIS

THIRD DISTRICT

A.D., 2013

KRESS CORPORATION, an Illinois Corporation,	)	Appeal from the Circuit Court
	)	of the 10th Judicial Circuit,
	)	Peoria County, Illinois,
Plaintiff-Appellant,	)	
	)	Appeal No. 3-12-0169
v.	)	Circuit No. 08-L-104
	)	
HCH ADMINISTRATION, INC., an Illinois Corporation,	)	
	)	Honorable
	)	David J. Dubicki,
Defendant-Appellee.	)	Judge, Presiding.

JUSTICE CARTER delivered the judgment of the court.
Presiding Justice Wright and Justice Holdridge concurred in the judgment.

ORDER

¶ 1 *Held:* In an action for breach of contract and negligence, the appellate court found that the defendant, who was the administrator of plaintiff's employee health plan, did not owe a duty to plaintiff in either contract or tort to determine if plaintiff's employees were eligible for coverage in the plan and that any negligence by defendant in handling a claim with plaintiff's stop-loss insurer was not a cause of plaintiff's losses in this case because the employee in question was not entitled to coverage, in any event, for the medical expenses at issue. The appellate court, therefore, affirmed the trial court's grant of summary judgment for defendant.

¶ 2 Plaintiff, Kress Corporation (Kress), brought suit against defendant, HCH

Administration, Inc. (HCH), for breach of contract and negligence to recover money damages for the losses Kress incurred because of the enrollment of an ineligible Kress employee into Kress's health plan and the payment of that employee's medical expenses. HCH filed a motion for summary judgment as to both counts of the complaint, which the trial court granted after a hearing. Kress appeals. We affirm the trial court's judgment.

¶ 3 FACTS

¶ 4 Kress, a heavy equipment and machinery manufacturer in Peoria County, provided its employees with an employee benefits program, which included a health plan. The health plan was administered by HCH, a third-party administrator of benefit plans, who was retained because of its expertise in that area. The health benefits were paid for by Kress through self-insurance for claims up to $50,000 and through stop-loss insurance from Mutual of Omaha (Mutual) for claims over that amount. Under Kress's rules, employees could only enroll in the health plan during specified time periods and generally did so by turning in an enrollment form to Kress's human resources person, who would forward the form to HCH.

¶ 5 In February 2005, Kress hired Terry Rossell as a new employee. Rossell did not initially enroll in the health plan because he had existing coverage through his prior employer. When that coverage ended, Rossell sought to enroll in the health plan but did not turn in his enrollment form until August 1, 2005, about a week after the applicable enrollment period had ended. Kress's human resources person forwarded the form to HCH. HCH enrolled Rossell in the plan and backdated the effective date to the date in June 2005 when Rossell's prior coverage had ended.

¶ 6 In September 2005, Rossell was diagnosed with cancer and stopped physically working at

Kress. In an effort to keep Rossell's health benefits active, Kress allowed Rossell to take various types of days off and leave, some of which exceeded what was permissible under Kress's employee rules, and mistakenly placed Rossell on leave pursuant to the Family and Medical Leave Act of 1993 (29 U.S.C. § 2601 *et seq*. (2006)), for which he did not qualify. Kress did not inform HCH of any of the changes in Rossell's status of employment with Kress. The cost of Rossell's medical treatment exceeded Kress's self-insured amount, and HCH sought reimbursement for Kress from Mutual under the stop-loss insurance. After initially reimbursing some of the cost, Mutual refused to make any further reimbursement to Kress and demanded that Kress return the initial payment because, according to Mutual, Rossell was not eligible to participate in Kress's health plan. HCH tried to facilitate reimbursement from Mutual and, in the process, made conflicting and at times, arguably false, statements to Mutual about whether Rossell had continuation health insurance coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. § 1161 *et seq*. (2006)) and the effective date of any such coverage. Mutual cited those inconsistencies as an additional reason for denying the request for reimbursement. Rossell was never able to return to work at Kress and passed away in September 2006.

¶ 7 In August 2008, Kress brought suit against HCH for breach of contract and negligence regarding HCH's handling of Rossell's claim. Kress alleged that HCH, as the administrator of Kress's health plan, owed a duty to Kress in contract and in tort to determine whether Rossell was eligible for coverage and to reject coverage if Rossell was ineligible. Kress alleged further that HCH had failed to perform that duty in breach of contract or had performed that duty negligently and that HCH had also handled the claim with Mutual in a negligent manner. Kress sought

damages for the losses it incurred relating to Rossell's claim.

¶ 8 HCH filed a motion for summary judgment, alleging that it had no duty, either in contract or in tort, to determine eligibility for coverage under Kress's health plan and that it was not liable for Kress's non-reimbursed costs. Kress filed a response to the motion for summary judgment and a hearing was later held. At the time of the hearing, the trial court had before it numerous documents, which had been filed by the parties in support of their respective positions.

¶ 9 Two of the documents before the trial court were the written agreement between Kress and HCH and the summary plan description for the Kress health plan. The agreement, which was drafted by HCH and was to be carried out consistently with the purpose of the health plan, provided that the only obligations that HCH owed to Kress were those that were specifically listed in the agreement itself. Determining eligibility for coverage was not listed as one of those obligations and the only reference to "eligibility" in the obligations was a requirement that HCH maintain the eligibility records of the plan. The agreement provided further that: (1) upon request, Kress would provide HCH with guidance as to the meaning and intent of the plan provisions, including eligibility determinations; (2) Kress retained ultimate responsibility for the operation of the plan; (3) HCH would perform its duties under the agreement subject to the direction of Kress; and (4) HCH would attempt to provide Kress with information on its options when legal issues arose as to the operation of the plan. The agreement also contained an indemnity clause, which stated that HCH would indemnify Kress but only for those losses that were caused by HCH's willful malfeasance, bad faith, or reckless disregard of HCH's obligations and duties under the terms of the agreement.

¶ 10 In addition to the written documents, the trial court had before it the deposition testimony

of several witnesses. Of relevance to this appeal, conflicting deposition testimony was presented regarding the course of dealings between the parties. Although her testimony was inconsistent at times, Kress's human resource person suggested that HCH made the eligibility determinations and provided Kress with the effective date of coverage and that HCH did so in the present case. HCH's eligibility coordinator provided testimony to the contrary. The rest of the deposition testimony primarily corroborated the facts as set forth above.

¶ 11 After considering the submissions of the parties, the trial court granted HCH's motion for summary judgment as to both counts of the complaint, finding that HCH had no duty in contract or in tort to make eligibility determinations, that Kress had directed HCH to enroll Rossell in the health plan, and that any negligence by HCH was not the cause of the loss to Kress. Kress appealed.

¶ 12 ANALYSIS

¶ 13 On appeal, Kress argues that the trial court erred in granting HCH's motion for summary judgment on Kress's complaint for breach of contract and negligence. Kress asserts that the existence of genuine issues of material fact as to such questions as which party was responsible under the agreement for determining eligibility for coverage in the health plan, which party made the eligibility determination as to Rossell, and whether HCH had acted negligently in either making the eligibility determination or in the manner in which it handled the claim with Mutual, precluded a grant of summary judgment for HCH as to either count of the complaint. HCH, on the other hand, argues that the trial court's ruling was proper and should be affirmed.

¶ 14 The purpose of summary judgment is not to try a question of fact, but to determine if one exists. *Adams v. Northern Illinois Gas Co.*, 211 Ill. 2d 32, 42-43 (2004). Summary judgment

should be granted only where the pleadings, depositions, admissions, and affidavits on file, when viewed in the light most favorable to the nonmoving party, show that there is no genuine issue as to any material fact and that the moving party is clearly entitled to a judgment as a matter of law. 735 ILCS 5/2-1005(c) (West 2010); *Adams*, 211 Ill. 2d at 43. Summary judgment should not be granted if the material facts are in dispute or if the material facts are not in dispute but reasonable persons might draw different inferences from the undisputed facts. *Adams*, 211 Ill. 2d at 43. Although summary judgment is to be encouraged as an expeditious manner of disposing of a lawsuit, it is a drastic measure and should be allowed only where the right of the moving party is clear and free from doubt. *Adams*, 211 Ill. 2d at 43. In appeals from summary judgment rulings, the standard of review is *de novo*. *Adams*, 211 Ill. 2d at 43. A trial court's grant of summary judgment may be affirmed on any basis supported by the record. *Illinois State Bar Ass'n Mutual Insurance Co. v. Coregis Insurance Co.*, 355 Ill. App. 3d 156, 163 (2004).

¶ 15 The interpretation of a contract is a question of law and is also subject to *de novo* review on appeal. *Gallagher v. Lenart*, 226 Ill. 2d 208, 219 (2007). The primary goal of contract interpretation is to give effect to the intent of the parties. *Virginia Surety Co. v. Northern Insurance Co. of New York*, 224 Ill. 2d 550, 556 (2007). In determining the intent of the parties, a court must consider the contract document as a whole and not focus on isolated portions of the document. *Gallagher*, 226 Ill. 2d at 233. If the language of a contract is clear and unambiguous, the intent of the parties must be determined solely from the language of the contract document itself, which should be given its plain and ordinary meaning, and the contract should be enforced as written. *Virginia Surety Co.*, 224 Ill. 2d at 556; *J.M. Beals Enterprises, Inc. v. Industrial Hard Chrome, Ltd.*, 194 Ill. App. 3d 744, 748 (1990); *Reaver v. Rubloff-Sterling, L.P.*, 303 Ill. App. 3d

578, 581 (1999). However, if the contract language is ambiguous, the meaning of the contract language must be ascertained through a consideration of extrinsic evidence. *Gallagher*, 226 Ill. 2d at 233.

¶ 16 In the present case, after having reviewed the record, we find that HCH had no duty in either contract or in tort to determine if Rossell was eligible for enrollment under the terms of the Kress health plan. From a contract standpoint, there was simply nothing in the parties' agreement that required HCH to make eligibility determinations for coverage under the health plan. The agreement clearly and unambiguously listed the obligations that HCH owed to Kress, and "determining eligibility" was not one of those obligations. Indeed, the only reference to "eligibility" in the obligations was a straightforward requirement that HCH maintain eligibility records. Despite Kress's efforts on appeal, that requirement cannot in any way be construed as imposing an obligation on HCH to determine whether Kress employees were eligible for coverage, when considered with the additional language in the agreement, which limited HCH's responsibilities under the agreement to only those specifically listed. In addition, although Kress suggests that conflicting testimony about the course of dealing between the parties creates a material issue of fact as to the eligibility question, the clear and unambiguous language of the agreement would prevail over the evidence of course of dealing in a situation such as this, even if we assume that a course of dealing had been established. See Restatement (Second) of Contracts §§ 203, 223 (1981). Finally, as to the negligence claim, it must be rejected, as well, because the duty upon which it was based was not one of HCH's obligations under the contract (see *Eichengreen v. Rollins, Inc.*, 325 Ill. App. 3d 517, 525-27 (2001) (where a negligence claim is based upon the negligent performance of a contractual duty, the claim will fail if it is determined

that the duty alleged was not one of the contractual duties of the offending party) and because even if Kress was negligent in the manner in which it handled the claim with Mutual, that negligence was not in any way the cause of Kress's losses since Rossell was not properly enrolled in the health plan and was not entitled to coverage for the medical expenses at issue. We conclude, therefore, that the trial court properly granted HCH's motion for summary judgment on Kress's complaint for breach of contract and negligence. Having concluded as such, we need not determine whether summary judgment for HCH would also have been properly granted based upon the indemnity clause in the agreement.

¶ 17 CONCLUSION

¶ 18 For the foregoing reasons, we affirm the judgment of the circuit court of Peoria County.

¶ 19 Affirmed.