2017 IL App (3d) 150774-U

Order filed March 8, 2017

IN THE

APPELLATE COURT OF ILLINOIS

THIRD DISTRICT

2017

DANIEL J. BRADLEY, as an employee of a municipal entity and also on Behalf of Its employees, and on Behalf of all other similarly situated Municipal Employees in the State of Illinois Who are Insured By HEALTHCARE SERVICE CORPORATION d/b/a BLUE CROSS AND BLUE SHIELD OF ILLINOIS,	)	Appeal from the Circuit Court of the 12th Judicial Circuit, Will County, Illinois,
Plaintiff-Appellant,	)	Appeal No. 3-15-0774 Circuit No. 13-CH-1080
v.	)	
HEALTH CARE SERVICES CORPORATION d/b/a BLUE CROSS AND BLUE SHIELD OF ILLINOIS,	)	Honorable John Anderson,
Defendant-Appellee.	)	Judge, Presiding.

JUSTICE WRIGHT delivered the judgment of the court.
Presiding Justice Holdridge and Justice McDade concurred in the judgment.

ORDER

¶ 1 *Held*: The trial court properly dismissed plaintiff's fourth amended complaint with prejudice.

¶ 2 On June 9, 2015, plaintiff filed a fourth amended complaint alleging, *inter alia*, that HCSC committed breach of contract, common law fraud, and consumer fraud, resulting in damages to plaintiff. Defendant filed a motion to dismiss plaintiff's fourth amended complaint on July 7, 2015. On October 15, 2015, the trial court, citing several pleading deficiencies, dismissed counts I, III, and IV of plaintiff's fourth amended complaint with prejudice and struck counts II, V, VI, VII, and VIII. Plaintiff appeals this ruling.

¶ 3 FACTS

¶ 4 On March 14, 2013, a municipal employee filed a class action lawsuit on behalf of himself and all other municipal employees similarly situated in the State of Illinois who were entitled to health care coverage through self insurance offered by various municipalities and administered by defendant Health Care Services Corporation (HCSC) pursuant to a contract with the municipality and HCSC. After the subsequent filing of several amended complaints, the trial court granted defendant's combined section 2-615 and section 2-619 motion to dismiss counts II, V, VI, VII, and VIII with prejudice, and counts I, III, and IV of plaintiff's third amended complaint without prejudice on May 12, 2015. On June 9, 2015, plaintiff filed a fourth amended complaint that re-pled counts I, III, and IV.

¶ 5 According to the fourth amended complaint, Daniel J. Bradley (plaintiff) is an employee of the Village of Bolingbrook[1] (the Village). The Village is self insured and provides health care benefits to the Village's employees and their dependents. The fourth amended complaint alleges HCSC does business as Blue Cross/Blue Shield of Illinois and asserts HCSC is an Illinois mutual insurance company, licensed to act as a third-party administrator to service health care benefit plans for employers and consumers in the State of Illinois.

[1]The record indicates that Daniel J. Bradley did not become a named plaintiff until the first amended complaint.

¶ 6 According to the fourth amended complaint, the Village hired HCSC to act as the third-party administrator of the Village's self-insured health care plan (the Plan) offered to the Village's employees. The third-party administrator's contract (the Contract) requires the Village to pay a specified fee directly to HCSC for acting as the claims administrator who reviews, approves, and then pays health care providers for the charges the providers bill for their services to employees covered under the Plan. The payment for these provider services is made by HCSC out of the Village's funds. The fourth amended complaint asserts plaintiff is a third-party beneficiary to the Contract between the Village and HCSC.

¶ 7 The fourth amended complaint alleges the Contract required HCSC to prepare a booklet describing the claims procedure and scope of the Village's self-insurance plan. Accordingly, HCSC drafted and distributed a "Benefit Booklet" (the Booklet) describing the scope of coverage provided to the Village's employees under the Village's self-insurance plan. The Booklet contains information advising the insured employees that HCSC will process claims as the "Claim Administrator." The Booklet was attached as an exhibit to the fourth amended complaint.

¶ 8 The Booklet defines coinsurance as "a percentage of an eligible expense that you are required to pay towards a Covered Service[.]" The Booklet includes language explaining that HCSC "shall" compute the deductible and coinsurance amounts payable by employees for services rendered by hospitals and other facilities by making calculations "based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP")."

¶ 9 The Booklet defines ADP as:

"a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums[.] *** The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs[.]"

¶ 10 The Booklet contains a step-by-step description of how the ADP process works by providing a narrative example within the text.

¶ 11 The Booklet addresses the independent and separate financial arrangements between HCSC[2] and other health care service providers, as follows:

"The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or

[2]The Booklet refers to HCSC as "The Claim Administrator."

- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them."

Further, the Booklet includes the following language:

> "Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP."

The Booklet also provided:

> "NOTICE
>
> Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers[.]
>
> Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements[.]
>
> Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers[.] Please refer to the

provision entitled "Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements[.]"

¶ 12 Plaintiff's fourth amended complaint alleges "HCSC is therefore bound to the terms and provisions contained in the Benefit Booklet and may not bind or limit or attempt to bind or limit Plaintiff or others similarly situated to any contradictory or limiting terms contained in its contract with the Village." Plaintiff alleges the written representations that HCSC drafted and incorporated into the Booklet create a binding promise by HCSC to the insured employee for HCSC to compute deductibles and copayments documented in the EOB consistent with the formula contained in the Booklet.

¶ 13 Count I of the fourth amended complaint alleges HCSC breached its contractual obligation with plaintiff by improperly instructing its insureds to pay miscalculated amounts for deductibles and coinsurance payments as required by the Village's self-insurance health care plan. Count I alleged breach of the Contract because HCSC applied the ADP to an inflated, non-discounted, bill from plan providers rather than applying the ADP to that amount claimants were contractually obligated to accept as full payment for services from plans administered by HCSC. Specifically, count I alleges a breach occurred because the Booklet required "payment of coinsurance to be based on the actual payment made by Defendant to the health care Provider[,]" while the EOB advised insureds that coinsurance is "based on a fictitious or exaggerated charge created by Defendant rather than the actual charge ultimately paid by Defendant to the Provider[.]" Count I describes plaintiff's damages, *inter alia*, as the artificially inflated amount that employees paid out of pocket for their share of deductible and copayments under the Plan.

¶ 14 Count III of the fourth amended complaint alleges common law fraud exists because HCSC intended to deceive the Village and thus plaintiff by failing to disclose the estimated average amount of public funds HCSC would be permitted to retain following payments to providers. Therefore, plaintiff claimed HCSC fraudulently induced the Village and plaintiff into contracting with HCSC to act as third-party administrator of the Plan.

¶ 15 Count IV of the fourth amended complaint alleges HCSC violated the Illinois Consumer Fraud and Deceptive Business Practices Act by intentionally failing to disclose the amount of profit defendant derived from separate contractual relationships with providers submitting claims to the Village seeking payment for eligible services rendered by the providers to insured Village employees.[3]

¶ 16 HCSC filed a motion to dismiss and/or strike certain allegations in plaintiff's fourth amended complaint pursuant to section 2-615 of the Illinois Code of Civil Procedure (735 ILCS 5/2-615 (West 2012)) on July 7, 2015. HCSC argued: count I of plaintiff's complaint failed because it did not allege a breach of any contract term; and counts III and IV failed because they did not allege common law fraud and consumer fraud with the required specificity and particularity.

¶ 17 The trial court granted HCSC's section 2-615 motion to dismiss the fourth amended complaint with prejudice on October 15, 2015, citing multiple pleading deficiencies. The court's order explained that "the facts and circumstances of the case, the prior pleading history, and the Court's conclusion that further efforts at repleading would not substantially cure the defects set forth herein."

[3]Counts II, V, VI, VII, and VIII of plaintiff's third amended complaint were dismissed with prejudice on section 2-615 and section 2-619 grounds on May 12, 2015. These counts were re-pleaded in plaintiff's fourth amended complaint for the purpose of preserving the counts for appeal. However, plaintiff fails to raise any argument pursuant to these counts on appeal.

¶ 18 Plaintiff filed a timely notice of appeal on November 6, 2015.

¶ 19 ANALYSIS

¶ 20 On appeal, plaintiff argues that the trial court improperly dismissed counts I, III, and IV of the fourth amended complaint because the trial court placed an impossible burden of pleading on plaintiff, applied the wrong standard of review to the language of the Plan, and because HCSC's disclosures were unclear. For purposes of this appeal, HCSC asserts plaintiff's claims of breach of contract, common law fraud, and statutory consumer fraud were properly dismissed with prejudice.

¶ 21 Appellate courts review a trial court's grant of a motion to dismiss pursuant to section 2-615 of the Code of Civil Procedure (the Code) using a *de novo* standard of review. 735 ILCS 5/2-615 (West 2012); *Compton v. Country Mutual Insurance Co.*, 382 Ill. App.3d 323 (2008). Section 2-615 of the Code attacks the legal sufficiency of a complaint by raising defects apparent on the face of the complaint. *Chandler v. Illinois Central R.R. Co*., 207 Ill. 2d 331, 348 (2003). When determining the legal sufficiency of a complaint, all well-pleaded facts are taken as being true, and all reasonable inferences from those complaints are viewed in the light most favorable to the plaintiff. *Lykowski v. Bergman*, 299 Ill. App. 3d 157, 162 (1998).

¶ 22 In order to survive a motion to dismiss, plaintiff's complaint must state a cause of action that is both legally and factually sufficient. *Id*. at 163. Illinois is a fact-pleading state, meaning a plaintiff is required to allege facts sufficient to bring the claim within the scope of the cause of action asserted. *Beahringer v. Page*, 204 Ill. 2d 363, 369 (2003). As such, plaintiffs *cannot rely only on conclusions of law or facts not supported by specific factual allegations*. (Emphasis added.) *Anderson v. Vanden Dorpel*, 172 Ill. 2d 399, 408 (1996). Exhibits attached to the complaint are considered part of the pleadings for purposes of considering a section 2-615

motion to dismiss. *Falls v. Silver Cross Hospital and Medical Centers*, 2016 IL App (3d) 150319, ¶ 26 (citing *Gagnon v. Schickel*, 2012 IL App (1st) 120645, ¶ 18). Complaints should be dismissed when it becomes "clearly apparent that no set of facts can be proven which will entitle the plaintiff to recovery." *Chandler*, 207 Ill. 2d at 349.

¶ 23 I. Count I

¶ 24 Count I of the fourth amended complaint is based on a theory involving the breach of the Contract between the Village and HCSC for the benefit of the insureds. To properly state a claim for breach of contract, a plaintiff must allege: (1) the existence of a valid and enforceable contract, (2) performance by plaintiff, (3) breach by defendant, and (4) a result of damages or injury to the plaintiff. *Razor Capital v. Antaal*, 2012 IL App (2d) 110904 ¶ 30.

¶ 25 For purposes of this analysis, we simplify the allegations of count I for the reader. Count I of the fourth amended complaint alleges HCSC violated the Contract terms by applying the incorrect formula when calculating plaintiff's out of pocket charges for deductibles and coinsurance payments. Count I alleges HCSC calculated plaintiff's deductibles and coinsurance payments based on an artificially inflated amount, consisting of the provider's original charge for covered services. Plaintiff asserts HCSC was contractually obligated to calculate plaintiff's deductibles and coinsurance payments based on the greatly discounted rate for covered charges or the actual cost for covered services that HCSC paid the provider for the same services from the Village's funds.

¶ 26 We cannot ignore the fact that plaintiff has not attached a copy of the Contract between HCSC and the Village to the fourth amended complaint. In order to overcome the secrecy surrounding the precise terms of the Contract, plaintiff relies on information HCSC incorporated in the Booklet HCSC prepared for the Village as evidence of HCSC's contractual duties as plan

administrator for the Village. We conclude plaintiff's complaint is properly premised on a reasonable assumption that the Booklet prepared by HCSC accurately reflects the binding provisions of the Contract concerning the formula HCSC was required to use when calculating coinsurance and deductible amounts the insureds must pay under the Plan.

¶ 27 However, the Booklet, attached as exhibit A to the fourth amended complaint, informs the insured that HCSC "shall" calculate the insured's coinsurance and deductible amounts "based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims." The EOB[4] attached to plaintiff's complaint as exhibit B shows that HCSC calculated the coinsurance amount based on the provider's bill for covered services, reduced by the ADP. The example calculation set forth in the Booklet also mirrors the calculation reflected in the EOB.

¶ 28 Contrary to the allegations of the fourth amended complaint, the Booklet plaintiff relies on as the basis for his breach of contract does *not* require HCSC to calculate coinsurance and deductibles based on the actual amount HCSC paid the providers for covered services. Our careful review of count I of the fourth amended complaint reveals that the allegations set forth by plaintiff are explicitly contradicted by the language in the Booklet itself.

¶ 29 As stated earlier, the case law provides that complaints should be dismissed when it becomes "clearly apparent that no set of facts can be proven which will entitle the plaintiff to recovery." *Chandler*, 207 Ill. 2d at 349. Such is true in the case at bar. We conclude count I failed to include adequate allegations establishing HCSC breached the Contract with the Village. Consequently, the trial court properly dismissed Count I with prejudice.

[4]The EOB plaintiff attached to his complaint fails to identify the recipient.

¶ 30 II. Count III

¶ 31 Plaintiff contends count III of the fourth amended complaint properly alleged HCSC committed common law fraud. Count III alleged HCSC fraudulently induced the Village into entering into an agreement with HCSC to administer the Plan. HCSC argues count III failed to allege common law fraud with the requisite specificity and particularity and was properly dismissed with prejudice by the trial court.

¶ 32 The case law provides that in order to properly state a claim based on fraud, the complaint must allege the fraudulent acts with particularity and specificity. *Connick v. Suzuki Motor Co., Ltd.*, 174 Ill. 2d 482, 496 (1996). To properly allege common law fraud a plaintiff must allege: "(1) a false statement or omission of material fact; (2) knowledge or belief of the falsity by the party making it; (3) intention to induce the other party to act; (4) action by the other party in reliance on the truth of the statements; and (5) damage to the other party resulting from such reliance." *Weidner v. Karlin*, 402 Ill. App. 3d 1084, 1087 (2010). If plaintiff bases his claim on an alleged omission, "it is necessary to show the existence of a special or fiduciary relationship, which would raise a duty to speak." *Id*. In order to make a successful common law fraud complaint, plaintiff must allege "facts from which fraud is the necessary or probable inference, including what misrepresentations were made, when they were made, who made the misrepresentations and to whom they were made." *Connick*, 174 Ill. 2d at 496-97.

¶ 33 Count III alleges that while negotiating the Contract, HCSC failed to disclose information about their profit margin as measured by the difference between the following two amounts: (1) the provider's claim for non-discounted charges for covered services provided to the insured; and (2) the amount the provider contractually agreed to accept from HCSC as payment in full for the fully discounted charges for covered services provided to the insured. Count III alleges HCSC

"did not disclose to the Village or its agents that the terms of the contract to act as the Third Party Administrator and to pay claims on behalf of the Village using the Village's own funds contained any provision allowing HCSC to obtain an additional payment to itself or take any benefit for itself out of these payments." In other words, Count III alleges that HCSC deliberately withheld information from the Village disclosing that HCSC would receive additional payments and/or would retain portions of the Village's funds with the intent to defraud the Village.

¶ 34 Again, the Booklet prepared by HCSC discloses that HCSC has independent contractual relationships with providers. The Booklet contains a disclosure by HCSC that these separate contracts between HCSC and the providers could, and often would, result in profits for HCSC which, the Booklet expressly declares could be "substantial." Thus, allegations that HCSC omitted information about the profit margin HCSC could reap is not supported by the contents of the Booklet relied upon by plaintiff. The Booklet reveals these "substantial" discounts HCSC negotiated with the providers would not be passed on to the Village. The amount of profit was in essence limitless, as described in the Booklet, and would only be passed on to the Village up to a cap of 15% for the ADP.

¶ 35 Clearly, if we construe the Booklet as an accurate reflection of the contractual relationship between HCSC and the Village, HCSC fully disclosed to the Village that HCSC 's profit margin could be "substantial" due to HSCS's contracts with the providers. Therefore, the trial court did not err by dismissing count III of plaintiff's fourth amended complaint with prejudice.

¶ 36 III. Count IV

¶ 37 Count IV of plaintiff's fourth amended complaint alleges a violation of section 505/1 of the Illinois Consumer Fraud and Deceptive Business Practices Act (the Act). 815 ILCS 505/1 *et seq* (West 2012). Plaintiff argues the trial court applied the wrong standard when reviewing count IV and erroneously dismissed count IV. HCSC argues count IV fails because plaintiff failed to allege the elements of statutory consumer fraud with the requisite specificity and particularity.

¶ 38 The Act prohibits "the concealment, suppression or omission of any material fact, with intent that others rely upon the concealment, suppression or omission of such material fact." 815 ILCS 505/2 (West 2010); *Falls,* 2016 IL App (3d) 150319 at ¶ 30. In order to state a cause of action under the Act, a plaintiff must allege: (1) a deceptive act or practice, (2) defendant's intent that the plaintiff rely on the deception, (3) the occurrence of this deception in the course of trade or commerce, (4) actual damage to the plaintiff, and (5) that such damage was proximately caused by the deception. *Oliveira v. Amoco Oil Co.*, 201 Ill. 2d 134, 149 (2002). Claims under the Act must be plead with the same particularity and specificity required for claims of common law fraud, meaning plaintiff must again allege what misrepresentations were made, when they were made, who made the misrepresentations and to whom they were made. *Connick*, 174 Ill. 2d at 496-97, 501.

¶ 39 We again attempt to simplify the allegations in count IV for purposes of discussion. In essence, plaintiff alleges the insured consumer is defrauded because HCSC deliberately omits information from the Booklet and EOB informing the insured consumer of the difference between the provider's claim charges for covered services versus the discounted amount HCSC actually pays the providers using the Village's funds. According to the fourth amended

complaint, this omitted information about the margin of profit that HCSC retains inflates the cost of premiums, deductibles, and co-payments shouldered by the insured.

¶ 40 Assuming these allegations are true, we agree that HCSC likely reaps significant profits from their contractual arrangements as a middleman while processing both claims and payments to the providers. We also agree that if HCSC calculated co-payments and deductibles based on the amount the providers agree to accept from HCSC as payment in full for services rendered to the insureds, employees would likely pay much smaller sums for co-payments and deductibles.

¶ 41 Yet, count IV fails to include specific factual allegations describing how HCSC intended to defraud the consumer by failing to disclose HCSC's precise margin of profit, measured by the difference the Village paid HCSC and the amount HCSC remitted to the provider. Again, the Booklet advises the insured that HCSC will be profiting from the difference between the provider's claim, reduced by the ADP, and the reduced rate the provider will accept from HCSC, on behalf of the Village, as payment in full. Further, the Booklet informs the consumer that neither the Village nor its employees are entitled to receive the benefits of any discounts and/or other allowances stemming from HCSC's negotiations with the providers in excess of the capped 15% ADP. Therefore, we conclude the trial court did not err by dismissing count IV of plaintiff's fourth amended complaint with prejudice.

¶ 42 We affirm the trial court's ruling dismissing counts I, III, and IV of plaintiff's fourth amended complaint with prejudice.

¶ 43 CONCLUSION

¶ 44 The judgment of the circuit court of Will County is affirmed.

¶ 45 Affirmed.