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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

Appeal from Chester County
Circuit Court

Brian M. Gibbons, Circuit Court Judge

Trial Court Case No. 2020-CP-12-00207
Appellate Case No. 2023-000654

Alexis Jones, ...Respondent-Appellant,

v.

Progressive Northern Insurance Company,...Appellant-Respondent.

INITIAL BRIEF OF RESPONDENT / CROSS-APPELLANT

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STATEMENT OF ISSUES ON APPEAL

1. **Whether the Circuit Court's ruling was legally sound and was supported to a reasonable degree by the evidence.**

ARGUMENT

The Circuit Court correctly applied the law to the case at bar in determining Respondent's breach of contract claim could proceed against the Appellant because the Circuit Court correctly construed the term "incurred" in accordance with *Haselden* and its progeny. *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003).

First, the trial court properly distinguished the case at bar from the facts of *Gordon*. *Gordon v. Fid. & Cas. Co.*, 238 S.C. 438, 120 S.E.2d 509 (1961). In *Gordon*, the insured and the insurance carrier stipulated that "the plaintiff incurred no expense or made no cash outlay since he was a soldier and treated at the Fort Jackson hospital." *Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. As a result, the *Gordon* court held:

> Since the parties to this action stipulated that the respondent incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the appellant was not liable to the respondent for the reasonable cost of his hospitalization, because the appellant had limited its liability to pay only 'all reasonable expenses incurred' by the respondent.

Gordon, 238 S.C. at 446, 120 S.E.2d at 513. The trial court identified this distinction in its ruling, noting the medical providers did charge the Respondent "the full cost of her medical treatment at the time services was (sic) rendered as she became obligated for that amount irrespective of Medicaid." (Form 4 Order, p.2). The court in *Gordon* highlighted numerous cases that illuminate this concept such as when a veteran is provided medical care through the

Veterans' Administration. *Gordon*, 238 S.C. at 445, 120 S.E.2d at 512. Looking to the federal statute, the court ruled the government "could not recover from [the]insurer, since, under statute, [the]veteran had incurred no liability" arising from their treatment. *Gordon*, 238 S.C. at 445-46, 120 S.E.2d at 512-13 (citing *United States v. St. Paul Mercury Indemnity Co.*, 8 Cir., 238 F.2d 594, 595 (8th Cir. 1956)). The court found this was an operative statute rendering the core element of the plaintiff's claim moot because the statute defined the veteran's medical care as incurring no obligation to the veteran. *Gordon*, 238 S.C. at 446, 120 S.E.2d at 513. Unlike in *Gordon*, there is no statute that renders the medical treatment free for the Respondent. (Order, p.3). The plaintiff did incur "the full amount charged <u>at the time services were rendered</u> and thus became entitled to the full amount of reimbursement coverage under the policy." (Order, p.3) (emphasis in original). The Circuit Court correctly applied the law and its order should be affirmed.

This is supported by the principles set forth in *Barker v. Wash. Nat'l. Ins. Co.*, where an insured sought the policy limits for expenses incurred when the insured was a Medicare recipient. No. 9:12-cv-1901-PMD, 2013 U.S. Dist. LEXIS 58437 (D.S.C. Apr. 24, 2013). Noting the statutory provision of 42 U.S.C. § 1395cc(a)(1)(A), the district court held "[a]s a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill." *Barker*, at *14. Unlike the plaintiff in *Barker*, Respondent was "charged for the services rendered at the time they were rendered," necessarily distinguishing the facts from *Gordon* and from *Barker*. (Order, p.3; Stip. of Fact, ¶¶5, 8, 11, 14). Effectively, this is a collateral source case whereby Medicaid is used to reduce the insurance carrier's obligation to the insured Respondent.

In *Haselden*, the court considered whether it was appropriate to use the "amount paid by Medicaid (or similar programs) [a]s dispositive of the reasonable value of medical services."

Haselden, 353 S.C. at 485, 579 S.E.2d at 295. Considering the collateral source rule as a limitation to overcompensating an injured plaintiff, the *Haselden* court ruled the "amount billed by [the doctor] was relevant to establish the reasonable value of the services provided" even though Medicaid ultimately paid less than what was billed. *Haselden*, 353 S.C. at 485, 579 S.E.2d at 295. Furthermore, the argument raised by Appellant was resolved by the *Haselden* court regarding Medicaid when holding a plaintiff's recovery is not limited to damages in the amount actually paid by Medicaid. *Haselden*, 353 S.C. at 485, 579 S.E.2d at 295.

From the outset, this case has been about interpretation to determine what financial obligation the insurance carrier can avoid because of third-party contribution. (Tr. 5:6-25). As noted at trial, vague and ambiguous terms must be construed in favor of the insured. *South Carolina Ins. Co. v. White*, 301 S.C. 133, 137, 390 S.E.2d 471, 474 (Ct. App. 1990); *Pitts v. Glens Falls Indemnity Co.*, 222 S.C. 133, 72 S.E.2d 174 (1954). (Form 4 Order, p.2). The core question posed to the trial court is whether South Carolina forbids an automobile insurance carrier from reducing their agreed-upon obligation to the insured when a third-party remits payment to the insured for the same expenses. Asserting a limiting definition of "incurred expenses" not found in the policy, Appellant only offered to satisfy the medical expenses after a third-party's payment had reduced them. (Form 4 Order, p.2). The trial court correctly interpreted this as a setoff in violation of S.C. Code Ann. § 38-77-144. (Order, p.3).

"In *Haselden*, the question was whether the Plaintiff could recover the amounts 'written off' by healthcare providers. A majority of this Court held that those amounts are recoverable by a plaintiff in a personal injury suit." *Covington v. George*, 359 S.C. 100, 102, 597 S.E.2d 142, 143 (2004) (internal citations omitted). "While a defendant is permitted to attack the necessity and reasonableness of medical care and costs, he cannot do so using evidence of payments made

by a collateral source." *Covington v. George*, 359 S.C. 100, 105, 597 S.E.2d 142, 145 (2004). "*Covington*, however, specifically limited the holding in *Haselden*: 'The admissibility of the actual payment amount was not an appellate issue in *Haselden*, but rather the issue was Plaintiff's entitlement to *recover* the difference between the billed amount and the actual payment amount.'" *Parker v. Spartanburg Sanitary Sewer Dist.*, 362 S.C. 276, 288-89, 607 S.E.2d 711, 718 (Ct. App. 2005) (quoting *Covington v. George*, 359 S.C. at 103, 597 S.E.2d at 143-44) (emphasis in original).

Here, the collateral source rule is equally applicable as the Appellants are challenging the appropriateness of considering payments made by a third-party on behalf of an injured party. "We are cognizant that several courts hold that the amount paid by Medicaid (or similar programs) is dispositive of the reasonable value of medical services." *Haselden*, 353 S.C. at 485, 579 S.E.2d at 295. This is not a matter of providing the Respondent a "windfall," as the dissent in *Haselden* urges, but a matter of correctly determining "the reasonable value of those medical services, not necessarily the amount paid." 353 S.C. at 484, 579 S.E.2d at 295 ("Clearly, the amount actually paid for medical services does not alone determine the reasonable value of those medical services. Nor does it limit the finder of fact in making such a determination.").

In *Cothran*, the Supreme Court determined an insurance carrier violated the setoff prohibition because the carrier reduced its payment by the remitted Workers' Compensation payment. *Cothran v. State Farm Mut. Auto. Ins. Co.*, 427 S.C. 545, 549, 831 S.E.2d 919, 921 (2019). Noting the lack of definition concerning a "setoff," the Supreme Court considered two definitions and defined a setoff when applying S.C. Code § 38-77-144. *Id.* 427 S.C. at 548-49, 831 S.E.2d at 920-21. The definition from *Cothran* is salient and succinct: a setoff arises when the insurer's obligation to the insured is reduced by the amount of a third-party's payment to the

insured, where the insurer's and the third-party's obligations to pay arose from the same transaction or subject matter. *Id.* 427 S.C. at 549, 831 S.E.2d at 921.

The Supreme Court further noted that the statute would apply when the insurance carrier's policy provisions have this effect. *Id.* 427 S.C. at 549, 831 S.E.2d at 921. The Supreme Court ruled the insurance policy was a first-party, primary, and no-fault policy with the Workers' Compensation payments being unable to limit the carrier's liability unless the policy provision had the effect of being a setoff. *Id.* 427 S.C. at 552-53, 831 S.E.2d at 923. The insurance carrier violated the statute because the effect of its policy provisions was to violate the legislative intent behind S.C. Code § 38-77-144. *Id.* 427 S.C. at 555, 831 S.E.2d at 924. The instruction in *Cothran* answers the case *sub judice* as the Medicaid provisions are neither primary nor does Medicaid achieve the same purpose as the insurance policy at issue here.

The *Cothran* court laid bare the mechanics of when insurance policy provisions have the effect of a setoff: an insurance carrier lessens the amount owed to the insured because of payments made by a third-party. *Id.* 427 S.C. at 549, 831 S.E.2d at 921. Appellant sought to reduce the amount owed under the policy "based on a third party's previous payment for the same claim." *Id.* 427 S.C. at 555, 831 S.E.2d at 924. Appellant cannot prevail because the third-party payor is Medicaid instead of Workers' Compensation as both remit obligated payments to the insured upon their claim for payment and serve similar purposes. *Id.* 427 S.C. at 548-49, 831 S.E.2d at 921. *See also*, *Ellis v. Oliver*, 335 S.C. 106, 109, 515 S.E.2d 268, 270 (Ct. App. 1999).

> South Carolina, Mississippi, Wisconsin, North Carolina, and Hawaii, for example, have held that Medicaid payments *are* subject to the collateral-source rule. These courts have included gratuitous services in the rule's protection, reasoning that tortfeasors should be

liable for the *value* of medical services, rather than the cost. See *Haselden v. Davis*, 353 S.C. 481, 483, 579 S.E.2d 293, 294 (2003); *Brandon HMA, Inc. v. Bradshaw*, 809 So. 2d 611, 619 (Miss. 2001); *Ellsworth v. Schelbrock*, 2000 WI 63, 235 Wis. 2d 678, 685, 611 N.W.2d 764, 767 (2000); *Cates v. Wilson*, 321 N.C. 1, 6, 361 S.E.2d 734, 738 (1987); *Bynum v. Magno*, 106 Haw. 81, 88, 101 P.3d 1149, 1156 (2004)."

Wills v. Foster, 372 Ill. App. 3d 670, 675, 311 Ill. Dec. 237, 241, 867 N.E.2d 1223, 1227 (Ill. Ct. App. 2007) (emphasis in original). Determination of the reasonable value therefore requires defining "incurred expenses," a term not defined within the policy. *Haselden*, 353 S.C. at 485 n.4, 295. The evidence supports the trial court's ruling. The court's ruling is in accord with *Gordon* and *Haselden* by determining the amount incurred when the medical services were provided and limited by the explicit terms of the policy, which mandate a total obligation of no more than $10,000.00 per person. (Order, p.4; Stip. of Fact, ¶2; Tr. 13-14).

Appellant urges a reading of *Gordon* inapposite to its holding by looking to the dissent in *Haselden* for the principle that a plaintiff has no "right to be reimbursed for money that will never be expended." 353 S.C. at 488, 579 S.E.2d at 297 (J. Pleicones, dissenting) (describing the majority opinion as obligating "doctors to bear the cost of reimbursing an injured party for a non-existent debt"). The stipulated facts of this case evidence medical bills being incurred following Respondent's medical treatment. (Stip. of Fact ¶¶1-2). Determination of the reasonableness of those fees is a question of fact for the trial court. *Haselden*, 353 S.C. at 484, 579 S.E.2d at 295. The trial court did not err in its determination and the ruling should be affirmed.

CONCLUSION

The policy issued by Progressive obligated the insurance carrier to the maximum extent of $10,000.00 for "expenses incurred" by the insured and only after the insured's loss did Progressive seek to reframe the policy in its own interests. The trial court appropriately considered the South Carolina Supreme Court's holding that incurred expenses are not limited to the amount actually paid by Medicaid.

For the reasons stated, this Court should affirm the Circuit Court's rulings as they are correct under the law, appropriately applied to the facts, and substantially supported by the evidence.

Respectfully submitted,

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