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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones ....Respondent – Appellant,

v.

Progressive Northern Insurance Company......................................Appellant – Respondent.

INITIAL RESPONDENT'S BRIEF OF APPELLANT-RESPONDENT

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STATEMENT OF ISSUES ON APPEAL[1]

I. Whether the Circuit Court properly dismissed Jones' "violation of South Carolina Code of Laws Section 38-77-144" claim because the "violation" alleged by Jones is not the conduct prohibited by the statute and because the statute does not create a private cause of action.

II. Whether the Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act, bad faith, breach of the covenant of good faith and fair dealing, and breach of fiduciary duty claims because Progressive's alleged actions at issue were in accordance with the terms of the insurance contract and South Carolina law.

III. Whether the Circuit Court properly dismissed Jones' "breach of the covenant of good faith and fair dealing" and "breach of fiduciary duty" claims because such claims are duplicative of her bad faith claim.

IV. Whether the Circuit Court properly dismissed Jones' bad faith claim because she lacked standing to bring such claim and Progressive had a reasonable basis to dispute paying her medical payments claim at a higher rate than the Medicaid-adjusted rates.

V. Whether the Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act claim because the acts alleged were not fraudulent acts.

VI. Whether the Circuit Court properly denied Jones' claim for attorney's fees.

STATEMENT OF THE CASE

This action arises out of Progressive's payment of Alexis Jones' medical payments claim for an October 8, 2019 auto accident. The auto policy at issue includes a $10,000 medical payments coverage limit for certain medical "expenses incurred" by an insured as a result of an accident. Alexis Jones ("Jones") is a Medicaid recipient. In South Carolina, Medicaid has agreements in place with medical service providers wherein the providers have agreed, prior to treating Medicaid recipients, to accept reduced rates as payment-in-full. Progressive reimbursed Jones under the medical payments

[1] Jones Complaint also alleges a "violation of the South Carolina Unfair Trade Practice Act" claim, which the Circuit Court dismissed. According to her Brief, Jones is not appealing that ruling. (Jones' Appellant Br., p. 7 ("The circuit court initially dismissed only the SCUPTA claim and Ms. Jones does not appeal that ruling.")).

coverage based on the Medicaid-adjusted rates charged and accepted by her medical providers rather than the total charges listed on the medical providers' initial bills. In her Complaint, Plaintiff bases her various causes of action on Progressive's payment of the Medicaid-adjusted provider rates rather than the providers' "sticker price." The policy only provides medical payments coverage for certain medical "expenses incurred" by Jones. Since Jones did not incur expenses beyond the Medicaid-adjusted rates, Progressive appropriately reimbursed her, pursuant to the medical payments coverage, at the Medicaid-adjusted rates.

FACTUAL AND PROCEDURAL BACKGROUND

A. The Progressive Policy

Progressive Northern Insurance Company ("Progressive") issued a personal auto policy, Policy No. 930693102, to Willie Brown with effective dates of June 21, 2019 to December 21, 2019 (the "Policy"). (Policy, p. 1). The Policy includes a medical payments coverage limit of $10,000 each person. (Policy, p. 2). The Policy only provides medical payments coverage for certain medical expenses actually incurred by an insured person. The Policy provides in pertinent part:

> **PART II – MEDICAL PAYMENTS COVERAGE**
>
> **INSURING AGREEMENT**
> If **you** pay the premium for this coverage, **we** will pay the reasonable expenses incurred for necessary **medical services** received within three years from the date of a **motor vehicle** accident because of **bodily injury**:
> 1. Sustained by an **insured person**; and
> 2. Caused by that **motor vehicle** accident.

(Policy, p. 14). Thus, the Policy only provides medical payments coverage for certain "expenses **incurred** for necessary medical services."

B. The October 8, 2019 Accident and Jones' Resulting Medical Payments Claim

On October 8, 2019, Jones was involved in an auto accident. (Compl. ¶ 11). Jones made a claim for medical payments coverage under the Policy. (Compl. ¶ 13). With her claim, Jones

submitted medical provider billing statements in excess of $10,000. (Compl. ¶¶ 12-13). However, Jones is a Medicaid recipient. (Stipulation of Fact ¶ 4); (February 10, 2021 Circuit Court Order, p.1). Prior to her ever receiving treatment, Medicaid had agreements in place with her medical service providers wherein the providers agreed to accept reduced rates as payment-in-full. (Stipulation of Fact); (February 10, 2021 Circuit Court Order, p.1). Medicaid paid $1,323.60 total for the medical treatment Jones received, and the medical providers accepted this amount as payment-in-full for the treatment rendered. *See* (April 6, 2023 Circuit Court Order, p. 1). Progressive paid medical payments coverage to Jones in the amount of $1,323.60 – the same amount her medical providers accepted as payment in full for the treatment rendered. (*Id.*). Jones "has not paid any additional sums to any of the medical providers, nor is she legally obligated to pay any additional sums to the medical providers. All of the charges for the treatment rendered to her has been paid in full based upon the providers receipt of the Medicaid payments…." (Stipulation of Fact ¶ 17). At the bench trial, Jones testified as follows:

> Q. Ms. Jones, as I understand it, Medicaid paid the hospital bill at MUSC and all the other doctors you went to from the accident on your behalf?
> A. Yes.
> Q. You've paid no money yourself?
> A. No.
> Q. Is that correct?
> A. Correct.
> Q. And you're not legally obligated to pay any money to any of those by virtue of you being a Medicaid beneficiary. The hospital and doctors that you saw have agreed to accept what Medicaid paid them for a payment in full?
> A. Yes.
>
> ***
>
> Q. And you had no deductibles, out-of-pockets, nothing. Everything that you owed the doctors have been paid for by Medicaid?
> A. Yes.

(Tr. Transcript 15:4-24).

Despite the foregoing, Jones alleges she is owed the full $10,000 medical payments coverage limit and that Progressive still owes her "$8,676.40 in outstanding Medpay coverage." (Compl. ¶¶ 14, 16, 25, Wherefore B.). Jones' Complaint asserted the following causes of action related to her medical payments coverage claim: (1) bad faith; (2) breach of contract; (3) breach of fiduciary duty; (4) breach of the covenant of good faith and fair dealing; (5) breach of contract accompanied by a fraudulent act; (6) violation of the South Carolina Unfair Trade Practice Act; and (7) violation of South Carolina Code § 38-77-144. (Compl.).

C. Motions and Circuit Court Orders[2]

On May 11, 2020, Progressive filed a Motion to Dismiss the Complaint and a Memorandum of Law in support. (Progressive's Mot. to Dismiss and Mem. in Supp.). On August 10, 2020, the Circuit Court entered an Order granting the Motion in part and dismissing Jones' South Carolina Unfair Trade Practices Act claim. (August 10, 2020 Circuit Court Order). On August 20, 2020, Progressive filed a Motion to Reconsider the August 10, 2020 Order. (Progressive's Mot. to Reconsider). On February 10, 2021, the Circuit Court entered an Order granting the Motion to Reconsider in part and denying it in part. (February 10, 2021 Circuit Court Order). In this Order, the Circuit Court dismissed all the causes of action except for the breach of contract cause of action. The Order states:

> [T]he Court finds that based on the allegations of the Complaint, and the legal positions of the parties, that South Carolina law would not recognize a cause of action for bad faith, breach of the duty of good faith and fair dealing (which is duplicative), breach of fiduciary duty (which is also duplicative) or breach of contract accompanied by a fraudulent act under these circumstances. Therefore, those causes of action in the Plaintiff's Complaint, are hereby dismissed.

[2] When the case was originally filed, Willie Brown was a plaintiff. On September 3, 2020, the parties filed a Stipulation wherein it was acknowledged that he is not a real party in interest, and he was dismissed from the case.

(February 10, 2021 Circuit Court Order, p. 3). The Order recognized that Progressive had submitted legal authority that the phrase "expenses incurred" meant the amount of money which an insured is legally obligated to pay for medical treatment and that South Carolina law allows an insurer to litigate a novel issue of law without fear of a bad faith or extra contractual claim. (*Id.* at p. 2). The Order also dismissed Jones' "violation of South Carolina Code § 38-77-144" claim because the statute does not create a private cause of action. (*Id.* at p. 3).

The Circuit Court then held a bench trial on the only remaining cause of action for breach of contract. By Orders filed March 29, 2023 and April 6, 2023, the Circuit Court found for Jones on her breach of contract cause of action, awarding her $8,676.40. (March 29, 2023 Circuit Order); (April 6, 2023 Circuit Court Order). The Orders denied Jones' request for attorney's fees. (*Id.*). Progressive's appeal and Jones' cross-appeal followed.

STANDARD OF REVIEW

"[A] respondent—the 'winner' in the lower court—may raise on appeal any additional reasons the appellate court should affirm the lower court's ruling, regardless of whether those reasons have been presented to or ruled on by the lower court." *I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 419, 526 S.E.2d 716, 723 (2000). With respect to Jones': (1) breach of contract accompanied by a fraudulent act claim; (2) bad faith claim; (3) breach of the covenant of good faith and fair dealing claim; (4) breach of fiduciary duty claim; (5) SCUTPA claim; (6) Section 38-77-144 claim; and (7) attorney's fees claim, Progressive was the "winner" in the lower court. Therefore, as to these claims, the Court may affirm the Circuit Court's ruling in favor of Progressive on any ground supported by the record on appeal. *See id.*

ARGUMENT

Alexis Jones appeals dismissal of one of her statutory claims – "violation of South Carolina Code of Laws Section 38-77-144." (Compl. ¶¶ 24-25). This cause of action was properly dismissed because the statute is inapplicable to the conduct alleged and because the statute does not create a private cause of action. Her Complaint also asserts numerous common-law causes of action, all of which are premised on Progressive's payment of Jones' medical payments claim at the Medicaid-adjusted provider rates. Because the Progressive Policy only provides medical payments coverage for "expenses incurred," such claims were properly dismissed. Under both federal and state Medicaid provisions, Jones never incurred expenses beyond her medical providers' Medicaid-adjusted rates. Furthermore, the common law causes of action were properly dismissed for separate, additional reasons.

I. Jones' "violation of South Carolina Code of Laws Section 38-77-144" claim was properly dismissed for two independent reasons.

A. This claim was properly dismissed because the "violation" alleged by Jones is not the conduct prohibited by the statute.

South Carolina Code § 38-77-144 provides that "medical payments coverage…is not subject to a setoff." S.C. Code § 38-77-144. Jones alleges that Progressive's payment of medical payments coverage at the Medicaid-adjusted provider rates constitutes a setoff under § 38-77-144, but it does not. *See* (Compl. ¶ 25). The South Carolina Supreme Court recently described what constitutes a "setoff" under South Carolina Code § 38-77-144. In *Cothran v. State Farm Mut. Auto. Ins. Co.*, a provision in the insurance policy purported to reduce the insurer's obligation to pay PIP coverage to the insured by the amount the workers compensation carrier paid for the insured's medical expenses. 427 S.C. 545, 550, 831 S.E.2d 919, 922 (2019) ("In this case, State Farm's obligation to pay PIP coverage to Wadette is reduced—eliminated, in fact—by the amount her employer's workers'

compensation carrier paid her for medical expenses."). The Court held that this was a "setoff" in violation of § 38-77-144. *Id.*

As the Court explained: "The term 'setoff' is used universally to describe the reduction of PIP benefits by the amount of a third-party payment." *Id.* at 550 n.3, 831 S.E.2d at 922 n.3. A setoff under the statute occurs when the insurer's obligation to pay the insured is reduced by the amount of a third-party's payment to the insured. The Court used a mathematical calculation to describe a setoff scenario:

> Wadette incurred approximately $40,000 in medical expenses. Her PIP benefits policy limit is $5,000....If her workers' compensation benefits were $37,500, the "Coordination" provision would take effect and State Farm would owe her $2,500. In this case, her workers' compensation benefits equaled the total amount of her medical expenses, so the effect of the "Coordination" provision would be to eliminate State Farm's obligation to pay any PIP benefits.

Id. at 550 n.2, 831 S.E.2d at 922 n.2. Given this example, a setoff occurs when the medical payments insurer takes the total medical expense amount the insured incurred and subtracts the benefits paid by a third-party to determine the amount of the policy limit it is required to pay (i.e., $40,000 [incurred medical expenses] - $40,000 [workers' compensation benefits] = $0 [medical payments coverage]).

Thus, a "setoff," as that term has been defined by the South Carolina Supreme Court, would occur if Progressive attempted to reduce its medical payments coverage by the amounts paid by Medicaid – i.e., paid no medical payments coverage because Medicaid had already taken care of Jones' treatment expenses. That is not what Progressive did or even what Jones alleges Progressive did. (Compl. ¶ 25); (April 6, 2023 Circuit Court Order, p.1 (recognizing that Progressive paid Jones the same "amount Medicaid paid to satisfy the medical bills")). Her Complaint does not allege that Progressive reduced its medical payments benefits by the amount of the Medicaid payment. *See* (Compl. ¶ 25). Rather, Jones alleges that Progressive "violated Section 38-77-144 by refusing to pay Plaintiff ***any amount above*** what Medicaid paid to Plaintiff Jones's health care providers." (Compl.

¶ 25) (emphasis added). Paying medical payments coverage at a Medicaid-adjusted provider rate does not constitute a "reduction of PIP benefits by the amount of a third-party payment." *Cothran,* 427 S.C. at 550 n.3, 831 S.E.2d at 922 n.3. Because this does not constitute a "setoff" under South Carolina Code § 38-77-144, Jones' "violation of South Carolina Code of Laws Section 38-77-144" claim was properly dismissed.

Moreover, nothing in South Carolina Code § 38-77-144 requires medical payments coverage for amounts greater than those actually incurred by the insured – i.e., amounts greater than the reduced rates negotiated between Medicaid and medical providers. As explained in Progressive's Appellant Initial Brief and Reply Brief, such a requirement would be contrary to prior South Carolina Supreme Court precedent.

B. This claim was also properly dismissed because the statute does not create a private cause of action.

"'[T]he general rule is that a statute which does not purport to establish a civil liability, but merely makes provision to secure the safety or welfare of the public as an entity is not subject to a construction establishing a civil liability.'" *Adkins v. South Carolina Dep't of Corr.*, 360 S.C. 413, 418, 602 S.E.2d 51, 54 (2004) (quoting *Whitworth v. Fast Fare Markets of South Carolina, Inc.*, 289 S.C. 418, 420, 338 S.E.2d 155, 156 (1985)). "Where a statute does not specifically create a private cause of action, one can be implied **only if the legislation was enacted for the special benefit of a private party**." *Id.* (emphasis in orig.). "A statute creates no liability to the person injured unless it discloses an intention, express or implied, that from disregard of the statutory command, a liability for resultant damage arises, <u>which would not exist but for the statute</u>." *Denson v. National Cas. Co.*, 439 S.C. 142, 150, 886 S.E.2d 228, 233 (2023) (emphasis added).

South Carolina Code § 38-77-144, entitled "Personal injury protection (PIP) coverage not mandated," does not purport to establish a civil liability. *See* S.C. Code § 38-77-144; *see also* (Jones'

Appellant Brief, p. 14 ("The statute does not expressly create a private right of action....")). It provides in full:

> There is no personal injury protection (PIP) coverage mandated under the automobile insurance laws of this State. Any reference to personal injury protection in Title 38 or 56 or elsewhere is deleted. If an insurer sells no-fault insurance coverage which provides personal injury protection, medical payment coverage, or economic loss coverage, the coverage shall not be assigned or subrogated and is not subject to a setoff.

S.C. Code § 38-77-144. Thus, the statute was enacted to make PIP/medical payments coverage non-mandatory. *See* (Jones' Appellant Brief, p. 14 ("This statute removed the requirement that automobile insurers offer PIP of MedPay coverage....")). Furthermore, there is no need for this statutory provision to create a private cause of action. "Statutory provisions relating to an insurance contract are part of the contract as a matter of law." *Nakatsu v. Encompass Indem. Co.*, 390 S.C. 172, 178, 700 S.E.2d 283, 287 (Ct. App. 2010); *Williams v. Gov't Emps. Ins. Co. (GEICO)*, 409 S.C. 586, 598, 762 S.E.2d 705, 712 (2014) (same). Consequently, a violation of this statutory provision may constitute a breach of the insurance contract but would not give rise to its own independent cause of action. *See Denson*, 439 S.C. at 149–50, 886 S.E.2d at 232 ("[T]he duty or standard of care, statutory or otherwise, is merely an element of proof that comes into play *after* an action has been rightfully commenced *pursuant to the preexisting common-law cause of action*.") (emphasis in orig.). Jones' prior Respondent Brief on her breach of contract claim demonstrates this principle. It specifically incorporates her "setoff" argument into her breach of contract argument. (Jones' Respondent Brief, pp. 3-5). Therefore, Jones' "violation of South Carolina Code of Laws Section 38-77-144" claim was also properly dismissed because the statute creates no private cause of action, and such claim is duplicative of her breach of contract claim.

II. The Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act, bad faith, breach of the covenant of good faith and fair dealing, and breach of fiduciary duty claims because Progressive's alleged actions at issue were in accordance with the terms of the insurance policy and South Carolina law.

The Circuit Court properly dismissed all of the above common-law claims. (February 10, 2021 Circuit Court Order). Each of these claims are premised on Progressive paying the reduced rates Medicaid previously negotiated with Jones' medical providers rather than the "sticker prices" on the providers' initial bills. *See* (Compl. ¶¶ 12-13, 20.c, 21.d.iii., 25.d., Wherefore B.); (Tr. Transcript, pp. 5-7) As more fully explained in Progressive's Appellant Initial Brief and Reply Brief, these actions were taken in accordance with the policy terms and allowed under South Carolina law.[3] Therefore, those claims were properly dismissed.

In her Complaint, the "breach of contract accompanied by a fraudulent act" section does not set forth any alleged breach of the insurance contract, a required element of the claim. *See* (Compl. ¶ 22); *Conner v. City of Forest Acres*, 348 S.C. 454, 465, 560 S.E.2d 606, 612 (2002) ("In order to have a claim for breach of contract accompanied by a fraudulent act, the plaintiff must establish three elements: (1) a breach of contract...."). From the remainder of the Complaint, the only potential breach Jones alleges is failure to pay medical payments coverage based on the total charges listed on the initial medical bills rather than the Medicaid-adjusted amounts actually accepted for services rendered. *See* (Compl. ¶¶ 12-13, 25, Wherefore B.). This conduct is also the basis for Jones' other claims.[4]

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[3] Progressive's arguments set forth in its Appellant Initial Brief (filed August 14, 2023) and Reply Brief (filed November 3, 2023) are fully incorporated herein by reference.

[4] In the Complaint, Jones' "breach of fiduciary duty" and "breach of the covenant of good faith and fair dealing" claim sections do not set forth any specific "breach" but merely state that Progressive breached its duties by its actions and conduct alleged elsewhere in the Complaint.

An insurer's obligation under an insurance policy is defined by the terms of the policy and cannot be enlarged by judicial construction. *South Carolina Ins. Co. v. White*, 301 S.C. 133, 137, 390 S.E.2d 471, 474 (Ct. App. 1990).[5] "[I]f the intention of the parties is clear, courts have no authority to torture the meaning of policy language to extend or defeat coverage that was never intended by the parties." *Kay v. State Farm Mut. Auto. Ins. Co.*, 349 S.C. 446, 450, 562 S.E.2d 676, 679 (Ct. App. 2002). The Policy provides medical payments coverage for certain "reasonable **expenses incurred** for necessary medical services." (Policy, p. 14) (emphasis added). In the context of a medical payments coverage claim, the South Carolina Supreme Court in *Gordon v. Fidelity & Cas. Co. of N. Y.* clearly articulated that "expenses incurred" means there is an obligation on the part of the insured to pay that amount for the medical treatment or service received. 238 S.C. 438, 446, 120 S.E.2d 509, 513 (1961). It further explained that "**a thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'**." *Id.* at 445, 120 S.E.2d at 512 (emphasis added).

Due to the way Medicaid works, Jones never became obligated to pay any amounts beyond the Medicaid-adjusted rates. Medicaid already has agreements in place with Medicaid providers before a Medicaid recipient ever receives any treatment. Pursuant to the South Carolina Medicaid provider agreement, the provider agrees before rendering treatment "that Medicaid reimbursement is payment in full...for care or services to a recipient/patient" and "that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient...." Medicaid

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(Compl. ¶¶ 20-21). Jones' bad faith section alleges Progressive acted in bad faith by "offering substantially less than the amount due" under the policy. (Compl. ¶ 17.g.).

[5] Under South Carolina law, there is no statutorily mandated medical payments/personal injury protection coverage. S.C. Code § 38-77-144; *State Farm Mut. Auto. Ins. Co. v. Richardson*, 313 S.C. 58, 60, 437 S.E.2d 43, 45 (1993).

Participation and Payment Agreement, Form (07/17), available at https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf (emphasis added). Pursuant to the Code of Federal Regulations, a Medicaid provider is required to accept these previously-agreed-to amounts as "payment in full." 42 C.F.R. § 447.15 (requiring state Medicaid agency to "limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayments required by the plan to be paid by the individual"). Prior to the bench trial in this case, the parties stipulated that beyond the Medicaid-adjusted rates "Plaintiff has not paid any additional sums to any of the medical providers, nor is she legally obligated to pay any additional sums to the medical providers. All of the charges for the treatment rendered to her has been paid in full based upon the providers receipt of the Medicaid payments." (Stipulation of Fact ¶ 17) (emphasis added).

Therefore, under South Carolina law, Jones has not "incurred" expenses for medical services beyond the Medicaid-adjusted rates, which Progressive has already paid. *See also Barker v. Washington Nat. Ins. Co.*, No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013) (granting insurer summary judgment on insured's breach of contract and bad faith claims where insurer paid medical payments coverage based on Medicare-adjusted rates rather than "total charges" listed on providers initial bills).[6] Consequently, the act of paying medical payments coverage based

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[6] *See also State Farm Mut. Auto. Ins. Co. v. Bowers*, 255 Va. 581, 585-586, 500 S.E.2d 212, 214 (1998) (holding insured did not "incur" expenses for medical payments coverage beyond those reduced rates negotiated between health insurance carrier and medical providers); *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *6 (N.D. Okla. Apr. 14, 2015) (stating "[a] number of courts in other jurisdictions have found 'expenses incurred' to mean the amount actually paid, as opposed to the amount charged by the care provider" and holding "expenses incurred" meant amount insured actually paid to satisfy medical providers after "other insurance coverage...negotiated a lower rate of payment"); *Metz v. U.S. Life Ins. Co. in City of New York*, 662 F.3d 600, 602 (2d Cir. 2011) (holding "incurred" for insurance coverage meant reduced rates negotiated by Medicare because insured "did not incur more than the amounts that

on medical providers' adjusted rates for a Medicaid patient rather than amounts listed on an initial bill is not a breach of the Progressive insurance contract. Therefore, Jones' breach of contract accompanied by a fraudulent act, bad faith, breach of the duty of good faith and fair dealing, and breach of fiduciary duty claims – all of which are premised on such act – were properly dismissed. *See Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359, 415 S.E.2d 393, 396 (1992) ("The elements of a cause of action for bad faith refusal to pay first party benefits under a contract of insurance are… (2) refusal by the insurer to pay benefits due under the contract….").

III. The Circuit Court properly dismissed Jones' bad faith, breach of the covenant of good faith and fair dealing, and breach of fiduciary duty claims because such claims were duplicative, and Progressive had a reasonable basis to argue that payment of medical payments coverage should be at the Medicaid-adjusted rates.

A. Jones' "breach of the covenant of good faith and fair dealing" and "breach of fiduciary duty" claims were properly dismissed because they are duplicative of her bad faith claim.

Jones' bad faith, breach of the duty of good faith and fair dealing, and breach of fiduciary duty claims amount to a single bad faith claim. (February 10, 2021 Circuit Court Order, p. 3 (finding them to be "duplicative")). First, bad faith and breach of an implied duty of good faith and fair dealing are not separate causes of action. *Ocean Winds Council of Co-Owners, Inc. v. Auto-Owners Ins. Co.*, 241 F. Supp. 2d 572, 577 (D.S.C. 2002) ("[B]ad faith refusal to pay benefits and breach of implied warranty of good faith and fair dealing are not separate causes of action."); *Sentry Select Ins. Co. v. Guess Farm Equip., Inc.*, No. CIV.A. 5:12-03504-JM, 2013 WL 5797742, at *10 (D.S.C. Oct. 25, 2013) (dismissing counterclaim for bad faith "because it is duplicative" of claim for breach of duty of good faith and fair dealing). Moreover, when a party's breach of

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her physicians had agreed ahead of time they would seek from her"); *Woodrich v. Farmers Ins. Co .*, 405 F.Supp.2d 1276, 1279 (N.D.Okla.2004).

fiduciary duty claim is based on the same duty and arises out of the same factual allegations as another claim, it is duplicative and should be dismissed. *See RFT Mgmt. Co. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 336, 732 S.E.2d 166, 173 (2012) (dismissing breach of fiduciary duty claim because duplicative of legal malpractice claim based on same attorney-client relationship and factual allegations). In the Complaint, Jones' "breach of fiduciary duty" and "breach of the covenant of good faith and fair dealing" claim sections do not set forth any specific "breach" but merely state that Progressive breached its duties by conduct alleged elsewhere in the Complaint. (Compl. ¶¶ 20-21 ("Defendant's conduct as averred hereinabove was in breach of fiduciary duty")). Jones' own Appellant Brief demonstrates that these three claims are duplicative as she too lumps them together when discussing them and analyzes them all as a bad faith claim. (Jones' Appellant Brief, pp. 8-12 (calling these three (3) claims all "claims for bad faith")). Therefore, Jones' "breach of the covenant of good faith and fair dealing" and "breach of fiduciary duty" claims were properly dismissed because they are duplicative of her bad faith claim.

B. Jones' bad faith claim was properly dismissed because Progressive had a reasonable basis to dispute paying her medical payments claim at a higher rate than the Medicaid-adjusted rates.

"[I]f there is any reasonable ground for contesting the claim, there is no bad faith." *Varnadore v. Nationwide Mut. Ins. Co.*, 289 S.C. 155, 158, 345 S.E.2d 711, 714 (1986); *Crossley*, 307 S.C. at 360, 415 S.E.2d at 397 (same); *BMW of N. Am., LLC v. Complete Auto Recon Servs., Inc.*, 399 S.C. 444, 453, 731 S.E.2d 902, 907 (Ct. App. 2012) ("[W]here an insurer has a reasonable ground for contesting a claim, there is no bad faith."). Here, Progressive had a reasonable basis for contesting paying Jones' medical payments claim at a higher rate than the Medicaid-adjusted rates her providers accepted as payment in full for her treatment. The Policy only provides medical payments coverage for certain "reasonable ***expenses incurred*** for necessary medical services."

(Policy, p. 14) (emphasis added). As Jones admits, she is a Medicaid recipient, and she is not "legally obligated to pay any additional sums to the medical providers. All of the charges for the treatment rendered to her has been paid in full based upon the providers receipt of the Medicaid payments...." (Stipulation of Fact ¶¶ 4, 17). Moreover, as shown above and in Progressive's Appellant Brief, numerous cases have held that "expenses incurred" for Medicaid and Medicare recipients are the adjusted rates their providers agreed to accept as payment in full prior to their treatment. Thus, as a matter of law, Progressive had a reasonable basis for contesting this claim, and Jones' bad faith cause of action was properly dismissed.

As the Circuit Court correctly held and explained:

> Under South Carolina law, an insurer who has a meritorious coverage defense is free to litigate the issue without fear of a bad faith or extra contractual claim. *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359, 415 S.E.2d 393, 396 (1992). Moreover, an insurer is not required to concede a novel issue of law in order to avoid a bad faith lawsuit. *Id.*; *Helena Chem. Co. v. Allianz Underwriters Ins. Co.*, 357 S.C. 631, 645, 594 S.E.2d 455, 462 (2004). In this case, Progressive Northern submitted legal authority that the term or the phrase "expenses incurred" meant the amount of money which an insured is legally obligated to pay for medical treatment. *Gordon v. Fidelity & Cas. Co. of N. Y.*, 238 S.C. 438, 446, 120 S.E.2d 509, 513 (1961); *Barker v. Washington Nat. Ins. Co.*, 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013). Progressive Northern also submitted out of jurisdiction cases supporting this principle of law.... [T]he Court finds that based on the allegations of the Complaint, and the legal positions of the parties, that South Carolina law would not recognize a cause of action for bad faith, breach of the duty of good faith and fair dealing (which is duplicative), breach of fiduciary duty (which is also duplicative) or breach of contract accompanied by a fraudulent act under these circumstances. Therefore, those causes of action in the Plaintiff's Complaint, are hereby dismissed.

(February 10, 2021 Circuit Court Order).[7] Therefore, the Circuit Court properly dismissed Jones' bad faith claim.

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[7] Like in her Respondent Brief on the breach of contract claim, Jones' Appellant Brief attempts to distinguish *Gordon* and *Barker* and inject the irrelevant issue of collateral source. (Jones' Appellant Brief, pp. 9-12). For the reasons previously articulated in Progressive's Reply Brief, *Gordon* is controlling and *Haselden* and its progeny are irrelevant.

IV. The Circuit Court properly dismissed Jones' breach of contract accompanied by a fraudulent act claim because she did not allege a separate fraudulent act and the only alleged acts were not fraudulent.

"To maintain an action for breach of contract accompanied by a fraudulent act, a plaintiff must prove three elements: (1) a breach of contract; (2) fraudulent intent relating to the breaching of the contract and not merely to its making; and (3) a fraudulent act accompanying the breach." *RoTec Servs., Inc. v. Encompass Servs., Inc.*, 359 S.C. 467, 470, 597 S.E.2d 881, 883 (Ct. App. 2004). Under this claim in her Complaint, Jones does not set forth what the alleged breach of contract is or what the alleged fraudulent act is. (Compl. ¶ 22). From the remainder of the Complaint, the only potential breach and fraudulent act Jones alleges is failure to pay medical payments coverage based on the total charges on the initial medical bills rather than the Medicaid-adjusted amounts for services rendered. *See* (Compl. ¶¶ 12-13, 25, Wherefore B.).

Consequently, this claim was properly dismissed for three (3) separate reasons. Jones did not allege a fraudulent act separate from her alleged breach of contract. Additionally, as explained above and in Progressive's Appellant Brief, paying medical payments coverage at the Medicaid-adjusted

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Furthermore, for Progressive the bad faith claim has a lower bar than the breach of contract claim. The question is whether Progressive had a reasonable basis for paying her medical payments claim at the Medicaid-adjusted rates. Although Progressive believes *Gordon* is controlling in this case, at a minimum *Gordon*, *Barker*, and the other cases cited by Progressive provide a reasonable basis for the belief that a Medicaid recipient does not incur expenses for amounts beyond the Medicaid-adjusted rates because there is no obligation to pay those amounts. *See Gordon*, 238 S.C. at 446, 120 S.E.2d at 513 ("[A] thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'."). In her Brief, Jones essentially admits that the Court would have to reject the analysis in *Barker* to reach her desired result in this case. (Jones' Appellant Brief, p. 11 ("Respectfully, Judge Duffy's unpublished order is wrong, and this Court should reject that analysis.")). This further demonstrates that Progressive had a reasonable basis under the *Barker* analysis for paying her claim at the Medicaid-adjusted rates.

rates is not a breach of the insurance policy. This is also not a fraudulent act, as required for this claim. Thus, for each of these separate reasons, this cause of action was properly dismissed.

The key element of this claim is a fraudulent act; "mere breach of a contract, even if willful or with fraudulent purpose, is not sufficient." *Lister v. NationsBank of Delaware, N.A.*, 329 S.C. 133, 142, 494 S.E.2d 449, 454 (Ct. App. 1997). The alleged fraudulent act must be "separate and distinct from the act(s) constituting the breach." *Smith v. Canal Ins. Co.*, 275 S.C. 256, 260, 269 S.E.2d 348, 350 (1980) (emphasis added); *see also Minter v. GOCT, Inc.*, 322 S.C. 525, 530, 473 S.E.2d 67, 70–71 (Ct. App. 1996) (requiring "evidence of an independent fraudulent act which accompanied the breach"). Where, as here, the alleged breach of contract and fraudulent act are one and the same, this claim is properly dismissed. *See Smith*, 275 S.C. at 260, 269 S.E.2d at 350 (holding this cause of action should have been struck where complaint merely restated manner in which defendant was alleged to have breached contract and the acts alleged "merely reaffirm [the insurer's] position on coverage and are not fraudulent in and of themselves"). Jones' Complaint does not articulate any separate allegedly fraudulent act.

Even now, Jones has failed to articulate a separate fraudulent act from her alleged breach of contract – i.e., paying the medical payments coverage at the Medicaid-adjusted rates. In her Appellant Brief, Jones argues that the "fraudulent act" underpinning her claim is actually "unfair dealing in the manner in which Progressive adjusted her claims for MedPay benefits" – i.e., "Progressive relied upon *Gordon*...and *Barker*" to pay her the Medicaid-adjusted rates. (Jones' Appellant Brief, pp. 12-13) (emphasis added). This conduct is not "separate and distinct from the act(s) constituting the [alleged] breach." *See Smith*, 275 S.C. at 260, 269 S.E.2d at 350. Therefore, the Circuit Court properly dismissed her "breach of contract accompanied by a fraudulent act" claim.

Additionally, to the extent this is her alleged "fraudulent act," this claim was properly dismissed because it is duplicative of her breach of the covenant of good faith and fair dealing claim, her breach of fiduciary duty claim, and her bad faith claim – all of which are premised on the same duty and acts. *See, e.g., Ocean Winds Council of Co-Owners, Inc*, 241 F. Supp. 2d at 577; *Sentry Select Ins. Co.*, 2013 WL 5797742, at *10; *RFT Mgmt. Co.*, 399 S.C. at 336, 732 S.E.2d at 173.

This claim was also properly dismissed because paying medical payments coverage at the Medicaid-adjusted rates is not a fraudulent act. "Fraudulent act" is defined as "any act characterized by dishonesty in fact or unfair dealing." *RoTec Servs., Inc.*, 359 S.C. at 470, 597 S.E.2d at 883. "This fraudulent act, although separate and distinct from the act(s) constituting the breach, must accompany the breach and not be too remote in either time or character." *Smith*, 275 S.C. at 260, 269 S.E.2d at 350. The "facts and circumstances peculiar to each case [are] to bear heavily upon the conscience and judgment of the court or jury in determining its presence or absence." *Conner*, 348 S.C. at 466, 560 S.E.2d at 612.

Based on long-standing South Carolina Supreme Court precedent, Progressive understood and understands "expenses incurred" to mean expenses that the insured becomes obligated to pay. *See Gordon*, 238 S.C. at 446, 120 S.E.2d at 513. Jones is a Medicaid beneficiary, so she was never obligated to pay more than the Medicaid-adjusted rates. As a result, Progressive paid her medical payments claim at the Medicaid-adjusted rates rather than the "sticker prices" she was never obligated to pay. As a matter of law, this was not a fraudulent act. Jones failed to allege any facts which would tend to prove Progressive committed a fraudulent act accompanying its alleged breach of contract. Therefore, the Circuit Court also properly dismissed her breach of contract accompanied by a fraudulent act claim for this reason. *See RoTec Servs., Inc.*, 359 S.C. at 470, 597

S.E.2d at 883 (holding trial court's dismissal of this claim was proper where Encompass "failed to allege any facts which would tend to prove Rotec committed a fraudulent act accompanying its alleged breach of contract").

V. The Circuit Court properly denied Jones' claim for attorney's fees.

"Attorney's fees are not recoverable unless authorized by contract or by statute." *South Carolina Dep't of Soc. Servs. v. Tharp*, 312 S.C. 243, 245, 439 S.E.2d 854, 856 (1994). Nothing in the Progressive insurance contract allows for the recovery of attorney's fees in this case. *See* (Policy). Although attorney's fees may be awarded in a bad faith action pursuant to South Carolina Code § 38-59-40, there must be a trial judge's specific "finding of fact supported by the evidence" that the refusal to pay was without reasonable cause. *Baker v. Pilot Life Ins. Co.*, 268 S.C. 609, 613, 235 S.E.2d 300, 302 (1977); S.C. Code § 38-59-40(1) (requiring "a finding on suit of the contract made by the trial judge that the refusal was without reasonable cause or in bad faith").[8] Here, there was no such finding of fact supported by the evidence. Rather, the Circuit Court properly dismissed Jones' bad faith claim, finding Progressive had a reasonable basis to refuse payment of Jones' medical payments claim at the "sticker prices" rather than the Medicaid-adjusted rates. (February 10, 2021 Circuit Court Order, pp. 2-3); (April 6, 2023 Circuit Court Order, p. 4). As shown above, Progressive had a reasonable basis for contesting this claim.[9]

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[8] In her Appellant Brief, Jones has limited her attorney's fees claim to this statute. (Jones' Appellant Brief, p. 16 (seeking attorney's fees "under S.C. Code Ann. § 38-59-40 (2015)")).

[9] In her own Brief, Jones acknowledges that the *Barker* court's analysis supports Progressive's position and that this Court would have to find its analysis to be in error to find for Jones. *See* (Jones' Appellant Brief, pp. 11, 13 (alleging Barker is "wrongly decided" and that "the district court wrongfully predicted the application of South Carolina law" and that the "order is wrong, and this Court should reject that analysis").

Moreover, the South Carolina Supreme Court has explicitly cautioned against awarding attorney's fees when an insurer is contesting "legal principles of novel impression is this State" because "[c]ertainly in a free society, one is entitled to properly litigate without the fear of unequal punishment." *Nelson v. United Fire Ins. Co. of New York*, 275 S.C. 92, 97, 267 S.E.2d 604, 607 (1980); *Greene v. Durham Life Ins. Co.*, 287 S.C. 197, 199, 336 S.E.2d 478, 480 (1985) (denying attorney's fees because insurer "should not be penalized for its decision to litigate a meritorious issue"); *see also Wiggins v. Travelers Ins. Co.*, 498 F. Supp. 211, 213 (D.S.C. 1979), *aff'd sub nom. Freddie Wiggins, Jr. v. Travelers Ins. Co.*, 636 F.2d 1215 (4th Cir. 1980). "The legislature did not intend, by enactment of [the attorney fee statute], that attorneys' fees should be paid in every contested case won by the insured." *Boggs v. Aetna Cas. & Sur. Co.*, 272 S.C. 460, 465, 252 S.E.2d 565, 568 (1979). Therefore, the Circuit Court properly denied Jones' claim for attorney's fees.

CONCLUSION

For the above-stated reasons, the Circuit Court's dismissal of Jones' bad faith, breach of fiduciary duty, breach of the covenant of good faith and fair dealing, breach of contract accompanied by a fraudulent act, and violation of South Carolina Code § 38-77-144 claims should be affirmed. With respect to the statutory cause of action, that statute is inapplicable to the conduct at issue and does not create a private cause of action.

With respect to the common law causes of action, many of which are duplicative, the alleged conduct at issue is permitted by the Policy terms and South Carolina law. The Policy only requires Progressive to pay for certain medical "expenses incurred" by the insured. The South Carolina Supreme Court previously held that the phrase "expenses incurred" requires an obligation on the part of the insured to pay such expense. Jones is a Medicaid recipient. Prior to treatment

being rendered, Medicaid has agreements in place with its providers to accept certain rates as payment in full. As a result, Jones never became obligated to pay any medical expenses beyond the Medicaid-adjusted rates, which Progressive has already paid. Therefore, all of Jones' common law claims based on this conduct were properly dismissed.

In addition, the Circuit Court properly found that Progressive had a reasonable basis to contest reimbursement to Jones under the medical payments coverage at a higher rate she rather than the Medicaid-adjusted rates. As a result, Jones' bad faith and statutory attorney's fees claims were also properly decided in Progressive's favor.

Progressive respectfully requests that the Court affirm the Circuit Court's rulings on these causes of action.

Respectfully submitted,

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November 13, 2023

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IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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

Alexis Jones ....Respondent – Appellant,

v.

Progressive Northern Insurance Company...Appellant – Respondent.

CERTIFICATE OF COMPLIANCE

I, J.R. Murphy, attorney for Appellant-Respondent, certify that the Initial Respondent Brief of Progressive Northern Insurance Company complies with the South Carolina Supreme Court Order of August 13, 2007.

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PROOF OF SERVICE

I certify that I have served the Initial Respondent Brief of Appellant-Respondent on Alexis Jones by depositing a copy of it in the United States Mail, postage prepaid, on November 13, 2023, addressed to her attorneys of record, J. Logan Cannon, Esquire, P.O. Drawer 36250, Rock Hill, South Carolina 29732 and by electronic mail at cannon@shawlawfirm.net and John S. Nichols, Esquire, Bluestein Thompson Sullivan, LLC, PO Box 7965, Columbia, SC 29202, and by electronic mail at john@bluesteinattorneys.com.

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