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.

FINAL APPELLANT'S BRIEF OF RESPONDENT / CROSS-APPELLANT

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II. Did the circuit court err in dismissing Ms. Jones's claims for violation of S.C. Code Ann. § 38-77-144 (2015) because the statute does not create a private cause of action?

III. Did the circuit court err in denying Ms. Jones's claim for an award of attorney fees pursuant to S.C. Code Ann. § 38-59-40 (Supp. 2022)?

STATEMENT OF THE CASE

Alexis Jones was injured in an automobile collision on October 8, 2019. (R. p. 22). She suffered bodily injury and incurred medical expenses for which her providers charged in excess of $10,000.00. (R. p. 22). Ms. Jones submitted the claims to Progressive for payment under a Progressive policy covering the vehicle Ms. Jones was driving which included a limit of $10,000 in MedPay coverage. (R. pp. 22-23). However, because Ms. Jones was independently covered by Medicaid, Progressive refused to pay the full amount of the medical bills, instead paying only those reduced amounts Medicaid paid.

On March 30, 2020, Ms. Jones filed an action against Progressive for a declaratory judgment that Progressive's MedPay policy owed her $10,000 in total benefits, for damages for breach of contract, damages for Progressive's bad faith or unreasonable conduct in adjusting the claim, and statutory attorney fees. (R. pp. 21-31).

On April 29, 2020, Progressive filed an answer, contending its obligation was to pay only those amounts Ms. Jones "actually incurred," and thus Progressive only owed $1,323.00, the amount Medicaid paid to Ms. Jones's medical providers. (R. pp. 32-38).

On May 11, 2020, Progressive moved to dismiss Ms. Jones's complaint. (R. p. 38). Ms. Jones filed a Memorandum in Opposition to Progressive's motion. (R. pp. 94-106). On August 10, 2020, the circuit court entered a Form 4 order granting Progressive's motion as to Ms. Jones's claim under the SC Unfair Trade Practices Act but denying the remainder of the motion. (R. pp. 2-4).

On August 17, 2020, Ms. Jones filed an Offer of Judgment pursuant to Rule 68, SCRCP for $12,500. Thereafter, Progressive moved pursuant to Rule 59, SCRCP, to Alter or Amend the

August 10, 2020 order. The circuit court granted the motion in part and denied it in part. (R. pp. 5-10). The court ruled that because Progressive submitted case law that appeared to support Progressive's position, "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." (R. p. 7). The circuit court also held that S.C. Code Ann. § 38-77-144 (2015) does not create a private cause of action. (*Id.*)The court dismissed Ms. Jones's causes of action except for a claim for breach of contract. (*Id.*)

On May 28, 2021, the parties entered into a stipulation of facts as follows:

1. Alexis Jones was injured in an automobile accident that occurred on October 8, 2019.

2. She was riding in a vehicle owned by Willie Brown and insured by Defendant Progressive Northern Insurance Company under policy number 930693102. The policy provided medical payments coverage of $10,000.00 per person.

3. The Plaintiff received medical treatment from several providers following an automobile accident that occurred on October 8, 2019. Those providers include the Medical University of South Carolina-Lancaster, and Carolina Radiology Associates, LLC.

4. The Plaintiff was a Medicaid recipient and was entitled to benefits pursuant to WellCare of South Carolina Medicaid.

5. On October 8, 2019, Plaintiff was treated at the MUSC facility in Lancaster, South Carolina. The total charges were $23,742.82.

6. MUSC was required by law and/or its agreement with South Carolina Medicaid to accept the sum of $115.52 for all treatment rendered to Plaintiff on October 8, 2019.

7. Plaintiff made no payments to MUSC for the treatment received on October 8, 2019 nor is she legally obligated to make any further payment

other than the amount accepted by MUSC from South Carolina Medicaid.

8. On October 8, 2019, Plaintiff was treated by physicians in the Emergency Room Department at the MUSC facility in Lancaster, South Carolina (App of South Carolina ED, PLLC). The total charges were $883.63.

9. App of South Carolina ED PPLC was required by law and/or its agreement with South Carolina Medicaid to accept the sum of $89.13 for all treatment rendered to Plaintiff on October 8, 2019 by the MUSC Emergency Room Department physicians.

10. Plaintiff made no payments to App of South Carolina ED PPLC for the treatment she received on October 8, 2019, nor is she legally obligated to may any further payment other than the amount accepted by App of South Carolina ED PPLC from South Carolina Medicaid.

11. On October 9, 2019, Plaintiff was treated at the MUSC facility in Lancaster, South Carolina. The total charges were for MUSC were $1,726.09.

12. MUSC was required by law and/or its agreement with South Carolina Medicaid to accept the sum of $165.17 for all treatment rendered to the Plaintiff on October 9, 2019.

13. Plaintiff made no payments to MUSC for the treatment received on October 8, 2019, nor is she legally obligated to make any further payment other than the amount accepted by MUSC from South Carolina Medicaid.

14. On October 9, 2019, Plaintiff underwent diagnostic radiology by Carolina Radiology Associates, LLC. The total charges for Carolina Radiology Associates, LLC were $550.00.

15. Carolina Radiology Associates, LLC was required by law and/or its agreement with South Carolina Medicaid to accept the sum of $70.15 for all treatment rendered to Plaintiff on October 9, 2019.

16. Plaintiff made no payments to Carolina Radiology Associates, LLC for the treatment received on October 9, 2019 nor is she legally obligated to make any further payment other than the amount accepted by Carolina Radiology Associates, LLC from South Carolina Medicaid.

17. Plaintiff was a recipient of South Carolina Medicaid which had agreements in place with the medical providers listed above which

> required the medical providers to accept the total sum of $439.97 for the treatment rendered to the Plaintiff. The 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 listed above.

(R. pp. 138-140).

The circuit court heard the matter by bench trial on March 23, 2023. (R. pp. 14-19). On March 29, 2023, the circuit court entered a Form 4 order ruling in favor of Ms. Jones that Progressive had to pay the full amount of the medical charges, not the amount reduced due to Medicaid payments. (R. pp. 10-13). The court denied Ms. Jones's claim for attorney fees based upon the court's prior order dismissing her claim of bad faith. (R. pp. 11). The court issued a more complete order on April 6, 2023 and ordered judgment for Ms. Jones in the amount of $8,676.40. (R. p. 18).

On April 24, 2023, Progressive served and filed a Notice of Appeal. Ms. Jones filed and served a Notice of Cross Appeal on May 3, 2023.

STANDARD OF REVIEW

There are separate standards of appellate review applicable to the issues Ms. Jones raises on appeal. Accordingly, Ms. Jones provides a separate discussion of the standard of review under each issue. Rule 208(b)(1)(D), SCACR.

ARGUMENTS

I. The Circuit Court Erred in Dismissing Ms. Jones's Claims for Bad Faith, Breach of the Duty of Good Faith and Fair Dealing, Breach of Fiduciary Duty, and Breach of Contract Accompanied by a Fraudulent Act Pursuant to Rule 12(b)(6), SCRCP

A. Standard of Review

The circuit court dismissed Ms. Jones's causes of action under Progressive's motion to dismiss pursuant to Rule 12(b)(6), SCRCP. This Court reviews the trial court's grant of Progressive's motion under the same standard as the circuit court when reviewing the dismissal of an action pursuant to Rule 12(b)(6), SCRCP. *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 631–32, 699 S.E.2d 699, 703 (Ct. App. 2010) ("In considering a motion to dismiss a complaint based on a failure to state facts sufficient to constitute a cause of action, the trial court must base its ruling solely on allegations set forth in the complaint.").

B. Discussion

Ms. Jones alleged causes of action for: (1) breach of contract; (2) bad faith/breach of duty of good faith and fair dealing/breach of fiduciary duty; (3) violation of the South Carolina Unfair Trade Practices Act (SCUTPA); (4) violation of South Carolina Code Ann. § 38-77-144 (2015); and (5) breach of contract accompanied by a fraudulent act. The circuit court initially dismissed only the SCUTPA claim and Ms. Jones does not appeal that ruling. However, on reconsideration, the circuit court also dismissed Ms. Jones's remaining claims except for the breach of contract claim. Ms. Jones contends dismissal of these other claims was in error.

(1) Bad Faith/Breach of Duty of Good Faith and Fair Dealing/Breach of Fiduciary Duty

The circuit court ruled as a matter of law that Ms. Jones could not pursue claims for bad faith against Progressive because Progressive had a "meritorious coverage defense" based upon Progressive's cite to *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. April 24, 2013), and cases from foreign jurisdictions purporting to support Progressive's position. (R. pp. 6-7). This Court should reverse this ruling.

As a means of protecting insureds who ordinarily possess no bargaining power when entering into an insurance contract, the Supreme Court recognized a tort action for an insurer's bad faith refusal to pay first party benefits in *Nichols v. State Farm Mut. Auto. Ins. Co.*, 279 S.C. 336, 306 S.E.2d 616 (1983). *Kleckley v. Northwestern Nat. Cas. Co.*, 338 S.C. 131, 134-135, 526 S.E.2d 218, 219 (2000).

> The elements of an action for bad faith refusal to pay benefits under an insurance contract include: "(1) the existence of a mutually binding contract of insurance between the plaintiff and the defendant; (2) refusal by the insurer to pay benefits due under the contract; (3) resulting from the insurer's bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing arising on the contract; (4) causing damage to the insured." *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359–60, 415 S.E.2d 393, 396–97 (1992). "An insured may recover damages for a bad faith denial of coverage if he or she proves there was no reasonable basis to support the insurer's decision to deny benefits under a mutually binding insurance contract." *Dowling v. Home Buyers Warranty Corp.*, 303 S.C. 295, 297, 400 S.E.2d 143, 144 (1991) (citing *Varnadore v. Nationwide Mut. Ins. Co.*, 289 S.C. 155, 345 S.E.2d 711 (1986); *Nichols v. State Farm Mut. Auto. Ins. Co.*, 279 S.C. 336, 306 S.E.2d 616 (1983)).

Cock-N-Bull Steak House v. Generali Ins. Co., 321 S.C. 1, 6, 466 S.E.2d 727, 730 (1996).

Progressive's ground for contesting Ms. Jones's claim for full benefits under the

insurance contract must therefore be reasonable. *See, e.g., Helena Chem. Co. v. Allianz Underwriters Ins. Co.*, 357 S.C. 631, 645, 594 S.E.2d 455, 462 (2004) ("Under South Carolina law, an insurer acts in bad faith when there is no reasonable basis to support the insurer's decision. But '[i]f there is a reasonable ground for contesting a claim, there is no bad faith.'") (quoting *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 360, 415 S.E.2d 393, 397 (1992))). The record demonstrates Progressive's denial was not reasonable as a matter of law such that the trial court should have denied the motion to dismiss.

Progressive cited to a 1961 South Carolina Supreme Court case involving a soldier's receipt of military medical care and a 2013 unpublished United States District Court case comparing payments under the Medicare program with payments due under a supplemental "limited benefit health coverage" policy. Neither of those cases related to Medicaid, neither case controlled this matter, and neither case was even persuasive on the issue of Progressive's reasonableness for denying Ms. Jones the full MedPay benefits under the insurance agreement, in light of settled precedent from the Supreme Court of South Carolina.

The first case Progressive cited is *Gordon v. Fidelity & Cas. Co. of N.Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961). Mr. Gordon was a career soldier in the US Army. He obtained from F&G a liability insurance policy covering a motor scooter. The F&G policy required the company:

> To pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical, x-ray and dental services, including prosthetic devices and necessary ambulance, hospital, professional nursing and funeral services * * *.

Gordon, at 441, 120 S.E.2d at 510. Mr. Gordon was injured while riding the scooter and was hospitalized at the government hospital at Fort Jackson for treatment of his injuries. He received

treatment at no charge due to his status as an Army soldier.

Mr. Gordon submitted claims to F&G for payment of the "reasonable cost" of his treatment based upon the appraisal of two physicians and the prevailing rates at a Columbia hospital. F&G refused to pay, asserting Mr. Gordon "incurred no expenses for the hospitalization and medical treatment received at the Fort Jackson hospital." *Id.*

The Court held "incur emphasizes the idea of liability." *Id.*, at 445, 120 S.E.2d at 512. The Court noted "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...." *Id.*, at 446, 120 S.E.2dat513. Because of the stipulation, the Court observed "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." *Id.* The Court concluded, "[t]here being no obligation on the part of the respondent to pay for the hospitalization he received at Fort Jackson hospital, he 'incurred' no expense within the meaning of the provision of the policy of insurance issued by the appellant." *Id.*, at 446, 120 S.E.2d at 513.

Gordon does not control here, nor is it persuasive on the issue. Unlike the plaintiff in *Gordon*, who stipulated he incurred no expense for treatment at the military hospital, Ms. Jones did incur liability for her medical care as well as expenses for her treatment. She was not a member of the Armed Forces eligible to receive treatment without expense at a military hospital. Furthermore, insofar as *Gordon* would permit Progressive to pay less than the ordinary charges for medical care, *Gordon* is inconsistent with much more recent Supreme Court precedent. *See Covington v. George*, 359 S.C. 100, 597 S.E.2d 142 (2004) (evidence that amount hospital accepted in payment was less than what hospital ordinarily charges for its services was

inadmissible under collateral source rule); *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003) (amounts "written off" by healthcare providers are recoverable by a plaintiff in a personal injury suit under the collateral source rule). The Court in *Covington* stated:

> In *Haselden*, the Plaintiff submitted evidence that she *incurred* medical expenses in the amount of $77,905.21. Medicaid paid $24,109.04 to cover the services. The difference between the amounts billed and the amounts actually paid by Medicaid was $51,620.59. Defendants entered a letter as a court exhibit, which showed the gross amount of the bills for Plaintiff's services and the corresponding Medicaid payments. 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.

Covington, 597 S.E.2d at 143-144 (emphasis added)(citations omitted). Because of the collateral source rule, the Supreme Court found the tortfeasor could not take advantage of the contract between the injured party and a third person, "no matter whether the source of the funds is 'an insurance company, an employer, a family member, or other source.'" *Id.* The Court noted the "actual payment amounts were made by a collateral source," *i.e.*, reductions by each medical provider. *Id.*

The other case Progressive cited was *Barker v. Washington Nat. Ins. Co.,* C.A. No. 9:12-cv-1901-PMD (D.S.C. 2013), 2013 WL 1767620. The U.S. district court in *Barker* attempted to predict South Carolina law. Citing to *Gordon*, the district court concluded "as a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill...." The district court did not analyze the case under the collateral source rule as described in *Covington* or *Haselden*. Respectfully, Judge Duffy's unpublished order is wrong, and this Court should reject that analysis. Additionally, the order is not binding on this Court.

Both *Barker* and *Gordon*, therefore, are distinct from this case in meaningful ways.

Progressive's reliance on these two authorities was not reasonable as neither case dictated the result Progressive sought. Thus, there was evidence that there was no reasonable basis for Progressive to refuse to pay the amount the contract with Ms. Jones required Progressive to pay. Dismissal of Ms. Jones's bad faith claims as a matter of law was not proper. See *Nichols v. State Farm Mut. Auto. Ins. Co.*, 279 S.C. 336, 306 S.E.2d 616 (1983) (negligence on the issue of unreasonable refusal to pay benefits due under an insurance contract is for the finder of facts).

Accordingly, this Court should reverse the circuit court's order and remand the matter for proceedings consistent with this Court's ruling.

(2) Breach of Contract Accompanied by a Fraudulent Act

The circuit court initially denied Progressive's motion to dismiss this cause of action. However, the court dismissed this cause of action following Progressive's motion for reconsideration, holding Ms. Jones may not pursue the claim "under these circumstances." (R. p. 6). This Court should reverse.

In *Connor v. City of Forest Acres*, the Supreme Court stated:

> 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; (2) fraudulent intent relating to the breaching of the contract and not merely to its making; and (3) a fraudulent act accompanying the breach. *Harper v. Ethridge*, 290 S.C. 112, 348 S.E.2d 374 (Ct. App. 1986). The fraudulent act is any act characterized by dishonesty in fact *or unfair dealing. Id.* "Fraud," in this sense, "assumes so many hues and forms, that courts are compelled to content themselves with comparatively few general rules for its discovery and defeat, and allow the facts and circumstances peculiar to each case to bear heavily upon the conscience and judgment of the court or jury in determining its presence or absence." *Sullivan v. Calhoun*, 117 S.C. 137, 139, 108 S.E. 189, 189 (1921) (citation omitted).

348 S.C. 454, 465-466, 560 S.E.2d 606, 612 (2002) (emphasis added).

Here, Ms. Jones provided evidence that Progressive engaged in unfair dealing in the manner in which Progressive adjusted her claims for MedPay benefits. Progressive relied upon *Gordon*, a case that is meaningfully distinct and greatly predates settled precedent to the contrary, and *Barker*, a non-binding US District Court case that is also meaningfully distinct and is wrongly decided. *Barker* relied upon *Gordon*, the same older case, and the district court wrongfully predicted the application of South Carolina law. Neither Progressive nor the district court analyzed relevant, applicable, and more recent precedent. Ms. Jones was therefore required to bring suit to force Progressive to honor its contractual commitments.

The circuit court should not have dismissed this cause of action under Progressive's motion to dismiss. This Court should reverse and remand for proceedings consistent with its mandate.

(3) Violation of South Carolina Code Ann. § 38-77-144 (2015)

The propriety of the circuit court's dismissal of this claim is discussed in the next section of this brief.

II. The Circuit Court Erred in Dismissing Ms. Jones's Claims for Violation of S.C. Code Ann. § 38-77-144 (2015) Because the Statute Permits a Private Cause of Action

A. Standard of Review

The circuit court ruled as a matter of law that S.C. Code Ann. § 38-77-144 (2015) does not provide a private right of action. Determining the proper interpretation of a statute is a question of law, and the appellate court reviews questions of law *de novo*. *State Farm Mut. Auto. Ins. Co. v. Windham*, 438 S.C. 156, 882 S.E.2d 754 (2022).

B. Discussion

In dismissing Ms. Jones's assertion of a violation of S.C. Code Ann. § 38-77-144 (2015), the circuit court held that Section 38-77-144 does not provide a private right of action. The Court should reverse that ruling and remand for further proceedings.

Section 38-77-144 provides:

> 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 Ann. § 38-77-144 (2015). This statute removed the requirement that automobile insurers offer PIP or MedPay coverage, and provided that if an insurer did sell PIP, MedPay, or economic loss coverage, "the coverage shall not be assigned or subrogated and is not subject to setoff." Under this clause, the coverage may not be reduced by recovery from collateral sources.

The statute does not expressly create a private right of action for an insurer's refusal to pay MedPay or PIP benefits due under the insurance contract. Ms. Jones contended the statute

must provide a private right in order to permit an insured to require an insurer to comply with the statute. The circuit court disagreed and dismissed this claim. This was error.

The Supreme Court recently set forth the applicable rules for determining whether a statute provides a private right of action:

> The main factor in determining whether a statute gives rise to a private cause of action is legislative intent, which is determined primarily from the language of the statute. *Kubic v. MERSCORP Holdings, Inc.*, 416 S.C. 161, 168, 785 S.E.2d 595, 599 (2016); *Georgetown Cnty. League of Women Voters v. Smith Land Co.*, 393 S.C. 350, 353, 713 S.E.2d 287, 289 (2011) (quoting [*Doe v. Marion*, 373 S.C. 390, 396, 645 S.E.2d 245, 248 (2007)]). Generally, when a statute does not expressly create civil liability, a duty will not be implied unless the statute was enacted for the special benefit of a private party. *Marion*, 373 S.C. at 397, 645 S.E.2d at 248; *see also 16 Jade St., L.L.C. v. R. Design Constr. Co.*, 405 S.C. 384, 389–90, 747 S.E.2d 770, 773 (2013) (applying the rules for establishing a private cause of action in the context of determining whether a statute imposes a legal duty); *Citizens for Lee Cnty., Inc. v. Lee Cnty.*, 308 S.C. 23, 28, 416 S.E.2d 641, 645 (1992) ("The threshold consideration here is whether or not [plaintiffs] ... have an implied cause of action under the statute, since no private right of action is expressly provided.... [T]his Court held that assuring that legislation was enacted for the special benefit of the private party is a test for determining whether a right of private action is created by implication." (citation omitted)). "In this respect, the 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." *Whitworth v. Fast Fare Mkts. of S.C., Inc.*, 289 S.C. 418, 420, 338 S.E.2d 155, 156 (1985) (quoting 73 Am. Jur. 2d. *Statutes* § 432 (1974)); *see also* [*Rayfield v. S.C. Dep't of Corr.*, 297 S.C. 95, 103, 374 S.E.2d 910, 914 (Ct. App. 1988)] ("In order to show that the defendant owes him a duty of care arising from a statute, the plaintiff must show two things: (1) that the essential purpose of the statute is to protect from the kind of harm the plaintiff has suffered; and (2) that he is a member of the class of persons the statute is intended to protect.").

Denson v. National Casualty Co., 439 S.C. 142, 151-152, 886 S.E.2d 228, 233-234 (2023).

The essential purpose of Section 38-77-144 is not to secure the safety or welfare of the public. Instead, the statute was enacted for the purpose of protecting an insured who elects to purchase PIP or MedPay coverages an insurer voluntarily offers to the insured. The essential

purpose of the statute is to create no-fault coverage for payment of medical bills or lost wages, and to prevent any assignment, subrogation or set-off of those benefits.

Progressive seeks a set-off for reductions done due to a collateral course, Medicaid. The only way Ms. Jones, as the insured, can enforce the express provisions of Section 38-77-144 is by bringing a private lawsuit. *Cf. Nichols v. State Farm Mut. Ins. Co.*, 279 S.C. 336, 340, 306 S.E.2d 616, 619 (1983) ("Absent the threat of a tort action, the insurance company can, with complete impunity, deny any claim they wish, whether valid or not."). Her right to sue to force Progressive to follow the plain language of Section 38-77-144 is implied within the statute's language and purpose.

This Court should reverse the trial court's ruling and remand the matter with instructions to permit Ms. Jones to proceed with her claim under Section 38-77-144.

III. The Circuit Court Erred in Denying Ms. Jones's Claim for an Award of Attorney Fees Pursuant to S.C. Code Ann. § 38-59-40 (Supp. 2022)

A. Standard of Review

Regarding the circuit court's denial of statutory attorney fees, the factual finding of unreasonableness or bad faith is a condition precedent to an award of attorney's fees under S.C. Code Ann. § 38-59-40 (2015). *Flynn v. Nationwide Mut. Ins. Co.*, 281 S.C. 391, 315 S.E.2d 817 (Ct. App. 1984) (construing predecessor statute), citing *Brown v. State Farm Mutual Insurance Company*, 275 S.C. 276, 269 S.E.2d 769 (1980). The determination of whether attorney's fees should then be awarded is one in equity, made without the aid of a jury. *Flynn.* Thus, this Court is free to find facts in accordance with its view of the preponderance of the evidence. *Flynn*,

citing *Brown* and *Baker v. Pilot Life Insurance Company*, 268 S.C. 609, 235 S.E.2d 300 (1977).

In an action at equity, tried by a judge alone, this Court's standard of review is *de novo*. *Fountain v. Fred's, Inc.*, 436 S.C. 40, 47, 871 S.E.2d 166, 170 (2022); *Lewis v. Lewis*, 392 S.C. 381, 385–86, 709 S.E.2d 650, 651–52 (2011). In short, "[w]e have jurisdiction in appeals in equity to find the facts in accord with our view of the preponderance or greater weight of the evidence, in the absence of verdict by jury." *Fountain*, at 47, 871 at 170, citing *Gilbert v. McLeod Infirmary*, 219 S.C. 174, 184, 64 S.E.2d 524, 528 (1951).

This factual determination should be made based on consideration of relevant evidence adduced at the trial of the case which resulted in judgment for the insured, as well as any other competent evidence of the lack of reasonable cause or bad faith of the insurer in refusing to pay the claim. *Flynn*, citing *Coker v. Pilot Life Insurance Company*, 265 S.C. 260, 217 S.E.2d 784 (1975).

B. Discussion

The circuit court held that because it found in a prior order that Progressive's denial of payment of the full amount was not in bad faith, "and made no finding at trial or in its review of the record that would suggest the refusal was made in bad faith or without reasonable cause," (R. p. 11), Ms. Jones was not entitled to attorney fees pursuant to S.C. Code Ann. § 38-59-40 (Supp. 2022). Ms. Jones has challenged the dismissal of her bad faith claim. Further, she presented evidence Progressive's refusal to pay full MedPay benefits was without reasonable cause. The Court should reverse this ruling and remand the matter for the court to enter an order awarding reasonable attorney fees pursuant to Section 38-59-40.

An insurer is not required to pay attorney's fees in every case won by an insured. *Flynn v. Nationwide Mut. Ins. Co.*, 281 S.C. 391, 315 S.E.2d 817 (Ct. App. 1984), citing *Nelson v. United Fire Insurance Company of New York*, 275 S.C. 92, 267 S.E.2d 604 (1980) and *Madden v. Pilot Life Insurance Company*, 272 S.C. 264, 251 S.E.2d 196 (1979). However, Section 38-59-40 of the South Carolina Code provides:

> In the event of a claim, loss, or damage which is covered by a policy of insurance or a contract of a nonprofit hospital service plan or a medical service corporation and the refusal of the insurer, plan, or corporation to pay the claim within ninety days after a demand has been made by the holder of the policy or contract and a finding on suit of the contract made by the trial judge that the *refusal was without reasonable cause or in bad faith*, the insurer, plan, or corporation *is liable to pay the holder*, in addition to any sum or any amount otherwise recoverable, all reasonable attorneys' fees for the prosecution of the case against the insurer, plan, or corporation. The amount of reasonable attorneys' fees must be determined by the trial judge and the amount added to the judgment. The amount of the attorneys' fees may not exceed one-third of the amount of the judgment.

S.C. Code Ann. § 38-59-40 (Supp. 2022) (emphasis added). Thus, an insurer "is liable" to an insured for reasonable attorneys' fees as determined by the trial judge upon a finding of one of two things: (1) refusal to pay the claim without reasonable cause, *or* (2) refusal to pay the claim due to bad faith. Here, the trial judge erred as a matter of law by stating that his finding that Progressive did not act in bad faith precluded payment under the statute. The preponderance of the evidence demonstrates that Progressive at least acted without reasonable cause in light of the settled law of South Carolina.

Progressive refused to pay Ms. Jones upon Progressive's erroneous argument that her contract of insurance permitted Progressive to limit payment to the medical expenses she "actually incurred," which Progressive arbitrarily deemed to be the reduced amount paid by a

collateral source, Medicaid. Settled precedent dictated that Progressive pay the full amount of the cost Ms. Jones incurred, not the reduced amount her medical provider agreed to accept from her health insurer. *See Covington v. George*, 359 S.C. 100, 597 S.E.2d 142 (2004) (evidence that amount hospital accepted in payment was less than what hospital ordinarily charges for its services was inadmissible under collateral source rule); *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003) (amounts "written off" by healthcare providers are recoverable by a plaintiff in a personal injury suit under the collateral source rule).

The circuit court correctly applied the collateral source rule in holding that Progressive could not benefit from the reduced amounts the medical providers accepted under Medicaid. However, the circuit court erred in refusing to award Ms. Jones her reasonable attorney fees for having to pursue this litigation to force Progressive to honor its agreement. This Court should reverse that ruling and remand the matter for further proceedings consistent with this Court's opinion.[1]

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[1] This would include an additional determination of attorney fees for having to pursue this appeal. See Cook v. Government Emp. Ins. Co., 266 S.C. 309, 223 S.E.2d 33 (1976) (an award under the statute for having to prosecute the case would include an award for fees before the lower court as well as fees for the appeal).

CONCLUSION

For the reasons stated the Court should reverse the trial court's order dismissing Ms. Jones's claims for bad faith, violation of Section 38-77-144, and breach of contract accompanied by a fraudulent act, and remand this matter for further proceedings. The Court should also reverse the circuit court's order denying Ms. Jones's motion for an award of fees and costs, and should remand the matter for entry of judgment in accordance with this Court's mandate.

Respectfully submitted,

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