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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.

APPELLANT BRIEF OF APPELLANT-RESPONDENT

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STATEMENT OF ISSUE ON APPEAL

I. **Whether the Circuit Court should have found in favor of Progressive on Jones' breach of contract cause of action because Jones, a Medicaid recipient, only incurred medical expenses at the Medicaid-adjusted rates and Progressive paid all such expenses.**

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. Jones submitted her Medical Payments claim under a personal auto policy issued to Willie Brown under which Jones is listed as a driver and resident relative. The policy includes a $10,000 Medical Payments coverage limit for certain medical "expenses incurred" by an insured as a result of an accident. Jones is a Medicaid recipient. In South Carolina, Medicaid has agreements in place with medical service providers wherein the providers have agreed to accept reduced rates as payment-in-full prior to treating Medicaid recipients. Progressive based payment of Jones' Medical Payments claim on the Medicaid-adjusted rates actually charged by the medical providers and paid by Medicaid, rather than 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." Because the policy only provides Medical Payments coverage for certain medical "expenses incurred" by Jones and Jones did not incur expenses beyond the Medicaid-adjusted rates, Progressive paid her Medical Payments coverage for the Medicaid-adjusted rates.

FACTUAL AND PROCEDURAL BACKGROUND

A. The Progressive Policy

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"). (R. p. 53). The Policy includes a Medical Payments coverage limit of $10,000 each person. (R. p. 54). 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.

(R. p. 66). 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. (R. p. 22 ¶ 11). Jones made a claim for Medical Payments coverage under the Progressive Policy. (R. p. 23 ¶ 13). With her claim, Jones submitted medical provider billing statements in excess of $10,000. (R. pp. 22-23 ¶¶ 12-13). However, Jones is a Medicaid recipient. (R. pp. 5, 138 ¶ 4). Medicaid had agreements in place with medical service providers wherein the providers agreed to accept reduced rates as payment-in-full when treating Medicaid recipients. (Stipulation of Fact, R. pp. 138-140); (February 10, 2021 Circuit Court Order, R. p. 5). 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, R. p. 14). 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, R. p. 140 ¶ 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.

(R. p. 123, lines 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., R. pp. 23, 29-30 ¶¶ 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., R. pp. 21-31).

C. Motions and Circuit Court Orders[1]

On May 11, 2020, Progressive filed a Motion to Dismiss the Complaint and a Memorandum of Law in support. (R. pp. 38-52). 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. (R. pp. 2-4). On August 20, 2020, Progressive filed a Motion to Reconsider the August

[1] 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.

10, 2020 Order. (R. pp. 107-08). On February 10, 2021, the Circuit Court entered an Order granting the Motion to Reconsider in part and denying it in part. (R. pp. 5-9). 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.

(R. p. 7). 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. (R. p. 6). 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. (R. p. 7).

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. (R. pp. 10-19). The Circuit Court found the term "incurred" to be ambiguous. (R. p. 16). The Orders denied Jones' request for attorney's fees. (R. p. 17). Progressive's appeal and Jones' cross-appeal followed.

STANDARD OF REVIEW

"This Court reviews all questions of law de novo." *Fesmire v. Digh*, 385 S.C. 296, 302, 683 S.E.2d 803, 807 (Ct. App. 2009); *see also Clardy v. Bodolosky*, 383 S.C. 418, 425, 679 S.E.2d 527, 530 (Ct. App. 2009) ("Questions of law may be decided with no particular deference to the trial court."). "An action for breach of contract is an action at law." *Electro-Lab of Aiken, Inc. v.*

Sharp Constr. Co. of Sumter, 357 S.C. 363, 367, 593 S.E.2d 170, 172 (Ct. App. 2004). "[I]n order for this Court to affirm the circuit court's judgment, there must be evidence which reasonably supports the judge's findings." *Steeger v. Otto Zollinger, Inc.*, 287 S.C. 207, 208, 336 S.E.2d 870, 871 (1985).

ARGUMENT

The Complaint asserted a breach of contract claim premised on Progressive's payment of Jones' medical payments claim at the Medicaid-adjusted provider rates. Jones is a Medicaid recipient. Jones' providers agreed prior to her treatment to accept such amounts as payment in full. Because the Progressive Policy only provides Medical Payments coverage for "expenses incurred," such claim should have been dismissed. Under both federal and state Medicaid provisions, Jones never incurred expenses beyond her medical providers' Medicaid-adjusted rates.

I. With respect to the breach of contract claim, the Circuit Courts' Orders were in degradation of prior South Carolina Supreme Court precedent and should be reversed.

The Circuit Court should have denied Jones' breach of contract claim because there was no breach of the insurance contract. Jones premised such claim on Progressive paying the reduced rates Medicaid previously negotiated with Jones' medical providers rather than the "sticker prices" on the providers' initial bills. (Tr. Transcript, R. pp. 113-15). The insurance contract only provides medical expenses coverage for "expenses incurred." According to prior South Carolina Supreme Court precedent, for something to qualify as an "expense incurred," there must be an obligation to pay it. Because Jones is a Medicaid beneficiary, neither Jones nor Medicaid ever had an obligation to pay these "sticker prices." Consequently, these "sticker prices" were not "expenses incurred," and Progressive did not breach the insurance contract by refusing to pay them.

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). "[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).[2] The Policy provides Medical Payments coverage for certain "reasonable expenses **incurred** for necessary medical services." (Policy, R. p. 66) (emphasis added). Under the South Carolina Supreme Court's prior precedent, Jones did not incur expenses beyond the Medicaid-adjusted rates. Therefore, as to the breach of contract claim, the Circuit Courts Orders should be reversed.

In a similar Supreme Court case, *Gordon v. Fidelity & Cas. Co. of N. Y.*, the insured had an insurance policy that included medical expense coverage under which the insurer "agreed 'to pay all reasonable expense incurred' for necessary medical and surgical service." 238 S.C. 438, 444, 120 S.E.2d 509, 512 (1961). The Court held the insurer was not required to provide any medical expense coverage to the insured because the insured did not incur any expenses for medical treatment. *Id.* at 446, 120 S.E.2d at 513. The insured was a soldier and received free medical treatment at an army hospital for injuries he sustained in a motor vehicle accident. *Id.* at 441, 120 S.E.2d at 510. Thus, the insured incurred no expense for his treatment. As the Court explained:

> [T]he [insured] incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the [insurer] was not liable to the [insured] for the reasonable cost of his hospitalization, because the [insurer] had limited its liability to pay only 'all reasonable expenses incurred' by the [insured]. There being no obligation on the part of the [insured] 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 [insurer].

[2] 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).

Id. at 446, 120 S.E.2d at 513. Likewise, when Medicaid negotiates with medical providers for reduced rates for medical services, the insured incurs no expense above the reduced rates negotiated with the providers, and the insurer has no duty to pay amounts the insured did not actually incur.

Unlike the Circuit Court here, the South Carolina Supreme Court in *Gordon* did not find the phrase "expenses incurred" to be ambiguous. *See* (April 6, 2023 Circuit Court Order, R. p. 16 (finding term "incurred" to be ambiguous)). The South Carolina Supreme Court 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. *Id.* at 446, 120 S.E.2d at 513. 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. 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, R. p. 140 ¶ 17) (emphasis added). Thus, under South Carolina law, Jones has not **incurred** any medical expenses beyond those charged at the Medicaid-adjusted rates, which Progressive has already paid. Consequently, Progressive's act of paying Medical Payments coverage based on the Medicaid-adjusted rates is not a breach of the Progressive insurance contract. Such conduct is consistent with the policy terms and South Carolina law. Therefore, the Circuit Court erred by finding for Jones on her breach of contract claim.

II. With respect to the breach of contract claim, the Circuit Courts' Orders should be reversed because its findings are inconsistent with the way Medicaid works.

Jones argued and the Circuit Court found that "Plaintiff incurred the full cost of her medical treatment at the time services was rendered as she became obligated for that amount irrespective of

Medicaid." (April 6, 2023 Circuit Court Order, R. pp. 16-17). This finding completely ignores and is inconsistent with the way Medicaid works. As shown below, Medicaid already has agreements in place with Medicaid providers before a Medicaid recipient ever receives any treatment. Under these agreements, the provider cannot bill, demand or receive more than the Medicaid-adjusted rate. Therefore, the patient does not incur medical expenses beyond these Medicaid-adjusted rates. Consequently, Jones' breach of contract claim should have been denied because there was no breach under the policy terms and South Carolina law.

In a factually similar case, *Barker v. Washington Nat. Ins. Co.*, the insured had a policy that provided coverage for "the expenses incurred" for certain medical services and materials. No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013). The insured was a Medicare beneficiary, and the insurer adjusted his claim "by paying benefits based only on the debt [the insured] owed to the medical provider." *Id.* at *2. The insured brought a breach of contract claim and bad faith claim against the insurer arguing that the insurer was obligated to pay him the "total charges" on the medical bills "prior to any reductions resulting from any prior agreement between Medicare and the hospital." *Id.* at *4. The insured argued that the insurer's "use of Medicare adjustments was improper." *Id.* at *2. The Court rejected the insured's arguments and explained:

> As a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill, i.e., $55,241. Under 42 U.S.C. § 1395cc(a)(1)(A), a provider of services can participate in Medicare only if the provider files an agreement with the Secretary of Health and Human Services. Pursuant to this agreement, the participant accepts "assignment" of the Medicare payment, meaning that the provider must accept the Medicare approved charge as the full charge for the covered service and "shall not collect from the beneficiary ... more than the applicable deductible and coinsurance." Medicare Participating Physician or Supplier Agreement, Form CMS–460 (04/10), available at http://www.cms.gov/Medicare/CMS–Forms/CMS–Forms/CMS–Forms–Items/CMS–007566.html; *see* Costs & Assignment, Medicare.gov, http://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html (last visited Apr. 24, 2013) (explaining that, under Medicare Part A, "Assignment means that your ... provider ... agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services" and can "charge

you only the Medicare deductible and coinsurance amount"). The Southern District of New York recently addressed the issue of whether a Medicare recipient can "incur" the full fee a medical provider lists on its bill prior to applying the agreed-upon Medicare reductions, concluding that "[w]here Medicare contracts with a medical provider to set fees for a given service, the Medicare beneficiary is never liable for the amount forgone by a doctor under that agreement." *Metz v. U.S. Life Ins. Co.*, No. 09 Civ. 10250(BSJ), 2010 WL 3703810, at *3 (S.D.N.Y. Sept.21, 2010). The court further explained:

> A doctor who accepts Medicare assignment has signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services. [He] agree[s] to ... charge [the beneficiary only] the Medicare deductible and coinsurance amount and wait for Medicare to pay its share. Given this agreement, it is essentially impossible that Plaintiff would ever face liability for a provider's hypothetical full fee.

Id. (internal quotations and citations omitted). The Second Circuit Court of Appeals affirmed, concluding that under New York law, the Medicare recipient "did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her." *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir.2011). Similarly, **this Court concludes that under South Carolina law, Barker was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare**, which amount appears to be about $15,929.29.

Id. at *5-6 (emphasis added). As a result, the Court granted the insurer summary judgment on the insured's breach of contract (and bad faith) claim. *Id.* at *9.

Medicaid works the same way as Medicare. A Medicaid provider is also required to accept the Medicaid payment 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"). Jones stipulated that she "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, R. p. 140 ¶ 17). 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 Participation and Payment Agreement, Form (07/17), available at https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf.

Therefore, like in the *Barker* case, Jones never "incurred" expenses for medical services beyond the Medicaid-adjusted rates. *See State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212, 214 (Va. 1998) (holding insured did not "incur" expenses for medical payments coverage beyond those reduced rates negotiated between health insurance carrier and medical providers).[3] Consequently, Jones' breach of contract claim, which is based on this conduct, should have been dismissed. *See Grimes v. Gov't Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019) (dismissing breach of contract claim based on the same theory alleged in Jones' Complaint).

CONCLUSION

For the above-stated reasons, the Circuit Court's ruling in favor of Jones on the breach of contract claim should be reversed. The policy only requires Progressive to pay for certain medical "expenses incurred" by the insured. The South Carolina Supreme Court has previously found the phrase "expenses incurred" to not be ambiguous and defined that phrase as requiring an obligation

[3] *See also 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*, 662 F.3d at 602 (holding "incurred" for insurance coverage meant reduced rates negotiated by Medicare because insured "did not incur more than the amounts that 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).

on the part of the insured to pay such expense. Jones is a Medicaid recipient. Medicaid has agreements in place with its providers to accept certain rates as payment in full for treatment rendered. As a result, Jones never became obligated to pay any medical expenses beyond the Medicaid-adjusted rates, which Progressive has already paid. Therefore, Progressive did not breach the insurance contract by paying her claim at the Medicaid-adjusted rates.

Respectfully submitted,

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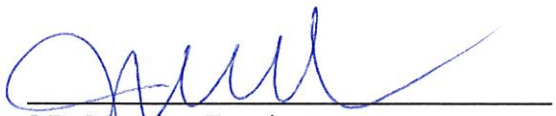
CERTIFICATE OF COMPLIANCE

I, J.R. Murphy, attorney for Appellant-Respondent, certify that the Final Appellant Brief of Progressive Northern Insurance Company complies with the South Carolina Supreme Court Order of August 13, 2007 and Rule 211(b), SCACR.



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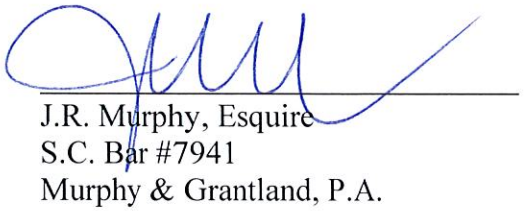
PROOF OF SERVICE

I certify that I have served the Final Appellant Brief of Appellant-Respondent on Alexis Jones by depositing a copy of it in the United States Mail, postage prepaid, on November 29, 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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