IN THE STATE OF SOUTH CAROLINA
In the Supreme Court

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

RECEIVED

May 16 2025

S.C. SUPREME COURT

Alexis Jones .....Respondent,

v.

Progressive Northern Insurance Company.....Petitioner.

PETITION FOR A WRIT OF CERTIORARI

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CERTIFICATION OF COUNSEL

The Court of Appeals issued its original Opinion in this case on February 26, 2025 (with an incorrect filing date of February 24, 2025 on the Opinion). (App. pp. 295-299). Counsel for the Petitioner certifies that the Petition for Rehearing was filed and served thirteen (13) days later on March 11, 2025. (App. pp. 300-309). The Court of Appeals ruled on the Petition for Rehearing by an Order filed on April 16, 2025. (App. pp. 326-327). The Court of Appeals also withdrew, substituted and refiled its Opinion on that same date without changing any of its substantive rulings. (App. pp. 328-332). This Petition for Writ of Certiorari is timely served and filed.

QUESTION PRESENTED

1. **With respect to Medical Payments coverage, whether a Medicaid recipient only incurs medical expenses at the Medicaid-adjusted rates that her medical providers have agreed to accept as payment in full before providing treatment?**

SUMMARY

Petitioner Progressive Northern Insurance Company ("Progressive") respectfully moves and petitions this Court, pursuant to Rule 242, SCACR, as well as other applicable law, for the issuance of a writ of certiorari to review the final decision of the Court of Appeals in this case. Petitioner respectfully submits that the Court of Appeals' April 16, 2025 decision is in direct conflict with this Court's prior decision of *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961) and demonstrates a fundamental misunderstanding of the way Medicaid works.

This appeal concerns what "expenses incurred" means in the context of medical payments coverage for a Medicaid recipient. The Progressive policy at issue only provides Medical Payments coverage for certain medical "expenses incurred" by an insured as a result of an accident. The Respondent is a Medicaid recipient. Before rendering treatment to Medicaid recipients, healthcare providers must first enter into a contract with the South Carolina Department of Health and Human Services. Under these provider contracts, the healthcare provider agrees 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. Thus, a Medicaid patient never incurs costs beyond the Medicaid-adjusted rates. His or her providers have already agreed before treatment to accept those rates as "payment in full." Consequently, Progressive paid Medical Payments coverage to Respondent in the amount of $1,323.60 – the same amount her medical providers accepted as payment in full for the treatment rendered. Respondent "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." (Stipulation of Fact, App. p. 141 ¶ 17). The Court of Appeals' April 16, 2025 Opinion held that Ms. Jones incurred $27,786.17 in medical expenses even though she readily admits that she never became obligated to pay this amount. (App. p. 330).

In *Gordon*, this Court defined what "expenses incurred" means in the context of Medical Payments coverage. As this Court explained, "a thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'." *Gordon*, 238 S.C. at 444, 120 S.E.2d at 512.[1] The Respondent stipulated that she was not obligated to pay more than $1,323.60. (App. pp. 138-140).

In the more than sixty (60) years since this decision, no court in South Carolina and no federal court applying South Carolina law has found that an insured can incur an expense for which there is no obligation to pay. In its February 26, 2025 and April 16, 2025 decisions, the Court of Appeals failed to accurately apply this binding Supreme Court precedent and, in doing so, upended

[1] The Court of Appeals' original Opinion purported to contain a quotation from the *Gordon* case defining "expenses incurred." However, no such quotation existed in *Gordon*. The Court of Appeals' substituted Opinion takes its definition of "expenses incurred" from a district court case. *Compare* (App. p. 296) *with* (App. p. 329).

more than sixty (60) years of precedent. Moreover, the case creates a conflict between the decisions of the South Carolina Court of Appeals and the United States District Court for the District of South Carolina when applying South Carolina law. *See Barker v. Washington Nat. Ins. Co.*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *6 (D.S.C. Apr. 24, 2013) ("[T]his 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.").

For the above-stated reasons, the Court of Appeals' decision conflicts with binding precedent from this Court. Moreover, this case presents an opportunity for this Court to provide sorely needed direction on this important question. Therefore, Petitioner respectfully requests that this Court grant the Petition.

STATEMENT OF THE CASE

I. Factual 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"). (App. p. 54). The Policy includes a Medical Payments coverage limit of $10,000 each person. (App. p. 55). 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.

(App. p. 67). Thus, the Policy only provides Medical Payments coverage for certain "expenses **incurred** for necessary medical services."

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

On October 8, 2019, Respondent was involved in an auto accident. (App. p. 23 ¶ 11). Respondent made a claim for Medical Payments coverage under the Progressive Policy. (App. p. 24 ¶ 13). With her claim, Respondent submitted medical provider billing statements in excess of $10,000. (App. pp. 23-24 ¶¶ 12-13). However, Respondent is a Medicaid recipient. (App. pp. 6, 139 ¶ 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, App. pp. 139-141); (February 10, 2021 Circuit Court Order, App. p. 6). Medicaid paid $1,323.60 total for the medical treatment Respondent received, and the medical providers accepted this amount as payment-in-full for the treatment rendered. *See* (April 6, 2023 Circuit Court Order, App. p. 15). Progressive paid Medical Payments coverage to Respondent in the amount of $1,323.60 – the same amount her medical providers accepted as payment in full for the treatment rendered. (*Id.*). Respondent 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, App. p. 141 ¶ 17). At the bench trial, Respondent 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.

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Q. And you had no deductibles, out-of-pockets, nothing. Everything that you owed the doctors have been paid for by Medicaid?
A. Yes.

(App. p. 124, lines 4-24).

Despite the foregoing, Respondent alleged that 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., App. pp. 24, 30-31 ¶¶ 14, 16, 25, Wherefore B.). Her 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., App. pp. 22-32).

II. Procedural History

On May 11, 2020, Progressive filed a Motion to Dismiss the Complaint and a Memorandum of Law in support. (App. pp. 39-53). 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. (App. pp. 3-5). On August 20, 2020, Progressive filed a Motion to Reconsider the August 10, 2020 Order. (App. pp. 108-09). On February 10, 2021, the Circuit Court entered an Order granting the Motion to Reconsider in part and denying it in part. (App. pp. 6-10). In this Order, the Circuit Court dismissed all the causes of action except for the breach of contract cause of action. (App. p. 8).

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. (App. pp. 11-20). The Circuit

Court found the term "incurred" to be ambiguous. (App. p. 17). Progressive and Respondent filed cross appeals.

On February 26, 2025, the Court of Appeals filed an unpublished decision affirming the Circuit Court as to all causes of action. (App. pp. 295-299). The Court of Appeals held that Respondent incurred medical expenses totaling $27,768.17, even though her providers agreed before treating her to accept $1,323.60 as payment in full for the treatment rendered. (April 16, 2025 Opinion, App. pp. 329-330). The Court of Appeals decision purports to distinguish *Gordon* on the ground that in *Gordon* "the plaintiff received *free* medical care from a military hospital" and never received a bill. (*Id.* at p. 331). The Court of Appeals stated: "[W]hile we acknowledge that her costs were eventually adjusted and paid by Medicaid, Jones still incurred the full amount charged...." (*Id.*).

On March 11, 2025, Progressive filed a Petition for Rehearing, pointing out that the Court of Appeals' Opinion failed to take into account the realities of how Medicaid works and that it was inconsistent with this Court's decision in *Gordon*, including its definition of "expenses incurred" and its holding. (App. pp. 300-307). By Order filed April 16, 2025, the Court of Appeals denied Progressive's Petition for Rehearing. (App. pp. 326-27). On April 16, 2025, the Court of Appeals withdrew, substituted and refiled its Opinion, which is the same in all substantive regards as its prior Opinion. (App. pp. 328-332).

ARGUMENT

I. The Court of Appeals' decision fails to take into account the realities of how tax-funded health insurance programs like Medicare and Medicaid work.

The Court's Opinion states: "[W]hile we acknowledge that her costs ***were eventually adjusted and paid by Medicaid***, Jones still incurred the full amount charged...." (App. p. 330)

(emphasis added). This statement underpins the Court of Appeals' holding. However, this statement demonstrates a fundamental misunderstanding of how Medicaid works.

With Medicaid, the federal government establishes certain parameters for all states to follow.[2] One such parameter is that "[a] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency...." 42 C.F.R. § 447.15.[3] Before rendering treatment to Medicaid recipients, "healthcare providers must first enter into a contract with the South Carolina Department of Health and Human Services ("SCDHHS"), the state agency responsible for the administration of the Medicaid program in South Carolina." *Pee Dee Health Care, P.A. v. Sanford*, 509 F.3d 204, 206 (4th Cir. 2007). "Healthcare providers in South Carolina are not required to accept Medicaid patients. However, if a healthcare provider elects to treat Medicaid patients..., it does so by entering into a contract ("provider contract" or "contract") with SCDHHS." *Id.* at 207. "The contract provides for the method and amounts of payment." *Id.; see also Anco, Inc. v. State Health & Hum. Servs. Fin. Comm'n*, 300 S.C. 432, 436, 388 S.E.2d 780, 783 (1989) ("The Finance Commission implements the Medicaid program by contracting with qualified providers.").

Pursuant to the South Carolina Medicaid provider contract, 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,

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[2] MEDICAID.GOV PROGRAM HISTORY AND PRIOR INITIATIVES, https://www.medicaid.gov/about-us/program-history (last visited May 6, 2025).

[3] In this case, it is undisputed that Ms. Jones was not responsible for "any deductible, coinsurance, or copayment" under Medicaid. *See* 42 C.F.R. § 447.15. Thus, the amount paid by the Medicaid agency was the amount the Medicaid providers had agreed to accept "as payment in full." *Id.*

Form (07/17), available at https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf. (emphasis added). Thus, a Medicaid patient never incurs costs beyond the Medicaid-adjusted rates. His or her providers have already agreed before treatment to accept those rates as "payment in full." *See id.*[4]

As Justice Burnett succinctly explained:

> The Medicaid program provides individuals with medical treatment by doctors who agree to accept such patients in exchange for payment at a predetermined rate schedule. The patient not only receives medical care, but also incurs no liability for the cost of the care once the doctor accepts payment. ***The difference between the amount billed and the amount paid, the amount in issue in this case, is "phantom" money in that no one has paid the amount and no one will incur a debt for the amount.***

Haselden v. Davis, 353 S.C. 481, 487, 579 S.E.2d 293, 296 (2003) (J. Burnett dissenting and J. Pleicones concurring in dissent) (emphasis added).[5] "[T]he plaintiff has never paid nor will ever be liable for the written-off difference between the billed and paid amount..." *Id.* Consequently, "it is unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person" and then allow that person to pocket an insurance windfall, raising future insurance rates for all South Carolinians. *See id.*

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[4] Medicare works the same way. *See Barker v. Washington Nat. Ins. Co.*, No. 9:12-CV-1901-PMD, 2013 WL 1767620 at *5-6 (D.S.C. Apr. 24, 2013).

[5] *See also McAmis v. Wallace*, 980 F. Supp. 181, 184 (W.D. Va. 1997) (recognizing that in a Medicaid situation no one pays the written-off amount and the patient "has not incurred this fee"); *Sheeks v. Farmers Ins. Exch.*, 146 Mich. App. 361, 365, 379 N.W.2d 493, 495 (Mich. Ct. App. 1985) ("[I]n the instant case, plaintiff's health care providers must accept as payment in full the Medicaid payments from the state. M.C.L. § 400.111b(11); M.S.A. § 16.490(21b)(11). Accordingly, the amount charged to and reimbursed by Medicaid is the reasonable charge incurred by plaintiff...."); *Grimes v. Gov't Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019); *Metz v. U.S. Life Ins. Co. in City of New York*, 662 F.3d 600, 602 (2d Cir. 2011); *State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212, 214 (Va. 1998); *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *5 (N.D. Okla. Apr. 14, 2015).

II. The Court of Appeals' decision directly conflicts with this Court's precedent in *Gordon* and, instead, relies upon no authority whatsoever.

The phrase "expenses incurred" is not ambiguous, and this Court has already defined it in this context. In *Gordon*, the insurer "agreed 'to pay all reasonable expense incurred' for necessary medical and surgical service." 238 S.C. at 444, 120 S.E.2d at 512. This Court stated: "There is no uncertainty or ambiguity in the language of the policy. It is too plain to call for judicial construction." *Id.*

As this Court explained:

> "Incur emphasizes the idea of liability * * *'. Webster's New International Dictionary. 1. Bouv. Law Dict., Rawle's Third Revision, p. 1531 similarly points to this inherency in its definition of the term incur: 'To have liabilities thrust upon one by act or operation of law * * *'. Also, there are examples in specific legal situations, where it has been held 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'***. *See e. g. Stern-Slegman-Prins Co. v. Commissioner*, 8 Cir., 79 F.(2d) 289; *Bauer Bros. Co. v. Commissioner*, 6 Cir., 46 F.(2d) 874.'
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> [T[he respondent incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the appellant was not liable to the respondent for the reasonable cost of his hospitalization, because the appellant had limited its liability to pay only 'all reasonable expenses incurred' by the respondent. There 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. (emphasis added). Thus, an "expense incurred" cannot be a thing for which there exists no obligation to pay. The amounts Medicaid providers bill beyond what they have previously agreed under their provider agreements to accept as payment in full – i.e. "phantom" charges – are exactly that, "a thing for which there exists no obligation to pay." *See id.*

In its Opinion, the Court of Appeals states that the distinguishing factor between *Gordon* and this case is that Gordon "received *free* medical care from a military hospital." (App. p. 330) (emphasis in orig.) ("Gordon's medical services were free so he was not obligated to pay for the

services rendered. *Id.* Therefore, he did not 'incur' an expense."). However, Gordon did not receive free medical care at a military hospital. His medical care was paid for by taxpayers. He just received free-to-him medical care. Likewise, Ms. Jones' medical care was paid for by taxpayers. She also received free-to-her medical care. Thus, the difference between medical expenses being paid by a taxpayer-funded Veterans' Administration or a taxpayer-funded Medicaid program is not a meaningful distinction.

As this Court stated: "[A] thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'." *Gordon*, 238 S.C. at 445, 120 S.E.2d at 512. Based on the way Medicaid works, those "phantom" charges from Ms. Jones' medical providers – which they issued in violation of their provider agreements – were "a thing for which there exists no obligation to pay." *See id.* Consequently, those "phantom" charges cannot be an "expense incurred." *See id.* at 446, 120 S.E.2d at 513 ("There 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."). Like the claimant in *Gordon*, Ms. Jones stipulated that she is not legally obligated to pay any money to any of her medical providers for the medical treatment she received. (App. p. 124, lines 4-24); (Stipulation of Fact, App. p. 141 ¶ 17). Thus, the *Gordon* decision required the Court of Appeals to find that Ms. Jones has "incurred" no expense, within the meaning of the policy provision, beyond the Medicaid-adjusted rates.

Additionally, an insured being sent a bill for "phantom" charges she was never required to pay is also not a meaningful distinction from the *Gordon* case. *See* (App. p. 330). This Court in *Gordon* specifically referenced and relied upon a case where an insured had been billed for an amount he was never required to pay, and that court held there were no expenses incurred. *See*

Gordon, 238 S.C. at 444-45, 120 S.E.2d at 512 ("In the case of *Drearr v. Connecticut General Life Ins. Co.*, La.App., 119 So.2d 149, 151, the plaintiff was a war veteran and was confined in a government hospital for treatment of and surgery for a duodenal ulcer. He had an insurance policy which contracted to pay him for the expense incurred for hospital charges and services. He brought an action to recover the amount of an alleged bill rendered by the Veterans' Administration for his hospital charges and services."). Thus, there is no meaningful distinction between this case and the *Gordon* case, which required a finding that Ms. Jones never incurred expenses beyond the Medicaid-adjusted rates. *Gordon* is controlling, and the Court of Appeals failed to apply this Court's binding precedent.

Instead of applying the *Gordon* holding, the Court of Appeals relied on no authority whatsoever. *See* (April 16, 2025 Opinion, App. p. 330 (citing no authority for the proposition that an insured could "incur" amounts that she admits no one was ever obligated to pay)). Numerous cases from other jurisdictions also align with the *Gordon* decision in holding that an insured does not "incur" an expense for which no one has an obligation to pay. *See, e.g., Metz v. U.S. Life Ins. Co.*, 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 her physicians had agreed ahead of time they would seek from her"); *State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212, 214 (Va. 1998); *Grimes v. Gov't Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019); *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *6 (N.D. Okla. Apr. 14, 2015).

Likewise, in *Barker v. Washington Nat. Ins. Co.*, the South Carolina District Court properly applied the *Gordon* decision to similar facts. No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013). In that case, the insured had a policy that provided coverage for "the expenses

incurred" for certain medical services and materials. *Id.* at *4. 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:
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> > 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.
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> *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).[6] As a result, the Court granted the insurer summary judgment on the insured's breach of contract (and bad faith) claim. *Id.* at *9. As explained above, Medicaid works the same way as Medicare in all pertinent respects.

III. In the alternative, if *Gordon* is not controlling, then this case presents a novel question of law.

Rule 242, SCACR, authorizes this Court to grant writs of certiorari when "[w]here there are novel questions of law." Rule 242, SCACR(b)(1). Thus, to the extent that *Gordon* is not controlling – which Petitioner disputes – then this case certainly presents a novel question of law. The fact that the Court of Appeals did not rely on any authority whatsoever for its holding that a

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[6] The Court of Appeals' Opinion takes its definition of "expenses incurred" from the *Barker* decision but then purports to distinguish the *Barker* case based on policy language:

> Progressive relies heavily on an unpublished order from *Barker v. Washington National Insurance Company*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013). However, the insurance contract in Barker contained a provision which provided the insurer would only pay the Medicare adjusted amount. We do not have such a provision in this case.

(April 16, 2025 Opinion, App. pp. 329, 330 n.1). However, the fight in *Barker* was over the "expenses incurred" language in the policy, which is identical to the language in this case. *Id.* at *4 ("Barker emphasizes the '100% in full' language, while WNIC emphasizes 'expenses incurred.'"). The *Barker* court did not address the Medicare limitation until after determining that the insured never "incurred" expenses above the Medicare-adjusted rates. *Id.* at *6 ("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."). The District Court in *Barker* based its opinion on the "expenses incurred" policy language and the way Medicare works – not any Medicare limitation in the policy. *Id.* at *4-6.

Medicaid insured can "incur" medical expenses beyond the Medicaid-adjusted rates demonstrates that the Court of Appeals thought this was a novel issue. In 2023, 17.2% of South Carolina's population were enrolled in Medicare and 19.9% of the population were enrolled in Medicaid and the Children's Health Insurance Program.[7] Thus, the Court's decision on this issue could have ramifications for over 37% of the State's population. This is an alternative basis for granting the Petition for Writ.

CONCLUSION

Over six decades ago, this Court held that a thing for which there exists no obligation to pay cannot in law be claimed to constitute an "expense incurred" within the meaning of Medical Payments coverage for "expenses incurred." Respondent is a Medicaid recipient. Before providing treatment, each of her medical providers entered into provider contracts with SCDHHS wherein they agreed to accept set Medicaid amounts as payment in full for treatment rendered and to not bill patients for any additional amounts. In violation of their provider contracts, the medical providers subsequently billed for additional amounts. These additional amounts are a thing for which there exists no obligation to pay. Consequently, they cannot in law constitute an "expense incurred" within the meaning of Progressive Northern's Medical Payments coverage. By reaching the opposite conclusion, the Court of Appeals either failed to comprehend the realities of how Medicaid works or failed to follow this Court's binding precedent set forth in *Gordon*.

This Court's guidance is needed. The Court of Appeals' decision stands in conflict with *Gordon*. Moreover, the Court of Appeals decision stands in conflict with the decision of the District Court applying the holding in *Gordon*. In the alternative, if *Gordon* is not controlling, then

[7] Georgetown University Center on Health Insurance Reforms, *South Carolina*, ASSOCIATION OF HEALTH CARE JOUNRALISTS, https://healthjournalism.org/wp-content/uploads/2025/01/South-Carolinafor-AHCJ2024.pdf (last visited May 6, 2025).

this case involves a novel question of law. This case presents an important opportunity for this Court to provide needed guidance on this issue.

For the above-stated reasons, Petitioner respectfully moves and petitions this Court for a writ of certiorari to answer this important question and to provide clarity on this issue of law.

Respectfully submitted,

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