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.

REPLY BRIEF OF APPELLANT-RESPONDENT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page Number

CASES

STATUTES

SUMMARY[1]

This is a breach of contract action. The policy issued by Progressive Northern Insurance Company ("Progressive") limits its medical payments coverage to certain medical "expenses incurred" by an insured as a result of an accident. The sole question in this action is the amount of medical expenses Alexis Jones ("Jones") incurred as a result of an October 8, 2019 auto accident.

The answer is $1,323.60 – the Medicaid-adjusted rates her providers agreed to accept as payment in full before rendering any treatment to her. According to well-established South Carolina Supreme Court precedent, an insured does not "incur" expenses within the meaning of a medical payments coverage provision unless she has an obligation to pay. Because of the way Medicaid works, Jones never became obligated to pay her medical providers for any other amount. Medicaid paid this amount to her providers as payment in full, and Progressive paid this amount to Jones. Thus, Progressive is entitled to judgment in its favor on Jones' breach of contract claim as there was no breach of the insurance contract.

Unable to answer the "expenses incurred" question in her favor, Jones' Brief instead focuses on the irrelevant question of the reasonable value of the medical services. Progressive's obligation is limited by contract to her medical "expenses incurred." Thus, this is the relevant question. Jones' Brief also makes red herring arguments about setoffs and the collateral source rule. As explained below, each of these arguments is also irrelevant and without merit in this breach of contract action.

[1] Jones' Brief did not include a "Statement of the Case." *See* (Jones Br.). Therefore, in accordance with Rule 208, Jones is bound by the matters stated and alleged in Progressive's statement of the case. Rule 208(b)(2), SCACR.

I. Because of the way Medicaid works, Jones never incurred medical expenses beyond the Medicaid-adjusted rates that her providers had agreed to accept as payment in full before rendering treatment.

According to longstanding 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 her providers' "sticker prices." Consequently, these "sticker prices" were not "expenses incurred," and Progressive did not breach the insurance contract by paying the Medicaid-adjusted rates.

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 Court's 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].

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.

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 (emphasis added). 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 established 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 policy. Such conduct is consistent with the policy terms and South Carolina law.

In another 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 (as Jones does here) 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.

As explained below, Medicaid works the same way as Medicare. 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).[2] Consequently, Jones' breach of contract claim 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).

In her Brief, Jones attempts to distinguish *Gordon* and *Barker* by repeatedly pointing to an erroneous finding made by the Circuit Court. *See* (Jones' Br., pp. 1-2). 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 is incorrect. To reach this finding, the Circuit Court had to first make two erroneous legal conclusions. First, the Circuit Court had to determine that "incurred" within the Progressive policy means the "sticker price" regardless of whether the insured is actually obligated to pay that amount. This legal conclusion is inconsistent with the *Gordon* Supreme Court case, which

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[2] *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).

held – in this context – that "incurred" means an "obligation on the part of the [insured] to pay." 238 S.C. at 446, 120 S.E.2d at 513. Additionally, the Circuit Court had to determine that the providers' "sticker prices" are the amounts a Medicaid beneficiary becomes legally obligated to pay, even if the Medicaid-adjusted rates are less. As explained in *Barker*, this legal conclusion is inconsistent with the way Medicare/Medicaid works. 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 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").

To the extent this conclusion constitutes a factual finding, it should still be overturned. There is no evidence to support the Circuit Court's finding that Jones became obligated to pay the "sticker prices" on her providers' initial bills. 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). Furthermore, before trial, 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). Thus, Jones' purported distinction of the *Gordon* and *Barker* cases is without merit because it is premised on an erroneous finding by the Circuit Court. The *Gordon* case is controlling.

II. *Haselden* and its progeny answer the question of how the reasonable value of medical service is established – which is not the question at issue in this breach of contract case.

Jones' Brief repeatedly cites to *Haselden v. Davis,* 353 S.C. 481, 579 S.E.2d 293 (2003), stating that the "the Circuit Court correctly construed the term 'incurred' in accordance with *Haselden* and its progeny." (Jones Br., pp. 1-3, 4, 6 (citing to *Haselden* 10 times in her 6 ½ page Brief)). However, the Circuit Court Order does not even mention *Haselden* – likely because *Haselden* is not relevant to the issue in this case. (April 6, 2023 Circuit Court Order, R. pp. 14-19). Jones' Brief goes even further, stating that the Supreme Court in *Haselden* held "that incurred expenses are not limited to the amount actually paid by Medicaid." (Jones' Br., p. 7 ("The trial court appropriately considered the South Carolina Supreme Court's holding that incurred expenses are not limited to the amount actually paid by Medicaid.")). This is simply not true. There is no such holding in the *Haselden* case. The *Haselden* case did not deal with the term "incurred," much less issue a holding about expenses incurred.

Unlike the cases addressed in Progressive's Brief, *Haselden* is not an insurance breach of contract case. It is a personal injury case addressing the amount a plaintiff may recover from a tortfeasor for medical services, i.e., the reasonable value of those medical services.

In *Haselden*, an estate sued a doctor for medical negligence. 353 S.C. at 483, 579 S.E.2d at 294. The question was what evidence a jury could consider in determining the reasonable value of medical services rendered. *Id.* As the Court explained, "[a] plaintiff in a personal injury action seeking damages for the cost of medical services provided to him as a result of a tortfeasor's wrongdoing is entitled to recover the reasonable value of those medical services, not necessarily the amount paid." *Id.* at 484, 579 S.E.2d at 295. The Court's own analysis in *Haselden* makes clear that the analysis for "reasonable value" of medical services is not applicable to the question of "expenses incurred":

> The measure of recovery is not the cost of services but their reasonable value. Recovery does not depend on whether there is any bill at all, and the tortfeasor is liable for the value of medical services even if they are given without charge, since it is their value and not their cost that counts. The value of medical services made necessary by the tort can ordinarily be recovered although they have created no liability or expense to injured person, as when a physician donates his services.

Id. at 484, 579 S.E.2d at 295 (cleaned up, citations omitted, emphasis added). Thus, in a personal injury case, "reasonable value" amounts can be recovered from the tortfeasor regardless of whether the patient ever became liable to the medical provider for such amounts. In contrast, this is a contract case. The insurer's liability to Jones is limited by the contract terms to the medical expenses she actually incurred – i.e., the amounts for which she was liable to her medical providers.

The holding in *Haselden* was that the amount billed was relevant to establishing the reasonable value of the medical services. *Id.* at 485, 579 S.E.2d at 295 ("Accordingly, we hold the amount billed by Davis was relevant to establish the reasonable value of the services provided to

Hill."). This was the extent of the *Haselden* Court's holding. This holding is not applicable to the contractual "expenses incurred" question at issue in the present case.[3]

Moreover, *Haselden* explains how Medicaid works, which supports Progressive's position. According to the Court in *Haselden*, a physician "agrees to become a Medicaid provider, thereby agreeing to accept as compensation for medical services those amounts set forth in the Medicaid agreement." *Id.* at 485, 579 S.E.2d at 295. Thus, prior to treating the Medicaid patient, a Medicaid provider has already agreed to the amount of compensation set forth in the Medicaid agreement. This previously-agreed-to amount is the medical expense incurred.

III. Contrary to the red herring arguments in Jones' Brief, there is no setoff or collateral source issue.

Jones' Brief contends that Progressive's payment of medical payments coverage at the Medicaid-adjusted provider rates constitutes a setoff under South Carolina Code § 38-77-144, but it does not. (Jones Br., pp. 3-5). South Carolina Code § 38-77-144 provides that "medical payments coverage…is not subject to a setoff." S.C. Code § 38-77-144. 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

[3] Jones Brief also cites to cases from several other jurisdictions for the proposition that "tortfeasors should be liable for the *value* of medical services, rather than the cost." (Jones Br., pp. 5-6) (underline emphasis added). This is a breach of contract case. Progressive is not a tortfeasor. Progressive is an insurer whose obligation to Jones is determined and limited by the terms of the insurance contract. Consequently, these cases Jones cites are inapplicable.

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 benefit 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., R. p. 29 ¶ 25); (April 6, 2023 Circuit Court Order, R. p. 14 (recognizing that Progressive paid Jones the same "amount Medicaid paid to satisfy the medical bills")). Her Complaint does not allege that Progressive had reduced its medical payments benefits by the amount of the Medicaid payment. *See* (Compl., R. p. 29 ¶ 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." (*Id.*) (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.

Even Jones' own definition of a setoff is not met in this case. Jones alleges that a setoff occurs when "an insurance carrier lessens the amount owed to the insured because of payments made by a third-party." (Jones Br., p. 5). Progressive did not lessen the amount owed to Jones "because of payments made by a third-party." If it had, Progressive would have paid Jones nothing because Medicaid had already fully covered her medical expenses. Instead, Medicaid's prior agreements with its service providers fixed the amount of medical expenses Jones incurred – the first number in the above calculation. This is not a setoff as the South Carolina Supreme Court has defined that term.[4]

Jones' Brief also makes another red herring argument about the collateral source rule. (Jones Br., pp. 2-4). The collateral source rule applies to a tortfeasor in a personal injury action, not an insurer in a contract action.[5] Progressive is not a tortfeasor. Progressive did not cause the auto accident at

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[4] Moreover, Jones' Complaint asserted a separate cause of action for "violation of South Carolina Code of Laws Section 38-77-144." The Circuit Court dismissed this claim. (February 10, 2021 Circuit Court Order, R. p. 6). Jones' Brief alleges that the "trial court correctly interpreted this as a setoff in violation of S.C. Code Ann. § 38-77-144." (Jones Br., p. 3). The Circuit Court's final Order and form 4 Order made no such finding. *See* (April 6, 2023 Circuit Court Order, R. pp. 14-19); (March 29, 2023 Circuit Court Form 4 Order, R. pp. 10-13).

[5] *See, e.g., Citizens & S. Nat'l Bank of S.C. v. Gregory*, 320 S.C. 90, 92, 463 S.E.2d 317, 318 (1995) ("The collateral source rule provides that compensation received by an injured party from a source wholly independent of the wrongdoer will not reduce the amount of damages *owed by the wrongdoer.*" (emphasis added)); *Estate of Rattenni v. Grainger*, 298 S.C. 276, 277, 379 S.E.2d 890, 890 (1989) ("South Carolina has long followed the collateral source rule that compensation received by an injured party from a source wholly independent of the wrongdoer should not be deducted from the amount of damages *owed by the wrongdoer* to the injured party." (emphasis added)); *New Found. Baptist Church v. Davis*, 257 S.C. 443, 446, 186 S.E.2d 247, 249 (1972) ("[T]he 'collateral source rule' is that which holds that total or partial compensation for injury which an injured party receives from a collateral source, wholly independent of the wrongdoer, does not operate to lessen the damages recoverable *from the wrongdoer.*" (emphasis added)); *Young v. Warr*, 252 S.C. 179, 197, 165 S.E.2d 797, 806 (1969) ("Under the 'collateral source rule'

issue. The South Carolina Supreme Court in *Bardsley v. Government Emps. Ins. Co.* made this distinction clear:

> GEICO asserts the collateral source rule only applies to wrongdoers, it is not a wrongdoer....Francina counters that the collateral source rule applies to any party seeking to reduce obligations to a victim as a result of contributions made by others to the victim. In other words, she asserts the only requirement for the application of the collateral source rule is that the source is wholly independent of the wrongdoer.
>
> We find this contention plainly contrary to our jurisprudence, which makes clear that the collateral source rule only applies to a "wrongdoer"/ "tortfeasor."
>
> ***
>
> ....Because UIM coverage is a source wholly independent of the wrongdoer, a *fortiori*, a UIM insurer is not a wrongdoer and the collateral source rule does not apply.
>
> ***
>
> Moreover, we find applying the collateral source rule against GEICO as a UIM insurer is inappropriate because extending the collateral source rule to cover GEICO as a UIM insurer would not serve the policy behind the rule. As discussed, the purpose of the collateral source rule is to give the injured party the benefit of any windfall rather than allowing the tortfeasor to profit by his wrongful acts. Here, GEICO as a UIM insurer has not acted wrongly or tortiously towards Francina and would not experience a windfall by not having to pay the UIM property damage benefits.....Instead, this is merely a contractual issue, and GEICO should be treated according to the terms of the contract.

405 S.C. 68, 79–81, 747 S.E.2d 436, 441–42 (2013) (citations omitted). Like UIM coverage, medical payments coverage is a first-party insurance coverage. It "is a source wholly independent of the wrongdoer, a *fortiori*, a [medical payments] insurer is not a wrongdoer and the collateral source rule does not apply." *See id.* "Instead, this is merely a contractual issue, and [Progressive] should be treated according to the terms of the contract." *See id.*

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a *tort feasor* has no right to any mitigation of damages because of payments or compensation received by the injured person from an independent source." (emphasis added)); *Covington v. George*, 359 S.C. 100, 103, 597 S.E.2d 142, 144 (2004) (stating that the collateral source rule applies to "tortfeasors"); *Dixon v. Besco Eng'g, Inc.*, 320 S.C. 174, 181, 463 S.E.2d 636, 640 (Ct. App. 1995) ("The collateral source rule prevents a *tortfeasor* from receiving a reduction in damages due to payments or compensation received by the injured person from a source wholly independent of the *tortfeasor*." (emphasis added)).

Under the terms of the contract, Progressive is only liable to Jones for certain medical expenses she "incurred." She did not incur medical expenses beyond the Medicaid-adjuster rates her providers agreed to accept as payment in full. Progressive has already paid this amount of medical payments coverage. Therefore, Progressive is entitled to judgment in its favor on the breach of contract cause of action.

CONCLUSION

For the above-stated reasons and those set forth in Progressive's Opening Brief, 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 previously defined "expenses incurred" to require an obligation on the part of the insured to pay such expense. Because of the way Medicaid works, Jones never became obligated to pay any medical expenses beyond the Medicaid-adjusted rates. Prior to rendering treatment, her providers agreed to accept such amounts as payment in full and to not charge her any additional amounts. 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 Reply Brief of Appellant-Respondent 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 Reply 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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