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S.C. SUPREME COURT

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. 2025-000943

Alexis JonesRespondent-Petitioner,

v.

Progressive Northern Insurance Company.....Petitioner-Respondent.

RETURN TO PETITION FOR A WRIT OF CERTIORARI

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TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

COUNTER-STATEMENT OF QUESTIONS PRESENTED..... 1

COUNTER-STATEMENT OF THE CASE 1

FACTUAL AND PROCEDURAL BACKGROUND..... 2

 I. The Progressive Policy. 2

 II. The October 8, 2019 Accident and Jones’ Resulting Medical Payments Claim. 2

 III. Procedural History. 4

STANDARD OF REVIEW 5

ARGUMENT 5

 I. There are no special reasons justifying review of Jones’ “violation of South Carolina Code of Laws Section 38-77-144” claim, and it was properly dismissed..... 6

 A. This claim was properly dismissed because the “violation” alleged by Jones is not the conduct prohibited by the statute..... 7

 B. This claim was also properly dismissed because the statute does not create a private cause of action..... 9

 II. There are no special reasons justifying review of Jones’ breach of contract accompanied by a fraudulent act and bad faith claims, and they were properly dismissed..... 11

 A. Jones’ breach of contract accompanied by a fraudulent act and bad faith claims were properly dismissed because, under this Court’s precedent, Jones cannot show that additional medical payments benefits were due under the insurance contract 11

 B. In addition, the Court of Appeals properly affirmed dismissal of Jones’ bad faith claim because Progressive had a reasonable basis to dispute paying her medical payments claim at a higher rate than the Medicaid rates..... 14

 C. *Haselden* and its progeny are irrelevant to the issue in this case..... 16

D. In addition, the Court of Appeals properly affirmed dismissal of Jones’ breach of contract accompanied by a fraudulent act claim because she did not allege a separate fraudulent act and the only alleged acts were not fraudulent.....20

III. There are no special reasons justifying review of Jones’ attorneys’ fees claim, and it was properly dismissed 23

Conclusion25

TABLE OF AUTHORITIES

Page Number

CASES

<i>Adkins v. South Carolina Dep't of Corr.</i> , 360 S.C. 413, 602 S.E.2d 51 (2004)	9
<i>Bardsley v. Government Emps. Ins. Co.</i> , 405 S.C. 68, 747 S.E.2d 436 (2013)	19-20
<i>Baker v. Pilot Life Ins. Co.</i> , 268 S.C. 609, 235 S.E.2d 300 (1977)	24
<i>Barker v. Washington Nat. Ins. Co.</i> , No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013).....	13-16, 22
<i>BMW of N. Am., LLC v. Complete Auto Recon Servs., Inc.</i> , 399 S.C. 444, 731 S.E.2d 902 (Ct. App. 2012).....	14
<i>Boggs v. Aetna Cas. & Sur. Co.</i> , 272 S.C. 460, 252 S.E.2d 565 (1979).....	25
<i>Citizens & S. Nat'l Bank of S.C. v. Gregory</i> , 320 S.C. 90, 463 S.E.2d 317 (1995)	18-19
<i>Cock-N-Bull Steak House, Inc. v. Generali Ins. Co.</i> , 321 S.C. 1, 466 S.E.2d 727 (1996).....	24
<i>Conner v. City of Forest Acres</i> , 348 S.C. 454, 560 S.E.2d 606 (2002).....	11-12, 23
<i>Cothran v. State Farm Mut. Auto. Ins. Co.</i> , 427 S.C. 545, 831 S.E.2d 919 (2019).....	7-8
<i>Covington v. George</i> , 359 S.C. 100, 597 S.E.2d 142 (2004).....	19
<i>Crossley v. State Farm Mut. Auto. Ins. Co.</i> , 307 S.C. 354, 415 S.E.2d 393 (1992)	14-16
<i>Denson v. National Cas. Co.</i> , 439 S.C. 142, 886 S.E.2d 228 (2023).....	9-10
<i>Diamond State Ins. Co. v. Homestead Indus., Inc.</i> , 318 S.C. 231, 456 S.E.2d 912 (1995).....	12
<i>Dixon v. Besco Eng'g, Inc.</i> , 320 S.C. 174, 463 S.E.2d 636 (Ct. App. 1995).....	19
<i>Dowling v. Home Buyers Warranty Corp.</i> , 303 S.C. 295, 400 S.E.2d 143 (1991).....	24
<i>Estate of Rattenni v. Grainger</i> , 298 S.C. 276, 379 S.E.2d 890 (1989).....	19
<i>Evans v. Liberty Nat. Life Ins. Co.</i> , No. 13-CV-0390-CVE-PJC, 2015 WL 1650192 (N.D. Okla. Apr. 14, 2015).....	14
<i>Gordon v. Fid. & Cas. Co. of N. Y.</i> , 238 S.C. 438,	

120 S.E.2d 509 (1961)	6, 12-13, 15-16, 18, 20, 22-23
<i>Greene v. Durham Life Ins. Co.</i> , 287 S.C. 197, 336 S.E.2d 478 (1985).....	25
<i>Haggins v. State</i> , 377 S.C. 135, 659 S.E.2d 170 (2008).....	5
<i>Hardee v. Penn Mut. Life Ins. Co. of Philadelphia</i> , 215 S.C. 1, 53 S.E.2d 861 (1949)	21
<i>Haselden v. Davis</i> , 353 S.C. 481, 579 S.E.2d 293 (2003)	11, 16-18, 20
<i>Helena Chem. Co. v. Allianz Underwriters Ins. Co.</i> , 357 S.C. 631, 594 S.E.2d 455 (2004)	15
<i>Hood v. United Servs. Auto Ass'n</i> , 445 S.C. 1, 910 S.E.2d 767 (2025)	12, 22, 24
<i>I'On, L.L.C. v. Town of Mt. Pleasant</i> , 338 S.C. 406, 526 S.E.2d 716 (2000).....	5
<i>Lister v. NationsBank of Delaware, N.A.</i> , 329 S.C. 133, 494 S.E.2d 449 (Ct. App. 1997).....	21
<i>Metz v. U.S. Life Ins. Co. in City of New York</i> , 662 F.3d 600 (2d Cir. 2011).....	14
<i>Minter v. GOCT, Inc.</i> , 322 S.C. 525, 473 S.E.2d 67 (Ct. App. 1996)	21
<i>Nakatsu v. Encompass Indem. Co.</i> , 390 S.C. 172, 700 S.E.2d 283 (Ct. App. 2010).....	10
<i>Nelson v. United Fire Ins. Co. of New York</i> , 275 S.C. 92, 267 S.E.2d 604 (1980)	25
<i>New Found. Baptist Church v. Davis</i> , 257 S.C. 443, 186 S.E.2d 247 (1972)	19
<i>Nichols v. State Farm Mut. Auto. Ins. Co.</i> , 279 S.C. 336, 306 S.E.2d 616 (1983).....	24
<i>Ocean Winds Council of Co-Owners, Inc. v. Auto-Owners Ins. Co.</i> , 241 F. Supp. 2d 572 (D.S.C. 2002).....	22
<i>RFT Mgmt. Co. v. Tinsley & Adams L.L.P.</i> , 399 S.C. 322, 732 S.E.2d 166 (2012)	22
<i>RoTec Servs., Inc. v. Encompass Servs., Inc.</i> , 359 S.C. 467, 597 S.E.2d 881 (Ct. App. 2004).....	20, 22-23
<i>Smith v. Canal Ins. Co.</i> , 275 S.C. 256, 269 S.E.2d 348 (1980)	21-23
<i>South Carolina Dep't of Soc. Servs. v. Benjamin</i> , 430 S.C. 235, 844 S.E.2d 373 (2020)	5
<i>South Carolina Ins. Co. v. White</i> , 301 S.C. 133, 390 S.E.2d 471 (Ct. App. 1990)	12
<i>State Farm Mut. Auto. Ins. Co. v. Bowers</i> , 500 S.E.2d 212 (Va. 1998)	14

<i>State Farm Mut. Auto. Ins. Co. v. Richardson</i> , 313 S.C. 58, 437 S.E.2d 43 (1993).....	12
<i>Varnadore v. Nationwide Mut. Ins. Co.</i> , 289 S.C. 155, 345 S.E.2d 711 (1986).....	14, 16
<i>Whitworth v. Fast Fare Markets of South Carolina, Inc.</i> , 289 S.C. 418, 338 S.E.2d 155 (1985)	9
<i>Williams v. Gov't Emps. Ins. Co. (GEICO)</i> , 409 S.C. 586, 762 S.E.2d 705 (2014)	10
<i>Woodrich v. Farmers Ins. Co .</i> , 405 F.Supp.2d 1276 (N.D. Okla. 2004).....	14
<i>Young v. Warr</i> , 252 S.C. 179, 165 S.E.2d 797 (1969).....	14

Page Number

STATUTES AND RULES

42 C.F.R. § 447.15	13
Rule 242. SCACR.....	5
South Carolina Code § 38-59-40	24
South Carolina Code § 38-77-144	1, 3-10, 25

COUNTER-STATEMENT OF QUESTIONS PRESENTED

- I. **Whether the Court of Appeals properly affirmed dismissal of Jones' "violation of South Carolina Code of Laws Section 38-77-144" claim because the "violation" alleged by Jones is not the conduct prohibited by the statute and because the statute does not create a private cause of action.**
- II. **Whether the Court of Appeals properly affirmed dismissal of Jones' breach of contract accompanied by a fraudulent act claim and bad faith claims because, under this Court's precedent, Jones cannot show that additional medical payments benefits were due under the insurance contract.**
- III. **Whether the Court of Appeals properly affirmed dismissal of Jones' bad faith claim because Progressive had a reasonable basis to dispute reimbursing her for medical expenses in amounts more than the Medicaid rates her providers accepted as payment in full.**
- IV. **Whether the Court of Appeals properly affirmed dismissal of Jones' breach of contract accompanied by a fraudulent act claim because Jones failed to allege a separate, fraudulent act.**
- V. **Whether the Court of Appeals properly affirmed denial of Jones' statutory claim for attorneys' fees.**

COUNTER-STATEMENT OF THE CASE

This action arises out of Progressive's payment of Alexis Jones' medical payments claim for an October 8, 2019 auto accident. The auto policy at issue provides medical payments coverage for certain medical "expenses incurred" by an insured as a result of an accident. Alexis Jones ("Jones") is a Medicaid recipient. Medicaid has agreements in place with medical service providers wherein the providers have agreed, prior to treating Medicaid recipients, to accept set rates as payment-in-full. Progressive reimbursed Jones under the medical payments coverage based on the amounts paid by Medicaid and accepted by her medical providers as payment in full. In her Complaint, Plaintiff bases her various causes of action on Progressive's payment of the medical payments coverage at the Medicaid provider rates. The policy only provides medical payments coverage for certain medical "expenses incurred" by Jones. Since Jones did not incur expenses beyond the amounts paid to her providers by Medicaid, Progressive appropriately reimbursed her.

FACTUAL AND PROCEDURAL BACKGROUND

I. The Progressive Policy

Progressive Northern Insurance Company (“Progressive”) issued a personal auto policy, Policy No. 930693102, to Willie Brown with effective dates of June 21, 2019 to December 21, 2019 (the “Policy”). (App. 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.

(App. p. 67). Thus, the Policy only provides medical payments coverage for certain “expenses incurred for necessary medical services.”

II. The October 8, 2019 Accident and Jones’ Resulting Medical Payments Claim

On October 8, 2019, Jones was involved in an auto accident. (App. p. 22 ¶ 11). Jones made a claim for medical payments coverage under the Policy. (App. p. 24 ¶ 13). With her claim, Jones submitted medical provider billing statements in excess of \$10,000. (App. pp. 23-24 ¶¶ 12-13). However, Jones is a Medicaid recipient. (Stipulation of Fact, App. p. 139 ¶ 4); (February 10, 2021 Circuit Court Order, App. p. 6). Prior to her ever receiving treatment, Medicaid had agreements in place with her medical service providers wherein the providers agreed to accept set rates as payment-in-full. (Stipulation of Fact, App. pp. 139-41); (February 10, 2021 Circuit Court Order, App. p. 6). Medicaid paid \$1,323.60, 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 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, App. p. 141 ¶ 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.

(App. p. 124, 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., App. pp. 24, 30-31 ¶¶ 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. (App. pp. 22-32).¹

¹ Jones did not appeal the dismissal of her “violation of the South Carolina Unfair Trade Practice Act” claim. (App. p. 252 (“The circuit court initially dismissed only the SCUPTA claim and Ms. Jones does not appeal that ruling.”)). It appears that Jones is also not petitioning for review of the

III. 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. 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.

(App. p. 8). 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. (App. p. 7). The Order also dismissed Jones' "violation of South Carolina Code § 38-77-144" claim. (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 Orders

dismissal of her "breach of the duty of good faith and fair dealing" and "breach of fiduciary duty" claims. *See* (Jones' Pet.).

denied Jones' request for attorney's fees. (App. p. 18). Progressive appealed, and Jones cross-appealed. The Court of Appeals affirmed. (App. pp. 328-332). Progressive and Jones filed Petitions for Writ of Certiorari.

STANDARD OF REVIEW

The Court "will grant certiorari to the Court of Appeals only where special reasons justify the exercise of that power." *Haggins v. State*, 377 S.C. 135, 136, 659 S.E.2d 170 (2008) (citation omitted); *South Carolina Dep't of Soc. Servs. v. Benjamin*, 430 S.C. 235, 236, 844 S.E.2d 373 (2020). Pursuant to Rule 242 of the South Carolina Appellate Court Rules, reasons for granting certiorari include "novel questions of law." "[w]here there is a dissent in the decision of the Court of Appeals," and "[w]here the decision of the Court of Appeals is in conflict with a prior decision of the Supreme Court," "[w]here substantial constitutional issues are directly involved," and "[w]here a federal question is included and the decision of the Court of Appeals conflicts with a decision of the United States Supreme Court." Rule 242(b), SCACR.

"[A] respondent—the 'winner' in the lower court—may raise on appeal any additional reasons the appellate court should affirm the lower court's ruling, regardless of whether those reasons have been presented to or ruled on by the lower court." *I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 419, 526 S.E.2d 716, 723 (2000). With respect to Jones' (1) Section 38-77-144 claim; (2) bad faith claim; (3) breach of contract accompanied by a fraudulent act claim; and (4) attorney's fees claim, Progressive was the "winner" in the lower court.

ARGUMENT

Jones' Petition for Writ of Certiorari fails to set forth any "special reasons" justifying the Court's review of her appeal in this case. Jones' Petition seeks review of the Court of Appeals' rulings on four of her claims: (1) the "violation of South Carolina Code of Laws Section 38-77-144" claim;

(2) the bad faith claim; (3) the breach of contract accompanied by a fraudulent act claim; and (4) the attorneys' fees claim. The only grounds for review set forth in Jones' Petition are "conflict with prior controlling precedent of this Court" and "novel questions of law." (Jones' Pet., p. 1). With respect to these claims, the Court of Appeals' dismissal Order does not merit review because it is in full accord with the rulings of this Court and does not involve a novel question of law. Under the standards set forth by this Court, the dismissal of these claims does not merit this Court's review.

At its core, Jones' Petition attempts to dupe this Court into believing that Progressive has "misinterpreted" or "misapplied" this Court's holding in *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961). In reality, Jones is the party misinterpreting and misapplying that holding. To succeed on any of her claims, Jones has to first show that she "incurred expenses" for phantom medical charges that she has already admitted no one ever became legally obligated to pay. *In more than five years of litigation, no one – not the Plaintiff, not the Trial Court, and not the Court of Appeals – has ever cited a single case holding that an insured can "incur" expenses for which no one is ever legally obligated to pay.* Medical payments coverage is a reimbursement coverage. Therefore, this Court should grant certiorari only as to the breach of contract claim to affirm that this Court's holding in *Gordon* applies to bar that claim.

I. There are no special reasons justifying review of Jones' "violation of South Carolina Code of Laws Section 38-77-144" claim, and it was properly dismissed.

With respect to this claim, Jones alleges that it presents a "novel issue." (Jones' Pet., p. 11). However, it does not present a novel issue. This Court has already explained: (1) what constitutes a set off under § 38-77-144; and (2) what the requirements are for showing that a statute creates a private cause of action. Jones' own prior briefs acknowledge this. (App. p. 217 ("The Cothran court laid bare the mechanics of when insurance policy provisions have the effect of a setoff....")); (App. p. 260 ("The Supreme Court recently set forth the applicable rules for determining whether a statute provides

a private right of action....)). Under this Court's definition, paying the medical payments claim at the Medicaid rates does not constitute a set-off. Additionally, the South Carolina Court of Appeals faithfully applied this Court's precedent to conclude that § 38-77-144 does not create a private cause of action.

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

South Carolina Code § 38-77-144 provides that "medical payments coverage...is not subject to a setoff." S.C. Code § 38-77-144. Jones alleges that Progressive's payment of medical payments coverage at the Medicaid provider rates constitutes a setoff under § 38-77-144, but it does not. *See* (Compl., App. p. 30 ¶ 25); (Jones' Pet., p. 12). This Court previously described what constitutes a "setoff" under South Carolina Code § 38-77-144. In *Cothran v. State Farm Mut. Auto. Ins. Co.*, a provision in the insurance policy purported to reduce the insurer's obligation to pay PIP coverage to the insured by the amount the workers compensation carrier paid for the insured's medical expenses. 427 S.C. 545, 550, 831 S.E.2d 919, 922 (2019) ("In this case, State Farm's obligation to pay PIP coverage to Wadette is reduced—eliminated, in fact—by the amount her employer's workers' compensation carrier paid her for medical expenses."). This Court held that this was a "setoff" in violation of § 38-77-144. *Id.*

As this 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. This Court used a mathematical calculation to describe a setoff scenario:

Wadette incurred approximately \$40,000 in medical expenses. Her PIP benefits policy limit is \$5,000....If her workers' compensation benefits were \$37,500, the "Coordination" provision would take effect and State Farm would owe her \$2,500. In

this case, her workers' compensation benefits equaled the total amount of her medical expenses, so the effect of the "Coordination" provision would be to eliminate State Farm's obligation to pay any PIP benefits.

Id. at 550 n.2, 831 S.E.2d at 922 n.2. Given this example, a setoff occurs when the medical payments insurer takes the total medical expense amount the insured incurred and subtracts the benefits paid by a third-party to determine the amount of the policy limit the insurer is required to pay. With the Court's first example, the calculation is \$40,000 [incurred medical expenses] - \$37,500 [workers' compensation benefits] = \$2,500 [medical payments coverage]. With the Court's second example, the calculation is \$40,000 [incurred medical expenses] - \$40,000 [workers' compensation benefits] = \$0 [medical payments coverage].

Thus, a "setoff," as that term has been defined by this 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 calculation would look like this: \$1,323.60 [incurred medical expenses] - \$1,323.60 [Medicaid benefits] = \$0 [medical payments coverage]. That is not what Progressive did or even what Jones alleges Progressive did. (Compl., App. p. 30 ¶ 25); (April 6, 2023 Circuit Court Order, App. p. 15 (recognizing that Progressive paid Jones the same "amount Medicaid paid to satisfy the medical bills")). Her Complaint does not allege that Progressive reduced its medical payments benefits by the amount of the Medicaid payment. *See* (Compl., App. p. 30 ¶ 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 provider rate does not constitute a "reduction of PIP benefits by the amount of a third-party payment." *Cothran*, 427 S.C. at 550 n.3, 831 S.E.2d at 922 n.3. Because this

does not constitute a “setoff” under South Carolina Code § 38-77-144, Jones’ “violation of South Carolina Code of Laws Section 38-77-144” claim was properly dismissed.

In her prior Brief, Jones alleged that a setoff occurs when “an insurance carrier lessens the amount owed to the insured because of payments made by a third-party.” (App., p. 217). 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 (i.e., \$1,323.60 [incurred medical expenses] - \$0 [no set off] = \$1,323.60 [medical payments coverage]). This is not a setoff as this Court has defined that term. Nothing in South Carolina Code § 38-77-144 requires medical payments coverage for amounts greater than those actually incurred by the insured – i.e., amounts greater than the rates negotiated between Medicaid and Medicaid providers. Thus, the Court of Appeals properly affirmed dismissal of the § 38-77-144 claim because the “violation” alleged by Jones is not the statutorily prohibited conduct, as defined by this Court.

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

“[T]he general rule is that a statute which does not purport to establish a civil liability, but merely makes provision to secure the safety or welfare of the public as an entity is not subject to a construction establishing a civil liability.” *Adkins v. South Carolina Dep’t of Corr.*, 360 S.C. 413, 418, 602 S.E.2d 51, 54 (2004) (quoting *Whitworth v. Fast Fare Markets of South Carolina, Inc.*, 289 S.C. 418, 420, 338 S.E.2d 155, 156 (1985)). “Where a statute does not specifically create a private cause of action, one can be implied **only if the legislation was enacted for the special benefit of a private party.**” *Id.* (emphasis in orig.). As this Court explained, “[a] statute creates no liability to the person injured unless it discloses an intention, express or implied, that from disregard of the statutory

command, a liability for resultant damage arises, which would not exist but for the statute.” *Denson v. National Cas. Co.*, 439 S.C. 142, 150, 886 S.E.2d 228, 233 (2023) (emphasis added).

South Carolina Code § 38-77-144, entitled “Personal injury protection (PIP) coverage not mandated,” does not purport to establish a civil liability. *See* S.C. Code § 38-77-144; *see also* (Jones’ Appellant Br., App. p. 259 (“The statute does not expressly create a private right of action....”). It provides in full:

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

S.C. Code § 38-77-144. Thus, the statute was enacted to make PIP/medical payments coverage non-mandatory. *See* (Jones’ Appellant Br., App. p. 259 (“This statute removed the requirement that automobile insurers offer PIP of MedPay coverage....”). Furthermore, there is no need for this statutory provision to create a private cause of action. “Statutory provisions relating to an insurance contract are part of the contract as a matter of law.” *Nakatsu v. Encompass Indem. Co.*, 390 S.C. 172, 178, 700 S.E.2d 283, 287 (Ct. App. 2010); *Williams v. Gov’t Emps. Ins. Co. (GEICO)*, 409 S.C. 586, 598, 762 S.E.2d 705, 712 (2014) (same). Consequently, a violation of this statutory provision may constitute a breach of the insurance contract but would not give rise to its own independent cause of action. *See Denson*, 439 S.C. at 149–50, 886 S.E.2d at 232 (“[T]he duty or standard of care, statutory or otherwise, is merely an element of proof that comes into play *after* an action has been rightfully commenced *pursuant to the preexisting common-law cause of action.*”) (emphasis in orig.). Jones’ prior Respondent Brief on her breach of contract claim demonstrates this principle. It specifically incorporates her “setoff” argument into her breach of contract argument. (Jones’ Respondent Br., App. pp. 215-217). Therefore, Jones’ “violation of South Carolina Code of Laws Section 38-77-144”

claim was also properly dismissed because the statute creates no private cause of action, and such claim is duplicative of her breach of contract claim. The Court of Appeals faithfully applied this Court's principles and precedent when affirming dismissal of this claim.

II. There are no special reasons justifying review of Jones' breach of contract accompanied by a fraudulent act and bad faith claims, and they were properly dismissed.

The only grounds for review set forth in Jones' Petition are "conflict with prior controlling precedent of this Court" and "novel questions of law." (Jones' Pet., p. 1). However, her Petition does not allege that the Court of Appeals' ruling on her breach of contract accompanied by a fraudulent act claim conflicts with a prior ruling of this Court or presents a novel question. *See (id.* at pp. 9-11). With respect to her bad faith claim, the only conflicting prior rulings of this Court that Jones asserts are *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003) and its progeny – all collateral source rule cases. (*Id.* at p. 8). As explained below, these cases were irrelevant to the issues before the Court of Appeals. Thus, under the standards set forth by this Court, the dismissal of these claims does not merit this Court's review. The Court of Appeals' rulings on these claims were in full accord with this Court's prior, relevant precedent.

A. Jones' breach of contract accompanied by a fraudulent act and bad faith claims were properly dismissed because, under this Court's precedent, Jones cannot show that additional medical payments benefits were due under the insurance contract.

The insurance contract only provides medical payments coverage for certain "expenses incurred for necessary medical services." (App. p. 67). Progressive paid medical payments coverage to Jones at the Medicaid rates – the amount her medical providers agreed to accept as payment in full before rendering any treatment. *See* (April 6, 2023 Circuit Court Order, App. p. 15). Thus, to succeed on either of these claims, Jones would first have to show that she "incurred" medical expenses beyond the Medicaid rates. *See Conner v. City of Forest Acres*, 348 S.C. 454, 465, 560 S.E.2d 606, 612 (2002)

(“In order to have a claim for breach of contract accompanied by a fraudulent act, the plaintiff must establish three elements: (1) a breach of contract...”); *Hood v. United Servs. Auto Ass'n*, 445 S.C. 1, 8, 910 S.E.2d 767, 771 (2025) (“The elements of a bad faith claim for failure to pay first-party benefits are... (2) refusal by the insurer to pay benefits due under the contract...”)²

As more fully explained in Progressive’s own Petition for Writ of Certiorari, under this Court’s prior precedent in *Gordon*, Jones cannot show that she “incurred” medical expenses beyond the Medicaid rates.³ Therefore, the Court of Appeals properly affirmed dismissal of Jones’ breach of contract accompanied by a fraudulent act and bad faith claims.

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).⁴ “[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.” *Diamond State Ins. Co. v. Homestead Indus., Inc.*, 318 S.C. 231, 236, 456 S.E.2d 912, 915 (1995). The Policy provides medical payments coverage for certain “reasonable **expenses incurred** for necessary medical services.” (App. p. 67) (emphasis added). In the context of a medical payments coverage claim, this Court in *Gordon* clearly articulated that “**a thing for**

² Each of these claims are premised on Progressive paying the amounts her Medicaid providers previously agreed to accept as payment in full before rendering treatment rather than the “sticker prices” on the providers’ initial bills, which they issued in violation of their Medicaid provider agreements. *See* (Compl., R. pp. 22-30 ¶¶ 12-13, 20.c, 21.d.iii., 25.d., Wherefore B.); (Tr. Transcript, R. pp. 113-15).

³ Progressive’s arguments set forth in its Petition for Writ of Certiorari are fully incorporated herein by reference. *See* (Progressive’s Pet.).

⁴ 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).

which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an ‘expense incurred’.” 238 S.C. at 445, 120 S.E.2d at 512 (emphasis added).

Due to the way Medicaid works, Jones never became obligated to pay any amounts beyond the Medicaid rates. Medicaid already has agreements in place with Medicaid providers before a Medicaid recipient ever receives any treatment. Pursuant to the South Carolina Medicaid provider agreement, the provider agrees before rendering treatment “that Medicaid reimbursement is payment in full...for care or services to a recipient/patient” and “that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient...” Medicaid Participation and Payment Agreement, Form (07/17), available at <https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf> (emphasis added). Pursuant to the Code of Federal Regulations, a Medicaid provider is required to accept these previously-agreed-to amounts as “payment in full.” 42 C.F.R. § 447.15 (requiring state Medicaid agency to “limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayments required by the plan to be paid by the individual”). Prior to the bench trial in this case, the parties stipulated that beyond the Medicaid 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.” (App. p. 141 ¶ 17) (emphasis added).

Therefore, under South Carolina law, Jones has not “incurred” expenses for medical services beyond the Medicaid rates, which Progressive has already paid. *See also Barker v. Washington Nat. Ins. Co.*, No. 9:12-CV-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013) (granting insurer summary judgment on insured’s breach of contract and bad faith claims where insurer paid medical

payments coverage based on Medicare rates rather than “total charges” listed on providers initial bills).⁵ Thus, Jones cannot show that she is owed any additional amounts under the insurance contract, and her breach of contract accompanied by a fraudulent act and bad faith claims were properly dismissed.

B. In addition, the Court of Appeals properly affirmed dismissal of Jones’ bad faith claim because Progressive had a reasonable basis to dispute paying her medical payments claim at a higher rate than the Medicaid rates.

As this Court has repeatedly stated, “if there is any reasonable ground for contesting the claim, there is no bad faith.” *Varnadore v. Nationwide Mut. Ins. Co.*, 289 S.C. 155, 158, 345 S.E.2d 711, 714 (1986); *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 360, 415 S.E.2d 393, 397 (1992) (same); see also *BMW of N. Am., LLC v. Complete Auto Recon Servs., Inc.*, 399 S.C. 444, 453, 731 S.E.2d 902, 907 (Ct. App. 2012) (“[W]here an insurer has a reasonable ground for contesting a claim, there is no bad faith.”). The Court of Appeals faithfully applied this rule to dismiss Jones’ bad faith claim. Here, Progressive had a reasonable basis for contesting paying Jones’ medical payments claim at a higher rate than the Medicaid rates her providers previously agreed to accept as payment in full for the treatment rendered. The Policy only provides medical payments coverage for certain “reasonable *expenses incurred* for necessary medical services.”

⁵ See also *State Farm Mut. Auto. Ins. Co. v. Bowers*, 255 Va. 581, 585-586, 500 S.E.2d 212, 214 (1998) (holding insured did not “incur” expenses for medical payments coverage beyond those reduced rates negotiated between health insurance carrier and medical providers); *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *6 (N.D. Okla. Apr. 14, 2015) (stating “[a] number of courts in other jurisdictions have found ‘expenses incurred’ to mean the amount actually paid, as opposed to the amount charged by the care provider” and holding “expenses incurred” meant amount insured actually paid to satisfy medical providers after “other insurance coverage...negotiated a lower rate of payment”); *Metz v. U.S. Life Ins. Co. in City of New York*, 662 F.3d 600, 602 (2d Cir. 2011) (holding “incurred” for insurance coverage meant reduced rates negotiated by Medicare because insured “did not incur more than the amounts that 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).

(App. p. 67) (emphasis added). As Jones admits, she is a Medicaid recipient, and she is not “legally obligated to pay any additional sums to the medical providers. All of the charges for the treatment rendered to her has been paid in full based upon the providers receipt of the Medicaid payments....” (Stipulation of Fact, App. pp. 138, 140 ¶¶ 4, 17). Moreover, as shown above and in Progressive’s Petition for Writ of Certiorari, numerous cases have held that “expenses incurred” for Medicaid and Medicare recipients are the rates their providers agreed to accept as payment in full prior to their treatment. Thus, as a matter of law, Progressive had a reasonable basis for contesting this claim, and Jones’ bad faith cause of action was properly dismissed.

As the Circuit Court explained:

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

(February 10, 2021 Circuit Court Order, App. pp. 7-8).⁶ Jones’ own allegation that *Barker* was “wrongly decided” and “wrongly predicted the application of South Carolina law” undermines her

⁶ For Progressive, the bad faith claim has a lower bar than the breach of contract claim. The question is whether Progressive had a reasonable basis for paying the medical payments claim at the Medicaid rates. Although Progressive believes *Gordon* is controlling in this case, at a minimum *Gordon*, *Barker*, and the other cases cited by Progressive provide a reasonable basis for the belief

argument that Progressive had no reasonable basis for disputing her claim. *See* (Jones' Pet., p. 10). Given the *Gordon* and *Barker* cases, Progressive had a reasonable basis for disputing Jones' medical payments claim. Therefore, the Circuit Court properly dismissed Jones' bad faith claim, and the Court of Appeals properly affirmed this dismissal.⁷

C. *Haselden* and its progeny are irrelevant to the issue in this case.

As explained above, the Court of Appeals faithfully applied this Court's precedent and held that there was no bad faith because Progressive had a reasonable ground for contesting the claim. *See, e.g., Varnadore*, 289 S.C. at 158, 345 S.E.2d at 714; *Crossley*, 307 S.C. at 360, 415 S.E.2d at 397 (same). Jones does not allege that her bad faith claim presents a "novel question of law" or that "the decision of the Court of Appeals [on this claim] is in conflict with a prior decision of the Supreme Court." *Compare* (Jones' Pet., pp. 6-9) *with* Rule 242(b), SCACR. Rather, Jones asserts that *Gordon* "greatly predates settled precedent to the contrary" – i.e., *Haselden* and its progeny – and that it was unreasonable for Progressive to rely on *Gordon*. (Jones' Pet., pp. 8, 10). This is not one of the "special reasons" for review set forth in Rule 242.

that a Medicaid recipient does not incur expenses for amounts beyond the Medicaid rates because there is no obligation to pay those amounts. *See Gordon*, 238 S.C. at 446, 120 S.E.2d at 513 ("[A] thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'."). In her Petition, Jones essentially admits that the Court would have to reject the analysis in *Barker* to reach her desired result in this case and would have to find that *Gordon* has been overturned by newer precedent. (Jones' Pet., p. 10 ("*Barker*...is wrongly decided. *Barker* relied upon *Gordon*, the same older case, and the district court wrongfully predicted application of South Carolina law."); (Jones' Pet., p. 8 (alleging that "each of these holdings [the *Gordon* and *Barker* holdings] is contrary to more current, settled precedent from this Court")). This further demonstrates that Progressive had a reasonable basis under the *Gordon* and *Barker* analysis for paying her claim at the Medicaid rates.

⁷ In her Petition, Jones attempts to factually distinguish *Gordon* and *Barker*. As fully explained in Progressive's own Petition for Writ of Certiorari, those purported factual distinctions are logical fallacies, distinctions without a difference that have no impact on the relevant holdings. (Progressive's Pet., pp. 9-13).

Moreover, *Haselden* and its progeny are irrelevant to the issue in this case. At the heart of this case is the proper interpretation of the contractual phrase “expenses incurred.” *Haselden* and its progeny are irrelevant because they: (1) answer an entirely different and immaterial question; (2) do not deal with the contractual term “incurred” – much less address that term in the context of medical payments coverage; and (3) are collateral source rule cases only applicable to tortfeasors.

Haselden and its progeny answer the question of how the reasonable value of medical services is established in a tort case – which is not the question at issue in this breach of contract 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 Petition, *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. How the reasonable value of medical services is established in a tort case is an entirely different analysis from how an “expense incurred” is determined within the context of medical payments coverage. This Court in *Gordon* made clear that an “expense incurred” cannot be the “[t]he value of medical services...although they have created no liability or expense to the injured person, as when a physician donates his services.” *Compare Haselden*, 353 S.C. at 483, 579 S.E.2d at 295 *with Gordon*, 238 S.C. at 484, 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.”). 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.

Furthermore, *Haselden* is a collateral source rule case. Contrary to the red herring arguments in Jones’ Petition, there is no collateral source issue in this case. The collateral source rule applies to a tortfeasor in a personal injury action, not an insurer in a contract action.⁸ Progressive is not a

⁸ *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

tortfeasor. Progressive did not cause the auto accident at issue. This 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.

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’ a *tortfeasor* 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)).

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.*

Thus, Jones’ argument about *Haselden* being “more current, settled precedent” than *Gordon* is nonsensical. *See* (Jones’ Pet., pp. 7-8). *Haselden* and *Gordon* do not even answer the same question. *Haselden* is entirely irrelevant and inapplicable to the question at issue in this case. *Gordon* answers the relevant question in favor of Progressive’s position. Therefore, Jones’ Petition fails to set forth any special reasons justifying review of the bad faith claim, which the Court of Appeals properly dismissed in accordance with this Court’s settled precedent.⁹

D. In addition, the Court of Appeals properly affirmed dismissal of Jones’ breach of contract accompanied by a fraudulent act claim because she did not allege a separate fraudulent act and the only alleged acts were not fraudulent.

“To maintain an action for breach of contract accompanied by a fraudulent act, a plaintiff must prove three elements: (1) a breach of contract; (2) fraudulent intent relating to the breaching of the contract and not merely to its making; and (3) a fraudulent act accompanying the breach.” *RoTec Servs., Inc. v. Encompass Servs., Inc.*, 359 S.C. 467, 470, 597 S.E.2d 881, 883 (Ct. App. 2004). Under this claim in her Complaint, Jones did not set forth what the alleged breach of contract was or what the alleged fraudulent act was. (App. p. 28 ¶ 22). From the remainder of the

⁹ 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.” 353 S.C. 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 – i.e. the contractual amount Progressive agreed to pay under the terms of the insurance contract.

Complaint, the only potential breach and fraudulent act Jones alleged was paying the medical payments coverage at the Medicaid rates for services rendered. *See* (App. pp. 23-24, 30-31 ¶¶ 12-13, 25, Wherefore B.).

Consequently, this claim was properly dismissed for three (3) separate reasons. Jones did not allege a fraudulent act separate from her alleged breach of contract. Additionally, as explained above and in Progressive’s Petition, paying medical payments coverage at the Medicaid rates is not a breach of the insurance policy. This is also not a fraudulent act, as required for this claim. Thus, for each of these separate reasons, this cause of action was properly dismissed.

The key element of this claim is a fraudulent act; “mere breach of a contract, even if willful or with fraudulent purpose, is not sufficient.” *Lister v. NationsBank of Delaware, N.A.*, 329 S.C. 133, 142, 494 S.E.2d 449, 454 (Ct. App. 1997); *Hardee v. Penn Mut. Life Ins. Co. of Philadelphia*, 215 S.C. 1, 11, 53 S.E.2d 861, 865 (1949). As this Court explained, the alleged fraudulent act must be “separate and distinct from the act(s) constituting the breach.” *Smith v. Canal Ins. Co.*, 275 S.C. 256, 260, 269 S.E.2d 348, 350 (1980) (emphasis added); *see also Minter v. GOCT, Inc.*, 322 S.C. 525, 530, 473 S.E.2d 67, 70–71 (Ct. App. 1996) (requiring “evidence of an independent fraudulent act which accompanied the breach”). Where, as here, the alleged breach of contract and fraudulent act are one and the same, this claim is properly dismissed. *See Smith*, 275 S.C. at 260, 269 S.E.2d at 350 (holding this cause of action should have been struck where complaint merely restated manner in which defendant was alleged to have breached contract and the acts alleged “merely reaffirm [the insurer’s] position on coverage and are not fraudulent in and of themselves”). Jones’ Complaint did not articulate any separate allegedly fraudulent act.

Even now, Jones has failed to articulate a separate fraudulent act from her alleged breach of contract – i.e., paying the medical payments coverage at the Medicaid rates. In her Appellant

Brief and Petition, Jones argues that the separate “fraudulent act” is Progressive relying on the *Gordon* and *Barker* cases when determining the amount of medical payments coverage to pay. (Jones’ Appellant Br., App. pp. 257-58); (Jones’ Pet., pp. 10-11). The analysis that went into Progressive’s decision-making process is not a separate “act” from the decision itself. *See Smith*, 275 S.C. at 260, 269 S.E.2d at 350 (requiring a “fraudulent act” that is “separate and distinct from the act(s) constituting the [alleged] breach”); *see also* (April 21, 2025 Court of Appeals’ Opinion (“There is no evidence of an independent fraudulent act that accompanied Progressive’s breach of contract because its failure to analyze and apply the relevant or proper cases when considering Jones’s claim was *part of* the breach.”)). Therefore, the Circuit Court properly dismissed the “breach of contract accompanied by a fraudulent act” claim.

Additionally, to the extent this is the alleged “fraudulent act,” this claim was properly dismissed because it is duplicative of her breach of the covenant of good faith and fair dealing claim, her breach of fiduciary duty claim, and her bad faith claim – all of which are premised on the same duty and acts. *See* (Jones Pet., pp. 10-11 (alleging that “Progressive’s action in ‘misreading’ or ‘misapplying’ these cases amounted to unfair dealing”) (emphasis added); *see, e.g., Hood*, 445 S.C. at 10, 910 S.E.2d at 772; *RFT Mgmt. Co. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 336–37, 732 S.E.2d 166, 173 (2012); *Ocean Winds Council of Co-Owners, Inc. v. Auto-Owners Ins. Co.*, 241 F. Supp. 2d 572, 577 (D.S.C. 2002).

This claim was also properly dismissed because paying medical payments coverage at the Medicaid rates is not a fraudulent act. “Fraudulent act” is defined as “any act characterized by dishonesty in fact or unfair dealing.” *RoTec Servs., Inc.*, 359 S.C. at 470, 597 S.E.2d at 883. “This fraudulent act, although separate and distinct from the act(s) constituting the breach, must accompany the breach and not be too remote in either time or character.” *Smith*, 275 S.C. at 260,

269 S.E.2d at 350. The “facts and circumstances peculiar to each case [are] to bear heavily upon the conscience and judgment of the court or jury in determining its presence or absence.” *Conner*, 348 S.C. at 466, 560 S.E.2d at 612.

Based on long-standing South Carolina Supreme Court precedent, Progressive understood and understands “expenses incurred” to mean expenses that the insured becomes obligated to pay. *See Gordon*, 238 S.C. at 446, 120 S.E.2d at 513. Jones is a Medicaid beneficiary, so she was never obligated to pay more than the Medicaid rates. As a result, Progressive paid her medical payments claim at the Medicaid rates rather than the phantom medical charges she was never obligated to pay. As a matter of law, this was not a fraudulent act. Jones failed to allege any facts which would tend to prove Progressive committed a fraudulent act accompanying its alleged breach of contract. Therefore, the Circuit Court also properly dismissed her breach of contract accompanied by a fraudulent act claim for this reason. *See RoTec Servs., Inc.*, 359 S.C. at 470, 597 S.E.2d at 883 (holding trial court’s dismissal of this claim was proper where Encompass “failed to allege any facts which would tend to prove Rotec committed a fraudulent act accompanying its alleged breach of contract”).

III. There are no special reasons justifying review of Jones’ attorneys’ fees claim, and it was properly denied.

The only grounds for review set forth in Jones’ Petition are “conflict with prior controlling precedent of this Court” and “novel questions of law.” (Jones’ Pet., p. 1). However, her Petition does not allege that the Court of Appeals’ ruling on her attorneys’ fee claim conflicts with a prior ruling of this Court or presents a novel question. *See (id.* at pp. 13-15). Under the standards set forth by this Court, the denial of this claim does not merit this Court’s review. The Court of Appeals’ ruling on this claim was in full accord with this Court’s prior precedent.

The Court of Appeals properly affirmed the denial of Jones' claim for attorney's fees. Although attorney's fees may be awarded in a bad faith action pursuant to South Carolina Code § 38-59-40, there must be a trial judge's specific "finding of fact supported by the evidence" that the refusal to pay was without reasonable cause. *Baker v. Pilot Life Ins. Co.*, 268 S.C. 609, 613, 235 S.E.2d 300, 302 (1977); S.C. Code § 38-59-40(1) (requiring "a finding on suit of the contract made by the trial judge that the refusal was without reasonable cause or in bad faith"). Jones' Petition does not cite to any specific finding of fact by the trial judge that "the refusal was without reasonable cause or in bad faith". See (Jones' Pet., pp. 13-15).¹⁰ Here, there was no such finding of fact, much less a finding of fact supported by the evidence. Rather, the Circuit Court properly dismissed Jones' bad faith claim, necessarily finding that Progressive had reasonable cause for paying the medical payments claim at the Medicaid rates. (February 10, 2021 Circuit Court Order, R. pp. 6-7 (dismissing the bad faith claim and stating that "an insurer who has a meritorious coverage defense is free to litigate the issue without fear of a bad faith or extra contractual claim"); (April 6, 2023 Circuit Court Order, R. p. 17 ("The court previously dismissed the bad faith cause

¹⁰ Jones' argument that there are two separate standards for recovery under § 38-59-40 is without merit. In the statutory phrase "refusal was without reasonable cause or in bad faith," the "or" is simply giving two phrases to describe the same thing – i.e., a tortious denial of contractual benefits. The *Nichols v. State Farm Mut. Auto. Ins. Co.* case, adopting common law bad faith, uses the same two phrases to define a single bad faith cause of action. 279 S.C. 336, 340, 306 S.E.2d 616, 619 (1983) (using the phrases "bad faith or unreasonable action"). A required element of a bad faith refusal to pay claim is "refusal by the insurer to pay... resulting from the insurer's **bad faith or unreasonable action** in breach of an implied covenant of good faith and fair dealing." *Cock-N-Bull Steak House, Inc. v. Generali Ins. Co.*, 321 S.C. 1, 6, 466 S.E.2d 727, 730 (1996) (emphasis added); see also *Hood*, 445 S.C. at 9, 910 S.E.2d at 771; *Dowling v. Home Buyers Warranty Corp.*, 303 S.C. 295, 297, 400 S.E.2d 143, 144 (1991) ("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."). Thus, the factual finding required to find for an insured on a bad faith refusal to pay claim is the same factual finding required to grant attorneys' fees under the statute. To argue that there are two separate paths to recovery under the statute is borderline frivolous.

of action in this matter finding that the insurer denial 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.”)). Moreover, as shown above, Progressive had a reasonable basis for contesting this claim.

Furthermore, this Court has explicitly cautioned against awarding attorney’s fees when an insurer is contesting “legal principles of novel impression is this State” because “[c]ertainly in a free society, one is entitled to properly litigate without the fear of unequal punishment.” *Nelson v. United Fire Ins. Co. of New York*, 275 S.C. 92, 97, 267 S.E.2d 604, 607 (1980); *Greene v. Durham Life Ins. Co.*, 287 S.C. 197, 199, 336 S.E.2d 478, 480 (1985) (denying attorney’s fees because insurer “should not be penalized for its decision to litigate a meritorious issue”). “The legislature did not intend, by enactment of [the attorney fee statute], that attorneys’ fees should be paid in every contested case won by the insured.” *Boggs v. Aetna Cas. & Sur. Co.*, 272 S.C. 460, 465, 252 S.E.2d 565, 568 (1979). Therefore, the Court of Appeals properly affirmed denial of Jones’ claim for attorney’s fees.

CONCLUSION

For the above-stated reasons and those set forth in Progressive’s Petition for Writ of Certiorari, Jones’ Petition for Writ of Certiorari should be denied. The Petition fails to set forth any “special reasons” justifying the Court’s review in this case. In addition, the Court of Appeals properly affirmed dismissal of Jones’ § 38-77-144, bad faith, breach of contract accompanied by a fraudulent act, and statutory attorneys’ fees claims in accordance with this Court’s relevant precedent. Therefore, Progressive respectfully requests that this Court grant its Petition for Writ of Certiorari and deny Jones’ Petition for Writ of Certiorari.

Respectfully submitted,

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