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IN THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

2025-UP-074 (S.C. Ct. App. filed Feb. 24, 2025)

Appellate Case No. 2023-000654
Trial Court Case No. 2020-CP-12-00207

Alexis Jones,..Petitioner,

v.

Progressive Northern Insurance Company...Respondent.

ALEX JONES' RETURN TO PETITION FOR WRIT OF CERTIORARI FILED BY PROGRESSIVE NORTHERN INSURANCE COMPANY

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Christina M. Frohock, *Schrödinger's Dissent: The Hybrid Authority of a Dissenting Opinion*, 107 Marquette Law Review 963 (Summer 2024) 6, 7

INTRODUCTION

Pursuant to Rule 242(f), SCACR, Respondent-Appellant Alexis Jones files the following Return to the Petition for Writ of Certiorari Progressive Northern Insurance Company (Progressive) filed in this matter seeking review of the Court of Appeals' opinion in *Jones v. Progressive Northern Ins. Co.*, 2025-UP-074 (S.C. Ct. App. filed Feb. 24, 2025). Ms. Jones asserts that the Court of Appeals correctly affirmed the circuit court's decision that Progressive owed Ms. Jones the entire amount due under her MedPay coverage and not a reduced amount reflective of payments the medical providers accepted from Medicaid. The Court should deny Progressive's petition.

COUNTER-STATEMENT OF THE QUESTIONS PRESENTED FOR REVIEW

I. Did the Court of Appeals correctly apply South Carolina law in affirming the Circuit Court's decision holding Progressive owes Ms. Jones under the MedPay coverage the full amount the medical providers would have billed instead of an amount offset due to the amount Medicaid paid on Ms. Jones' behalf?

II. Is the Court of Appeals' decision consistent with this Court's precedent, including *Gordon v. Fidelity & Cas. Co. of N.Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961), *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003), and *Covington v. George*, 359 S.C. 100, 597 S.E.2d 142 (2004), as well as the unpublished U.S. District Court case of *Barker v. Washington Nat. Ins. Co.*, 2013 WL 1767620 (D.S.C. Apr. 24, 2013)?

III. Does this case present a novel issue on the amount due to Ms. Jones under the MedPay coverage with Progressive?

COUNTER-STATEMENT OF THE CASE

Alexis Jones was injured in an automobile collision on October 8, 2019. (R. p. 22). She incurred medical expenses for which her providers charged in excess of $10,000.00. (R. p. 22). Ms. Jones submitted the claims to Progressive for payment under the Progressive policy covering the vehicle she was driving, which included a limit of $10,000.00 in MedPay coverage. (R. pp.

22-23). However, because Ms. Jones was independently covered by Medicaid, Progressive refused to pay Ms. Jones the full amount of the medical bills, instead paying only those reduced amounts the medical providers agreed to accept from Medicaid.

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

On April 29, 2020, Progressive filed an answer, contending its obligation was to pay only those amounts Progressive asserted that Ms. Jones "actually incurred" (which Progressive defined as the amount the medical providers agreed to accept from Medicaid) so that Progressive only owed Ms. Jones $1,323.00, the amount Medicaid actually paid to Ms. Jones' medical providers. (R. pp. 32-38).

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

On August 17, 2020, Ms. Jones filed an Offer of Judgment pursuant to Rule 68, SCRCP. Thereafter, Progressive moved pursuant to Rule 59, SCRCP, to Alter or Amend the August 10, 2020 order. The circuit court granted the motion in part and denied it in part. (R. pp. 5-10). The circuit court ruled that because Progressive submitted case law that appeared to support Progressive's position, "South Carolina law would not recognize a cause of action for bad faith,

breach of the duty of good faith and fair dealing (which is duplicative), breach of fiduciary duty (which is also duplicative) or breach of contract accompanied by a fraudulent act under these circumstances." (R. p. 7). The circuit court also held that Section 38-77-144 does not create a private cause of action. (*Id.*) The circuit court dismissed Ms. Jones' causes of action except for a claim for breach of the insurance contract. (*Id.*)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Plaintiff was a recipient of South Carolina Medicaid which had agreements in place with the medical providers listed above which required the medical providers to accept the total sum of $439.97[1] for the treatment rendered to the Plaintiff. The Plaintiff has not paid any additional sums to any of the medical providers, nor is she legally

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[1] There is no explanation for the difference in figures, that is, $439.97 versus $1,323.00 that Progressive contended was the limit of its exposure.

> obligated to pay any additional sums to the medical providers. All of the charges for the treatment rendered to her has been paid in full based upon the providers receipt of the Medicaid payments listed above.

(R. pp. 138-140).

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

On April 24, 2023, Progressive served and filed a Notice of Appeal. Ms. Jones filed and served a Notice of Cross-Appeal on May 3, 2023. The Court of Appeals heard arguments on December 3, 2024, and on February 26, 2024, the Court issued its opinion affirming the trial court's order in its entirety. *Jones v. Progressive Northern Ins. Co.*, 2025-UP-074 (S.C. Ct. App. filed Feb. 24, 2025). Each party petitioned for rehearing and on April 16, 2025, the Court issued its order denying both petitions but amending the opinion to correct a scrivener's error in the filing date.

Progressive served its Petition for a writ of certiorari on May 16, 2025. Ms. Jones has served her own petition for this Court to issue a writ of certiorari to review the decision affirming the trial court's rulings on her claims for bad faith, breach of contract accompanied by a fraudulent act, a cause of action under Section 38-77-144, and statutory attorney fees under Section 38-59-40. This Return addresses only those issues in Progressive's Petition.

ARGUMENTS

I. The Court of Appeals Correctly Applied South Carolina Law in Affirming the Trial Court's Decision on the Amount Progressive Owes Under the MedPay Policy

Progressive argues that the Court of Appeals' decision "fails to take into account the realities of how tax-funded health insurance programs like Medicare and Medicaid work." (Petition, p. 6). Progressive asserts that payments under Medicaid are not adjusted payments but are, in fact, "payment in full." (Petition, pp. 7-8). Progressive contends, therefore, that the amount a medical provider agrees to accept under Medicaid is "the amount incurred," and anything else is "phantom"money, citing to Justice E.C. Burnett's dissent in *Haselden v. Davis*, 353 S.C. 481, 487, 579 S.E.2d 293, 296 (2003). (Petition, p. 8). This Court should not be persuaded by this argument.

First, as noted, Progressive relies upon a discussion in Justice Burnett's dissent in *Haselden* in which Justice Pleicones concurred. A dissent, however, is not binding authority. As this Court stated over a century ago:

> * * * Even if a dissenting opinion sustains the appellants, it is not binding authority. A dissenting opinion is useful and throws light on the case, but is not controlling. The majority opinion is what is the law, and the dissenting opinion shows what is not the law. A justice dissents only when, in his judgment, the prevailing opinion is contrary to what the law has been.

State v. Batson, 107 S.C. 460, 93 S.E. 135 (1917). *See, also,* Christina M. Frohock, *Schrödinger's Dissent: The Hybrid Authority of a Dissenting Opinion*, 107 Marquette Law Review 963, 985 (Summer 2024) (noting "many courts resist following dissents even from a splintered bench" since "the dissent lost the vote"); *Id.* at 990 ("A dissent is the one judicial opinion that, *by definition*, is inconsistent with the law.") (emphasis in original).

A dissenting opinion may one day win adherents in a later majority. *Id.* at 990. However, both of the dissenters in *Haselden* joined the majority the very next year in *Covington v. George* to answer a question left open in *Haselden*; Justice Pleicones, one of the *Haselden* dissenters, actually authored the opinion in *Covington.* The Court in *Covington* described *Haselden* as follows:

> Whether the actual payment amount may be utilized to establish the reasonableness of medical expenses was ancillary to the main issue in *Haselden* because both the billed amount and the actual payment amount were admitted into evidence. In *Haselden*, the Plaintiff submitted evidence that she *incurred* medical expenses in the amount of $77,905.21. [*Haselden v. Davis*,] 341 S.C. 486, 501, 534 S.E.2d 295, 303 (Ct. App. 2000)[, *affirmed* 353 S.C. 481, 579 S.E.2d 293 (2003)]. Medicaid paid $24,109.04 to cover the services. 534 S.E.2d at 303. The difference between the amounts billed and the amounts actually paid by Medicaid was $51,620.59. *Id.* Defendants entered a letter as a court exhibit, which showed the gross amount of the bills for Plaintiff's services and the corresponding Medicaid payments. The admissibility of the actual payment amount was not an appellate issue in *Haselden*, but rather the issue was Plaintiff's entitlement to recover the difference between the billed amount and the actual payment amount.

Covington v. George, 359 S.C. 100, 597 S.E.2d 142, 143-144 (2004) (emphasis added). Not only did the *Haselden* dissenters abandon their prior position, they agreed in *Covington* that the plaintiff in *Haselden* "incurred" the gross expense, not the lower amount the providers accepted from the collateral source, Medicaid. *See*, *also*, *Gipson v. Coffee & McKenzie, P.A.*, 445 S.C. 395, 400, 914 S.E.2d 842, 844-845 (2025) ("Although it may appear in many contexts, the collateral source rule most often arises when the injured party has received money for the injury from one of the following sources of benefits: ... (4) social legislation benefits, *Haselden v. Davis*, 353 S.C. 481, 485, 579 S.E.2d 293, 295 (2003) (Medicaid payments).").

Progressive's contentions about Medicaid payments to providers is effectively that they are not from a "collateral source," nor do they represent an offset, but the payments are, in fact,

the full payment to the provider under the program. Progressive supports its argument only with a dissenting opinion in *Haselden* and authorities from other jurisdictions that are contrary to *Haselden* and *Covington*. This position is entirely inconsistent with the majority decision in *Haselden*, the unanimous decision in *Covington*, and the very recent decision in *Gipson*. The Court should not find Progressive's argument persuasive and should deny Progressive's petition.

II. The Court of Appeals' Decision is Consistent with This Court's Precedent

Progressive contends the Court of Appeals' decision is not consistent with *Gordon v. Fidelity & Cas. Co. of N.Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961) or the unpublished United States District Court case of *Barker v. Washington Nat. Ins. Co.*, 2013 WL 1767620 (D.S.C. Apr. 24, 2013). Both *Gordon* and *Barker*, however, are distinct from this case in very meaningful ways. Furthermore, the Court of Appeals' decision is consistent with this Court's more recent precedent in *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003) and *Covington v. George*, 359 S.C. 100, 597 S.E.2d 142 (2004). The Court should reject Progressive's arguments.

A. *Gordon v. Fidelity & Cas. Co. of N.Y.*

Progressive rests the majority of its position on *Gordon*. However, *Gordon* is distinct from this case in very meaningful ways.

First, in *Gordon*, the insured and the insurance carrier *stipulated* that the plaintiff incurred no expense for his medical care. *Gordon*, at 446, 120 S.E.2d at 513 ("Since the parties to this action stipulated that the respondent incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the appellant was not liable to the respondent for the reasonable cost of his hospitalization, because the appellant had limited its liability to pay

only 'all reasonable expenses incurred' by the respondent."). That is, there was no bill for a collateral source to satisfy.

Second, the Court in *Gordon* relied upon *United States v. St. Paul Mercury Indemn. Co.*, 238 F.2d 594 (8th Cir. 1956) as persuasive authority. In *St. Paul*, a Federal Appeals Court held that when a servicemember or veteran is provided medical care through the Veterans' Administration, the veteran incurs no medical expenses. The *St. Paul* Court ruled the government "could not recover from [the] insurer, since, under statute, [the] veteran had incurred no liability" arising from the treatment. *United States v. St. Paul Mercury Indemnity Co.*, at 595. This is a very narrow holding aimed at a discrete segment of the population: Those individuals who are eligible for free medical care through the Veteran's Administration. That is, there never will be a bill for the services for which an insurer (including Medicaid) will have exposure.

Unlike *Gordon*, there is no statute that renders the medical treatment free for Ms. Jones from the start. (R. p. 11). As the trial court explained "[Ms. Jones] incurred the full cost of her medical treatment at the time services [were] rendered as she became obligated for that amount irrespective of Medicaid. " (R. p. 11). The trial court added, "Unlike *Gordon*, [Ms. Jones] in this case was in fact charged for the services rendered at the time they were rendered thereby incurring those expenses notwithstanding Medicaid." (R. p. 11).

Third, *Gordon* predates South Carolina's adoption of the Automobile Reparation Reform Act in 1974 (recodified in 1977). *See Shores v. Weaver*, 315 S.C. 347, 433 S.E.22d 913 (1993), *cert. denied* March 18, 1994 (describing the adoption of current automobile insurance laws in

South Carolina).[2] At the time of *Gordon*, there was *no* provision in the South Carolina Code that prohibited any setoff from PIP or MedPay benefits as there is now. *See* S.C. Code Ann. § 38-77-144 (2015) ("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*.") (emphasis added).

Fourth, *Gordon* predates more recent precedent from this Court in *Haselden* and *Covington*. Both of those cases hold that the appropriate measure of the cost of medical care is the amount a provider would have billed absent a *collateral source*, such as Medicaid. Thus, the amount the provider would have billed was the cost Ms. Jones incurred. The fact that the providers accepted Medicaid affects only the ultimate payment on her behalf, not the initial expense she incurred for treatment.

This Court should not be persuaded by Progressive's argument that *Gordon* controls the outcome in this case, and should deny Progressive's petition.

B. *Barker v. Washington Nat. Ins. Co.*

Progressive asserts the United States District Court "properly applied the *Gordon* decision to similar facts" in *Barker v. Washington Nat. Ins. Co.*, 2013 WL 1767620 (D.S.C. Apr. 24, 2013). (Petition, p. 11). Since *Barker* relied upon the same reading of *Gordon* that

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[2] Westlaw flags *Shores* as "superseded by statute," pointing to *McGee v. SC Dept. of Motor Vehicles*, 389 S.C. 540, 698 S.E.2d 841 (Ct. App. 2010). This is incorrect. *McGee* relied upon the Court of Appeals' opinion in *Cowan v. Allstate Ins. Co.*, 351 S.C. 626, 571 S.E.2d 715 (Ct. App. 2002) (*Cowan I*) (holding *Shores* was superseded by the adoption of S.C. Code Ann. § 38-77-142(B) (eff. 3/1/1999)). This Court, however, reversed *Cowan*, and held *Shores* is still good law. *Cowan v. Allstate Ins. Co.*, 357 S.C. 625, 594 S.E.2d 275 (2004) (*Cowan II*) (holding the adoption of S.C. Code Ann. § 38-77-142(B) did not impact the holding in *Shores*). Therefore, while *McGee* correctly described the effect of *Cowan I*, the *McGee* opinion lost any efficacy because Cowan *I* is no longer good law. Hence, Westlaw's flag is in error.

Progressive promotes, *Barker* is wrongly decided. Even so, *Barker* is distinct from this case in very meaningful ways. This Court should not be persuaded by Progressive's argument.

First, the district court in *Barker* attempted to predict South Carolina law. Citing to *Gordon*, the district court concluded "as a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill...." The district court did not analyze the case under the collateral source rule as described in *Covington* or *Haselden* (reaffirmed in *Gipson*). Respectfully, Judge Duffy's unpublished order is wrong, and this Court should reject that analysis.

Second, *Barker* involved a health insurance policy, not an automobile policy. This is a meaningful distinction. Insurers have more flexibility when including terms like the "Medicare Provision" found in the *Barker* policy as opposed to automobile insurance coverage. In an automobile policy, a term must comply with the governing statutory provisions or the term is void. *See, e.g.*, *Cothran v. State Farm. Mut. Auto. Ins. Co.*, 427 S.C. 545, 831 S.E.2d 919 (2019) (holding invalid a "coordination clause" which permitted insurer to reduce PIP payments for workers' compensation recovery). The "Medicare Provision" in *Barker* would be unenforceable if included in an automobile PIP/Medpay policy given the PIP/Medpay statute's provision that benefits "the coverage shall not be assigned or subrogated and is not subject to a setoff." S.C. Code Ann. § 38-77-144.

Finally, the district court's unpublished order is not binding on this Court. *See, e.g.*, *Laffite v. Brigestone Corp.*, 381 S.C. 460, 473 n. 9, 674 S.E.2d 154, 161 n. 9 (2009) ("a federal court decision interpreting state law is not binding on this Court."), citing *Blyth v. Marcus*, 335 S.C. 363, 368 n. 3, 517 S.E.2d 433, 435 n. 3 (1999) (noting a federal district court decision was

not binding on this Court). And because of the significant distinctions between this case and *Barker* set forth above, the district court's unpublished decision is not even persuasive authority.

Progressive asks the Court to focus on the amount ultimately *paid* to the medical providers, not the amount *incurred* when the patient received the services. Ms. Jones *incurred* the full amount the medical providers ordinarily charged; what was *paid* was the reduced amount the providers agreed to accept. Progressive's argument, taken to its extreme, would be that it should receive credit for *any* payment by *any* health insurer who negotiates a reduction with the provider, and is only liable for that amount plus any co-pay an insured must pay. That is not the law, nor is it the language of Progressive's insurance agreement.

The Court of Appeals' decision affirming the circuit court's order finding Progressive owed Ms. Jones the balance due under the applicable MedPay policy is entirely consistent with controlling authority from this Court. It is also consistent with the cases upon which Progressive relies because those cases are meaningfully distinct, they are not consistent with more recent case law, or they are not binding upon this Court. Accordingly, the Court should reject Progressive's arguments and deny its petition.

III. This Case Does Not Present a Novel Issue on the Amount Due to Ms. Jones under the MedPay Policy

Progressive argues in the alternative that "to the extent *Gordon* is not controlling – which [Progressive] disputes – then this case certainly presents a novel question of law" so as to fall within Rule 242(b)(1), SCACR. (Petition, p. 13-14). This Court should decline to address this

argument for several reasons.

First, Progressive did not make this argument to the Court of Appeals or in its Petition for Rehearing to the Court of Appeals. *See* Rule 242(d)(1), SCACR ("Only those questions raised in the Court of Appeals and in the petition for rehearing shall be included in the petition for writ of certiorari as a question presented to the Supreme Court."). *See, e.g.*, *Williams v. Jeffcoat*, 444 S.C. 224, 906 S.E.2d 588 (2024) (this Court refused to address an issue not raised in a petition for rehearing to the Court of Appeals, citing the Rule).

Second, the issue Progressive pursues is not novel. This Court in *Haselden* and *Covington* described the amount the medical provider normally charged as the amount an insured "incurred," and not the net amount a provider accepted from a collateral source such as Medicaid. The law is settled on this point. And Section 38-77-144 plainly states benefits payable under a MedPay policy are not subject to setoff, including from a collateral source like Medicaid. The issue *seems* novel because Progressive continues to advocate for a "misapplication" and "misinterpretation," (as stated in *Jones*, slip at *4) of the holdings of *Gordon* and *Barker*.

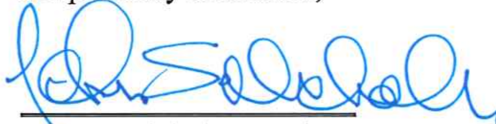
Again, the law on this point is settled; the issue is not novel. Section 38-77-144 mandates that Progressive pay what it agreed to pay under its policy without setoff for payments attributed to a collateral source such as Medicaid. *Haselden* and *Covington* set forth the rules governing which figures to use, that is, the normal charges and not the reduced charges under a provider's agreement to accept Medicaid.

Accordingly, the Court should reject Progressive's attempt to repackage its arguments as involving a novel issue meriting this Court's review under Rule 242(b)(1). The Court should therefore deny Progressive's petition.

Conclusion

For the reasons stated the Court should deny Progressive's Petition for Writ of Certiorari to the Court of Appeals and affirm the portion of that Court's opinion upholding the trial court's order finding that Progressive owed Ms. Jones the entire amount due under the MedPay policy.

Respectfully submitted,



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