IN THE STATE OF SOUTH CAROLINA
In the Supreme Court

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S.C. SUPREME COURT

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APPEAL FROM CHESTER COUNTY
Court of Common Pleas

Brian M. Gibbons, Circuit Court Judge

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Appellate Case No. 2025-000943

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Alexis Jones ..................................................................................Respondent,

v.

Progressive Northern Insurance Company..............................................Petitioner.

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# BRIEF OF PETITIONER

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## STATEMENT OF ISSUE ON APPEAL

I. **With respect to Medical Payments coverage, whether an insured only incurs medical expenses in the amount that her medical providers have agreed to accept as payment in full for the treatment she received?**

## STATEMENT OF THE CASE

This action arises out of Petitioner Progressive Northern Insurance Company's ("Progressive Northern") payment of Alexis Jones' Medical Payments claim stemming from an October 8, 2019, auto accident. Jones submitted her Medical Payments claim under a personal auto policy issued to Willie Brown under which Jones is listed as a driver and resident relative. The policy includes a $10,000 Medical Payments coverage limit. The policy provides Medical Payments coverage for certain medical "expenses incurred" by an insured as a result of an accident. Respondent alleges that Progressive Northern breached the insurance contract by paying the amount for medical expenses that the providers accepted as payment in full for the treatment rendered rather than paying the full amount of expenses itemized on the providers' invoices. Respondent's novel theory would provide a windfall recovery that is not required under South Carolina law or Progressive Northern's policy.

The Respondent is a Medicaid recipient. Before rendering treatment, her healthcare providers entered into provider contracts with the South Carolina Department of Health and Human Services. Under these provider contracts, the healthcare provider agreed to accept set rates as payment in full for services rendered to Medicaid patients. Thus, a Medicaid patient does not incur costs beyond the Medicaid rates. His or her providers have already agreed before treatment to accept those rates as "payment in full." Consequently, Progressive Northern paid Medical Payments coverage to Respondent in the amount of $1,323.60 – the same amount her medical providers accepted as payment in full for the treatment rendered. Respondent "has not paid any additional sums to any of the medical providers, nor is she legally obligated to pay any additional sums to the medical providers." (Stipulation of Fact, App. p. 141 ¶ 17). The Court of Appeals' April

16, 2025 Opinion held that Ms. Jones incurred $27,786.17, not the amount actually owed, in medical expenses even though she readily admits that she never became obligated to pay this amount. (App. p. 330).

In *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961), this Court defined what "expenses incurred" means in the context of Medical Payments coverage. As this Court explained, "a thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'." *Gordon*, 238 S.C. at 444, 120 S.E.2d at 512. The Respondent stipulated that she was not obligated to pay more than $1,323.60. (App. pp. 138-140).

In the more than sixty (60) years since this decision, no court in South Carolina and no federal court applying South Carolina law has found that an insured can incur an expense for which there is no obligation to pay. In its February 26, 2025 and April 16, 2025 decisions, the Court of Appeals failed to accurately apply *Gordon*, binding Supreme Court precedent. Moreover, the Court of Appeals' decision is at odds with decisions of the United States District Court for the District of South Carolina and numerous jurisdictions around the country. *See Barker v. Washington Nat. Ins. Co.*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *6 (D.S.C. Apr. 24, 2013) ("[T]his Court concludes that under South Carolina law, Barker was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare."). As this Court held in *Gordon*, a thing for which there exists no obligation to pay cannot be an "expense incurred." 238 S.C. at 444, 120 S.E.2d at 512. Consequently, an insured can never incur a medical expense beyond what his or her providers agree to accept as payment in full for the treatment rendered.

## FACTUAL AND PROCEDURAL BACKGROUND

### I. Factual Background

#### A. The Progressive Northern Policy

Progressive Northern issued a personal auto policy, Policy No. 930693102, to Willie Brown with effective dates of June 21, 2019 to December 21, 2019 (the "Policy"). (App. p. 54). The Policy includes a Medical Payments coverage limit of $10,000 each person. (App. p. 55). The Policy provides in pertinent part:

> **PART II – MEDICAL PAYMENTS COVERAGE**
>
> **INSURING AGREEMENT**
> If **you** pay the premium for this coverage, **we** will pay the reasonable expenses incurred for necessary **medical services** received within three years from the date of a **motor vehicle** accident because of **bodily injury**:
> 1. Sustained by an **insured person**; and
> 2. Caused by that **motor vehicle** accident.

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

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

On October 8, 2019, Respondent was involved in an auto accident. (App. p. 23 ¶ 11). Respondent made a Medical Payments coverage claim under the Progressive Northern Policy. (App. p. 24 ¶ 13). With her claim, Respondent submitted medical provider billing statements in excess of $10,000. (App. pp. 23-24 ¶¶ 12-13). However, Respondent is a Medicaid recipient. (App. pp. 6, 139 ¶ 4). Medicaid had agreements in place with her medical service providers wherein the providers agreed to accept set rates as payment in full when treating Medicaid recipients. (Stipulation of Fact, App. pp. 139-141); (February 10, 2021 Circuit Court Order, App. p. 6). Medicaid paid $1,323.60 total for the medical treatment Respondent received, and the medical providers accepted this amount as payment in full for the treatment rendered. *See* (April 6, 2023 Circuit Court Order, App. p. 15).

Progressive Northern paid Medical Payments coverage to Respondent in the amount of $1,323.60 – the same amount her medical providers accepted as payment in full for the treatment rendered. (*Id.*). Respondent stipulated that she "has not paid any additional sums to any of the medical providers, nor is she legally obligated to pay any additional sums to the medical providers. All of the charges for the treatment rendered to her has been paid in full based upon the providers receipt of the Medicaid payments…." (Stipulation of Fact, App. p. 141 ¶ 17). At the bench trial, Respondent testified as follows:

> Q. Ms. Jones, as I understand it, Medicaid paid the hospital bill at MUSC and all the other doctors you went to from the accident on your behalf?
> A. Yes.
> Q. You've paid no money yourself?
> A. No.
> Q. Is that correct?
> A. Correct.
> Q. And you're not legally obligated to pay any money to any of those by virtue of you being a Medicaid beneficiary. The hospital and doctors that you saw have agreed to accept what Medicaid paid them for a payment in full?
> A. Yes.
>
> ***
>
> Q. And you had no deductibles, out-of-pockets, nothing. Everything that you owed the doctors have been paid for by Medicaid?
> A. Yes.

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

Despite the foregoing, Respondent alleged that she is owed the full $10,000 Medical Payments coverage limit and that Progressive Northern therefore owes her "$8,676.40 in outstanding Medpay coverage." (Compl., App. pp. 24, 30-31 ¶¶ 14, 16, 25, Wherefore B.). Her Complaint asserted a breach of contract cause of action related to her Medical Payments coverage claim. (Compl., App. pp. 22-25).[1]

[1] Respondent's Complaint also asserted the following causes of action related to her Medical Payments coverage claim: (1) bad faith; (2) breach of fiduciary duty; (3) breach of the covenant of good faith and fair dealing; (4) breach of contract accompanied by a fraudulent act; (5) violation

## II. Procedural History

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

The Circuit Court then held a bench trial on the only remaining cause of action for breach of contract. By Orders filed March 29, 2023 and April 6, 2023, the Circuit Court found for Jones on her breach of contract cause of action, awarding her $8,676.40. (App. pp. 11-20). The Circuit Court found the term "incurred" to be ambiguous. (App. p. 17). Progressive Northern and Respondent filed cross appeals.

On February 26, 2025, the Court of Appeals filed an unpublished decision affirming the Circuit Court as to all causes of action. (App. pp. 295-299). The Court of Appeals held that Respondent incurred medical expenses totaling $27,768.17, even though her providers agreed before treating her to accept $1,323.60 as payment in full for the treatment rendered. (April 16, 2025 Opinion, App. pp. 329-330). The Court of Appeals decision purports to distinguish *Gordon* on the ground that in *Gordon* "the plaintiff received *free* medical care from a military hospital"

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of the South Carolina Unfair Trade Practice Act; and (6) violation of South Carolina Code § 38-77-144. (Compl., App. pp. 22-32). The Circuit Court dismissed these causes of action for various reasons, the Court of Appeals affirmed, and this Court denied certiorari as to those causes of action. (App. pp. 2-19, 328-332); (September 9, 2025 Order). Therefore, these causes of action are not addressed in this Brief.

and never received a bill. (*Id.* at p. 331). The Court of Appeals stated: "[W]hile we acknowledge that her costs were eventually adjusted and paid by Medicaid, Jones still incurred the full amount charged...." (*Id.*).

On March 11, 2025, Progressive Northern filed a Petition for Rehearing, pointing out that the Court of Appeals' Opinion was inconsistent with this Court's decision in *Gordon*, including its definition of "expenses incurred" and its holding. (App. pp. 300-307). By Order filed April 16, 2025, the Court of Appeals denied Progressive Northern's Petition for Rehearing. (App. pp. 326-27). On April 16, 2025, the Court of Appeals withdrew, substituted and refiled its Opinion, which is the same in all substantive regards as its prior Opinion. (App. pp. 328-332).[2] Neither the Circuit Court's nor the Court of Appeals' Opinion cited any case law to support the holding that an "expense incurred" in the context of Medical Payments coverage can be a thing for which there is no obligation to pay. *See* (App. pp. 17-18, 330).

**STANDARD OF REVIEW**

"This Court reviews questions of law de novo." *Lightner v. Hampton Hall Club, Inc.*, 419 S.C. 357, 363, 798 S.E.2d 555, 558 (2017) (citation omitted). "The construction of a clear and unambiguous contract is a question of law for the court to determine." *Williams v. Gov't Emps. Ins. Co. (GEICO)*, 409 S.C. 586, 594, 762 S.E.2d 705, 710 (2014). "When an appeal involves stipulated or undisputed facts, an appellate court is free to review whether the trial court properly applied the law to those facts. In such cases, the appellate court owes no particular deference to the trial court's legal conclusions." *J.K. Const., Inc. v. W. Carolina Reg'l Sewer Auth.*, 336 S.C.

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

162, 166, 519 S.E.2d 561, 563 (1999) (citations omitted). "[I]n order for this Court to affirm the circuit court's judgment, there must be evidence which reasonably supports the judge's findings." *Steeger v. Otto Zollinger, Inc.*, 287 S.C. 207, 208, 336 S.E.2d 870, 871 (1985).

## ARGUMENT

An insurer's obligation under an insurance policy is defined by the terms of the policy and cannot be enlarged by judicial construction. *South Carolina Ins. Co. v. White*, 301 S.C. 133, 137, 390 S.E.2d 471, 474 (Ct. App. 1990). "[I]f the intention of the parties is clear, courts have no authority to torture the meaning of policy language to extend or defeat coverage that was never intended by the parties." *Diamond State Ins. Co. v. Homestead Indus., Inc.*, 318 S.C. 231, 236, 456 S.E.2d 912, 915 (1995).[3] The Policy provides Medical Payments coverage for certain "reasonable expenses **incurred** for necessary medical services...." (Policy, App. p. 67) (emphasis added). Under this Court's prior precedent, Respondent did not incur expenses beyond the amount her medical providers agreed to accept and in fact accepted as payment in full for the treatment rendered. Progressive Northern previously paid this amount. Therefore, as to the breach of contract claim, the Court of Appeals' Opinion should be reversed.

### I. The amount the medical provider agrees to accept as payment in full for the treatment rendered is the "expense incurred" – not any other, greater amount.

Respondent is a Medicaid recipient. (App. pp. 6, 139 ¶ 4). Like many other health insurers, Medicaid has agreements in place with medical service providers wherein the providers agree to accept set rates as payment in full for treatment rendered to beneficiaries. (Stipulation of Fact, App. pp. 139-141); (February 10, 2021 Circuit Court Order, App. p. 6). The same would be true for "in-

[3] 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).

network" providers for private health insurance. The amounts medical providers agree to accept as payment in full are the "expenses incurred."

Specifically with Medicaid, the federal government establishes certain parameters for all states to follow.[4] One such parameter is that "[a] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency...." 42 C.F.R. § 447.15.[5] Before rendering treatment to Medicaid recipients, "healthcare providers must first enter into a contract with the South Carolina Department of Health and Human Services ("SCDHHS"), the state agency responsible for the administration of the Medicaid program in South Carolina." *Pee Dee Health Care, P.A. v. Sanford*, 509 F.3d 204, 206 (4th Cir. 2007). "Healthcare providers in South Carolina are not required to accept Medicaid patients. However, if a healthcare provider elects to treat Medicaid patients..., it does so by entering into a contract ("provider contract" or "contract") with SCDHHS." *Id.* at 207. "The contract provides for the method and amounts of payment." *Id.; see also Anco, Inc. v. State Health & Hum. Servs. Fin. Comm'n*, 300 S.C. 432, 436, 388 S.E.2d 780, 783 (1989) ("The Finance Commission implements the Medicaid program by contracting with qualified providers.").

Pursuant to the South Carolina Medicaid provider contract, the provider agrees before rendering treatment "that ***Medicaid reimbursement is payment in full***...for care or services to a recipient/patient" and "***that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient***...." Medicaid Participation and Payment Agreement,

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

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

Form (07/17), available at https://www.scdhhs.gov/sites/default/files/Participation%20%26%20Payment%20Agreement%20July%202017.pdf. (emphasis added). Thus, a Medicaid patient never incurs costs beyond the Medicaid rates. His or her providers have agreed before treatment to accept those rates as "payment in full." *See id.*[6]

As Justice Burnett succinctly explained:

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

*Haselden v. Davis*, 353 S.C. 481, 487, 579 S.E.2d 293, 296 (2003) (J. Burnett dissenting and J. Pleicones concurring in dissent) (emphasis added).[7] "[T]he plaintiff has never paid nor will ever be liable for the written-off difference between the billed and paid amount…" *Id.* Consequently, there is no "expense incurred" beyond the amount the medical provider agreed to accept as payment in full. The result would be the same if Respondent was a beneficiary of a private health

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[6] Medicare works the same way. *See Barker*, 2013 WL 1767620 at *5-6.

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

insurance plan that likewise had established rates with network providers for certain procedures and treatment.

## II. The Circuit Court's Order and Court of Appeals' decision directly conflict with this Court's precedent in *Gordon* and, instead, rely upon no authority whatsoever.

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

As this Court explained:

> "Incur emphasizes the idea of liability * * *'. Webster's New International Dictionary. 1. Bouv. Law Dict., Rawle's Third Revision, p. 1531 similarly points to this inherency in its definition of the term incur: 'To have liabilities thrust upon one by act or operation of law * * *'. Also, there are examples in specific legal situations, where it has been held that ***a thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'***. *See e. g. Stern-Slegman-Prins Co. v. Commissioner*, 8 Cir., 79 F.(2d) 289; *Bauer Bros. Co. v. Commissioner*, 6 Cir., 46 F.(2d) 874.'
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> ***
>
> [T[he respondent incurred no expense and made no cash outlay for the treatment he received at the Fort Jackson hospital, the appellant was not liable to the respondent for the reasonable cost of his hospitalization, because the appellant had limited its liability to pay only 'all reasonable expenses incurred' by the respondent. There being no obligation on the part of the respondent to pay for the hospitalization he received at Fort Jackson hospital, he 'incurred' no expense within the meaning of the provision of the policy of insurance issued by the appellant.

*Id.* (emphasis added). Thus, an "expense incurred" cannot be a thing for which there exists no obligation to pay. The amounts medical providers bill beyond what they agree to accept as payment in full – i.e. "phantom" charges – are exactly that, "a thing for which there exists no obligation to pay." *See id.*; *Haselden*, 353 S.C. at 487, 579 S.E.2d at 296 (J. Burnett dissenting and J. Pleicones concurring in dissent) (explaining that the difference between the amount a Medicare recipient is

billed and the amount paid by Medicare is "phantom" money in that no one has paid the amount and no one will incur a debt for the amount).

In its Opinion, the Court of Appeals stated that the distinguishing factor between *Gordon* and this case is that Gordon "received *free* medical care from a military hospital." (App. p. 330) (emphasis in orig.) ("Gordon's medical services were free so he was not obligated to pay for the services rendered. *Id.* Therefore, he did not 'incur' an expense."). However, Gordon did not receive free medical care at a military hospital. His medical care was paid for by taxpayers. He just received free-to-him medical care. Likewise, Ms. Jones' medical care was paid for by taxpayers. She also received free-to-her medical care. Thus, the difference between medical expenses being paid by a taxpayer-funded Veterans' Administration or a taxpayer-funded Medicaid program is not a meaningful distinction.

As this Court stated: "[A] thing for which there exists no obligation to pay, either express or implied, cannot in law be claimed to constitute an 'expense incurred'." *Gordon*, 238 S.C. at 445, 120 S.E.2d at 512. Those "phantom" charges from Ms. Jones' medical providers beyond $1,323.60 – which they issued in violation of their provider agreements – were "a thing for which there exists no obligation to pay." *See id.* Consequently, those charges cannot be an "expense incurred." *See id.* at 446, 120 S.E.2d at 513 ("There being no obligation on the part of the respondent to pay for the hospitalization he received at Fort Jackson hospital, he 'incurred' no expense within the meaning of the provision of the policy of insurance issued by the appellant."). Like the claimant in *Gordon*, Ms. Jones stipulated that she is not legally obligated to pay any money to any of her medical providers for the medical treatment she received. (App. p. 124, lines 4-24); (Stipulation of Fact, App. p. 141 ¶ 17). Thus, the *Gordon* decision requires this Court to overturn the Circuit Court and Court of Appeals and find that Ms. Jones has "incurred" no expense,

within the meaning of the policy provision, beyond what her providers agreed to accept as payment in full for the treatment rendered.

Additionally, an insured being sent a bill for charges she was never required to pay is also not a meaningful distinction from the *Gordon* case. *See* (App. p. 330). This Court in *Gordon* specifically referenced and relied upon a case where an insured had been billed for an amount he was never required to pay, and that court held there were no expenses incurred for the billed amount. *See Gordon*, 238 S.C. at 444-45, 120 S.E.2d at 512 ("In the case of *Drearr v. Connecticut General Life Ins. Co.*, La.App., 119 So.2d 149, 151, the plaintiff was a war veteran and was confined in a government hospital for treatment of and surgery for a duodenal ulcer. He had an insurance policy which contracted to pay him for the expense incurred for hospital charges and services. He brought an action to recover the amount of an alleged bill rendered by the Veterans' Administration for his hospital charges and services."). Thus, there is no meaningful distinction between this case and the *Gordon* case, which requires a finding that Ms. Jones never incurred expenses beyond the amount her providers agreed to accept as payment in full. *Gordon* is controlling, and the Circuit Court and Court of Appeals failed to apply this Court's binding precedent.

Instead of applying the *Gordon* holding, the Circuit Court and Court of Appeals relied on no authority whatsoever. *See* (April 6, 2023 Circuit Court Order, App. pp. 17-18 (citing no authority for the proposition that an insured could "incur" amounts that she admits no one was ever obligated to pay)); (April 16, 2025 Court of Appeals Opinion, App. p. 330 (also citing no authority for that proposition)).

The Virginia Supreme Court also aligns with the *Gordon* decision in holding that an insured does not "incur" an expense for which no one has an obligation to pay. In *Farm Mut. Auto.*

*Ins. Co. v. Bowers*, the Court addressed what expense "incurred" meant under Medical Payments coverage. 500 S.E.2d 212, 214 (Va. 1998). The insurer argued "that the 'incurred' expenses are those amounts which the health-care providers accepted as full payment for their services." *Id.* The insured argued that "he 'incurred' the full amount of the bills." *Id.* The Virginia Supreme Court sided with the insurer and explained:

> The evidence in the instant case was that Bowers would never be liable for any amount greater than that which the various health-care providers accepted as full payment for their services based on the Blue Cross fee schedule. Stated differently, the health-care providers' agreements with Blue Cross prevented them from collecting more than the scheduled fee and any required co-payment. Therefore, we conclude that the medical expenses Bowers "incurred" were the amounts that the health-care providers accepted as full payment for their services rendered to him. Bowers has not paid nor is he "legally obligated to pay" the amounts written off by the providers. To decide otherwise would be to grant Bowers a windfall because he would be receiving an amount greater than that which he would ever be legally obligated to pay.

*Id.* at 585–86, 500 S.E.2d at 214 (citations omitted).

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

> As a Medicare recipient, Barker at no time was obligated to pay the total charges listed on the hospital's bill, i.e., $55,241. Under 42 U.S.C. § 1395cc(a)(1)(A), a provider of

services can participate in Medicare only if the provider files an agreement with the Secretary of Health and Human Services. Pursuant to this agreement, the participant accepts "assignment" of the Medicare payment, meaning that the provider must accept the Medicare approved charge as the full charge for the covered service and "shall not collect from the beneficiary ... more than the applicable deductible and coinsurance." Medicare Participating Physician or Supplier Agreement, Form CMS–460 (04/10), available at http://www.cms.gov/Medicare/CMS–Forms/CMS–Forms/CMS–Forms–Items/CMS–007566.html; *see* Costs & Assignment, Medicare.gov, http://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html (last visited Apr. 24, 2013) (explaining that, under Medicare Part A, "Assignment means that your ... provider ... agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services" and can "charge you only the Medicare deductible and coinsurance amount"). The Southern District of New York recently addressed the issue of whether a Medicare recipient can "incur" the full fee a medical provider lists on its bill prior to applying the agreed-upon Medicare reductions, concluding that "[w]here Medicare contracts with a medical provider to set fees for a given service, the Medicare beneficiary is never liable for the amount forgone by a doctor under that agreement." *Metz v. U.S. Life Ins. Co.*, No. 09 Civ. 10250(BSJ), 2010 WL 3703810, at *3 (S.D.N.Y. Sept.21, 2010). The court further explained:

> 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).[8] As a result, the Court granted the insurer summary judgment on the insured's breach of contract (and bad faith) claim. *Id.* at *9. As explained above, Medicaid works the same way as Medicare in all pertinent respects.

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

Like the decisions in *Gordon*, *Barker* and *Bowers*, courts in numerous other jurisdictions have held that incurred expenses are only those amounts for which there is an obligation to pay. *See, e.g.*, *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir. 2011) (holding "incurred" for insurance coverage meant 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"); *Grimes v. Gov't Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019); *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *6 (N.D. Okla. Apr. 14, 2015); *Lefebvre v. Gov't Emp. Ins. Co.*, 259 A.2d 133, 135 (N.H. 1969); *Sanner v. Gov't Emp. Ins. Co.*, 376 A.2d 180, 182 (N.J. App. Div. 1977), *aff'd*, 383 A.2d 429 (N.J. 1978) ("If he neither pays the expenses nor becomes liable to pay them, we fail to see how it can be said, with any degree of realism, that he has incurred such expenses."); *Irby v. Gov't Emp. Ins. Co.*, 175 So. 2d 9, 10–11 (La. Ct. App. 1965); *Atkins v. Great Am. Ins. Co.*, 189 S.E.2d 501, 504 (N.C. 1972); *Rsrv. Life Ins. Co. v. Coke*, 183 So. 2d 490, 493 (Miss. 1966).

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

(April 16, 2025 Opinion, App. pp. 329, 330 n.1). However, the fight in *Barker* was over the "expenses incurred" language in the policy, which is identical to the language in this case. *Id.* at *4 ("Barker emphasizes the '100% in full' language, while WNIC emphasizes 'expenses incurred.'"). The *Barker* court did not address the Medicare limitation until after determining that the insured never "incurred" expenses above the Medicare rates. *Id.* at *6 ("The Second Circuit Court of Appeals affirmed, concluding that under New York law, the Medicare recipient 'did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her.' *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir.2011). Similarly, this Court concludes that under South Carolina law, Barker was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare, which amount appears to be about $15,929.29."). The District Court in *Barker* based its opinion on the "expenses incurred" policy language and the amounts the providers had agreed to accept as payment in full – not any Medicare limitation in the policy. *Id.* at *4-6.

As a North Carolina district court astutely recognized, "[t]he point of insurance is to be made whole. Requiring [the insurer] to pay an insured amounts the insured never paid and would never be responsible for would result in an inequitable windfall to the insured and needlessly increase premiums." *Grimes*, 2019 WL 3425227, at *10.

Therefore, both the Circuit Court and Court of Appeals should have found in favor of Progressive Northern on Respondent's breach of contract claim. The Policy limits its Medical Payments coverage to certain "reasonable expenses <u>incurred</u> for necessary medical services…." (Policy, App. p. 67) (emphasis added). The insured did not incur medical expenses beyond the actual amounts her providers agreed to accept as payment in full. The amount they agreed to accept was $1,323.60, which is also the amount Progressive Northern previously paid to the Respondent. (April 6, 2023 Circuit Court Order, App. p. 15 ("Progressive…only made payment to Plaintiff Jones for the amount Medicaid paid to satisfy the medical bills ($1,323.60) rather than the medical payment coverage limit.")). Allowing Respondent to receive the difference between what providers billed and what they accepted in full satisfaction of the bills would not reflect sound public policy as it would result in insurers providing benefits in addition to medical benefits, which is not required under the Policy. Respondent should not be permitted to receive more than her actual medical expenses. Thus, Progressive Northern did not breach the insurance contract by paying this amount of Medical Payments coverage.

## CONCLUSION

For the above-stated reasons, the Circuit Court's and Court of Appeals' rulings in favor of Respondent on the breach of contract claim should be reversed. This is a contract case, and the parties are bound by the terms of the insurance contract. The insurance contract only requires Progressive Northern to pay for certain medical "expenses incurred". This Court has previously

found the phrase "expenses incurred" to be unambiguous and defined that phrase as requiring an obligation on the part of the insured to pay such expense. The amount Respondent's medical providers agreed to accept as payment in full for treatment rendered to her is undisputed. As a result, Respondent, who happened to be a Medicaid beneficiary, never became obligated to pay any medical expenses beyond the Medicaid rates. Therefore, Progressive Northern did not breach the insurance contract by paying Respondent the amount her medical providers agreed to accept as payment in full for the treatment rendered. Under this Court's prior precedent, an "expense incurred" is not a charge for which there exists no obligation to pay.

Respectfully submitted,

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