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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 Jones .....Respondent,

v.

Progressive Northern Insurance Company.....Petitioner.

REPLY BRIEF OF PETITIONER

J.R. Murphy, Esquire
S.C. Bar # 7941
Megan Walker, Esquire
S.C. Bar # 103069
Murphy & Grantland, P.A.
P.O. Box 6648
Columbia, SC 29260
(803) 782-4100
jrmurphy@murphygrantland.com
mwalker@murphygrantland.com
Attorneys for Petitioner
Progressive Northern Insurance Company

Other Counsels of Record:

John S. Nichols, Esquire
Bluestein Thompson Sullivan, LLC
PO Box 7965
Columbia, SC 29202
(803) 779-7599
john@bluesteinattorneys.com

J. Logan Cannon, Esquire
Shaw Law Firm
PO Drawer 36250
Rock Hill, SC 29732
(803) 329-4200
cannon@shawcannon.com

Attorneys for Respondent

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page Number

CASES

STATUTES

SUMMARY

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 person is ever legally obligated to pay. Yet, that is exactly what Jones is arguing in this insurance breach of contract case. The policy issued by Progressive Northern Insurance Company ("Progressive Northern") limits its medical payments coverage to certain medical "expenses incurred" by an insured as a result of an accident. The sole question in this action is the amount of medical expenses Jones "incurred" as a result of an October 8, 2019 auto accident. The answer is $1,323.60 – the amount Jones' providers agreed to accept as payment in full for the treatment rendered. Jones was never obligated to pay nor has she paid her medical providers any additional amount.

According to longstanding South Carolina Supreme Court precedent, as well as case law from other jurisdictions, an insured does not "incur" an expense for which there is no legal obligation to pay. The only cases Jones cites in support of her position are irrelevant tort cases involving the collateral source rule that have no bearing on this breach of contract case. This Court defined the phrase "expenses incurred" in favor of the insurer over sixty years ago in *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 446, 120 S.E.2d 509, 513 (1961). The Court of Appeals' decision in this case is in direct conflict with this Court's prior decision in *Gordon*. Therefore, Progressive Northern respectfully requests that this Court reiterate its holding in *Gordon* and dismiss Jones' breach of contract claim.

ARGUMENT

I. The only cases Jones cites in support of her position are irrelevant and inapplicable to the issue in this case.

The relevant question in this case is what "expenses incurred" means in an insurance contract under the medical payments coverage. Prior to the bench trial in this case, Jones 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." (Stipulation of Fact, App. p. 141 ¶ 17) (emphasis added). Thus, Jones' position is necessarily that the phrase "expenses incurred" in the insurance contract can mean amounts for which no one is ever legally obligated to pay.

In the entirety of her Brief, Jones cites three (3) cases that purportedly support her position – (1) *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (2003); (2) *Covington v. George*, 359 S.C. 100, 597 S.E.2d 142 (2004); and (3) *Gipson v. Coffee & McKenzie, P.A.*, 445 S.C. 395, 914 S.E.2d 842 (2025). *See* (Jones' Brief). None of these cases are breach of contract cases.[1] None of these cases are insurance contract cases. *Id.* None of these cases are medical payments coverage cases. *Id.* None of these cases address the question of what "expenses incurred" means in medical payments coverage in an insurance contract. *Id.*

All of these cases are tort cases. *Id.* All of these cases address irrelevant issues.[2] All of these cases are collateral source cases – a rule which this Court has specifically held is inapplicable to a first party insurer, like Progressive Northern. *See id.*

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[1] *Haselden*, 353 S.C. at 482, 579 S.E.2d at 294 (wrongful death and survival actions against a doctor); *Covington*, 359 S.C. at 101–02, 597 S.E.2d at 143 (negligence action against an at-fault motorist); *Gipson*, 445 S.C. at 397–98, 914 S.E.2d at 843 (negligence action against a law firm).

[2] In *Haselden*, the issue was whether evidence of amounts billed by a treating physician could be admitted "to establish a medical malpractice plaintiff's damages" – i.e., "the reasonable value of the services." 353 S.C. at 483–85, 579 S.E.2d at 294–95. "***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 (emphasis added). Even though the medical provider accepted less than the amounts billed, the Court held that evidence of the amounts billed "was relevant to establish the reasonable value of the services," consistent with "the purposes behind the collateral source rule." *Id.*

The collateral source rule applies to a tortfeasor in a personal injury action, not an insurer in a contract action.[3] Progressive is not a tortfeasor. Progressive did not cause the auto accident at issue. This Court in *Bardsley v. Government Emps. Ins. Co.* made this distinction clear:

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at 485, 579 S.E.2d at 295. Jones is not a plaintiff in a personal injury action. The issue in this case is not the reasonable value of medical services to be recovered from a tortfeasor.

In *Covington*, the question for the Court was "whether a party can introduce evidence of the actual payment amount to challenge the reasonableness of the medical expenses sought by the plaintiff" from a tortfeasor. 359 S.C. at 103, 597 S.E.2d at 144. The Court held "that the collateral source rule is directly implicated in this case, and the actual payment amount was properly excluded." *Id.* Jones is not a plaintiff in a personal injury action. The issue in this case is not the reasonable value of medical services to be recovered from a tortfeasor.

In *Gipson*, "the question in this case [was], when the wrongdoer returns some of the money to the wronged party, may the wronged party still seek to recover the entire amount as damages from the wrongdoer?" 445 S.C. at 397, 914 S.E.2d at 843. "In a negligence case, a party who loses a sum of money due to another's wrongful conduct is entitled to recover the full amount as damages." *Id.* at 397, 914 S.E.2d at 843. The Court held that the source of the returned money was not collateral to the tortfeasor, and, consequently, the collateral source rule did not bar the reduction of the damages by this previously returned amount. *Id.* at 401, 914 S.E.2d at 845. Progressive Northern struggles to find any connection between the *Gipson* case and this case. Progressive Northern is a party to an insurance contract, not a "wrongdoer" in a negligence action who has returned money it negligently lost.

[3] *See, e.g., Citizens & S. Nat'l Bank of S.C. v. Gregory*, 320 S.C. 90, 92, 463 S.E.2d 317, 318 (1995) ("The collateral source rule provides that compensation received by an injured party from a source wholly independent of the wrongdoer will not reduce the amount of damages *owed by the wrongdoer*." (emphasis added)); *Estate of Rattenni v. Grainger*, 298 S.C. 276, 277, 379 S.E.2d 890, 890 (1989) ("South Carolina has long followed the collateral source rule that compensation received by an injured party from a source wholly independent of the wrongdoer should not be deducted from the amount of damages *owed by the wrongdoer* to the injured party." (emphasis added)); *New Found. Baptist Church v. Davis*, 257 S.C. 443, 446, 186 S.E.2d 247, 249 (1972) ("[T]he 'collateral source rule' is that which holds that total or partial compensation for injury which an injured party receives from a collateral source, wholly independent of the wrongdoer, does not operate to lessen the damages recoverable *from the wrongdoer*." (emphasis added)); *Young v. Warr*, 252 S.C. 179, 197, 165 S.E.2d 797, 806 (1969) ("Under the 'collateral source rule' a *tort feasor* has no right to any mitigation of damages because of payments or compensation received by the injured person from an independent source." (emphasis added)); *Covington*, 359 S.C. at 103, 597 S.E.2d at 144 (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)).

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

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

Tort law allows a plaintiff to recover from a tortfeasor the reasonable value of the medical services the plaintiff received. Contract law – specifically medical payments coverage – only allows an insured to be reimbursed for amounts actually paid to or legally owed to medical providers. These are two entirely different issues and areas of law.

After stripping away all of these irrelevant cases[4], Jones' Brief fails to cite a single case that supports her position, much less a controlling South Carolina case. *See* (Jones' Brief).

II. Longstanding South Carolina Supreme Court precedent, as well as case law from other jurisdictions, supports Progressive Northern's position.

The Policy provides medical payments coverage for certain "reasonable **expenses incurred** for necessary medical services." (Policy, App. p. 67) (emphasis added). According to longstanding South Carolina Supreme Court precedent, for something to qualify as an "expense incurred" within the context of an insurance contract, there must be an obligation to pay it. Because Jones is a Medicaid beneficiary, neither Jones nor Medicaid ever had an obligation to pay amounts beyond the Medicaid rates. Consequently, no amounts beyond the Medicaid rates were "expenses incurred," and Progressive Northern did not breach the insurance contract by paying the Medicaid rates her providers agreed to accept as payment in full.

In 1961, this Court clearly articulated that "expenses incurred" means there is an obligation on the part of the insured to pay that amount for the medical treatment or service received. *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 446, 120 S.E.2d 509, 513 (1961). This Court further explained that "**a thing for which there exists no obligation to pay, either express or implied,**

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[4] In its Brief, Progressive Northern cited the *Haselden* dissent's factual explanation of how Medicaid works. (Progressive Northern's Br., p. 9). Jones' Brief attacked Progressive Northern's reference to this factual explanation. (Jones' Brief, pp. 10-12). However, the way Medicaid works is not a legal dispute subject to a majority's or a dissent's holding. The way Medicaid works in South Carolina is established by the federal government under 42 C.F.R. § 447.15, the South Carolina General Assembly that creates the state-specific plan, and the South Carolina Department of Health and Human Services, the state agency responsible for the administration of the Medicaid program in South Carolina. It is not established by the South Carolina judiciary. Even the majority in *Haselden* acknowledged the factual realities of how Medicaid works. 353 S.C. at 485, 579 S.E.2d at 295 (As explained by the majority 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."). Thus, prior to treating the Medicaid patient, a Medicaid provider has agreed in his/her Medicaid provider agreement to accept set rates as "payment in full." Any of Jones' arguments to the contrary are without a basis in reality.

cannot in law be claimed to constitute an 'expense incurred'." *Id.* at 445, 120 S.E.2d at 512 (emphasis added). Prior to the bench trial in this case, Jones stipulated that "Plaintiff has not paid any additional sums to any of the medical providers, nor is she legally obligated to pay any additional sums to the medical providers. All of the charges for the treatment rendered to her has been paid in full based upon the providers receipt of the Medicaid payments." (Stipulation of Fact, App. p. 141 ¶ 17) (emphasis added). Thus, under established South Carolina law, Jones has not **incurred** any medical expenses beyond the amounts which Progressive Northern has already reimbursed her. Consequently, Progressive Northern's act of paying medical payments coverage based on the amounts actually accepted by Jones' providers as payment in full is not a breach of the Progressive Northern insurance policy. Such conduct is consistent with the policy terms and South Carolina law.

Gordon is a contract case. *Gordon* is an insurance contract case. *Gordon* is a medical payments coverage case. *See Gordon*, 238 S.C. at 444, 120 S.E.2d at 512 ("The liability of the insurer for medical expenses under such a provision depends upon the construction of the particular language used in the contract."). *Gordon* addresses the question of what "expense incurred" means in medical payments coverage in an insurance contract. *Id.* ("[T]he appellant agreed 'to pay all reasonable expense incurred' for necessary medical and surgical service. There is no uncertainty or ambiguity in the language of the policy. It is too plain to call for judicial construction. The words used must be taken in the plain and ordinary sense in which they are generally used and understood. What legal interpretations should be given to the words 'expense incurred'?"). Thus, *Gordon* is controlling, and *Gordon* requires finding in favor of Progressive Northern on Jones' breach of contract claim.

This Court is not the only court to hold that an insured does not "incur" a medical expense for which there is no legal obligation to pay. *See, e.g., Barker v. Washington Nat. Ins. Co.*, No. 9:12-CV-1901-PMD, 2013 WL 1767620, at *4 (D.S.C. Apr. 24, 2013) (holding Medicare recipient did not

"incur" expenses listed on bill beyond Medicare rates her providers had agreed to accept as payment in full); *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir.2011) (holding Medicare recipient "did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her" under their Medicare provider agreements); *State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212, 214 (Va. 1998) (holding insured did not "incur" expenses for medical payments coverage beyond those reduced rates negotiated between health insurance carrier and medical providers); *Grimes v. Gov't Employees Ins. Co.*, No. 1:18-CV-798, 2019 WL 3425227, at *9 (M.D.N.C. July 30, 2019) (dismissing breach of contract claim based on the same theory alleged in Jones' Complaint); *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").

Jones' Return alleges that *Gordon* and *Barker* are "distinct from this case in very meaningful ways." (Jones' Brief, p. 12). With respect to *Gordon*, Jones alleges that these "very meaningful ways" are: (1) there was a stipulation that the insured paid nothing; (2) there was no bill; (3) there was no statute that changes the amount Jones can "incur"; (4) *Gordon* predates South Carolina Code § 38-77-144; and (5) *Gordon* predates *Haselden* and *Covington*. (Jones' Brief, pp. 12-15).

With respect to the first argument, there was also a stipulation in this case. Jones stipulated pre-trial that she did not pay her providers' "sticker prices" and was not "legally obligated to pay any additional sums to the medical providers." (Stipulation of Fact, App. p. 141 ¶ 17). However, the holding in *Gordon* is not contingent on the parties having a stipulation. The gravamen of the *Gordon* holding is whether the alleged expense is a thing for which there exists a legal obligation to pay. This

is because "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. Whether an alleged expense is "a thing for which there exists no obligation to pay" can be shown through many different forms of evidence. It is not limited to a stipulation. Jones' own testimony at trial showed that there was no such obligation:

> 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). Thus, the presence or absence of a stipulation is not a "meaningful" distinction, as Jones alleges.[5]

With her second argument about a bill, Jones points to a case the *Gordon* court relied upon that did not include a bill. (Jones' Brief, pp. 13-14 (citing *United States v. St. Paul Mercury Indem. Co.*, 238 F.2d 594 (8th Cir. 1956)). However, Jones ignores the other case *Gordon* relied upon and discussed in detail – *Drearr v. Connecticut Gen. Life Ins. Co.*, 119 So. 2d 149 (La. Ct. App. 1960) – ***that did include a bill***. *Gordon*, 238 S.C. at 444-45, 120 S.E.2d at 512 ("In the case of *Drearr v.*

[5] Moreover, as the party seeking coverage under the insurance contract, Jones had the burden to prove that her alleged expenses were expenses she actually incurred – i.e. that there was a legal obligation to pay such expenses to her medical providers. *See Garrett v. Pilot Life Insurance Company*, 241 S.C. 299, 303, 128 S.E.2d 171, 173 (1962). The stipulation and her trial testimony refuted any allegation that she had a legal obligation to pay her medical providers amounts beyond the Medicaid payments.

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."). The *Gordon* Court's reliance on both of these cases demonstrates that it does not matter if there is or is not a bill. The question remains whether the insured became legally obligated to pay the alleged expenses. Moreover, this case demonstrates that there can be billed amounts that an insured does not "incur". Thus, this is not a "meaningful" distinction, as Jones alleges.

Jones also argues that *Gordon* is distinguishable because there is no statute that changes the amount Jones can "incur." (Jones' Brief, p. 14). However, there most certainly is a statute that limits the amount of medical expenses that a Medicaid recipient can "incur." Under 42 C.F.R. § 447.15, "[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 (emphasis added). The South Carolina agency responsible for administration of the Medicaid program has complied with this federal statute. *Pee Dee Health Care, P.A. v. Sanford*, 509 F.3d 204, 207 (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 and to seek reimbursement from SCDHHS for its services, it does so by entering into a contract ("provider contract" or "contract") with SCDHHS. The contract provides for the method and amounts of payment...."); 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 (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...."). Thus, Medicaid recipients can never incur expenses beyond this statutory limit. Regardless, the gravamen of the *Gordon* holding is whether the alleged expense is a thing for which there exists a legal obligation to pay. 238 S.C. at 445, 120 S.E.2d at 512. Although a statutory limitation is one reason why an alleged expense is not a thing for which there exists a legal obligation to pay, there are many other potential reasons why this would be true. Thus, this is not a "meaningful" distinction, as Jones alleges.

With respect to Jones' fourth argument, South Carolina Code § 38-77-144's "setoff" prohibition has no application in this case. 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 rates her providers agreed to accept as payment in full constitutes a setoff under § 38-77-144, but it does not. *See* (Compl., App. p. 30 ¶ 25); (Jones' Br., p. 14). 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 Northern attempted to reduce its medical payments coverage by the amounts paid by Medicaid – i.e., paid no medical payments coverage to Jones 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 Northern did or even what Jones alleges Progressive Northern 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 Northern reduced its medical payments benefits by the amount of the Medicaid payment. *See* (Compl., App. p. 30 ¶ 25). Rather, Jones alleges that Progressive Northern "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 the Medicaid rate her providers agreed to accept as payment in full 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.

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 Northern did not lessen the amount owed to Jones "because of payments made by a third-party." If it had, Progressive Northern 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.

This statute's irrelevance is further demonstrated by neither the Trial Court nor the Court of Appeals mentioning this statute in their opinions finding for Jones. (March 29, 2023 Trial Court Order, App. pp. 11-14); (April 6, 2023 Trial Court Order, App. pp. 15-20); (April 16, 2025 Court of Appeals Order, App. pp. 329-30).

With respect to Jones' arguments about *Haselden* and *Covington*, as explained above, those cases are entirely irrelevant to the issue before this court – i.e., what "expense incurred" means in the context of an insurance contract. Their irrelevance is also demonstrated by the Trial Court's and Court of Appeal's lack of reference to such cases. *Id.* Again, neither the Plaintiff, the Trial Court nor the Court of Appeals has ever cited a single case holding that an insured can "incur" an expense for which no one has a legal obligation to pay.

Jones' only purported "meaningful" distinctions for the *Barker* case are: (1) that "Judge Duffy's unpublished order is wrong, and this Court should reject that analysis"; and (2) automobile insurance policies are more highly regulated than health insurance policies. (Jones' Br., pp. 15-16). Obviously, the first is not a distinction, just a gripe. This Court in *Gordon*, the South Carolina District Court in *Barker*, the Second Circuit Court of Appeals in *Metz*, the Virginia Supreme Court in *Bowers*, the North Carolina District Court in *Grimes*, and the Oklahoma District Court in *Evans* all got it right. A thing for which there exists no obligation to pay is not an "expense incurred" within the meaning of an insurance contract. Medical payments coverage is reimbursement coverage, not windfall coverage.

With respect to her second argument, medical payments coverage, also known as personal injury protection coverage, is not a statutorily-required coverage. S.C. Code § 38-77-144 ("There is no personal injury protection (PIP) coverage mandated under the automobile insurance laws of this State."). Consequently, "the parties may choose their own terms" regarding this coverage. *See Howell v. United States Fid. & Guar. Ins. Co.*, 370 S.C. 505, 510, 636 S.E.2d 626, 628 (2006) (stating that the parties may choose their own terms for coverage that is not statutorily required). Moreover, the holding in *Barker* turned on the definition of the policy phrase "expenses incurred." 2013 WL 1767620, at *5 ("The Policy's Insuring Clause provides that WNIC 'will pay 100% in full of the expenses incurred for services and materials as set out in Part I of the policy.' The Policy does not provide a definition for 'incurred.' However, South Carolina law defines "expense incurred" for insurance purposes...."). There is no statutory provision that prevents an insurer from limiting its medical payments coverage obligation to "expenses incurred." Thus, the type of policy in which the "expenses incurred" limitation appears is not a meaningful distinction.

CONCLUSION

For the above-stated reasons and those set forth in its prior Brief, Progressive Northern respectfully requests that this Court reverse the Court of Appeals' ruling on the breach of contract claim and dismiss Jones' breach of contract claim. The Court of Appeals' decision conflicts with this Court's binding precedent in *Gordon*. The policy only requires Progressive Northen to pay for certain medical "expenses incurred" by the insured. Jones' medical providers agreed to accept set rates as payment in full for the treatment rendered. Progressive Northern paid these amounts to Jones under the policy's medical payments coverage. Any additional amounts are a thing for which there exists no obligation to pay. Consequently, they cannot in law constitute an "expense incurred" within the meaning of Progressive Northern's medical payments coverage. Therefore, Progressive Northern paid Jones medical payments coverage in accordance with the policy terms and South Carolina law.

Respectfully submitted,

MURPHY & GRANTLAND, P.A.

s/ J.R. Murphy
J.R. Murphy, Esquire
S.C. Bar No. 7941
Megan Walker, Esquire
S.C. Bar No. 103069
PO Box 6648
Columbia, South Carolina 29260
(803) 782-4100
jrmurphy@murphygrantland.com
mwalker@murphygrantland.com
Attorneys for Petitioner

Columbia, South Carolina
November 5, 2025