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S.C. SUPREME COURT

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,

BRIEF OF AMICI CURIAE THE AMERICAN PROPERTY AND CASUALTY INSURANCE ASSOCIATION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

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?

INTEREST OF AMICUS CURIAE

American Property Casualty Insurance Association ("APCIA") is the primary national trade association for home, auto, and business insurers. APCIA's member companies represent nearly 60% of the U.S. property-casualty insurance market, including 67% of the commercial property insurance market. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the United States and worldwide. APCIA's interests are in the clear, consistent, and reasonable development of law affecting its members and the policyholders they insure.

SUMMARY OF THE ARGUMENT

This action arises out of Petitioner Progressive Northern Insurance Company's ("Progressive Northern") payment of Alexis Jones' Medical Payments coverage 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.

Jones did not pay any medical expenses arising from the accident. She is a Medicaid recipient. Jones is not responsible for paying any amount above what Medicaid paid her medical providers. Progressive Northern reimbursed Jones the amount that Medicaid paid to the medical provider for her medical care.

Progressive Northern's policy ("policy") provides Medical Payments coverage for certain medical "expenses incurred" by an insured as a result of an accident. The South Carolina Court of

Appeals held that the policy requires Progressive Northern to pay Jones the full amount of the charges presented by the medical provider, even though Jones is not responsible for paying any amount above the payment made by Medicaid. This interpretation of the policy provides Jones with a windfall based on the arbitrary amount charged by the medical provider as opposed to the expense Jones actually incurred as a result of the accident. No basis exists under the language of the policy or public policy to support the Court of Appeals' decision. Such "phantom damages" are not compensable under the terms of the policy, and allowing recovery of such phantom damages could establish a precedent that insureds do not have to incur expenses to collect on other types of voluntary "incurred expense" or "reimbursement" coverages in South Carolina.

ARGUMENT

A. There is no sound basis in Progressive Northern's policy language or public policy for allowing an insured to recover phantom damages under voluntary first-party Medical Payments coverage.

Medical Payments coverage is a voluntary coverage in South Carolina. S.C. Code Ann. § 38-77-144; *State Farm Mut. Auto. Ins. Co. v. Richardson*, 313 S.C. 58, 60, 437 S.E.2d 43, 45 (1993). "Insurance companies and insureds are generally free to contract for exclusions or limitations on coverage." *E.g., Nationwide Ins. Co. of Am. v. Knight*, 433 S.C. 371, 375, 858 S.E.2d 633, 635 (2021). Courts have "no authority" to rewrite insurance policies based on "public policy." *See S. S. Newell & Co. v. Am. Mut. Liab. Ins. Co.*, 199 S.C. 325, 332, 19 S.E.2d 463, 466 (1942) ("The judicial function of a court of law is to enforce an insurance contract as made by the parties, and not to re-write or to distort, under the guise of judicial construction, contracts, the terms of which are plain and unambiguous. It is not the province of the courts to construe contracts broader than the parties have elected to make them, or to award benefits where none was intended.").

Here, the parties contracted for payment of reasonable "expenses incurred" (up to $10,000) for necessary medical services. It is undisputed that the only medical expense incurred by Jones is $1,323.60.[1] She is not responsible for paying more than $1,323.60, therefore, she has not incurred any amount more than $1,323.60. As argued by Progressive Northern in its briefing to this Court, the policy and South Carolina precedent support that Progressive Northern has satisfied its contractual obligation to Jones.

There is no basis under Progressive Northern's policy or public policy to require Progressive Northern to pay $8,676.40 in "phantom damages" to Jones.[2] The policy language is unambiguous and limits recovery to expenses incurred. There is no public policy in favor of an insured receiving a windfall under voluntary first-party coverage for expenses never incurred nor paid on behalf of an insured. A number of courts in other jurisdictions have interpreted "expenses incurred" within medical payment coverage to mean the amount actually paid, as opposed to the amount charged by the care provider. *See Woodrich v. Farmers Ins. Co.,* 405 F.Supp.2d 1276, 1279 (N.D.Okla. 2004) ("The plain meaning of [reasonable expense] . . . is no more than the provider actually agreed to accept as full payment . . . The benefit of the bargain provided by [insured's] insurance policy was for [the insurer] to pay what the medical providers actually agreed to charge, not the list price or 'sticker price.'"); *Metz v. U.S. Life Ins. Co. in N.Y.C.,* 662 F.3d 600, 602 (2d Cir. 2011) (applying New York law); *Barker v. Wash. Nat. Ins. Co.,* C.A. No. 9:12–cv–1901–PMD, 2013 WL 1767620, at *6 (D.S.C. April 24, 2013) (applying South Carolina law); *State Farm Mut. Auto. Ins. Co. v. Bowers,* 500 S.E.2d 212, 214 (Va. 1998).

[1] The medical services provided to her are actually free because she is a Medicaid recipient. However, she is obligated to reimburse Medicaid for $1,323.60 should she receive compensation for the medical services provided.

[2] In addition, the collateral source rule does not apply to this situation, although the Court of Appeals is essentially applying the collateral source rule in this case.

Scholarly treatises are in general agreement. *See* Steven Plitt et al., *Couch on Insurance* § 158:10 (3d ed. 2014) ("The medical payments provision most commonly requires that the insured have 'incurred' or 'actually incurred' medical expenses. The clause contemplates a liability thrust upon the insured by act or operation of law. . . . [E]xpenses are incurred within medical payments coverage only when one has become obligated to pay for them."); William J. Schermer & Irvin E. Schermer, *Automobile Liability Insurance* § 56:2 (4th ed. 2014) ("In an action for benefits under the policy, the amounts which the health provider have [sic] accepted in full payment are deemed 'incurred,' but not that portion that was 'written off' by the health care providers and not paid by the insured."); *Evans v. Liberty Nat. Life Ins. Co.*, No. 13-CV-0390-CVE-PJC, 2015 WL 1650192, at *5 (N.D. Okla. Apr. 14, 2015).

Other than the clear policy language, another reason for this sound rule is that the "charged amount" on a medical provider's bill does not provide a basis for determining the reasonable amount of expense incurred for medical treatment and should not be used to provide a windfall to an insured under their first-party coverage. It is common practice for healthcare providers to set a fee for each service or treatment, typically represented by a Current Procedural Terminology (CPT) code.[3] CPT codes are uniform and set by a panel of the American Medical Association, but the amount healthcare providers charge for these services are not. Each healthcare provider is free to set its own fee for each CPT code. Healthcare providers use a similar system to set list prices for various medical products, supplies, and services not included in CPT codes.[4] The healthcare provider records its list prices in its billing system or "chargemaster" and that "standard charge" or "gross rate" is often indicated on the provider's invoice, as it was here.

[3] *See* Am. Med. Ass'n, *The CPT® Code Process* (2024).
[4] *See* Centers for Medicare & Medicaid Services, *HCPCS Level II Coding Procedures* (explaining use of the Healthcare Common Procedure Coding System (HCPCS)).

Patients and insurers (whether private or governmental) rarely pay these "sticker prices."[5] Indeed, there is often a huge difference between a healthcare provider's list price for a particular service or procedure and the amount it customarily accepts as full payment, whether paid by a private insurer, a government program, or directly by a patient. Chargemaster rates are often many multiples away from the amount providers routinely accept. Rather, healthcare providers typically receive payment based on negotiated rates with managed care plans or schedules set by Medicare rules.[6]

Medical providers are free to "charge" whatever arbitrary rate they please. However, medical providers are rarely paid those amounts. Insurance premiums should not be driven higher to pay phantom damages under voluntary first-party medical payments coverage to an insured based upon an arbitrary, unrealistic charge appearing on a medical bill, as opposed to the amount of actual expense incurred as a result of an accident.

B. The Court of Appeals' decision will have adverse effects on other types of voluntary "incurred expense" or "reimbursement" coverages.

There are a variety of other voluntary "incurred expense" or "reimbursement" first-party coverages that will be adversely affected by the Court of Appeals' decision. Coverages such as Debris Removal, Temporary Repair After a Loss, and Additional Living Expense coverages are routinely found in homeowners policies in South Carolina. These coverages, like Medical Payments coverage, are meant to reimburse an insured for expenses incurred as a result of a loss.

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[5] *See Haygood v. De Escabedo*, 356 S.W.3d 390, 393 (Tex. 2011) (observing that healthcare provider "list" rates reflect negotiations with government programs and private insurers and are rarely collected).

[6] *See Daughters of Charity Health Servs. of Waco v. Linnstaedter*, 226 S.W.3d 409, 410 (Tex. 2007) ("Few patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates."); *see also* Centers for Medicare & Medicaid Services, *Fee Schedule - General Information*.

However, it is clear that such expenses must actually be incurred to obtain coverage. *See Snyder v. Auto-Owners Ins. Co.*, 634 F. Supp. 3d 252, 260 (D.S.C. 2022) (finding that homeowners policy containing debris removal coverage stating, "We will pay reasonable [sic] necessary expenses you incur to remove debris of covered property . . . following a loss caused by a peril we insure against," "plainly contemplates reimbursement."); *Snyder v. Auto-Owners Ins. Co.*, 618 F. Supp. 3d 292, 302 (D.S.C. 2022) ("Under the Policy, the Plaintiffs are not entitled to any additional living expenses that they have not incurred."); *Am. Res. Ins. Co. v. Palmer*, No. CIV.A. 4:08-03314, 2010 WL 3282579, at *12 (D.S.C. Aug. 19, 2010) (determining that "incurred expense" policy language indicates expense must be incurred before reimbursement is required); *Bethel v. Berkshire Hathaway Homestate Ins. Co.*, 822 F. App'x 835 (10th Cir. 2020) (holding bid that insured obtained for demolition of property that was destroyed by fire did not establish that insured incurred an expense for removal of debris); *Turner v. Fed. Ins. Co.*, No. CV 20-851-MWF (AGRX), 2021 WL 4894272, at *1 (C.D. Cal. Aug. 18, 2021) ("[T]he debris removal provision requires Plaintiffs to actually incur expenses before coverage is triggered."); *Green v. Allstate Ins. Co.*, No. 3:11-CV-00210-TMB, 2015 WL 10939709, at *5 (D. Alaska Mar. 26, 2015), aff'd, 691 F. App'x 356 (9th Cir. 2017), as amended on denial of reh'g (June 6, 2017) ("The [debris removal] provision . . . limits payment to 'reasonable expenses [the insured] incur[s].' Because it is for expenses incurred, Green may not receive payment under this provision in advance; he must first remove the debris from his property."); *Am. Nat'l Prop. & Cas. Co. v. Felix*, 399 F. Supp. 3d 324, 342 (W.D. Pa. 2019) (holding that policy language stating policy will cover "any necessary increase in living expenses incurred by you" means that the insured must actually incur costs to be eligible for additional living expenses and loss-of-use coverage – evidence that insured "could have" incurred cost was not sufficient); *Christopherson v. Am. Strategic Ins. Corp.*, 483 F. Supp.

3d 631 (E.D. Wis. 2020), aff'd, 999 F.3d 503 (7th Cir. 2021) (concluding that insurer had no obligation to pay insured for emergency repairs before emergency repairs were made).

The issue presented in this case is no different from other types of voluntary "expense incurred" or "reimbursement" coverages. The fact that this case involves medical services as opposed to contractor or housing services is not a determining factor. The important factor is whether the insured incurred the expense for which they are seeking reimbursement. Here, Jones did not incur an additional $8,676.40 in expense. Just as an insured who does not incur debris removal, additional living, or temporary repair expense is not entitled to those coverages, Jones is not entitled medical payment coverage in excess of her actual incurred expenses. Allowing Jones a windfall for an expense that she did not incur is precluded under the policy and serves no legitimate purpose.

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.

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