

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

BONNIE LARSON,

Plaintiff,

v.

GOLDEN RULE INSURANCE COMPANY,

Defendant.

OPINION and ORDER

11-cv-138-bbc

Plaintiff Bonnie Larson has sued defendant Golden Rule Insurance Company for its refusal to pay for certain medical treatments that plaintiff has received to treat metastatic melanoma. Plaintiff contends that defendant's refusal to pay for the treatments is a breach of the parties' insurance contract and a violation of defendant's duty of good faith and fair dealing. Plaintiff has also asserted claims against defendant for equitable estoppel under Wisconsin law and for interest under Wisconsin's "Timely payment of claims" statute, Wis. Stat. § 628.46(1). Jurisdiction is present under 28 U.S.C. § 1332 because the amount in controversy is more than \$75,000, dkt. #2, and there is complete diversity of citizenship between plaintiff (a citizen of Wisconsin) and defendant (an Indiana corporation with its principal place of business in Illinois).

Now before the court is defendant's motion for summary judgment, dkt. #14, in which defendant contends that plaintiff's treatment is excluded completely from coverage

by the “investigational treatment” exclusion in her insurance policy. Also, defendant contends that plaintiff’s claims are precluded under the definition of “covered expenses” in the insurance policy and that plaintiff has failed to adduce evidence to support her bad faith, estoppel and statutory interest claims. Because defendant made several arguments for the first time in its reply brief, I gave plaintiff an opportunity to file a sur-reply. With that filing, defendant’s motion is ready for decision. (Defendant filed a motion for leave to file a sur-sur-reply brief to respond to plaintiff’s argument that defendant waived its preclusion defense. Because I do not need to reach this issue, I am denying defendant’s motion as unnecessary.)

I conclude that plaintiff’s insurance policy does not cover plaintiff’s use of the drug Avastin as part of her chemotherapy because Avastin qualifies as investigational under the terms of the policy. Additionally, I conclude that plaintiff has not adduced evidence to support her claims for bad faith, equitable estoppel or statutory interest. Therefore, I am granting defendant’s motion on those issues. However, I conclude that the policy is ambiguous with respect to coverage for the non-Avastin components of plaintiff’s chemotherapy treatments. Because the policy is ambiguous, I must construe it in favor of coverage. Thus, I conclude that the policy covers the non-Avastin, non-investigational components of plaintiff’s treatment. Specifically, I conclude that the policy covers medical expenses plaintiff would have incurred if she had not been using Avastin. Therefore, I am denying defendant’s motion and granting summary judgment to plaintiff with respect to coverage for the non-Avastin components of plaintiff’s treatment. The parties may have

until March 22, 2012 to notify the court whether they can stipulate to the amount of damages plaintiff is owed for the non-Avastin components of her treatment or whether there are disputed issues that require a jury trial.

From the parties' proposed findings of fact and the record, I find the following facts to be material and undisputed.

UNDISPUTED FACTS

A. Plaintiff's Medical Treatment

Plaintiff Bonnie Larson developed ocular melanoma in 2006 and her left eye was removed. At a routine follow-up visit in December 2009, an ultrasound detected lesions in plaintiff's liver. Following a biopsy, doctors diagnosed metastatic ocular melanoma, meaning the melanoma had spread to her liver. In January 2010, plaintiff was referred to an oncologist at Mayo Clinic, Svetomir Markovic, MD, PhD, an expert in treating metastatic melanoma.

Dr. Markovic recommended treating plaintiff's metastatic melanoma through chemotherapy with a combination of the drugs paclitaxel, carboplatin and bevacizumab. (Paclitaxel is also known as "Taxol" and bevacizumab is also known as "Avastin.") Chemotherapy is generally an accepted method for treating metastatic melanoma and the National Comprehensive Cancer Network guidelines recognize paclitaxel and carboplatin as acceptable forms of treatment for patients with metastatic melanoma. Under the guidelines, Avastin is accepted for treatment of certain neoplastic diseases, but has not been approved

by the National Comprehensive Cancer Network or by the Food and Drug Administrative for treatment of metastatic melanoma. Also, the National Government Services Local Coverage, which lists coverage of drugs for label and off-label uses, does not list malignant melanoma as an acceptable disease category for reimbursement for use of Avastin. Nonetheless, Dr. Markovic recommended that plaintiff use Avastin as part of her treatment because Mayo Clinic had reported research results showing that the use of Avastin in combination with paclitaxel and carboplatin produced results for patients with stage IV melanoma “above and beyond” results with paclitaxel and carboplatin alone. In particular, at the time Dr. Markovic recommended the three-drug combination to plaintiff, the results of three phase II clinical studies showed that the combination was beneficial for patients with malignant melanoma.

Plaintiff followed Dr. Markovic’s recommendation and started chemotherapy at Mayo Clinic in 2010. Plaintiff received eight courses of chemotherapy treatment with paclitaxel, carboplatin and Avastin, after which she continued maintenance treatment with Avastin. At the time she was taking the three drugs, Mayo Clinic and other cancer research facilities were conducting phase II clinical trials using paclitaxel, carboplatin and Avastin for treatment of metastatic melanoma, although plaintiff was not part of a study or trial. In April 2010, plaintiff began receiving her chemotherapy at Marshfield Clinic Regional Cancer Center, a location more convenient to her Osseo, Wisconsin home. At Marshfield Clinic, plaintiff was treated directly by Muhammad Muslim, MD, but Dr. Markovic at Mayo Clinic continued to oversee her cancer treatment.

By May 2010, plaintiff's melanoma was "clinically stable," with no evidence of progression. On October 22, 2010, plaintiff was treated at Mayo Clinic with radiation for progressive liver metastases. In April 2011, plaintiff's metastatic melanoma was again clinically stable. Dr. Markovic recommended that plaintiff continue maintenance therapy with Avastin, which she did. In June 2011, Dr. Markovic found that plaintiff had received "a good response" to her chemotherapy treatments, except for a couple of areas of her liver, for which she continued to receive treatment. In July 2011, Marshfield Clinic noted progressive liver and bone metastases, and discussed treatment options, including potentially additional treatment with paclitaxel, carboplatin and Avastin. In August and September 2011, plaintiff was "clinically stable," despite metastasis, and was receiving treatment with paclitaxel and Avastin.

B. Insurance Contract

In 2005, a year before her ocular melanoma was discovered, plaintiff purchased an individual health insurance plan from defendant Golden Rule Insurance Co. The policy defines "covered expenses" as "an expense which is (A) incurred while you or your dependent's insurance is in force under the policy; (B) covered by a specific benefit provision of the policy; and (C) not excluded or limited anywhere in the policy." Dkt. #34-1, § 2. The policy specifically covers the cost of "standard medical covered expenses," which include charges "[f]or chemotherapy and radiation therapy or treatment." Id. at § 6G. It also covers the cost of inpatient and outpatient facility care, professional services of doctors and medical

practitioners, necessary medical supplies, outpatient prescription drugs and related expenses.

Id. at § 6.

The “General Exclusions and Limitations” section of the policy states that “covered expenses” do not include, among other things, charges incurred

[f]or or while receiving *investigational treatment* or for complications therefrom, including expenses which might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving *investigational treatment*.”

Id. at § 7CC. (Emphasis in original). “Investigational treatment” under the policy “means [defendant] determine[s] one or more of the following after consultation with a medical professional:

- (A) The procedure, service, or supply is under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (“USFDA”) regulation, regardless of whether the trial is subject to USFDA oversight.
- (B) The procedure, service or supply has not been determined through prevailing peer-reviewed medical literature to be safe and effective for the proposed use.
- (C) In the case of a drug, device or other supply that is subject to USFDA approval:
 - (1) It does not have USFDA approval;
 - (2) It has USFDA approval only under its Treatment Investigational NewDrug regulation or similar regulation; or
 - (3) It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a USFDA approved drug is a use which is determined by us to be: (a) included in authoritative compendia as identified from time to time by Secretary of Health and Human Services; or (b) safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical

publications.

- (D) The provider's research protocols indicate that the procedure, service or supply is investigational or experimental.

Items (C) and (D) above do not apply to phase III or IV USFDA clinical trials.

Id. at § 2.

C. Plaintiff's Claim for Coverage

Before plaintiff began receiving chemotherapy through Mayo Clinic, defendant approved out-of-network cancer treatment for her at Mayo Clinic. On April 9, 2010, Valerie Loizides, the managed care coordinator at Marshfield Clinic, called defendant regarding plaintiff's chemotherapy medications and asked whether pre-authorization was necessary. Loizides asked specifically about Avastin (code J9035), Taxol (code J9265) and cisplatin (code J9060). Defendant's representative responded that those codes "just go towards deductible and co-insurance." Defendant also stated that "this [phone] service is not a guarantee that a claim will be paid. All services and supplies must be medically necessary and fall within the terms of the contract." Dkt. #37-3. On April 20, 2010, Loizides again contacted defendant to ask about plaintiff's treatment, asking specifically about carboplatin (code J9045). Defendant's representative told Loizides that no prior authorization was required for carboplatin, but that his response was "not a guaranty that the claim will be paid." He stated that "all services and supplies must be medically necessary and fall within the terms of the contract . . . have to be ordered by a doctor, filled by a licensed pharmacy, FDA approved for the treatment or conditions not otherwise excluded by the plan, not

investigational or experimental and medically necessary.” Dkt. #38-3.

Plaintiff submitted her chemotherapy costs to defendant for payment. On April 19, 2010, defendant notified plaintiff by letter that her treatment costs incurred at Mayo Clinic were being denied as “investigational treatment” under the terms of her policy because her plan excludes coverage for charges “incurred for or while receiving investigational treatment or for complications therefrom, including expenses which might otherwise be covered” Dkt. #34-5. Defendant denied plaintiff’s claims for coverage of all expenses for chemotherapy and related services, including charges for doctor visits, medication to control pain and infection, facility charges and charges for administering chemotherapy. In the letter, defendant stated that it had sent plaintiff’s medical records to a medical consultant for review and that the medical consultant stated that the treatment is “investigational treatment” as defined by the insurance policy. Defendant attached a copy of a ProPeer medical review dated April 5, 2010. The medical reviewer expressed the opinion that plaintiff’s treatment was investigational under the terms of the policy because (1) Avastin was in phase II of a clinical trial; (2) it had not been determined through peer review literature to be safe and effective for her condition; and (3) her chemotherapy protocol was not an accepted off-label use for her condition. The reviewer also stated that “[m]etastatic melanoma has a very poor prognosis. . . For this reason there are numerous ongoing trials to improve current treatment results. . . The components of the proposed treatment as well as the treatment plan itself are undergoing ongoing phase II studies.”

On June 1, 2010, plaintiff filed a grievance with defendant regarding its denial of her

claim. In the grievance, she stated that her chemotherapy had been approved by her doctors, the chemotherapy was working and that defendant's communication about her prognosis for survival had upset her greatly.

On July 23, 2010, defendant again rejected payment for plaintiff's chemotherapy expenses. Defendant sent plaintiff another ProPeer medical review, this one dated June 22, 2010. The reviewer stated that "The combination of Carboplatin/Taxol has been determined to be safe and effective. The addition of Avastin to this combination has not been determined to be effective." The reviewer stated that all three drugs in plaintiff's chemotherapy had been approved by the FDA for uses other than metastatic melanoma. However, the use of Avastin for metastatic melanoma is not an "accepted off-label use." Also, the reviewer noted that the National Comprehensive Cancer Network guidelines had approved paclitaxel and carboplatin as being acceptable for use in the treatment of metastatic melanoma, but had not approved Avastin for that use.

OPINION

A. Breach of the Insurance Policy

Plaintiff contends that defendant breached the insurance policy by refusing to pay for her cancer treatments. Defendant contends it had no obligation to pay for the treatments because they were not covered by the contract. Plaintiff's use of Avastin to treat her metastatic melanoma was "investigational treatment" and she received all other treatment "in conjunction with, as a result of, or while receiving" Avastin.

The first question is whether plaintiff's use of Avastin qualified as "investigational treatment" under the terms of the policy. Under the policy, a treatment is investigational if it is "under study in an ongoing phase I or II clinical trial" or is "being used for an indication or at a dosage that is not an accepted off-label use," as determined by "authoritative compendia as identified from time to time by Secretary of Health and Human Services" or "supportive clinical evidence in peer-reviewed medical publications." Defendant relies on the Food and Drug Administration, the National Government Services Local Coverage and the National Comprehensive Cancer Network as authoritative guidelines for accepted off-label uses of medications and treatments.

There is no genuine dispute that Avastin qualifies as an investigational treatment for metastatic melanoma under the terms of the policy. Although plaintiff was not part of a phase II clinical trial involving Avastin, it is undisputed that Mayo Clinic was conducting phase II clinical trials using carboplatin, paclitaxel and Avastin to treat melanoma. Further, the evidence shows that Avastin has not been approved by the Food and Drug Administration for treatment of metastatic melanoma. In addition, neither the National Government Services Local Coverage nor the National Comprehensive Cancer Network lists Avastin as an accepted treatment for malignant melanoma.

Plaintiff contends that Avastin should not be considered investigational or experimental because studies have shown that Avastin can be helpful for patients with metastatic melanoma; her doctor recommended that she take Avastin; and Avastin was effective in treating her disease. However, these facts are irrelevant under the definition of

“investigational treatment” in the policy. Under the policy, defendant uses specific criteria to determine whether a treatment is investigational. Plaintiff has adduced no evidence refuting the determination regarding Avastin in this case. Thus, I have to conclude that defendant did not breach the terms of the policy by refusing to cover the costs of plaintiff’s Avastin treatment.

The next question is whether defendant breached the policy by refusing to cover costs plaintiff incurred for the non-Avastin components of her chemotherapy. Defendant does not deny that if plaintiff had not received Avastin, her chemotherapy costs would have been covered by her policy. The charges for the other treatment plaintiff received, including the medications carboplatin and paclitaxel, as well as office visits and administrative costs, would have been covered as costs associated with standard and customary treatment for her disease. However, according to defendant, because these costs were incurred while plaintiff was receiving Avastin, they are not covered by the policy.

In its opening brief in support of its motion for summary judgment, defendant’s theory appeared to be that adding Avastin to plaintiff’s chemotherapy treatment rendered the entire treatment, including all expenses connected to the chemotherapy, “investigational” within the policy’s definition of that term. However, defendant provided no facts or argument to support this theory, focusing solely on the investigatory nature of Avastin. Further, after plaintiff argued in her opposition brief that defendant had no justification for denying coverage for the non-Avastin components of her treatment, defendant raised a new argument. In its reply brief, defendant relied on the provision of plaintiff’s policy stating

that covered expenses do not include, among other things, charges incurred “[f]or or while receiving investigational treatment or for complications therefrom, including expenses which might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving investigational treatment.” Defendant contends that because all of plaintiff’s chemotherapy charges were incurred “while” receiving Avastin, an investigational treatment, they are excluded from coverage.

Thus, the question to be resolved by the court is whether the “covered expenses” exclusion precludes coverage of all of plaintiff’s chemotherapy expenses. Aul v. Golden Rule Insurance Co., 2007 WI App 165, ¶ 17, 304 Wis. 2d 227, 737 N.W.2d 24 (contract interpretation is question of law to be resolved by court). Under Wisconsin law, courts interpreting an insurance policy should give the policy’s words their common, ordinary meaning, that is, what a reasonable person in the position of the insured would have understood the words to mean. Id.; Van Erden v. Sobczak, 2004 WI App 40, ¶ 22, 271 Wis. 2d 163, 677 N.W.2d 718. If the policy terms are clear, courts should interpret the policy as written and avoid writing a better insurance policy than the one purchased. Hirschhorn v. Auto-Owners Insurance Co., 2012 WI 20, ¶ 24, —Wis. 2d. —, —N.W.2d— (Mar. 6, 2012). Siebert v. Wisconsin American Mutual Insurance Co., 2011 WI 35, ¶ 31, 333 Wis. 2d 546, 797 N.W.2d 484; Peace ex rel. Learner v. Northwestern National Insurance Co., 228 Wis. 2d 106, 121, 596 N.W.2d 429 (1999) (“[T]his principle does not allow a court to eviscerate an exclusion that is clear from the face of the insurance policy.”). However, when an ambiguity exists within an insurance contract, courts should construe the

policy in favor of the insured, that is, in favor of coverage. Hirschhorn, 2012 WI 20, at ¶ 23. The test for ambiguity under Wisconsin law is whether the words or phrases at issue are “reasonably susceptible of more than one construction from the viewpoint of a reasonable person of ordinary intelligence in the position of the insured.” Schroeder v. Blue Cross & Blue Shield, 153 Wis. 2d 165, 174, 450 N.W.2d 470 (1989).

The pertinent coverage provision is the one relied on by defendant in its reply brief. Dkt. #34-1 at 31. Defendant interprets the policy as not covering *any* expenses incurred during a time when an insured is receiving investigational treatment. As defendant argues in its reply brief, “the real inquiry pertains to whether **any** of the treatment administered to [plaintiff] was investigational as defined by the policy,” because “[i]f [plaintiff] was receiving any investigational treatment . . . then any other medical expenses she incurred while receiving that investigational treatment are specifically excluded from coverage.” Dft.’s Reply Br., dkt. #40, at 4 (emphasis in original).

Plaintiff interprets the provision as allowing for coverage of “standard medical covered expenses” as defined by the policy unless they are “caused by” the investigational treatment. For example, if a patient visiting a doctor because of a broken bone also receives an investigational sleeping pill, the policy would cover the costs of setting the bone, taking an x-ray and receiving pain medication. The policy would not cover the investigational sleeping pills. On the other hand, if a patient visits a doctor to participate in an investigational sleep clinic and receives pain medication and an x-ray, services that ordinarily would be covered, the policy would not cover any of the charges. In sum, under plaintiff’s interpretation,

expenses that the insured would have incurred even in the absence of investigational treatment are not excluded by this provision, while expenses that are incurred because of investigational treatment would be excluded.

The policy provides no definition or examples of “charges incurred . . . for or while receiving investigational treatment,” and this language does not necessarily mandate an interpretation as broad as defendant’s. Defendant’s interpretation of the phrase operates as a total exclusion on coverage for *all* charges incurred whenever the insured is also using an investigational treatment, regardless whether the charges are administrative or medical costs necessary to the investigational treatment or even related to it. Taken to the extreme, defendant’s interpretation could lead to unreasonable and absurd results. Kopp v. Home Mutual Insurance Co., 6 Wis. 2d 53, 57, 94 N.W.2d 224 (1959) (“[P]olicies of insurance are to be given a reasonable construction, and not one that leads to an absurd result.”) For example, the policy would not cover charges for setting a broken bone or stitching a deep wound if the insured is using an investigational treatment for depression. The policy would not cover a routine physical examination or an emergency room visit for an insured who is using an investigational treatment for unrelated high blood pressure. Further, because the definition of investigational treatment includes any “procedure, service or supply [that] has not been determined through prevailing peer-reviewed medical literature to be safe and effective for the proposed use,” defendant’s interpretation could result in denial of coverage for insured patients using a broad range of alternative remedies to treat symptoms. I am not persuaded that an average insured reading the exclusion would expect coverage for all other

treatment to dry up solely because he or she also tries a remedy that would satisfy the definition of an investigational treatment. To a reasonable insured, this would be an arbitrary basis on which to deny coverage and one that is not required by the policy language.

The Court of Appeals for the Seventh Circuit’s discussion in Kenseth v. Dean Health Plan, Inc., 610 F.3d 452 (7th Cir. 2010), is instructive. In that case, the plaintiff’s health insurance plan had refused coverage for an expensive surgical procedure to treat an acid reflux condition, which was a complication resulting from the gastric bands surgically inserted in the plaintiff’s stomach years earlier to help her lose weight. Id. at 456. The plan stated that it did not cover “any surgical treatment” for “morbid obesity” and any service “related to” such surgery. Id. at 474. The plaintiff contended that her health plan administrator breached its fiduciary duty under the Employment Retirement Income Security Act, 29 U.S.C. §§ 1001-1461, in part, by providing her with plan documentation that was unclear as to coverage for her surgery. Id. at 464. As a threshold issue, the court considered whether the plan was indeed ambiguous as to coverage for the type of surgical procedure that the plaintiff underwent. Id. at 473. The court concluded that although a lay person would have easily discovered and understood from the plan language that the original gastric bands surgery was not covered, the exclusion for “related” services was “[f]ar less straightforward.” Id. at 474. As the court of appeals explained, the provision was

[O]ne of twenty-three ‘General Limitations and Exclusions’ set out at the end of the ‘Specific Benefit Provisions’ section . . . To appreciate the relevance of that exclusion, one would have to understand that because the [acid reflux] procedure was intended to resolve complications resulting from the [gastric

bands procedure], the [acid reflux] surgery itself was a service ‘related to’ the [original procedure], and because the [original procedure] would be excluded from coverage . . . as a surgery for morbid obesity . . . , the [acid reflux] procedure was likewise excluded as a service related to a non-covered service. But it is anything but certain that a layperson would realize that treatment for complications occurring some eighteen years after a procedure that currently is not covered under the plan . . . is treatment that is ‘related to’ the non-covered procedure. One might rationally believe the ‘related to’ exclusion to cover only those medical services and supplies (e.g., hospitalization, medication, and rehabilitation) that are necessarily and contemporaneously provided with the non-covered procedure, as opposed to services supplied decades later to deal with the procedure's after-effects. . . .

Id. at 474-75. The court concluded that the exclusion was ambiguous and its applicability would not be obvious to a lay person. Id. at 476.

As with the exclusion for treatment “related to” obesity surgery in Kenseth, the “covered expenses” exclusion for charges incurred “for or while receiving investigatory treatment” is one of a number of “General Exclusions and Limitations” set out at the end of the insurance policy, more than 30 in this case. In an earlier section, the policy identifies chemotherapy and radiation as expenses specifically covered by the policy. To understand that the “covered expenses” exclusion could preclude coverage for non-investigational chemotherapy expenses, plaintiff would have had to realize that Avastin was an investigational treatment and that by using Avastin, *all* of her other expenses would be precluded from coverage. This is not an obvious conclusion because the provision does not say clearly that charges for *all other medical treatment* are excluded if incurred while the insured is receiving investigational treatment. Rather, the provision excludes “charges incurred . . . for or while receiving investigational treatment.” Using the court of appeals’ approach in Kenseth, a reasonable insured could understand the language as precluding coverage only for

charges that are necessary to the non-covered investigational component of his or her treatment.

In sum, the “covered expenses” exclusion does not have clear parameters and is open to multiple interpretations, some more reasonable than others. Thus, the provision is ambiguous and must be construed against defendant and in favor of coverage. American Family Mutual Insurance Co. v. American Girl, Inc., 2004 WI 2, ¶ 24, 268 Wis. 2d 16, 673 N.W.2d 65 (“Exclusions are narrowly or strictly construed against the insurer if their effect is uncertain.”); Sprangers v. Greatway Insurance Co., 182 Wis. 2d 521, 536, 514 N.W.2d 1 (1994) (“Exclusions are to be narrowly construed against the insurer and in favor of coverage especially if they are uncertain as to effect. . . . Any ambiguity in exclusionary clauses or exceptions is to be strictly construed against the insurer and reasonable doubts about uncertain language should be resolved against the insurer.”). A narrow interpretation of the exclusion would provide coverage for plaintiff without rendering the exclusion meaningless. In particular, under a narrow interpretation, the exclusion would preclude coverage for charges that are incurred because of the investigational treatment, but would not exclude coverage for charges that an insured would have incurred regardless whether the insured was also receiving investigational treatment. Because the exclusion is ambiguous, such a narrow interpretation is appropriate in this case.

Defendant has not denied that plaintiff would have received standard chemotherapy using carboplatin and paclitaxel even if she had not received Avastin. Nor has defendant denied that plaintiff would have incurred costs for doctor visits and administrative costs even

if she had not received Avastin. Thus, applying the narrow interpretation of the “covered expenses” exclusion, I conclude that the costs for plaintiff’s standard chemotherapy treatments are not precluded by the “covered expenses” exclusion and that defendant is required to pay plaintiff for those costs.

Accordingly, I am granting defendant’s motion for summary judgment with respect to plaintiff’s claim for coverage of the costs for administering Avastin, but I am denying the motion with respect to plaintiff’s claim for coverage of the non-Avastin components of her chemotherapy treatment. I am granting summary judgment to plaintiff on the issue of coverage for the non-investigational, non-Avastin components of her treatment.

It is not clear whether there are factual disputes regarding the charges plaintiff incurred for her chemotherapy treatment that are covered under this interpretation of the provision. I will give the parties an opportunity to file briefs explaining whether they can stipulate to damages or whether there are disputed issues of fact related to damages that will require a jury trial.

B. Bad Faith

In addition to her breach of contract claim, plaintiff asserts a claim of bad faith against defendant, contending that defendant denied her claim on the basis of an unreasonable interpretation of the policy and because it believed plaintiff’s prognosis for recovery was very low. To establish a claim for bad faith denial of insurance benefits under Wisconsin law, the insured “must show the absence of a reasonable basis for denying

benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim.” Weiss v. United Fire & Casualty Co., 197 Wis. 2d 365, 377-78, 541 N.W.2d 753 (1995) (citations omitted).

Defendant’s decision to deny coverage for plaintiff’s Avastin treatments is supported by the contract. Thus, that denial was not in bad faith. Additionally, although I concluded above that defendant should not have denied coverage for the non-Avastin portions of plaintiff’s treatment, plaintiff has adduced no evidence that defendant’s denial was in bad faith. The “covered expenses” exclusion is ambiguous, and defendant’s interpretation had some support in the language of the provision.

Further, even if defendant had relied on an unreasonable interpretation of the provision to deny coverage, this would be insufficient to establish a bad faith claim. Jones v. Secura Insurance Co., 2002 WI 11, ¶ 29, 249 Wis. 2d 623, 638 N.W.2d 575 (“Compared to California's bad faith action . . . , which requires an insured only to establish that the insurer unreasonably interpreted the insurance contract, Wisconsin's bad faith claim is considerably more narrow.”) (citation omitted); see also Mowry v. Badger State Mutual Casualty Co., 129 Wis. 2d 496, 517, 385 N.W.2d 171 (1986) (“A finding of bad faith must not be measured solely against a backdrop that coverage was ultimately found to exist under the policy.”). Rather, “to determine whether the insurer acted in bad faith the trier of fact measures the insurer's conduct against what a reasonable insurer would have done under the particular facts and circumstances to conduct a fair and neutral evaluation of the claim.” Weiss, 197 Wis. 2d 365, 378, 541 N.W.2d 753. Bad faith results when there is an

“absence of honest, intelligent action or consideration based upon a knowledge of the facts and circumstances upon which a decision in respect to liability is predicated.” Trinity Evangelical Lutheran Church & School-Freistadt v. Tower Insurance Co., 2003 WI 46, ¶ 34, 261 Wis. 2d 333, 661 N.W.2d 789 (citation omitted). In this case, defendant researched and evaluated plaintiff’s claim for coverage by contacting an independent medical reviewer who concluded that plaintiff’s treatment qualified as investigational. Plaintiff has not adduced evidence showing that a reasonable insurer would have acted differently under the circumstances.

Finally, plaintiff’s argument that defendant denied her claims because it believed she had a poor prognosis is not supported by the facts. Plaintiff has adduced no evidence that defendant ever determined that plaintiff had a bad prognosis. Rather, defendant consulted an independent medical reviewer regarding whether plaintiff’s treatment was “investigational.” After reviewing plaintiff’s chemotherapy protocol, the medical reviewer expressed the opinion that plaintiff’s treatment was investigational under the terms of the policy because (1) the Avastin treatment was in phase II of a clinical trial; (2) it had not been determined through peer review literature to be safe and effective for her condition; and (3) her chemotherapy protocol was not an accepted off-label use for her condition. The only statements made by the medical reviewer regarding prognosis were that “[m]etastatic melanoma has a very poor prognosis. . . For this reason there are numerous ongoing trials to improve current treatment results. . . The components of the proposed treatment as well as the treatment plan itself are undergoing ongoing phase II studies.” Neither defendant nor

the medical reviewer decided that plaintiff personally had a poor prognosis or that the generally poor prognosis for patients with metastatic melanoma was any basis for denying claims. Thus, plaintiff has adduced no evidence that defendant's denial of her claim was dishonest or reckless or based on anything more than its narrow interpretation of the policy language. Therefore, I am granting defendant's motion for summary judgment on plaintiff's bad faith claim.

C. Equitable Estoppel

Plaintiff contends that defendant is equitably estopped from denying payment for chemotherapy and related charges because defendant approved plaintiff for out-of-network treatment at Mayo Clinic and told Marshfield Clinic via telephone that her treatments were covered without pre-authorization. Plaintiff contends that she relied on defendant's statements when she decided to go forward with her chemotherapy treatments.

Under Wisconsin law, the general rule is that equitable estoppel may be applied when the action or inaction of a party induces reliance by another person to that person's detriment. Affordable Erecting, Inc. v. Neosho Trompler, Inc., 2006 WI 67, ¶ 33, 291 Wis. 2d 259, 715 N.W.2d 620; Nugent v. Slaght, 2001 WI App 282, ¶ 19, 249 Wis. 2d 220, 638 N.W.2d 594. However, an insured generally cannot assert the doctrine of equitable estoppel to estop an insurer from asserting a scope of coverage clause that acts to include or exclude a potential claim. Shannon v. Shannon, 150 Wis. 2d 434, 450-54, 442 N.W.2d 25 (1989) (estoppel cannot be used to expand scope of coverage to "include coverage which was not

provided for or was excluded from the contract”); Watertown Tire Recyclers, LLC v. Nortman, 2011 WI App 27, ¶¶ 47-48, 331 Wis. 2d 730, 795 N.W.2d 493 (unpublished). Thus, plaintiff cannot assert equitable estoppel to prevent defendant from relying on an exclusionary provision in the insurance policy.

Moreover, even if plaintiff could assert an equitable estoppel claim, she has adduced no evidence to support such a claim. The recordings and transcripts of the telephone calls at issue show that defendant never explicitly told Marshfield Clinic that plaintiff’s chemotherapy treatment would be covered under the terms of the policy. Although defendant’s representatives told Marshfield Clinic that pre-authorization was not required, the representatives made it clear that the decision whether an expense was covered depended upon the policy language and the particular circumstances of treatment. Thus, plaintiff could not have relied reasonably on the conversations between Marshfield Clinic and defendant’s representatives. For these reasons, I am granting defendant’s motion for summary judgment on plaintiff’s equitable estoppel claim.

D. Interest under Wis. Stat. § 628.46

Finally, plaintiff has filed a claim under Wisconsin’s “Timely payment of claims” statute, Wis. Stat. § 628.46, which imposes an annual rate of 12% interest on any insurer who fails to pay a claim within 30 days of being provided written notice of such claim. However, a claim cannot “be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment.” Wis. Stat. § 628.46.

“Reasonable proof” means that amount of information which is sufficient to allow a reasonable insurer to conclude that it may not be responsible for payment of a claim.” Froedtert Memorial Lutheran Hospital, Inc. v. National States Insurance Co., 2009 WI 33, ¶ 59, 317 Wis. 2d 54, 765 N.W.2d 251 (citation omitted). Generally, reasonable proof is equated with whether coverage is considered “fairly debatable.” Kontowicz v. American Standard Insurance Co. of Wisconsin, 2006 WI 48, ¶ 48, 290 Wis. 2d 302, 714 N.W.2d 105 (quoting Allstate Insurance Co. v. Konicki, 186 Wis. 2d 140, 160, 519 N.W.2d 723 (Ct. App. 1994)).

Although I conclude that plaintiff’s insurance policy covers the expenses of her chemotherapy treatment, with the exception of the charges for Avastin and services stemming from her Avastin treatment, the coverage issue was “fairly debatable.” The “covered expenses” exclusion at issue is ambiguous and defendant’s interpretation is arguably supported by the language of the exclusion. Thus, defendant had reason to believe that it might not be responsible for payment, and plaintiff is not entitled to interest under § 628.46. I am granting defendant’s motion for summary judgment on this issue.

ORDER

IT IS ORDERED that

1. Defendant Golden Rule Insurance Company’s motion for summary judgment, dkt. #14, is GRANTED IN PART and DENIED IN PART. The motion is GRANTED with respect to plaintiff Bonnie Larson’s claims for (1) coverage of her Avastin treatments; (2) bad

faith; (3) equitable estoppel; and (4) interest under Wis. Stat. § 628.46. The motion is DENIED in all other respects.

2. Plaintiff's motion for partial summary judgment on the issue of coverage for the non-Avastin components of her chemotherapy treatment, dkt. #30, is GRANTED.

3. Defendant's motion for leave to file a sur-sur reply, dkt. #46, is DENIED.

4. The parties may have until March 22, 2012 to notify the court whether there are disputed issues related to damages that require a jury trial.

Entered this 14th day of March, 2012.

BY THE COURT:

/s/

BARBARA B. CRABB

District Judge