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

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ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs,

v. Case No. 17-CV-0264

STATE OF WISCONSIN DEPARTMENT
OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

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**DEFENDANTS' BRIEF REGARDING PLAINTIFFS' BURDEN TO PROVE CAUSATION IN ORDER TO OBTAIN DAMAGES**

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## INTRODUCTION

Pursuant to this Court's direction at the telephonic pre-trial conference on October 4, 2018, Defendants submit this brief addressing why they must be permitted to challenge Plaintiffs' evidentiary basis for arguing that the coverage exclusion at issue here (the "Exclusion") caused them to suffer damages. In short, Plaintiffs have the burden to prove causation; it is not Defendant's burden to *disprove* causation. Defendants must be permitted to offer evidence—both through a Wisconsin Employee Trust Fund (ETF) witness and through cross-examination—that identifies critical gaps in Plaintiffs' causation theory, gaps which show that Plaintiffs may not have

received coverage for their gender reassignment surgeries, even absent the Exclusion.

## ARGUMENT

### I. Applicable legal principles.

Under Federal Rule of Evidence 401, evidence is relevant if it "has any tendency to make a fact more or less probable than it would be without the evidence" and if the "fact is of consequence in determining the action." Federal Rule of Evidence 402 provides that, generally, "relevant evidence is admissible." "A party faces a significant obstacle in arguing that evidence should be barred because it is not relevant, given that the Supreme Court has stated that there is a 'low threshold' for establishing that evidence is relevant." *United States v. Boros*, 668 F.3d 901, 907 (7th Cir. 2012). These rules "do not limit the [parties] to the 'most' probative evidence; all relevant evidence is admissible and the Rules define relevance broadly." *United States v. McKibbins*, 656 F.3d 707, 711 (7th Cir. 2011).

Proof of causation is a basic requirement of Plaintiffs' damages claims under Title VII and the Affordable Care Act. "A plaintiff must prove a causal link between the violation and the injury for which he is seeking damages." *Baer v. City of Wauwatosa*, 716 F.2d 1117, 1121 (7th Cir. 1983). "Causation is a standard element of tort liability, and includes two requirements: (1) the act must be the 'cause-in-fact' of the injury, i.e., 'the injury would not have

occurred absent the conduct'; and (2) the act must be the 'proximate cause,' sometimes referred to as the 'legal cause,' of the injury, i.e., 'the injury is of a type that a reasonable person would see as a likely result of his or her conduct.'" *Whitlock v. Brueggemann*, 682 F.3d 567, 582 (7th Cir. 2012) (citation omitted) (applying these causation principles to § 1983 claim). Although Title VII does not contain a strict cause-in-fact (or "but-for") causation standard for status-based discrimination claims, it still requires a showing of proximate cause. *See Univ. of Texas Sw. Med. Ctr. v. Nassar*, 570 U.S. 338, 348–49 (2013) (no "but-for" causation in Title VII discrimination claims); *Shick v. Illinois Dep't of Human Servs.*, 307 F.3d 605, 614 (7th Cir. 2002) (proximate cause required under Title VII). Under standard proximate cause principles, a party may not be held liable for damages that result from an intervening (or superseding) cause. *See Shick*, 307 F.3d at 614–15 (applying superseding cause principles to Title VII claim).

## II. Evidence that undermines an element of Plaintiffs' damages claim is relevant and should not be excluded.

Plaintiffs cannot obtain damages unless they prove that the Exclusion caused those damages. As the Court put it, the jury here "must determine the amount of money that will fairly and reasonably compensate plaintiffs for any injury that [it] find[s] they sustained *as a result of the Exclusion* of coverage

for gender-confirming surgery and related hormone therapy for state employees." (Closing Jury Instructions 2.) More specifically, Plaintiffs seek damages based on out-of-pocket medical expenses that they purportedly would not have incurred, but for the Exclusion. They also seek damages based on emotional distress they experienced because the Exclusion supposedly delayed necessary medical treatment for their gender dysphoria. To obtain either kind of these damages, Plaintiffs have the burden to prove causation—that is, they must prove that they would not have suffered these damages, but for the Exclusion.

Plaintiffs may believe that they can prove causation solely by pointing to the Exclusion and arguing that, absent the Exclusion, they necessarily would have received coverage for their gender reassignment surgeries. But that causation theory is incomplete. As the Court knows from its experience considering a preliminary injunction request involving a similar Medicaid coverage exclusion in *Flack, et al. v. Wisconsin Department of Health Services, et al.*, No. 18-cv-309 (W.D. Wis.), a beneficiary's third-party health insurer may still deny claims for coverage, even if no categorical coverage exclusion exists. When the Court enjoined enforcement of the similar coverage exclusion in *Flack*, it did not also order that the plaintiffs' coverage requests be approved. Rather, it recognized that, even without the categorical Medicaid coverage exclusion, the plaintiff's third-party HMO still had its own

decision to make and could deny the claim: "As to plaintiff Sara Ann Makenzie, defendants will provide a copy of this decision to her third-party HMO and, if applicable, complete their authorization review within 10 business days of receipt of *any appeal from the denial of coverage by the HMO*." (*Flack*, No. 18-cv-309, Dkt. 70:39 (emphasis added).) Similarly, plaintiffs' counsel in *Flack* identified the "critical problem" of categorical coverage exclusions as that they create an "inability to have . . . specific cases reviewed and their individual medical necessity reviewed." (*Flack*, No. 18-cv-309, Dkt. 69 Hrg. Tr. at 7:4-7.)

Defendants intend to present relevant evidence showing that the same individual medical necessity review by third-party insurers in *Flack* would also need to be performed here by Plaintiffs' third-party insurers, even without the Exclusion. The Uniform Benefits, which apply to all state employees (including Plaintiffs), provide that "[a]ll services must be Medically Necessary, as determined by the Health Plan . . . ."[1] (Dkt. 103-3:31.) Neither ETF nor the Group Insurance Board decides whether a given procedure—including the gender reassignment surgeries at issue here—is "medically necessary." That decision rests with the third-party insurer. To decide

[1] The term "health plan" in the Uniform Benefits refers to the third-party health insurance companies that adjudicate and pay claims made by state employees.

whether a procedure is "medically necessary," the third-party insurer examines whether a given procedure is:

> 1. consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; and
>
> 2. appropriate under the standards of acceptable medical practice to treat that Illness or Injury; and
>
> 3. not solely for the convenience of the Participant, physician, Hospital or other health care Provider; and
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> 4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.

(Dkt. 103-3:25.) Simply put, Plaintiffs would only have obtained coverage for the procedures at issue here if their third-party insurers concluded that the procedures were medically necessary under this definition.

Plaintiffs have always known of this process, as shown by both their testimony and the operative complaint. Moreover, this evidence indicates that Plaintiffs' third-party insurers would *not* have concluded that these gender reassignment surgeries were medically necessary—and thus would not have covered them. Alina Boyden testified that Dean Health Plan denied her coverage request in 2017 on the basis of medical necessity, after an outside plastic surgeon reviewed her request. (Boyden Dep. 160:5–20.)[2] Likewise, she

[2] This deposition transcript has not yet been filed on the docket because Defendants did not receive it until October 3, and Plaintiffs have raised confidentiality concerns that the parties have not yet resolved.

alleges in the operative complaint that "[i]n a letter dated February 21, 2017, Dean upheld its denial of Ms. Boyden's request for coverage, citing the reinstatement of the ban, Dean Health Plan Medical Policy MP9469, and an external review of Ms. Boyden's case conducted by a Board Certified Plastic Surgeon." (Dkt. 108-1:18 ¶ 65.) This indicates that Dean had multiple independent bases for denying Boyden's coverage request, only one of which was the Exclusion.

Plaintiffs may also argue that the Court has already decided the issue of medical necessity at summary judgment, and thus that Plaintiffs' third-party insurers somehow would have been required to approve Plaintiffs' coverage requests. That argument would fail for four reasons. First, the Court's summary judgment decision did not address the Uniform Benefits' broad definition of medical necessity. Rather, that decision only addressed Defendants' narrower argument that inadequate evidence exists to show that surgical procedures are safe and effective to treat gender dysphoria. (Dkt. 207:37–41.) Second, the Court did not even resolve that issue on the merits—it held instead that this asserted state interest was *post hoc* and not genuine.[3] (Dkt. 207:40.) Third, even if the Court had resolved the issue of medical necessity, that September 2018 decision obviously would not have been

available to insurers when considering Plaintiffs' past coverage requests. To obtain damages for past expenses and distress, Plaintiffs must show that their claims would have been approved in the past—the Court's non-existent decision would not have guided insurers when evaluating Plaintiffs' coverage claims at the time. Fourth, Plaintiffs' insurers are not parties to this case, and so the Court's decision could not even bind them when considering future coverage claims. Indeed, in *Flack*, when considering the need for the plaintiff's third-party HMO to review her coverage request, the Court noted that it was "not going to enjoin a third party who hasn't been heard from." (*Flack*, No. 18-cv-309, Dkt. 69 Hrg. Tr. at 45:4–20.) Those third parties have not been heard from in this case, either.

In sum, since third-party insurers had the authority to deny Plaintiffs' claims for coverage even absent the Exclusion, and since evidence indicates that they may have denied those claims anyway, Plaintiffs face a missing link between the Exclusion and their purported damages. If their claims would have been denied anyway, Plaintiffs still would have paid out-of-pocket for medical expenses—and those expenses could not be recovered as damages. And if their claims would have been denied anyway, Plaintiffs still would

[3] The Court did address the available safety and efficacy evidence in a footnote, but it properly declined to resolve this disputed issue at summary judgment.

have had emotional distress arising from delayed medical treatment—and that distress could not be recovered as damages, either.

As the party with the burden of proof, it is Plaintiffs' job to fill in this missing causal link with evidence—specifically, evidence that their insurers would have approved their coverage claims if the Exclusion had not existed. This would not have been an impossible burden to carry. For example, Plaintiffs could have sought testimony from an insurer representative who would have evaluated their claims, but they never did so and have no such witnesses now. Without any such evidence, Plaintiffs are the ones who must ask the jury to speculate that causation exists here. Defendants, who do not have the burden of proof, need not offer definitive evidence that Plaintiffs' claims would have been denied anyway. They need only create doubt in the jury's mind that Plaintiffs have not carried their burden of proof. Because this evidence has a "tendency to make a fact"—i.e. that the Exclusion caused Plaintiffs' damages—"less probable than it would be without the evidence," it clears the "'low threshold' for establishing that evidence is relevant" under Federal Rule of Evidence 401. *Boros*, 668 F.3d at 907. (Citations omitted.)

## CONCLUSION

Defendants should be permitted to offer evidence through an ETF witness and cross-examination showing that Plaintiffs have failed to carry

their burden to prove causation, in that third-party insurers may have denied their coverage claims even if the Exclusion had not existed.

Dated this 5th day of October, 2018.

Respectfully submitted,

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