

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

CASE NO.: 17-cv-264

- - - - -X

ALINA BOYDEN AND SHANNON ANDREWS, :  
PLAINTIFFS :  
:

VS :  
:

STATE OF WISCONSIN DEPARTMENT OF :  
EMPLOYEE TRUST FUNDS, ET AL., :  
DEFENDANTS :

- - - - -X

Deposition of DAVID VAUGHN WILLIAMS taken  
at the offices of Milliman, 80 Lamberton Road,  
Windsor, Connecticut, before San Edwards, RPR, a  
Registered Professional Reporter and Notary Public,  
in and for the State of Connecticut on June 15,  
2018, at 12:57 p.m.

A P P E A R A N C E S:

ON BEHALF OF THE PLAINTIFFS:

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## STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the parties that each party reserves the right to make specific objections at the trial of the case to each and every question asked and of the answers given thereto by the deponent, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that proof of the official authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that the reading and signing of this deposition by the deponent is not waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing parties that all defects, if any, as to the notice of the taking of the deposition are waived.

Filing of the Notice of Deposition with the original transcript is waived.

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DAVID VAUGHN WILLIAMS, employed at Milliman, 80 Lambertson Road, Windsor, Connecticut, 06095, having first been duly sworn, deposed and testified as follows:

## DIRECT EXAMINATION

BY MR. DUPUIS:

Q Good morning, Mr. Williams. So as you know, I'm Larry Dupuis. I'm one of the lawyers for the plaintiffs in the case of Boyden, et al. versus Wisconsin Department of Employee Trust Funds.

Have you ever been deposed before?

A I have.

Q Okay. So you probably know most of the ground rules. One -- the major one being that we try to avoid talking other one another, if that's all right?

A Yes.

Q And similar kinds of things are -- are related to the fact that we're recording. Make sure to say "yes" or "no" when you are -- have a "yes" or "no" question.

Obviously, the tape, or whatever recording devices we're using here, won't pick up

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nods of the head. Is that all right?

A That's all right.

Q And similarly, if -- if you -- it'd be -- it's best to say "yes" or "no," rather than "uh-huh" or "uh-uh," because those are ambiguous on -- on -- on the transcript. Is that all right?

A I understand.

Q All right. So if you don't understand a question that I ask at any point, feel free to ask me to ask it again or clarify. Is that okay?

A Yes.

Q If you do answer a question, I will assume that you understood. Is that fair?

A It is. Although, I reserve the right to review it later on. And if I didn't understand it or felt like I needed to clarify it, I -- I will do that.

Q All right. So Mr. Roth may occasionally object to questions that I ask. In general, if he objects but you understand the question, you can go ahead and answer the question. Is that okay?

A Understood. Yes.

Q If he instructs you not to answer, then don't answer it, unless we resolve -- resolve any dispute. It's unlikely to be a whole lot of

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questions that would result in this kind of a deposition. But if there are, we'll try to resolve that. Okay? Okay?

A Yes.

Q Is there any reason you can think of today why you wouldn't be able to answer my questions fully and accurately?

A I can't think of any at this time.

Q Okay. And you understand that you're under oath?

A I do.

Q We're going to try to make up for some lost time here. But if you need a break at any point, just let us know.

The -- the one exception to taking a break at any time is if there's a pending question. I ask that we finish answering the question before we break. Okay?

A I understand.

Q Did you meet with Mr. Roth in preparing for this deposition?

A I did.

Q When was that?

A Yesterday.

Q Okay. For how long?

3 (Pages 3 to 6)

Page 7

Page 9

1 A My -- a few hours. A couple of hours. I  
2 don't recall exactly how long.

3 Q Okay. Was there any other preparation  
4 for the deposition besides that meeting with  
5 Mr. Roth yesterday?

6 A Other than reviewing my documents, no.

7 Q When you say reviewing your documents,  
8 what documents did you review?

9 A The one that I wrote. It had the ones  
10 that I relied on for the report.

11 Q Okay. So we'll get into this in a little  
12 more detail when we look at the report.

13 But When you say the documents you relied  
14 on in preparing your report, what documents do you  
15 mean?

16 A They are -- they're listed in the -- at  
17 the end of the report that I think I called it the  
18 bibliography.

19 Q Okay. So we'll be talking about some  
20 documents that were produced in discovery in  
21 addition to your report.

22 Some of those will have page numbers.  
23 Some won't. Some will have identifying numbers  
24 that we've handwritten on the bottom that are  
25 essentially the -- the file names of the documents

1 A This is my curriculum vitae or my  
2 resume, I call it.

3 Q Okay. And this -- this is a -- a  
4 version of the resume that was produced to us by  
5 the defendants. That's why it has the Boyden  
6 production No. 9 on the bottom.

7 Can you just take a look and make sure  
8 that this is a current and accurate reflection of  
9 your work history and experience, education,  
10 publications, and so forth?

11 A Yes.

12 Q Okay. Anything that needs to be added  
13 to that to make sure it's accurate and up-to-date?

14 A No.

15 Q Okay.

16 A There may be things that I -- I -- that  
17 I've done in addition to this. But this right  
18 reflects my education and my work experience.

19 Q Okay. When you say other things you've  
20 done, what do you mean by that?

21 A I think -- I -- I don't know that I've  
22 recorded everything that I've done. But I don't  
23 recall everything that I've done to be able to  
24 record it. But this does reflect my -- my work  
25 history.

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1 as they were produced to us.

2 But I will generally refer to them by  
3 the "Plaintiff's Exhibit" number. So if we are  
4 referring to documents, if you can refer to the  
5 "Plaintiff's Exhibit" number that will be on this  
6 lit- -- little yellow or blue or whatever color  
7 tabs we end up using. Okay?

8 A Yes.

9 Q Do you live in Connecticut?

10 A I do.

11 Q How long have you lived here?

12 A Approximately 26 years.

13 Q Okay.

14 A I don't remember exactly when we moved  
15 here.

16 Q Okay. I'm going to have you take a look  
17 at what's been marked as Plaintiff's Exhibit 1 -- or  
18 I'm sorry -- Williams Exhibit 1.

19 (Whereupon, Plaintiff's Exhibit  
20 Williams No. 1, Curriculum Vitae,  
21 was marked for identification.)

22 BY MR. DUPUIS:

23 Q Do you recognize that?

24 A I do.

25 Q And what is a it?

1 Q Okay. But are there additional  
2 publications that are not reflected on here?

3 A None that are publicly available that I  
4 recall.

5 Q Okay. Any that are not publicly  
6 available?

7 A Good question. There -- we do a lot of  
8 work for our clients. But generally, those are  
9 proprietary and -- and we publish a lot for our  
10 clients. But they aren't necessarily made public.  
11 And --

12 Q And so --

13 A -- so we wouldn't put them on the  
14 résumé.

15 Q So sometimes, they're not publications  
16 for general --

17 A They are clients -- they are client  
18 work. Yes.

19 Q Okay. Where did you go to high school?

20 A Kendrick High School in Idaho.

21 Q Is Kendrick a town in Idaho?

22 A It is. My brother lives in Idaho, in  
23 Boise.

24 Q When did you graduate from high school?

25 A 1978.

4 (Pages 7 to 10)

Page 11	Page 13
<p>1 Q And you went college at Brigham Young. 2 Is that correct? 3 A I did. 4 Q And what years were you at BYU? 5 A I recall 1982 through 1987. 6 Q And you got a bachelor's degree in 1987. 7 Is that correct? 8 A I did. 9 Q Okay. And that was in economics? 10 A Yes. 11 Q You also took some master's level courses 12 in -- at Brigham Young. Is that correct? 13 A I did. 14 Q When -- when were you taking those? 15 A Yeah. Right after -- 16 Q College? 17 A -- right after -- yeah. Right after my 18 undergraduate work. 19 Q Okay. Were you in a master's program? 20 A I was. 21 Q Okay. Did you complete the master's 22 program? 23 A I did not. 24 Q Okay. How -- how you long were you in 25 the master's program?</p>	<p>1 didn't finish the thesis. 2 Q Okay. Did any of the -- so -- so what 3 years were those? '87 -- did you do two years of 4 coursework? 5 A No. One year of coursework. 6 Q Okay. 7 A So the graduate -- the undergraduate, now 8 that you're triggering my memory -- this is 9 thirty-something years ago -- 10 Q Yeah. Yeah. 11 A So I graduated with the undergraduate in 12 '86. I started the -- the master's program in '86 13 and left in the summer of '87. 14 Q Okay. Did any of that coursework deal 15 with health care economics? 16 A I don't recall. 17 Q Okay. Anything to deal with 18 insurance -- the insurance business? 19 A Not specifically that I recall. 20 Q So you went to work, then, at Kaiser 21 Permanente. Is that -- 22 A Yes. 23 Q -- the position? 24 Okay. And that was in 1987? 25 A That's correct.</p>
Page 12	Page 14
<p>1 A One year. 2 Q And what degree would it have led to 3 had -- 4 A A degree -- 5 Q -- you finished -- 6 A -- in economics. 7 Q -- it? 8 A Managerial economics was the degree in. 9 Q And what is managerial economics? 10 A So it's economics. But it's focused more 11 on the business side, rather than the social 12 sciences side. 13 Q So sort of a microeconomics firm -- 14 A Focus. Yeah. 15 Q -- kind of -- 16 Why -- why did you leave that program? 17 A I went to work in Los Angeles. 18 Q Had you been admitted to a -- a master's 19 program intending to complete the master's program? 20 A I did. 21 Q Okay. 22 A Yes. 23 Q All right. And you went work in LA. Was 24 that -- 25 A So I completed the coursework, but I</p>	<p>1 Q And you were there for approximately 2 seven years? 3 A Yes. A combination of southern 4 California and the northeast. 5 Q Okay. So you have -- you also list some 6 other education on -- on your CV here -- master's 7 courses -- or database administration courses and 8 mas- -- and you say "master classes in data 9 mining." Are those -- were those -- 10 A They're graduate level classes. 11 Q Okay. They were mas- -- graduate level 12 classes. 13 Were they leading toward a degree? Or 14 could they have been leading toward a degree? 15 A They could have, but that was not my 16 intent. 17 Q Okay. So can you tell me the -- looking 18 at the second page, the education section, I assume 19 the master's courses were -- that didn't work -- I 20 assume the master's courses at BYU were all in '86 21 and '87. Right? 22 A Yes. 23 Q Okay. When -- when was the database 24 administration courses listed here? 25 A I don't recall.</p>

5 (Pages 11 to 14)

<p style="text-align: right;">Page 15</p> <p>1 Q Is that while you were in California? Do 2 you recall?</p> <p>3 A I think some were California, and some 4 were Connecticut.</p> <p>5 Q Okay. And so this is just software 6 training.</p> <p>7 Is that -- would that be fair?</p> <p>8 A That's a fair description.</p> <p>9 Q Would -- would that have been master's 10 level work or no?</p> <p>11 A Well, they're professional development 12 courses leading to certifications.</p> <p>13 (Whereupon, there was an 14 interruption.)</p> <p>15 (Whereupon, there was a recess taken 16 from 1:10 p.m. to 1:15 p.m.)</p> <p>17 MR. DUPUIS: Okay. Back on. 18 Just to step back a -- a bit.</p> <p>19 You -- we wanted to put on the record 20 that counsel for the plaintiff and the 21 defendants have agreed to take this 22 deposition by audio recording of the 23 deposition on the court reporter's 24 computer and a -- a backup on Asma 25 Kadri's computer; and that we stipulate</p>	<p style="text-align: right;">Page 17</p> <p>1 A I do not.</p> <p>2 Q Roughly?</p> <p>3 A No.</p> <p>4 Q Were you working for Milliman?</p> <p>5 A Yes. I was working for -- yes. I was 6 working for Milliman at that point.</p> <p>7 Q Okay. So does that put us sometime since 8 1999?</p> <p>9 A Ninety-nine. Yeah.</p> <p>10 Q And you indicated already, I believe, 11 that those could have led to a -- a degree -- 12 graduate degree, but you were not pursuing them for 13 that purpose. Is that correct?</p> <p>14 A That's correct.</p> <p>15 Q And they were both online courses?</p> <p>16 A Correct.</p> <p>17 Q Okay. Is it -- was each of these a 18 single course?</p> <p>19 A There were multiple courses involved over 20 a period of time.</p> <p>21 Q And so there were a series of data mining 22 courses. Is that correct?</p> <p>23 A Yes.</p> <p>24 Q Can you describe, generally, what that is 25 about?</p>
<p style="text-align: right;">Page 16</p> <p>1 that the transcript will be prepared from 2 that audio recording unless we are able 3 to correct the technical difficulties at 4 some point.</p> <p>5 And -- and we will all accept that 6 that transcript will be appropriate. You 7 will have an opportunity to read -- read 8 and correct.</p> <p>9 Does that cover it?</p> <p>10 MR. ROTH: Very good.</p> <p>11 BY MR. DUPUIS:</p> <p>12 Q All right. So we were talking about 13 your -- your educational background. The -- and I 14 think we just concluded the database administration 15 coursework that you said led -- could lead to 16 certification of -- of some sort.</p> <p>17 Did you get a certification in -- in that 18 area?</p> <p>19 A I don't recall.</p> <p>20 Q Okay. And then, the next thing is these 21 master's classes at Central Connecticut State 22 University and UMass Amherst both online. Is that 23 correct?</p> <p>24 A That's correct.</p> <p>25 Q Do you know what years those were?</p>	<p style="text-align: right;">Page 18</p> <p>1 A Those are courses in -- in technology as 2 used to mine data sources, precursors to artificial 3 intelligence, advanced statistical techniques to -- 4 to work with data.</p> <p>5 Q And is this, like, data mining public 6 databases? Or --</p> <p>7 A We would typically use public databases 8 for the coursework. Yes.</p> <p>9 Q Okay. Were there -- was any of that 10 coursework, specifically in the data mining area, 11 specifically related to health informatics?</p> <p>12 A I don't recall.</p> <p>13 Q So you don't recall whether it did? Or 14 you don't --</p> <p>15 A I don't recall whether there were 16 specific coursework components that related directly 17 to health data.</p> <p>18 Q Okay. The master's classes in public 19 health, also online courses. Correct?</p> <p>20 A Correct.</p> <p>21 Q Do you know how many courses were 22 involved in that?</p> <p>23 A I don't remember exactly how many.</p> <p>24 Q Is -- is it more than -- more than one?</p> <p>25 A It was more than one.</p>

6 (Pages 15 to 18)

Page 19

1 Q Fewer than 10?  
 2 A Fewer than 10 probably.  
 3 Q Okay.  
 4 A Yes.  
 5 Q And did those courses deal with health  
 6 informatics in any way?  
 7 A They were public health courses. So  
 8 they dealt with -- with health care issues  
 9 specifically.  
 10 Q Okay. But were they health data as  
 11 part -- was that part of it?  
 12 A If you consider epidemiology health  
 13 data, then, yes.  
 14 Q Okay. So you had an epidemiology  
 15 course?  
 16 A One was a -- I do remember one was an  
 17 epidemiology course.  
 18 Q So an Intro Epidemiology course?  
 19 A It was a master's level.  
 20 Q Had you had epidemiology before?  
 21 A I've been in- -- introduced to the  
 22 concepts of epidemiology. I don't remember if I've  
 23 taken any classes specific --  
 24 Q Okay.  
 25 A -- to that.

Page 20

1 Q Other than the one --  
 2 A Other than the one. Yeah.  
 3 Q What about biostatistics?  
 4 A I don't think I've had a biostatistics  
 5 class specifically.  
 6 Q Have you had any courses in --  
 7 specifically in actuarial science?  
 8 A No.  
 9 Q Did you -- did any of your -- well,  
 10 let -- let's -- let's continue here. The  
 11 "Predictive Modeling and Data Science Using R  
 12 through Coursera."  
 13 Can you explain what that is and say  
 14 about when it was that you took it?  
 15 A Those were more recent, within the last  
 16 three years --  
 17 Q Okay.  
 18 A -- three or four years. Those are --  
 19 again, those are -- are similar to the data mining  
 20 courses. They are data statistical courses using  
 21 statistical software.  
 22 Q And R is the statistical --  
 23 A R is the --  
 24 Q -- software.  
 25 A -- statistical software.

Page 21

1 Q I'd just caution again, we sort of talked  
 2 over one another there.  
 3 A (Witness nods head.)  
 4 Q How -- how many courses were involved in  
 5 that?  
 6 A I think I took two courses. But there  
 7 may have been an additional course or two.  
 8 Q And -- and what is Coursera?  
 9 Is that an online --  
 10 A Coursera is an online tool that  
 11 aggregates courses from different universities in  
 12 different areas and facilitates the online  
 13 instruction.  
 14 Q Okay. Was that -- was -- were those  
 15 courses in- -- intended by you to lead to a graduate  
 16 degree by any --  
 17 A No.  
 18 Q No. Okay.  
 19 In any of this, did you -- was there any  
 20 other formal education that you've had?  
 21 A By "formal education," you mean --  
 22 Q Outside of, sort of, employer-provided  
 23 training. So university, college courses.  
 24 A Very likely. I'm trying to recall  
 25 various courses that I may have taken. I may have

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1 audited a course at the University of Connecticut.  
 2 And that may have been a -- a health-related  
 3 course.  
 4 Q That would have been at Storrs here?  
 5 A At UConn Health Center in Farmington.  
 6 Q Okay. And do you recall the subject  
 7 matter of that --  
 8 A It was --  
 9 Q -- audited health --  
 10 A -- health-related data similar to  
 11 epidemiology.  
 12 Q Okay. Was that a -- a -- you -- you  
 13 audited it. But had it been a four-credit course,  
 14 would it have been graduate?  
 15 A Yes.  
 16 Q Okay. And when was that about?  
 17 A That would have been probably between  
 18 1994 and 1999.  
 19 Q So it was while you were at Medspan?  
 20 A Yes.  
 21 Q Okay. And what sorts of health data were  
 22 covered in that?  
 23 A I don't recall.  
 24 Q Okay. You say -- I think you said that  
 25 it was similar to the epidemiology course.

7 (Pages 19 to 22)

Page 23

1 Is it -- was it --  
 2 A I remember --  
 3 Q -- public --  
 4 A -- components of epidemiology.  
 5 Q Okay. So aside from the epidemiology  
 6 course and this health data course that you audited  
 7 at UConn, do you have any other coursework on health  
 8 informatics?  
 9 A I can't recall any at this time.  
 10 Q Okay. Any courses at any time in  
 11 actuarial science?  
 12 A I'm going to answer, No. Not formal  
 13 courses on actuarial science.  
 14 Q Okay. But you've worked with actuaries.  
 15 Correct?  
 16 A Extensively.  
 17 Q Extensively.  
 18 You play an actuary on TV?  
 19 A You could say that.  
 20 MR. ROTH: Yeah. I -- I'm going to  
 21 insert an objection to that question.  
 22 I just think it's argumentative. I  
 23 don't want that showing up in -- go on,  
 24 though.  
 25

Page 24

1 BY MR. DUPUIS:  
 2 Q So you -- you hesitated about answering  
 3 that question.  
 4 Have you had formal training in actuarial  
 5 science in capacities other than, you know, going to  
 6 a college or university or taking a course online  
 7 like that?  
 8 A Working for an actuarial firm, you're  
 9 frequently taught in actuarial science concepts  
 10 and -- and -- and approaches, both formally and  
 11 informally.  
 12 Q Okay. So --  
 13 A It's the nature of what we do.  
 14 Q Okay. But you're not an actuary.  
 15 Correct?  
 16 A I am not an actuary.  
 17 Q And did you -- did you ever take the  
 18 actuarial exams?  
 19 A I did not.  
 20 Q Okay. And you're -- let -- let's go to  
 21 your employment. Well, actually, let me ask you one  
 22 more thing about your education.  
 23 Have you had any courses at all on gender  
 24 dysphoria?  
 25 A No.

Page 25

1 Q Its treatment?  
 2 A No.  
 3 Q Have you had any training on -- or  
 4 education on transgender identity generally?  
 5 A No.  
 6 Q Okay. Do you know what the term  
 7 "transgender" mean?  
 8 A I do. I -- I -- I do.  
 9 Q Can you tell me what your understanding  
 10 of transgender is?  
 11 A So my understanding is that -- well --  
 12 (Whereupon, there was an  
 13 interruption.)  
 14 A -- are you speaking specifically for  
 15 transgender or transgender dysphoria?  
 16 BY MR. DUPUIS:  
 17 Q Ini- -- initially, just transgender. But  
 18 transgender identity, too.  
 19 THE COURT REPORTER: Sorry.  
 20 MR. DUPUIS: Let's go off the  
 21 record, even though we've got a pending  
 22 question.  
 23 (Whereupon, there was a recess taken  
 24 from 1:27 p.m. to 1:34 p.m.)  
 25

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1 BY MR. DUPUIS:  
 2 Q Okay. So could you tell us your  
 3 understanding of the term "transgender"?  
 4 Not gender dysphoria at this point. Just  
 5 transgender.  
 6 A I understand it to be -- so I'm not an  
 7 expert in this area. I acknowledge that.  
 8 I understand transgender to mean that  
 9 the -- an individual identifies as a gender other  
 10 than the natal -- the gender that he was or she was  
 11 born with -- natal gender.  
 12 Q Okay. And what you understand gender  
 13 dysphoria to be?  
 14 A That there may be some identity that --  
 15 or -- or wish to transform to a -- to the new  
 16 gender. I -- I -- I -- frankly, I don't understand  
 17 that completely, the -- the difference.  
 18 I have read the -- the description in  
 19 the DSM-IV. But that wasn't the focus of my expert  
 20 opinion. It was the -- it informed me, but it  
 21 wasn't the focus of what I was doing.  
 22 Q Okay. So you -- you would agree that  
 23 you're not an expert on gender identity?  
 24 A I would agree with that.  
 25 Q You're not an expert on gender

8 (Pages 23 to 26)

<p style="text-align: right;">Page 27</p> <p>1 dysphoria?</p> <p>2 A That's correct.</p> <p>3 Q You're not an expert on the treatment of</p> <p>4 gender dysphoria?</p> <p>5 A That's correct.</p> <p>6 Q Would you consider yourself an expert on</p> <p>7 the cost of treatment for gender dysphoria?</p> <p>8 MR. ROTH: Objection. Vague and to</p> <p>9 the extent that it calls for a legal</p> <p>10 conclusion.</p> <p>11 Whether the witness is qualified as</p> <p>12 an expert is ultimately --</p> <p>13 MR. DUPUIS: All right. You --</p> <p>14 MR. ROTH: -- up to the Court to</p> <p>15 decide.</p> <p>16 MR. DUPUIS: We don't need speaking</p> <p>17 objections. That's okay.</p> <p>18 A I -- I would consider myself an expert in</p> <p>19 the cost of benefits, whether it be gender dysphoria</p> <p>20 or other benefits.</p> <p>21 BY MR. DUPUIS:</p> <p>22 Q But no specific expertise in the</p> <p>23 bene- -- in the cost of benefits for gender</p> <p>24 dysphoria, other than your general knowledge as</p> <p>25 a -- a -- you -- your general expertise in the cost</p>	<p style="text-align: right;">Page 29</p> <p>1 But I have reviewed -- we have clients</p> <p>2 that have asked for benefits to be added related to</p> <p>3 gender dysphoria. And we have reviewed the cost for</p> <p>4 those benefits for them in the past.</p> <p>5 Q And did those clients add those</p> <p>6 benefits?</p> <p>7 A They had not at the time that we did the</p> <p>8 study.</p> <p>9 Q Did they after?</p> <p>10 A Yes, they did.</p> <p>11 Q So when -- when, about, did you -- did</p> <p>12 you review those studies?</p> <p>13 A I participated in those studies. Yes.</p> <p>14 Q In doing the -- the analysis?</p> <p>15 A Yes.</p> <p>16 Q How -- how did you participate in doing</p> <p>17 the analysis?</p> <p>18 A We discussed sources of data and the</p> <p>19 cost related to gender dysphoria. And we supplied</p> <p>20 information back to the clients related to that.</p> <p>21 Q Okay. Were any of those clients -- were</p> <p>22 those clients health clients?</p> <p>23 A No.</p> <p>24 Q Who were they?</p> <p>25 A They were employers and state</p>
<p style="text-align: right;">Page 28</p> <p>1 of benefits?</p> <p>2 MR. ROTH: Objection. Vague. Asked</p> <p>3 and answered.</p> <p>4 You can answer.</p> <p>5 A I would consider myself an expert in</p> <p>6 the -- in the cost of benefits, whether they be</p> <p>7 gender dysphoria or other benefits.</p> <p>8 BY MR. DUPUIS:</p> <p>9 Q Okay. But you don't have any</p> <p>10 specialized knowledge with respect to the cost of</p> <p>11 benefits for the treatment of gender dysphoria?</p> <p>12 A I have an --</p> <p>13 MR. ROTH: Objection. Objection.</p> <p>14 Vague. Asked and answered.</p> <p>15 You can answer.</p> <p>16 A I have -- I have expertise in the cost</p> <p>17 of benefits for gender dysphoria and other</p> <p>18 benefits.</p> <p>19 BY MR. DUPUIS:</p> <p>20 Q Have you studied the cost of gender</p> <p>21 benefits for gender dysphoria treatment before this</p> <p>22 case?</p> <p>23 A Yes.</p> <p>24 Q When?</p> <p>25 A We need to explore "study."</p>	<p style="text-align: right;">Page 30</p> <p>1 governments.</p> <p>2 Q What state governments?</p> <p>3 MR. ROTH: I'll object. You know,</p> <p>4 I've -- I've talked with David about</p> <p>5 this. And my understanding is that</p> <p>6 there are various confidentiality</p> <p>7 provisions that attach to his work he's</p> <p>8 done with former clients.</p> <p>9 And, I mean, I don't think he has</p> <p>10 an obligation to -- to answer that.</p> <p>11 Or -- or -- I mean, he can -- he can</p> <p>12 explain better than I can. But -- nor</p> <p>13 am I sure he can answer that without</p> <p>14 breaching client confidentiality.</p> <p>15 BY MR. DUPUIS:</p> <p>16 Q Could you tell me if believe that you</p> <p>17 can't disclose the names of the state governments</p> <p>18 that you consulted with without breaching</p> <p>19 confidentiality?</p> <p>20 A I would like to have their permission to</p> <p>21 share that information before I shared it.</p> <p>22 Q Okay. How many state governments?</p> <p>23 A Two.</p> <p>24 Q Okay. Did those state governments</p> <p>25 extend benefits for treatment of gender dysphoria?</p>

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1 A Yes.  
 2 Q Okay. Were your estimates of the cost of  
 3 those benefits to those state governments  
 4 commensurate with your estimates of the cost of  
 5 benefits in this case?  
 6 A These are two different -- two different  
 7 examples, and I don't think they are comparable.  
 8 Q Were either of them state employee --  
 9 A Yes.  
 10 Q -- benefits?  
 11 A Yes.  
 12 Q One --  
 13 A Both of them.  
 14 Q Both of them were state employees  
 15 benefits?  
 16 A Yes.  
 17 Q Can you say why you didn't consider them  
 18 commensurate?  
 19 A They're two different time periods. And  
 20 there's different data available between the two  
 21 different time periods.  
 22 Q Okay. So -- so what were the time  
 23 periods we're talking about?  
 24 A 2011, 2014.  
 25 MR. ROTH: I just ask that both of

Page 32

1 you speak up a little bit more. I just  
 2 want make sure we're picking this all up  
 3 on the -- on the recording.  
 4 MR. DUPUIS: Okay.  
 5 MR. ROTH: You guys kind of  
 6 whisper, almost, at times.  
 7 BY MR. DUPUIS:  
 8 Q So you did one state employee --  
 9 consulted with one state employee -- employer in  
 10 2011 and another one in 2014. Correct?  
 11 A Correct.  
 12 Q Okay. Were those in connection with  
 13 litigation?  
 14 A No.  
 15 Q Okay. And both of those states adopted  
 16 benefits for treatment of gender dysphoria, in  
 17 part, based on the work that you did?  
 18 MR. ROTH: Ob- -- objection.  
 19 Vague. Lacks foundation.  
 20 You can answer.  
 21 BY MR. DUPUIS:  
 22 Q To the extent you know.  
 23 A The answer is, I don't know whether -- if  
 24 our work made a difference or not.  
 25 Q Okay. But they did, in fact, adopt

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1 these benefits after your work was provided to  
 2 them?  
 3 A Yes.  
 4 MR. ROTH: Same objection. I'll  
 5 insert the same objection before the  
 6 witness had answered.  
 7 BY MR. DUPUIS:  
 8 Q That was before -- both of those were  
 9 before the Affordable Care Act regulations were  
 10 promulgated, the Section 1557, nondiscrimination --  
 11 sex -- sex nondiscrimination provisions were  
 12 promulgated. Correct?  
 13 A Correct. Particularly in 2011. But the  
 14 2014 was -- as those had begun to be discussed,  
 15 was, in part, in -- as a result of the di- -- of  
 16 the ACA rules that were being discussed at the  
 17 time.  
 18 Q So -- so the -- the reason for the  
 19 consultation in 2014 was because of --  
 20 A Anticipated regulations. Yes.  
 21 Q Okay. So in your report, you indicated  
 22 that you were -- been the director of two health  
 23 plans.  
 24 And just trying to get a sense or  
 25 whether those two health plans were both part of

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1 Kaiser, or if Medspan was also a -- a health plan?  
 2 A Now, let me correct you a little bit. I  
 3 was a director in two health plans -- Director of  
 4 Medical Economics in both Kaiser and at Medspan.  
 5 Q Okay. So you were a director of medical  
 6 economics.  
 7 You didn't oversee the entire operation  
 8 of these health plans?  
 9 A No.  
 10 Q Okay. So can you tell me -- so you --  
 11 you started at Kaiser in 1987. Your resumé  
 12 indicates you were Director of Medical Economics  
 13 for the southern California and northeast regions.  
 14 Is that the position you started with?  
 15 A No.  
 16 Q Could -- could you tell me what position  
 17 you started with?  
 18 A I started as a -- as a -- I don't  
 19 remember the title. I started as a staff person in  
 20 the medical economics department.  
 21 Q Okay. And worked your way up to  
 22 director?  
 23 A I did. Within a year.  
 24 Q Within a year?  
 25 A (Witness nods head.)

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1 Q Okay. So from, basically, '88 or so  
2 until '94, you were --  
3 A Uh-huh.  
4 Q -- Director of Medical Economics?  
5 What did you do as director of medical  
6 economics?  
7 A I oversaw a staff that was related to  
8 pricing, market research, client reporting, member  
9 and economic -- member and revenue forecasting.  
10 Q And when you say "pricing," pricing of  
11 what?  
12 A Pricing of health plan benefits.  
13 Q Okay. You say you oversaw staff.  
14 How big was the staff?  
15 A At various times, between five and 12,  
16 13 people.  
17 Q Did you have actuaries working for you in  
18 that -- in that position?  
19 A I don't recall any actuaries working for  
20 me.  
21 Q Did you hire consulting actuaries?  
22 A Yes. At Medspan.  
23 Q Okay. What about at Kaiser?  
24 A No.  
25 Q Okay. Actually, I've been trying to

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1 focus on Kaiser here. But maybe, that wasn't  
2 clear.  
3 A Uh-huh.  
4 Q So you say you did work on pricing,  
5 market research, client reporting, member and  
6 revenue forecasting.  
7 Was that something -- were all of those  
8 things part of your bailiwick at -- at Kaiser?  
9 A Yes.  
10 Q Okay. Were all of those things part of  
11 your bailiwick at Medspan?  
12 A Yes.  
13 Q Okay. And you consulted with -- you --  
14 you -- or you hired consulting actuaries at  
15 Medspan, you said?  
16 A I did. Yes.  
17 Q For -- to do what?  
18 A We asked them to help us with our  
19 Medicare Advantage bids.  
20 Q Do you -- in doing the pricing work for  
21 the cost of health -- or the pricing for health  
22 benefits, did you consult with actuaries for that  
23 purpose?  
24 A No.  
25 Q Okay. And at Medspan, you were Director

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1 of Quality Management Risk Share Arrangements.  
2 What -- what does that mean?  
3 And how does that differ, if -- if at  
4 all, from being the director of medical economics?  
5 A So those -- those were additional  
6 responsibilities. I participated in our NCQA  
7 accreditation process. That's the quality manager  
8 part.  
9 And then, I also did the contracting for  
10 our risk share arrangements with 32 hospitals in  
11 Connecticut and any physicians that were affiliated  
12 with the hospitals and other physicians that would  
13 be contracted.  
14 Q Okay. You said "32." This says, "23."  
15 I assume one of them is a --  
16 A Transposition error.  
17 Q -- transposition error.  
18 A That's possible. There are 32 hospitals  
19 in Connecticut.  
20 Q Okay.  
21 A And we contracted with all of them.  
22 Q Okay. And what did Medspan do for them?  
23 A We -- well, we're the -- we were the  
24 insurer. And we took -- took part of the risk.  
25 And we then transferred some of that risk to the

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1 hospitals in risk share arrangements that -- where  
2 they shared some of the -- the proceeds from the --  
3 from the profits that would be assumed in the plan.  
4 Q So is this a hospital with the -- so is  
5 it an HMO of some sort?  
6 A So Medspan was an HMO. Yes.  
7 Q Okay. Does Medspan still exist?  
8 A It does not.  
9 Q When did it expire?  
10 A Shortly after I left. 2000, I will say.  
11 Q Okay. Why did you leave Kaiser?  
12 A To take a position at Medspan.  
13 Q Okay. Was it a better position?  
14 A It was different.  
15 Q And why did leave Medspan?  
16 A I was -- I was laid off in anticipation  
17 of their sale.  
18 Q And it was sold in 2000 --  
19 A Yes.  
20 Q -- or thereabouts?  
21 A Yup.  
22 Q To whom was it sold?  
23 A Health Net.  
24 Q So when you say you shared -- you worked  
25 out these risk-sharing arrangements -- this

11 (Pages 35 to 38)

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1 financial risk-sharing arrangements --  
 2 A Yes.  
 3 Q -- so were these, like, capitation  
 4 contracts -- that kind of thing -- where you were  
 5 just paying a certain amount per procedure; and if  
 6 they could do it more efficiently, they got the  
 7 benefit of it?  
 8 A That's the gist of it.  
 9 Q Okay. That's sort of what HMOs did at  
 10 the time?  
 11 A Back in the day. Yeah.  
 12 Q Yeah. Okay. So you've been with  
 13 Milliman since you left Medspan. Is that correct?  
 14 A That's correct.  
 15 Q Your current position is senior health  
 16 care consultant. Is that right?  
 17 A It is.  
 18 Q Did you have any other job titles over  
 19 the years?  
 20 A No.  
 21 Q Okay. So at Medspan and Kaiser, did you  
 22 ever deal with gender dysphoria or benefits for the  
 23 treatment of gender dysphoria?  
 24 A I don't recall ever dealing with them.  
 25 Q Okay. And at Milliman, other than the

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1 work that you described in -- for states in 2011,  
 2 2014, and then, your work on this case, have you  
 3 done any other work on the cost of -- well,  
 4 actually, I take that back.  
 5 I think you said employees and state  
 6 government -- employers and state governments. Is  
 7 that correct?  
 8 A That's correct.  
 9 Q How many employers were involved in  
 10 that?  
 11 A I don't recall.  
 12 Q So when do you recall first looking at  
 13 benefits for treatment of gender dysphoria?  
 14 A I will have say it was 2011.  
 15 Q Okay. Can you say how many employers  
 16 you've worked with? More -- and I -- I -- I know  
 17 you said you couldn't come up with an exact number.  
 18 A Yeah.  
 19 Q But more than five? fewer than 10?  
 20 A There was a flurry of activity as the  
 21 runup to the ACA happened. So I participated in  
 22 general discussions that probably related to several  
 23 employers, some of which I may or may not have been  
 24 directly involved with, but may have done some  
 25 general work.

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1 Q And when you say "general work," like,  
 2 referring people to data sources?  
 3 A Yeah. Looking for data sources or just  
 4 generally crafting some communication that talked  
 5 about the -- the cost related to gender dysphoria.  
 6 Q Okay. So you -- one -- one of the  
 7 things you say -- list as part of your work at  
 8 Milliman on your résumé -- or -- or your -- your CV  
 9 is that you were a lead consultant for the State of  
 10 Connecticut employee benefits managing 1.4 billion  
 11 in medical claims twenty six -- 2006 to 2015.  
 12 What -- what does it mean to have been  
 13 the lead consultant for employee benefits?  
 14 A I was the primary contact for the state  
 15 and led the -- and led the direction of the work --  
 16 led the work for the other consultants that work on  
 17 that contract.  
 18 Q Okay. What -- what did Milliman do for  
 19 the State of Connecticut as part of that contract?  
 20 A We -- we managed the health care,  
 21 pharmacy -- medical, pharmacy, dental benefits;  
 22 produced reports for them related to the price  
 23 of -- of medical benefits.  
 24 We did RFPs for them to secure vendors  
 25 for those benefits. We participated in their

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1 meetings. And we worked, also, with the Department  
 2 of Justice in -- in helping them understand some of  
 3 the -- the issues that would arise -- sometimes  
 4 fraud; sometimes other issues.  
 5 But that was the general -- the general  
 6 nature of the contract.  
 7 Q Okay. Milliman was not an insurer,  
 8 though. Correct?  
 9 A Milliman is not an insurer. No.  
 10 Q It -- it did not take on any risk?  
 11 A It -- it -- we did not take medical,  
 12 pharmacy, or general risk. No.  
 13 Q Okay. Did -- did you actually process  
 14 claims?  
 15 A No.  
 16 Q Okay. that would have been a vendor --  
 17 A Yes.  
 18 Q -- presumably?  
 19 A Yes.  
 20 Q Okay. I'd like to take a look at your  
 21 professional publications.  
 22 So you have three listed here, and one  
 23 of which is a journal article relating to wound  
 24 therapy for diabetic foot amputations from 2007?  
 25 A Uh-huh.

12 (Pages 39 to 42)

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1 Q The other two appear not to have been  
2 published in -- well, let me ask you. Is that a  
3 peer-reviewed journal?  
4 A That -- that -- that is a peer-reviewed  
5 journal. Yes.  
6 Q Okay. The other two publications were an  
7 expert report in Parks vs. USAA. Correct?  
8 A Yes.  
9 Q Is that a peer-reviewed report?  
10 A Can you explain "peer-reviewed" for me?  
11 Q Yeah. Did you -- so was the report  
12 submitted to a panel of other experts who  
13 determined whether it was valid or worthy of  
14 publication?  
15 A A comment on that. Internally as a --  
16 as a firm, everything is peer-reviewed by our peers  
17 internally. And to the extent it gets published  
18 outside of -- or is potentially made public, it is  
19 also peer-reviewed by a reviewer outside of our  
20 office. So another consultant in another office.  
21 But in terms of a panel of -- of peers  
22 similar to a -- a pub- -- a journal, then, no, it  
23 doesn't. It doesn't get reviewed that way.  
24 Q Okay. And then, "Demystifying the  
25 Medical Underwriting Cycle" for the

Page 44

1 Kaiser Foundation.  
2 A That's an old publication that I wrote  
3 when I first came on board at -- at Kaiser. And I  
4 think it may have been posted publicly at some point  
5 and used by others.  
6 It -- it may -- I don't recall for sure,  
7 but I think it may have been put in some of Kaiser's  
8 literature for others to understand. That's why  
9 it's listed.  
10 Q Okay. Was that, to your knowledge,  
11 peer-reviewed?  
12 A Again, it was peer-reviewed by the  
13 individuals within the firm, but not as a panel of  
14 outside experts similar to a -- a journal.  
15 Q Okay. And when you say that -- that --  
16 that anything that Milliman publishes outside is  
17 reviewed by somebody at another office, you mean,  
18 another Milliman office?  
19 A Correct.  
20 Q Okay. So it's not just the people who  
21 are sort of working together on a particular  
22 publication? Someone else takes a look at it?  
23 A Somebody else takes a look at it.  
24 Q All right.  
25 A It's usually somebody that has expertise

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1 in that area.  
2 Q Okay. Is that true of your report in  
3 this case?  
4 A Yes.  
5 Q Okay. So who -- well, we'll get back to  
6 that.  
7 Have you written any publications on the  
8 costs of benefits for the treatment of gender  
9 dysphoria?  
10 A No.  
11 Q Do you have any nonprofessional  
12 publications?  
13 MR. ROTH: Objection. Vague.  
14 A Yeah. I don't understand that question.  
15 BY MR. DUPUIS:  
16 Q Letters to the editor.  
17 I mean, do you -- are -- are you  
18 published in any other forms?  
19 A So in -- in the course of our work, we  
20 publish a lot of -- a lot of material -- a lot of  
21 reports. Some of them joint -- joint reports with  
22 other consultants.  
23 So the answer's, yes. But much of that  
24 is client-specific work that is proprietary to  
25 them.

Page 46

1 Q Okay.  
2 A And I -- I -- I will tell you, I -- I do  
3 think I need to disclose, there is one publication  
4 that is not on here that was made public recently.  
5 And that -- that I was -- I did an extensive amount  
6 of writing for. And that was a 1332 waiver  
7 publication for the state of Maine. And that could  
8 be found on the Department of Insurance's website.  
9 Q And can you say what a 1332 waiver is?  
10 A Briefly, it is a provision of the ACA to  
11 waive certain requirements of the ACA in order to  
12 fund certain aspects of health care at the state  
13 level.  
14 Q Okay. So it's a waiver of certain  
15 requirements that would ordinarily apply to states  
16 under the ACA?  
17 A Right.  
18 Q Are they Medicaid waivers?  
19 A They could be.  
20 Q Okay. Did that touch, in any way, on  
21 benefits for gender dysphoria?  
22 A No.  
23 Q Can you set that aside for the moment at  
24 least?  
25 I'd ask you to take a look at what's been

13 (Pages 43 to 46)

Page 47

1 marked as Exhibit 2.

2 (Whereupon, Plaintiff's Exhibit  
3 Williams No. 2, Expert Report on  
4 Reassignment Benefits, was marked  
5 for identification.)

6 BY MR. DUPUIS:

7 Q Taking a look at that document, do you  
8 recognize that?

9 A I do.

10 Q And what is it?

11 A This is our expert report on gender  
12 reassignment benefits?

13 Q Okay.

14 A My gender -- my benefit -- my report.

15 Q If you take a look at page 2, there is  
16 a -- a publication that I believe does not appear  
17 on your pub- -- publication list on your résumé,  
18 which is the "Analysis of Medical Bill Audit  
19 Services."

20 You see that?

21 A Yeah. From 2004?

22 Q Yeah. Is that correct?

23 A Yes. I can see that that's -- there's a  
24 difference there.

25 Q Okay. Did -- I assume that that had

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1 nothing do with benefits for gender dysphoria?

2 A It does not.

3 Q Okay.

4 A That's correct.

5 Q And what sort of publication -- did --  
6 did USAA, the United States -- United Services  
7 Automobile Association, publish that?

8 A They submitted that to a court in -- I  
9 can't remember the court. I think it was Arizona in  
10 relation to a class action suit related to UCR  
11 values.

12 Q Okay. And when you say "UCR values," you  
13 mean --

14 A Usual and customary -- usual, customary,  
15 and reasonable. Although, we would describe that as  
16 "reasonable fee analysis."

17 Q Okay. And that was the fees of  
18 physicians?

19 A This is -- relates to the billing  
20 practices of physicians, yes, and how those are paid  
21 for when there's no contract.

22 Q Okay. Which is the usual, customary, and  
23 reasonable?

24 A Historically. Yeah.

25 Q Uh-huh. Before the advent of HMOs, for

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1 example?

2 A Well -- or -- or -- in situations such  
3 as automobile accidents where the -- where the  
4 insurer may not have a contract for payment with  
5 the provider that cared for the patient.

6 Q Okay. So would that litigation -- so  
7 you did a reasonable fee methodology -- actually,  
8 both of those don't seem to appear on here -- the  
9 Milliman reasonable fee methodology. Although  
10 that -- the timing of that one seems to coincide  
11 with the Parks litigation. So I'm wondering if  
12 that's really the same thing?

13 A It's -- it's related. There are --  
14 there are actually two components to that. There  
15 was an expert report that was filed in conjunction  
16 with -- in support of the reasonable fee  
17 methodology that we developed.

18 So we are a consultant for USAA and --  
19 and produced that reasonable fee methodology. And  
20 the expert report was in support of that  
21 methodology to a court.

22 Q Okay. And you -- who did -- who did --  
23 on whose behalf did you submit reports in the -- in  
24 the Parks case?

25 A USAA.

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1 Q So the defendants?

2 A Yes.

3 Q Okay. Were you deposed in that case?

4 A Not in that case.

5 Q And then, there's another -- there's  
6 another case mentioned the MySpine versus USAA  
7 Casualty Company?

8 A Yes.

9 Q And again, I assume you did expert work  
10 for USAA, the defendant?

11 A I -- I did.

12 Q Okay. And you were -- did -- was there  
13 an expert report in that case?

14 A There was not a report.

15 Q Okay. But there was a deposition?

16 A There was a deposition.

17 Q Was that also about reasonable fee  
18 methodology?

19 A Yes.

20 Q Okay. So none of your publications and  
21 none of your prior expert work dealt with gender  
22 dysphoria or its treatment?

23 A That's correct.

24 Q Or its pricing?

25 A That's correct.

14 (Pages 47 to 50)

Page 51

1 Q Is there any other expert work you did  
2 not listed here -- expert litigation work?  
3 I'm sorry.  
4 A I consult with USAA because of our  
5 client regarding litigation, both in the works  
6 and -- and potential litigation. So to that  
7 extent, yes, I do expert work with USAA as part of  
8 my client work.  
9 In terms of in a courtroom or as expert  
10 witnesses, I can't recall any other --  
11 Q Okay.  
12 A -- work that we have done. But  
13 sometimes, those boundaries get blurred.  
14 Q Understood.  
15 Do you consider yourself -- self an  
16 expert in the pricing of surgical benefits?  
17 A If -- I -- I consider myself an expert in  
18 benefits in general. Yes. In- -- including  
19 surgical benefits.  
20 Q On -- on -- on what basis do you say that  
21 you're an expert in that area?  
22 A From extensive work history and work  
23 experience primarily.  
24 Q Other than the publication on negative  
25 pressure wound therapy and its correlation with

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1 rate of amputations, have you ever published  
2 anything else about surgical costs?  
3 A I have done client work for surgical  
4 costs and surgical complications --  
5 Q Okay.  
6 A -- and -- and produced several reports  
7 for my clients in that regard.  
8 Q Okay. Any on gender dysphoria surgery?  
9 A I don't recall any on gender dysphoria  
10 surgery as part of that work.  
11 Q Okay. So taking a look at your report  
12 again, Exhibit 2, are there any opinions about --  
13 profes- -- expert opinions you have about this case  
14 that are not contained in this report?  
15 A I don't recall any. I don't have any at  
16 this time. No. I don't have any other -- no, at  
17 this time.  
18 Q Okay. Is -- is there -- is there  
19 anything you would change or revise in the report at  
20 this time?  
21 A Yes, there are.  
22 Q Okay. Can you tell me what you would  
23 change or revise?  
24 A There is a table on page 9 of my report,  
25 Table 3.

Page 53

1 Q Uh-huh.  
2 A And you'll see it's a percentage of  
3 individuals by age category.  
4 Q Uh-huh.  
5 A And the age category between 18 and 40  
6 should say "55 percent" rather than "56 percent."  
7 Q Okay. Anything else that you would  
8 change or revise?  
9 A Not at this time.  
10 Q All right. Have you reviewed any  
11 materials not referenced in this report since you  
12 prepared this report?  
13 A No.  
14 Q Did you review any materials in preparing  
15 this report that are not specifically mentioned in  
16 the report?  
17 A I may have.  
18 Q So you may have reviewed documents other  
19 than what appear in the -- what appears in the  
20 bibliography and the database that you looked at and  
21 the attachments?  
22 A Yes.  
23 Q Can you think of any in particular at  
24 this time?  
25 A I -- I can't.

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1 Q Okay. Did you rely on those in any way?  
2 A I did not.  
3 Q Okay. So anything that's not in here  
4 you would not have relied on in reaching your  
5 opinion?  
6 A That's correct.  
7 THE COURT REPORTER: Can I just have  
8 one second?  
9 MR. DUPUIS: Yeah.  
10 (Thereupon, there was a discussion  
11 off the record.)  
12 BY MR. DUPUIS:  
13 Q Okay. All right. So you were hired as  
14 an expert witness in this case. Correct?  
15 A Correct.  
16 Q By -- by whom?  
17 A By Mr. Roth.  
18 Q Okay. What -- when were you contacted by  
19 Mr. Roth?  
20 A I don't remember exactly. It's been a  
21 month or two ago. More than a month ago.  
22 Q Did you enter into an agreement with the  
23 State of Wisconsin for the services that you're  
24 providing in this case?  
25 A We did.

15 (Pages 51 to 54)

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1 Q You didn't sign the contract. Is that  
2 correct?  
3 A I don't remember if I signed the contract  
4 or not.  
5 Q Okay.  
6 A Somebody at Milliman with signature  
7 authority signed the contract. It may have been  
8 me.  
9 Q Could it have been Daniel Skwire?  
10 A It could have been Danbury Skwire. Yes.  
11 Q If you didn't sign it, do you know why  
12 you didn't sign it?  
13 A So Daniel Skwire is the conduit for which  
14 we got this work. So the State of Wisconsin is his  
15 client, and he -- and I am working under his -- his  
16 contract, essentially.  
17 Q So Milliman -- did Milliman have a prior  
18 arrangement with State of Wisconsin --  
19 A Yes.  
20 Q -- before this case?  
21 A Yes.  
22 Q What was the nature of that arrangement?  
23 A To supply consulting work for benefit  
24 management for disability benefits. It -- it -- I  
25 think it was disability. It may have been Workers'

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1 Compensation, but I think it's disability.  
2 Q Is that work with the Department of  
3 Employee Trust Funds?  
4 A Yes. I'm reasonably sure it is. Yes.  
5 Q How -- do you know how long Milliman has  
6 had this a contract with the State of Wisconsin?  
7 A I do not.  
8 Q Do you know the value of that contract?  
9 A I do not.  
10 Q So who -- what is Mr. Skwire's position?  
11 A He's a consulting actuary.  
12 Q Did he have any role in the preparation  
13 of the expert report?  
14 A No.  
15 Q Did he review the expert report?  
16 A He did not.  
17 Q Did he provide any input to you at all in  
18 preparation of the contract -- of the --  
19 A He did not.  
20 Q -- of the -- the preparation of the  
21 report?  
22 A He did not.  
23 Q Who is Donna Wix?  
24 A Donna Wix is my employee. She works for  
25 me.

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1 Q Works for you at Milliman?  
2 A At Milliman.  
3 Q Okay. So she's a Milliman employee?  
4 A She's a Milliman employee.  
5 Q Okay. And what is her position?  
6 A She's a associate actuary.  
7 Q So she's passed the actuarial exams and  
8 all of that kind of thing?  
9 A She is an associate, which means ASA.  
10 ASA is a professional designation within the Society  
11 of Actuaries.  
12 Q And what does that designation  
13 designate?  
14 A It designates that she's passed a  
15 sufficient number of exams and profes- -- and passed  
16 the professional requirements to become an  
17 associate.  
18 Q Okay. What role did she have, if any, in  
19 preparing the report?  
20 A She initiated some of the work related to  
21 the report and gathered some of the preliminary data  
22 related to the benefit -- the description of the  
23 benefit.  
24 Q So when you say "initiated some of the  
25 work" regarding the description of the benefit, was

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1 that looking at the various health plans that had  
2 coverage for gender dysphoria treatments?  
3 A Yes.  
4 Q So that would have been, in this case,  
5 Dean Health Care and WPS?  
6 And what was the third?  
7 A I'll help you with that.  
8 Q Yes. Thank you.  
9 A There was a -- primarily, we used the  
10 Blue Cross Blue Shield of Massachusetts benefit  
11 design. We also reviewed several others including  
12 Dean -- Dean and WPS --  
13 Q Okay.  
14 A -- and -- and others. But we --  
15 ultimately, we, for the -- for our purpose, we used  
16 the Blue Cross Blue Shield of Massachusetts  
17 benefit.  
18 Q And was that primarily because it had a  
19 more comprehensive description of the CPT codes and  
20 other, sort of, billing codes --  
21 A Correct.  
22 Q -- that we -- okay. And you said she did  
23 some -- she initiated some other work. And I -- I'm  
24 not sure I -- I caught that.  
25 A So she started looking at our databases

16 (Pages 55 to 58)

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1 for individuals that had been identified as -- with  
2 a CPT -- with the diagnosis codes of gender  
3 dysphoria and started the preliminary data gathering  
4 in our databases for that.

5 Q So that in -- in the report, you mention  
6 the Truven database.

7 Were there other databases she looked  
8 at?

9 A We used the Truven database for this  
10 purpose.

11 Q Was there any other -- were there any  
12 other databases that she initially looked at?

13 A I don't know, but I don't think so.

14 Q So it's not like Truven was chosen from a  
15 number of other options? Or was it?

16 A Truven was chosen from another -- a  
17 number of other options.

18 Q And who made the decision to -- to use  
19 the Truven database?

20 A I did.

21 Q Okay. And what was the reason for using  
22 Truven?

23 A It was the most comprehensive database  
24 for this purpose that we had available.

25 Q Okay. So what -- what made it most --

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1 the most comprehensive?

2 Are you talking about just number of --  
3 number of beneficiaries, number -- I mean, what --  
4 what is it about it that comprehensive.

5 A It's really big. And it is a most  
6 representative of the ac- -- active employee  
7 population in the U.S.

8 Q Okay.

9 A The other criteria that I should mention  
10 is it's also the -- the best known; that is, it  
11 would resonate with -- with others that might be  
12 looking at this.

13 Q So she -- she was looking at ICD-9  
14 codes.

15 Was she also -- was she -- what other  
16 mechanism did she use to identify people with --

17 A Typically, that --

18 Q -- the diag- --

19 A -- answer is, No, she's using ICD-10.

20 Q Oh, sorry. Yes. It's 2016.

21 Were -- were there other means that -- so  
22 she was identifying individual employees or  
23 beneficiaries in this database who carried a  
24 diagnosis of gender dysphoria?

25 A Correct.

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1 Q And that was ascertained -- that  
2 diagnosis was ascertained either by ICD codes? Or  
3 were there other mechanisms by which that might be  
4 identified?

5 A So the first step was to identify  
6 individuals with the diagnosis code of F- -- F64 is  
7 the one we used.

8 Q Okay.

9 A And -- and -- and that is the primary  
10 way to identify the individuals that would be --  
11 that we would be looking at for -- for costing.

12 Q Okay. So there would not be DSM  
13 diagnoses in some separate data field.

14 This would have been looking pretty  
15 strictly at ICD codes?

16 A So that's a vague question. Can you be  
17 more specific?

18 Q In identifying the universe of people who  
19 carry the diagnosis of gender dysphoria, was  
20 there -- I mean, did this database have anything  
21 other than IC- -- the ICD code that would identify a  
22 person as having gender dysphoria?

23 A Not that I know of.

24 Q Okay. Isn't -- did Ms. Wix contribute to  
25 the writing of the report?

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1 A She reviewed a draft of it.

2 Q Who wrote the draft? Did she --

3 A I wrote the draft.

4 Q Did she make any changes to the draft  
5 based on her review?

6 A No.

7 Q Who is Tom Murawski?

8 A He's a consultant in our Hartford  
9 office.

10 Q Is he an actuary?

11 A Yup. Yes. A new actuary.

12 Q Was he an associate actuary until  
13 recently?

14 A He's an FSA, a Fellow of the Society of  
15 Actuaries.

16 Q And what role did he play, if any, in the  
17 preparation of this report?

18 A He also reviewed a draft.

19 Q Did he make any comments or changes?

20 A He would make comments, but no changes.

21 Q Did his comments lead you to make any  
22 changes?

23 A I don't recall. Whatever changes were  
24 made were my own decision.

25 Q Okay. Did he have any other role besides

17 (Pages 59 to 62)

Page 63

1 reviewing -- reviewing drafts?  
 2 A We discussed the -- the -- the concepts  
 3 and the project. And so he was a colleague in terms  
 4 of -- of discussing the -- the -- the benefits and  
 5 the -- any issues that we should talk about -- that  
 6 sort of discussion.  
 7 Q Did he have any prior experience at --  
 8 well, actually let me ask you this. Did -- did  
 9 Ms. Wix or Mr. Murawski have any prior experience in  
 10 the price -- estimating the pricing for benefits for  
 11 gender dysphoria treatment?  
 12 A I don't recall asking that question of  
 13 them specifically.  
 14 Q To your knowledge, did they have any?  
 15 A To my knowledge, they -- they did not.  
 16 Q Is there anyone else at Milliman who was  
 17 involved in the research or preparation of your  
 18 expert report?  
 19 A I -- I did have two other individuals  
 20 review the report.  
 21 Q Okay.  
 22 A One was Susan Philips [sic]?  
 23 Q And who is she?  
 24 A She is a consultant in our San Francisco  
 25 office.

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1 Q Is she an actuary?  
 2 A No.  
 3 Q Did she do anything besides review a  
 4 draft?  
 5 A No. We had discussions. But, no, she  
 6 didn't do anything further than that.  
 7 Q Did -- did she make any comments or  
 8 changes to the report?  
 9 A She made comments, but I -- again, I take  
 10 responsibility for any changes that were made in the  
 11 report.  
 12 Q Did you make any changes as a result of  
 13 her comments?  
 14 A I don't recall specifically.  
 15 Q Okay. You mentioned a section -- a  
 16 second person?  
 17 A Steve Kaczmarek.  
 18 Q Okay. Who is he?  
 19 A He's the -- he's the -- how do you  
 20 describe it? He's the principal of our office.  
 21 Q When -- when you say "our office," you  
 22 mean, the --  
 23 A The Hartford office.  
 24 Q Hartford office.  
 25 And what were his contributions to that?

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1 A He read the report for its -- just in  
 2 general. But he did not make any specific comments  
 3 or --  
 4 Q Okay. Is he an actuary?  
 5 A He is.  
 6 Q To your knowledge, did either -- either  
 7 Ms. Philips [sic] or Mr. Kaczmarek have any prior  
 8 experience with estimating the cost of benefits for  
 9 treatment of gender dysphoria?  
 10 A Yes.  
 11 Q Can you tell me that experience was?  
 12 A Susan Philips [sic] authored a report  
 13 that is posted on our website related to gender  
 14 dysphoria and its costs.  
 15 Q And that --  
 16 (Whereupon, the court reporter  
 17 requests clarification.)  
 18 THE WITNESS: To gender dysphoria  
 19 and its costs.  
 20 BY MR. DUPUIS:  
 21 Q Was that an article that she co-authored  
 22 with Andrew Naugle?  
 23 A Yes.  
 24 Q Who is Andrew Naugle?  
 25 A Andrew Naugle is a consultant in our

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1 Seattle office.  
 2 Q Is he an actuary?  
 3 A No.  
 4 Q Did he play any role, other than whatever  
 5 role this article that he wrote with Ms. Philip --  
 6 is it Philip or Philips [sic]?  
 7 A Philips [sic].  
 8 Q Philips [sic].  
 9 So there's an error in the -- on the  
 10 website, it appears?  
 11 A Well, it may be Philip, then. I may be  
 12 wrong.  
 13 Q Oh, okay. Did he have any role in  
 14 preparing the report that you did for this case?  
 15 A He's aware of the work that we were  
 16 doing. He's in senior -- a senior role now. And  
 17 one of his roles is to monitor any reports that are  
 18 likely to be made public, such as this.  
 19 So we had a discussion with him about  
 20 the nature of the -- of the -- of the client and  
 21 the work that we're doing. And he was the one that  
 22 al- -- that also worked with me to have Susan  
 23 review the report.  
 24 Q Okay.  
 25 A But otherwise, he did got participate in

18 (Pages 63 to 66)

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1 reading the report or in contributing in any way to  
 2 the -- to the development of the report.  
 3 Q So he did a review because it was going  
 4 to be made public? Or --  
 5 A He --  
 6 Q -- likely to be made public?  
 7 A -- he different review the report. He  
 8 just reviewed the -- the proposed work that we would  
 9 be doing.  
 10 Q Okay. So you mentioned that Mr. Skwire  
 11 is a -- is a consultant to the State of Wisconsin.  
 12 Are there any other -- does Milliman have  
 13 any other contracts with the State of Wisconsin that  
 14 you're aware of, besides the ones that he's involved  
 15 in and this one?  
 16 A I'm not aware of any, but I haven't done  
 17 an exhaustive search to look.  
 18 Q Earlier you mentioned that anything that  
 19 is -- any report that's likely to become public,  
 20 gets a quote/unquote peer review, maybe, if we can  
 21 call it --  
 22 A Uh-huh.  
 23 Q -- by someone at another Milliman  
 24 office?  
 25 A Uh-huh.

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1 Q Who -- who did that in this case?  
 2 A Ms. Philips [sic] -- Ms. Philip,  
 3 apparently.  
 4 Q Do you know how much time she spent  
 5 reviewing the -- the report?  
 6 A I don't off the top of by head.  
 7 Q Do you know when you sent it to her,  
 8 roughly, in relation to when it was finalized for  
 9 the State?  
 10 A Probably a week to 10 days before --  
 11 well, it was probably before that. It was probably  
 12 two weeks before it was finalized -- two or three  
 13 weeks.  
 14 But my -- my memory is vague, though, so  
 15 I may be off on that.  
 16 Q Did you follow the Actuarial Standards Of  
 17 Practice in preparing this report?  
 18 A That's -- that's a good question.  
 19 Generally, our work follows the Actuarial Standards  
 20 Of Practice as required by our work product review  
 21 cycles.  
 22 I'm not an actuary, and I'm not subject  
 23 to the Actuarial Standards Of Practice. But I am  
 24 subject to Milliman's guidelines and review  
 25 requirements for our work, which generally follow

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1 the Actuarial Standards Of Practice.  
 2 Q Can you identify which actuarial  
 3 standards would apply to this work?  
 4 A I can't off the top of my head.  
 5 Q Aside from Milliman's internal  
 6 procedures, are there other standards of practice  
 7 that apply to you as a consultant?  
 8 A I -- no. Not that I'm aware of.  
 9 Q Did you review the expert reports --  
 10 plaintiff's expert reports in this case?  
 11 A The -- can you be more specific?  
 12 Q Yeah. So I -- I gathered from the report  
 13 that you reviewed Dr. Budge's --  
 14 A Oh, his --  
 15 Q -- expert report?  
 16 A -- I did. Yes.  
 17 Q Okay.  
 18 A Well, I reviewed the section in his  
 19 report related to the cost effectiveness analysis.  
 20 Q Okay.  
 21 A Beyond that, I didn't read a lot.  
 22 Q Okay. Do you know Dr. Budge?  
 23 A I do not.  
 24 Q Other than your comments in your report  
 25 about the the cost effectiveness, do you have any

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1 opinions about the quality of her work?  
 2 A I do not.  
 3 Q Okay. Did you review any rebuttal  
 4 reports?  
 5 A I reviewed a report by -- to a Segal --  
 6 no. To Axene consultants.  
 7 Q Okay. Do you know -- do you know Joan  
 8 Barrett?  
 9 A I do not.  
 10 Q Okay. Do you know --  
 11 MS. KADRI KEELER: Elaine.  
 12 BY MR. DUPUIS:  
 13 Q -- Elaine --  
 14 MS. KADRI KEELER: Corrough.  
 15 MR. DUPUIS: I'm sorry?  
 16 MS. KADRI KEELER: Corrough.  
 17 BY MR. DUPUIS:  
 18 Q Corrough?  
 19 MR. DUPUIS: Thank you.  
 20 A I do not.  
 21 BY MR. DUPUIS:  
 22 Q Are you familiar with Axene?  
 23 A I am.  
 24 Q Okay. What do you know about them?  
 25 A Well, I -- I have met David Axene.

19 (Pages 67 to 70)

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1 Q Okay.

2 A But it's been a long time. David used to  
3 work for Milliman.

4 Q Okay. Do you know why he left Milliman?

5 A I don't.

6 Q Do you know anything about Axene's  
7 reputation?

8 A That's a large -- big question. Can you  
9 be more specific?

10 Q Yeah. Their reputation as consultants  
11 and actuaries?

12 A So David has been always -- as far as I  
13 know, has been well-respected in the actuarial  
14 community. He was one of the cofounders, for  
15 instance, of the Milliman Care Guidelines a long  
16 time ago, which became very used extensively in the  
17 marketplace. But other than that, I don't have a  
18 any knowledge about his reputation.

19 Q Okay. Do you have any reason to question  
20 Ms. Barrett's expertise in pricing health care  
21 benefits?

22 A I don't at this time. No.

23 Q Okay. Were you aware that she's been on  
24 committees of the Actuarial Standards Board?

25 A I was unaware of that.

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1 Q Did you review the rebuttal report of  
2 Loren Schechter by any chance.

3 A I don't recall that report.

4 Q Okay. You're not an expert on medical  
5 necessity of treatments?

6 A I am not.

7 Q Or their safety or efficacy?

8 A I am not.

9 Q Okay. Including procedures for services  
10 related to treatment of gender dysphoria?

11 A I'm not an expert in that field.

12 Q Okay. Was there anything in Ms.  
13 Barrett's report that you disagreed with?

14 A Not at this time.

15 Q All right. When you say "not at this  
16 time," what do you mean?

17 A There are parts that I would like to  
18 understand better.

19 Q Okay. Can you -- let's mark that.  
20 (Whereupon, Plaintiff's Exhibit  
21 Williams No. 3, Expert Report by  
22 Joan Barrett and Elaine Corrough,  
23 was marked for identification.)  
24 MR. DUPUIS: Thank you.  
25 THE COURT REPORTER: You're

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1 welcome.

2 BY MR. DUPUIS:

3 Q I'm showing you what's been marked as  
4 Exhibit 3. Do you recognize that document?

5 A Yes, I do.

6 Q And what is it?

7 A This is the expert report for Joan Bart  
8 before and Elaine Corrough.

9 Q And can you identify the parts you'd like  
10 to understand more?

11 A Just a minute. There's -- there's one  
12 paragraph that I would like to under- -- I'd like to  
13 understand the table found on page 6.

14 Q Okay. And what about the table?

15 A She made some assumptions in -- in -- in  
16 producing this table based -- which are -- parts of  
17 it are based on my report.

18 Q Okay.

19 A And I'd -- and I would like to  
20 understand her -- what she was considering when she  
21 produced this table. And there are a couple of  
22 components in there I'd like to understand better.

23 Q So are there -- could you identify the  
24 specific components?

25 A I believe she made an assumption about

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1 the nonsurgical patients and their categories and  
2 their costs that I may or may not agree with as she  
3 produced those.

4 Q Okay. Can you say what the difference is  
5 between -- or what the assumptions are that you  
6 think she's making that you may or may not agree  
7 with?

8 A So it appears to me that she did a simple  
9 subtraction between the two. And I am not positive  
10 that that is a -- that if you were to look at the  
11 data specifically, that we would end up with the  
12 same result.

13 Q She sim- -- simple subtraction of what  
14 from what?

15 A She took all patients -- so the  
16 bottom --

17 Q Uh-huh.

18 A -- section there. And she took the  
19 surgical patients, which are the two tables that I  
20 have.

21 Q Right.

22 A And then, she subtracted to come up with  
23 the nonsurgical patients.

24 Q Okay. And you don't think that the --  
25 that that's an appropriate --

20 (Pages 71 to 74)

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1 A I don't know yet.  
 2 Q You don't know yet.  
 3 What would you need to know to know  
 4 that?  
 5 A I would need to review my data relate --  
 6 related to what she did --  
 7 Q Okay.  
 8 A -- to verify that that is indeed  
 9 correct.  
 10 Q Okay. When did you first see this  
 11 report?  
 12 A Oh --  
 13 Q It -- well, I'm sorry. The Exhibit 3.  
 14 A I -- shortly after it came out.  
 15 Q Okay.  
 16 A Shortly after Mr. Roth received it.  
 17 But --  
 18 Q Okay.  
 19 A -- I don't remember the exact date.  
 20 Q Okay. So you've not had a chance to  
 21 determine whether simply subtracting surgical  
 22 patients from all patients --  
 23 A No.  
 24 Q -- is, in your view, an appropriate way  
 25 to determine the per member per month cost for

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1 nonsurgical patients?  
 2 A Right.  
 3 Q Okay.  
 4 A Also, on page 7 --  
 5 Q Uh-huh.  
 6 A -- there is a bullet -- a third bullet in  
 7 the review --  
 8 Q Uh-huh.  
 9 A -- where she discusses the -- my comments  
 10 on Dr. Budge's report.  
 11 She makes the statement at the end of  
 12 that bullet that based on that, we assume savings  
 13 exist, even though they can not be quantified  
 14 precisely. And I would need to understand that  
 15 question better before I would be able to agree with  
 16 it.  
 17 Q Okay. But you don't -- at this point,  
 18 don't disagree with it. You just don't --  
 19 A I don't know that I agree with it. But I  
 20 can't say that I disagree with it yet either.  
 21 Q And what would you need to know in order  
 22 to say whether you disagree with it?  
 23 A I would need to have her point out the  
 24 point -- points of the study that led her to believe  
 25 that.

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1 Q Okay.  
 2 A Need more specifics.  
 3 Q Anything else?  
 4 A She makes a statement, also, on page 7,  
 5 at the very bottom under "Final Estimate of  
 6 Materiality" --  
 7 Q Uh-huh.  
 8 A -- she states, "Although we agree that  
 9 Mr. Williams' best estimate is appropriate, we  
 10 believe his risk premium represents a worst case  
 11 scenario, as opposed to a more reasonable  
 12 scenario."  
 13 And I don't understand her definition  
 14 completely of what a "reasonable scenario" would be  
 15 to make that assessment.  
 16 Q Well, what -- what additional  
 17 information would you need to know in order to  
 18 determine whether you agree with that or don't  
 19 agree with all that?  
 20 A Well, I would like her explain more  
 21 about what her -- in her -- what, in her opinion,  
 22 "reasonable scenario" would mean.  
 23 Q Okay. So you don't view the discussion  
 24 on page 8 of risk premium and final estimate is  
 25 sufficiently laying out her reasoning for you to

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1 make a determination of whether you agree with her  
 2 or not?  
 3 A Correct.  
 4 Q Okay.  
 5 A She does give some sup- -- you know,  
 6 what she sees as some support here. About mid page  
 7 where it says, "The" -- "There were two factors  
 8 supporting the recommended" -- "recommended  
 9 margin."  
 10 Q Uh-huh.  
 11 A Let me just finish reading this before I  
 12 continue.  
 13 So I -- I may not be able to completely  
 14 agree with that statement. I think there are some  
 15 contradictions in there. And there are some  
 16 statements that need further clarification for me to  
 17 be able to support it. For example --  
 18 Q When you say "that" -- "that  
 19 statement" --  
 20 MR. ROTH: Can you let -- please let  
 21 the witness finish. He said "for  
 22 example."  
 23 A Yeah. So let me give you -- let me give  
 24 you a couple of -- are we okay?  
 25

21 (Pages 75 to 78)

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1 BY MR. DUPUIS:

2 Q Yeah. I'd jus like to ask, Are we  
3 talking about the statement in that paragraph that  
4 we're --

5 A Taking --

6 Q -- talking about?

7 A -- so let -- we're going to consider this  
8 paragraph in total.

9 Q Okay.

10 A So I'm going to make a couple of comments  
11 about the -- the paragraph.

12 So for example, "We expect to see a  
13 steady growth over time" -- mid -- mid paragraph.

14 Q Uh-huh.

15 A -- "but not a doubling of the number of  
16 surgeries."

17 So I'd kind of like to understand what  
18 their expectations of the future are related to  
19 where we've been in the past, and also in  
20 relationship to the current published studies and  
21 the current understanding of benefits as derived  
22 from health claims data, for example. So I -- I  
23 think there's further explanation that can be made  
24 there.

25 Second, "In our experience, there's a

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1 materiality. I think she describes -- I think some  
2 of the words that she uses to describe the -- the  
3 increases that we have -- words like "trickling"  
4 and things of that nature are, while technically  
5 correct, may be overstating her -- potentially  
6 overstating her -- her rebuttal.

7 But again, I think that there's some  
8 more to be discussed there.

9 Q So --

10 A Let me -- let me --

11 Q Go ahead.

12 A -- try to be more specific.

13 Q Okay. Thank you.

14 A Since I was being vague.

15 So that -- regardless, there would be no  
16 way to validate the accuracy of a projection of a  
17 cost at or below this threshold after the fact.  
18 Because normal variance for a group the size of  
19 this state is between three and five percent based  
20 on our experience. That statement I just don't  
21 understand. I think that needs clarification.

22 Then, it goes, "For the state plan, this  
23 .1 percent materiality level translates to the  
24 2016 PMPM of 50 cents or more than triple.  
25 Mr. Williams' final estimate of .5 are more than

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1 natural tendency to overstate the cost of the  
2 benefit when it is relatively new, since there is  
3 so little known about cost and utilization  
4 initially."

5 And then, she states, "Employers have  
6 been offering this benefit for over a decade now.  
7 So there is no need to be overly cautious."

8 I'm not sure I'd agree with that last  
9 statement completely.

10 Q Okay. Well --

11 A Whether there are some employers that may  
12 have been offering it, I don't know that there's  
13 been enough experience to be able to make that  
14 statement in total.

15 Q Okay. So you're disagreeing with her  
16 judgement there or not sure you agree with her  
17 judgment?

18 A Well, I'm not sure I agree with her  
19 judgment. I would like to see more information.

20 I -- it feels like this was not --  
21 there's no footnotes or sources cited for these  
22 statements. I'd like to understand more about what  
23 she's thinking.

24 Q Okay. Anything else?

25 A We could discuss further on the

Page 82

1 five times of our estimate of .09. and more than  
2 seven times are mutual best estimate of .07."

3 But in this paragraph, she's trying  
4 to -- I think she's making an assumption that we're  
5 trying to price -- we're trying to somehow put a  
6 judgment on the total cost of benefits for the  
7 entire plan. And then -- and then -- but the  
8 exercise here is really to address the cost of  
9 benefits for those that have -- are anticipating a  
10 surgical benefit for gender dysphoria.

11 And so while there may be a relationship  
12 to the overall cost of the plan, the real purpose of  
13 the exercise is to look at the costs that are  
14 specific to those individuals, and the costs of the  
15 state are related to that.

16 And she -- she dismisses those costs in  
17 relationship to the entire amount. But they -- that  
18 may not be -- that may not be the appropriate way to  
19 judge --

20 Q What would --

21 A -- the -- the -- the costs.

22 Q -- what would be the appropriate way to  
23 judge the materiality of the cost of a benefit?

24 MR. ROTH: Ob- -- objection.

25 Vague.

22 (Pages 79 to 82)

Page 83

1 A That's not really for me to decide.  
2 That's really for the -- that's really for the  
3 fiduciaries of the state or whoever's taking the  
4 risk to decide that.

5 Our job is to -- or my job is to produce  
6 what the cost would be. And if that's material,  
7 that would be for them to -- them to decide.

8 BY MR. DUPUIS:

9 Q So would -- would you say there's no  
10 definition of materiality that would -- that  
11 actuaries would generally apply in a situation like  
12 this?

13 MR. ROTH: Objection. Vague.

14 A I don't know of standards specific to  
15 materiality. There may be. But in terms of whether  
16 or not to add a benefit, I think that those are  
17 fiduciary decisions that need to be made by those  
18 that are taking the risk and expected to pay the  
19 costs.

20 BY MR. DUPUIS:

21 Q Are you aware of any entity, employer,  
22 insurance company -- whatever -- that has decided  
23 to not include a benefit solely because of cost  
24 when its cost was less than .1 percent of total per  
25 month -- per member per member costs?

Page 84

1 MR. ROTH: Objection. Vague.  
2 You can answer.

3 A I have seen employers scrutinize costs at  
4 this amount or less very, very carefully before they  
5 decide how and if they are going to provide the  
6 benefit.

7 BY MR. DUPUIS:

8 Q Can you give examples?

9 A I can. There was a bargaining situation  
10 where we scrutinized 200,000-dollar or 300,000-  
11 400,000-dollar benefits very, very carefully. And  
12 in some cases, in small components of it, we spent  
13 \$50,000 analyzing a 20,000-dollar increase to see  
14 whether or not they wanted to add that benefit or  
15 not because of the added expenses to the plan.

16 Q How -- how large a plan is that?

17 A It was a 1.3-billion-dollar plan.

18 Q Is that a state employer?

19 A Yes.

20 Q Okay. Did they end up covering the  
21 benefit?

22 A They ended up covering some of them, but  
23 not all of them.

24 Q Well, can you give me the -- the -- can  
25 you describe what the benefit was?

Page 85

1 A Yeah. Those -- those are related to  
2 dental benefits. But --

3 Q And the dental benefit was 1.1 --

4 A The dental --

5 Q -- billion?

6 A -- benefit was not that amount. But the  
7 total spend of the benefits, in general, for the  
8 plan. Actually, it's probably a little more than  
9 that. But --

10 Q Do you know what this -- the dental  
11 benefit was?

12 A No. I don't recall exactly what the  
13 dental benefit was.

14 Q Can you think of another -- any other  
15 examples where a benefit at this level re- --  
16 received that level of scrutiny?

17 A In terms of adding a new benefit, I  
18 can't recall any directly. But I will tell you  
19 that, as part of our role as -- as actuaries and  
20 consultants for these groups, we frequently monitor  
21 and point out areas that -- where it -- a benefit  
22 may be increasing beyond what their budget amount  
23 was down to the 200,000-, 300,000-dollar levels.

24 And in many cases, they will consider  
25 modifying the benefit in order to put those --

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1 put -- keep those costs under control. So that  
2 it's -- it's a fiduciary responsibility to monitor  
3 all the aspects of the benefit and to -- and our  
4 job is to point out where those increases are  
5 occurring.

6 And it's their job to decide whether or  
7 not they want to maintain that benefit and -- or  
8 whether they want -- and pay for it -- or whether  
9 they want to introduce changes to the benefit that  
10 will keep those costs under control.

11 Q And again, was that -- those examples  
12 that you gave of a hundred-thousand-, 200,000-  
13 300,000-dollar benefits in the context of large  
14 plans the size of the State of Wisconsin?

15 A Yes.

16 MR. ROTH: You were reviewing the  
17 report. Are you finished reading through  
18 it and noting it?

19 I just want to make sure.

20 MR. DUPUIS: Yup.

21 MR. ROTH: I think the answer's  
22 yes, but I just want to make sure.

23 A I think I'm at the end of the report, and  
24 I have no further comments --  
25

23 (Pages 83 to 86)

Page 87

1 BY MR. DUPUIS:  
 2 Q Okay.  
 3 A -- at this time.  
 4 Q Did you --  
 5 THE WITNESS: Before -- before --  
 6 MR. DUPUIS: Oh, go ahead.  
 7 THE WITNESS: -- before you start  
 8 that question, is it appropriate to take  
 9 a 10-minute break?  
 10 MR. ROTH: Oh, sure.  
 11 MR. DUPUIS: It's perfectly  
 12 acceptable to take a 10-minute break.  
 13 (Whereupon, there was a recess taken  
 14 from 2:54 p.m. to 3:01 p.m.)  
 15 MR. DUPUIS: Back on.  
 16 BY MR. DUPUIS:  
 17 Q So actually, I don't remember exactly  
 18 where we were. But we had just -- I know we had  
 19 just finished talking about the Barrett report.  
 20 So I'd like to go through your -- the  
 21 bibliography for this report of yours, which is  
 22 Exhibit 2. And some of these I'm going to show you  
 23 the document. Others, I'm just going to ask more  
 24 generally what -- how -- how they played into your  
 25 analysis and report.

Page 88

1 So the -- the APA Diagnostic and  
 2 Statistical Manual of Mental Disorders, what role  
 3 did that play in your -- in your report?  
 4 A That just helps us to understand the --  
 5 the diagnosis codes that we were using to verify  
 6 that those were the codes that were likely to find  
 7 the individuals that we were looking for.  
 8 Q So in the DSM actually include -- include  
 9 diagnostic codes? Do you recall?  
 10 A Oh, the DSM?  
 11 Q Yup. Well -- yup.  
 12 A Yes, it does.  
 13 Q And was it -- were they the diagnostic  
 14 codes that you used to search the database?  
 15 A Yeah.  
 16 Q Okay.  
 17 A So that -- so there is a relationship  
 18 between what DSM -- there's a crosswalk,  
 19 basically --  
 20 Q Okay.  
 21 A -- of what DSM produces and what is found  
 22 in the ICD --  
 23 Q Okay.  
 24 A -- world nine and 10. I think they are  
 25 now reflecting 10 in the newest DSM manual.

Page 89

1 Q Okay.  
 2 A So yes. In addition, I also used that to  
 3 check the utilization. There's a -- a small  
 4 section, I believe, I cite. It talks about the  
 5 expected utilization.  
 6 Q Is it actually utilization, or is  
 7 more --  
 8 A You -- you would think of it as  
 9 prevalence or incidence. Yeah.  
 10 Q Okay. And for you, you would have  
 11 been -- I -- I -- your report makes pretty clear  
 12 that you understand that not all people who have  
 13 gender dysphoria -- I -- or who are transgender have  
 14 gender dysphoria?  
 15 A Right. Right.  
 16 Q And not all people who have gender  
 17 dysphoria seek or need particular treatments  
 18 that --  
 19 A Absolutely.  
 20 Q Okay.  
 21 A Yes. I understand that well.  
 22 Q So when you say there's a bridge, is it  
 23 actually in the DSM that it identifies the -- oh,  
 24 I -- it -- okay. So let me give you --  
 25 A The exhibit to look at. I don't --

Page 90

1 Q Yeah.  
 2 A -- have anything to look at.  
 3 Q I think I found it.  
 4 A Yeah. If you're asking me --  
 5 Q So this -- do you want to --  
 6 A Label that?  
 7 Q Yup.  
 8 MR. DUPUIS: Sorry. I think we're  
 9 up to Exhibit 4.  
 10 I could just do it.  
 11 THE COURT REPORTER: Thank you.  
 12 (Whereupon, Plaintiff's Exhibit  
 13 Williams No. 4, Chapter on Gender  
 14 Dysphoria, was marked for  
 15 identification.)  
 16 BY MR. DUPUIS:  
 17 Q All right. Showing you what's been  
 18 marked as Exhibit 4. And I'll represent to you that  
 19 this is just the chapter on gender dysphoria.  
 20 Can you identify where in there --  
 21 A Yeah.  
 22 Q -- it bridges to the ICD --  
 23 A So if --  
 24 Q -- codes?  
 25 A -- you start looking at page 4 -- or

24 (Pages 87 to 90)

Page 91	Page 93
<p>1 459, counting the last page here --</p> <p>2 Q Uh-huh.</p> <p>3 A -- where it has the -- the "Other</p> <p>4 specified gender dysphoria, 302.6" --</p> <p>5 Q Uh-huh.</p> <p>6 A -- and the F64.8 --</p> <p>7 Q Uh-huh.</p> <p>8 A -- so we're using -- the F64.8 refers</p> <p>9 back to the ICD 10 codes.</p> <p>10 Q Okay. And 302 is the number in -- is the</p> <p>11 DSM --</p> <p>12 A It's the --</p> <p>13 Q -- number?</p> <p>14 A -- DSM. Yeah.</p> <p>15 Q Okay.</p> <p>16 A But the other piece of it that we used</p> <p>17 this for was un- -- under the prevalence section on</p> <p>18 page 454 --</p> <p>19 Q Correct.</p> <p>20 A -- that paragraph that talks a little bit</p> <p>21 about it, we reviewed that.</p> <p>22 Q And ultimately, your opinions, do they</p> <p>23 depend, in any way, on underlying prevalence of</p> <p>24 transgender identity or even prevalence of gender</p> <p>25 dysphoria?</p>	<p>1 we were presenting.</p> <p>2 And so I spent a fair amount of time</p> <p>3 reviewing the various litera- -- pieces of</p> <p>4 literature that talked about it and tried to</p> <p>5 triangulate that with what was happening in the</p> <p>6 database to see what was happening.</p> <p>7 This is the first time in my review that</p> <p>8 I've seen database work being relied on for costing</p> <p>9 this benefit. And so there was some question as to</p> <p>10 whether -- in my mind, as to whether or not the</p> <p>11 former studies that were used a lot in some other</p> <p>12 pricing exercises were -- if -- if it was</p> <p>13 reasonable to rely on the database as opposed to</p> <p>14 some of the other studies and some of the other</p> <p>15 costing exercises that I had seen done.</p> <p>16 So I spent a fair amount of time just</p> <p>17 reviewing the literature and the various sources of</p> <p>18 those literature and reasons why they might differ</p> <p>19 from the database number that we were seeing.</p> <p>20 Q Okay. And -- and ultimately, though, you</p> <p>21 concluded that the database number was the number</p> <p>22 you were going to use --</p> <p>23 A To use --</p> <p>24 Q -- rather than some other --</p> <p>25 A Correct. Correct.</p>
<p>Page 92</p> <p>1 A Ultimately, no. We -- we reviewed</p> <p>2 the -- as -- as mentioned in my report, we reviewed</p> <p>3 the incidence on prevalence studies that have been</p> <p>4 done.</p> <p>5 But ultimately, we decided and we relied</p> <p>6 on what was in the database in terms of what was</p> <p>7 actually appearing for people that were seeking</p> <p>8 treatment to inform us in our opinion.</p> <p>9 Q So you ultimately depended on claims.</p> <p>10 Not --</p> <p>11 A That's correct.</p> <p>12 Q -- not prevalence --</p> <p>13 A Yes.</p> <p>14 Q -- of disorder?</p> <p>15 A But we did spend a -- I did spend a fair</p> <p>16 amount of time reviewing the -- the literature that</p> <p>17 talked about incidence and prevalence.</p> <p>18 Q Is there a reason you did that?</p> <p>19 A Yes. So -- so -- the -- the -- the two</p> <p>20 components of the -- of the formula are utilization</p> <p>21 and average cost.</p> <p>22 And I wanted to be sure that -- in -- in</p> <p>23 reviewing some of the other reports that I had</p> <p>24 seen, I wanted to be sure that we were in a</p> <p>25 reasonable range of expectation in the numbers that</p>	<p>Page 94</p> <p>1 Q -- u- -- u- -- estimate of utilization?</p> <p>2 A Correct.</p> <p>3 Q Okay.</p> <p>4 A That was the reason for the report as --</p> <p>5 as you went through and some the, kind of, the</p> <p>6 evolution of the thinking I did in the report.</p> <p>7 Q Okay. So -- so the idea was just to,</p> <p>8 sort of, make sure that what you were seeing in the</p> <p>9 database that -- wasn't, itself, an outlier --</p> <p>10 A Correct.</p> <p>11 Q -- or could be explained in ways that are</p> <p>12 consistent with prior research?</p> <p>13 A That's a good way to describe it. Yes.</p> <p>14 Q Okay. Okay. The second one is a chapter</p> <p>15 from a -- a book, I believe, estimating medical</p> <p>16 claims costs --</p> <p>17 A Uh-huh.</p> <p>18 Q -- written by D. D. Skwire. Is that</p> <p>19 your --</p> <p>20 A That's Dan Skwire.</p> <p>21 Q All right. So you --</p> <p>22 A But he's the editor. Not the -- not</p> <p>23 the -- he's the principle editor.</p> <p>24 Q But not the author of that particular --</p> <p>25 A Chapter. That's --</p>

Page 95

1 Q -- chapter?  
 2 A -- correct.  
 3 Q Okay. Do you know any of those authors,  
 4 by any chance?  
 5 A I do not.  
 6 Q Okay. And how -- how did that factor  
 7 into your work?  
 8 I'm not going to show you that one,  
 9 because we could not find it.  
 10 A That is a standard text for actuaries in  
 11 pricing benefits. And it was the chapter that most  
 12 related to the works that we were doing in this  
 13 instance.  
 14 And so I cited that -- that chapter. And  
 15 I used it in the beginning to describe the -- the  
 16 steps that you would go through to -- to price the  
 17 benefit.  
 18 Q Uh-huh. And so those steps being the  
 19 steps that you describe in summary version on page  
 20 4?  
 21 A Correct.  
 22 Q Okay.  
 23 A Yeah. And this is a summary version of  
 24 what is found in the text.  
 25 Q Chapter -- the text --

Page 96

1 A Chap- -- chapter --  
 2 Q -- in chapter --  
 3 A -- three. You got it.  
 4 Q Okay. Did you write this or did an  
 5 actuary write this part of the --  
 6 A I wrote it.  
 7 Q Okay. Okay. So did write the original  
 8 draft of the report?  
 9 A I did.  
 10 Q Okay. Did anybody else contribute to the  
 11 original draft? Any sections that were written by  
 12 somebody else?  
 13 A I wrote it.  
 14 Q Okay. Back to the bibliography. The  
 15 third cited article is a -- Grant, et al.,  
 16 "Injustice at Every Turn."  
 17 This one, I did not make copies of  
 18 because it's a 288-page --  
 19 A Okay. Un- --  
 20 Q -- document.  
 21 A -- understood.  
 22 Q And -- but it did not appear to be  
 23 actually cited at any point in the reports. I'm  
 24 wondering what -- how -- how this may have played a  
 25 role in your thinking?

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1 A I read it, more or less, from cover to  
 2 cover for two reasons. One is to search for  
 3 elements of prevalence and incidence, but also to  
 4 understand the nature of transgender -- the  
 5 experiences of transgender individuals, and if that  
 6 would inform me in what -- in the information that  
 7 I was looking at in the databases we were  
 8 examining.  
 9 So this is background information,  
 10 primarily.  
 11 Q Okay. Did you find anything that  
 12 actually led to a -- a -- any particular conclusions  
 13 or altered your thinking in any way?  
 14 A I don't --  
 15 Q Yeah.  
 16 A -- think so. But it was informative.  
 17 Q Okay. Do you know any transgender  
 18 people?  
 19 A I -- I don't know.  
 20 Q Okay.  
 21 A None that I'm aware of.  
 22 Q Okay. The next is the Naugle and Philip  
 23 report --  
 24 A Yeah.  
 25 Q -- which we had already talked about.

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1 And I think it's here.  
 2 MR. DUPUIS: I -- let's it mark  
 3 now.  
 4 (Whereupon, Plaintiff's Exhibit  
 5 Williams No. 5, Milliman White  
 6 Paper, was marked for  
 7 identification.)  
 8 BY MR. DUPUIS:  
 9 Q Showing you what's -- what's been marked  
 10 as Exhibit 5 --  
 11 MR. DUPUIS: And each of you gets a  
 12 pink staple. Lucky you.  
 13 BY MR. DUPUIS:  
 14 Q So can you explain how -- well, ac- --  
 15 actually, can you describe, sort of, what this  
 16 document is and how it came to be prepared, if you  
 17 know?  
 18 A So Milliman frequently publishes you  
 19 might call them white papers or research on various  
 20 topics of interest, either that some actuaries are  
 21 currently participating in or are interested in --  
 22 in understanding.  
 23 And then, they get published and get put  
 24 on our website. This is one of those papers. And  
 25 this paper had information in it similar to what we

26 (Pages 95 to 98)

<p style="text-align: right;">Page 99</p> <p>1 were interested in exploring.  2 So I -- I used this as a reference  3 document. The primary thing that it helps me with  4 is to understand part of the evolution of -- of  5 claims data and the use of claims data between 2014  6 and 2016.  7 And 2012 is the database that they  8 ultimately were ini- -- initially -- and they may  9 not have referenced that. But it -- it talked to  10 evolution of the claims data between 2012 and  11 2016.  12 Q And -- and what -- what conclusions did  13 you draw from that -- from their as- -- assessment  14 of the -- of the trends.  15 A That it -- so it helps me to understand  16 that information that was being used in 2012, -13,  17 perhaps 14, had limited -- we'll call it  18 credibility -- limited confidence in what you were  19 looking at in terms of -- of being used.  20 And so there's a lot -- what it  21 informed me is that in past studies, there's a lot  22 of uncertainty about -- about the costing of the  23 benefits and -- and how much things would cost.  24 Q And where -- where in this report does  25 that come out, as opposed to -- I mean, I -- I -- I</p>	<p style="text-align: right;">Page 101</p> <p>1 "For now, however, self-reported  2 information provides the most credible view of  3 prevalence."  4 So this was written --  5 Q Mid 2016?  6 A Yeah. But the -- the databases that they  7 had to review from were 20- -- were 2012.  8 Q Okay. And so they -- they reviewed which  9 databases? Do you know?  10 A Oh --  11 Q Looks like a Medicaid database?  12 A They reviewed a Medicaid database. And  13 I -- I don't know if it was --  14 Q Maybe it's Medicare.  15 A I don't know. They -- they did -- they  16 also reviewed a Medicare database. And they -- I do  17 know -- let's see if I can find that -- find the  18 list of questions.  19 Yeah. I don't think it states it  20 specifically. And -- and it may not. But they --  21 I know that they had also looked at the Truven  22 database to see if there was anything in there.  23 Q Okay. So -- so this where they say it's  24 a -- a challenge for health insurers attempting to  25 estimate costs because of a lack of claims-based</p>
<p style="text-align: right;">Page 100</p> <p>1 saw that -- a fair amount about the difficulty of  2 assessing the prevalence and incidence.  3 But I didn't see a lot about the cost of  4 particular services being --  5 A Yes.  6 Q -- unpredictable.  7 A And they didn't say a lot. So there's a  8 couple of things. "Currently, lack of claims-based  9 data is a challenge..." This is on page --  10 sorry -- page 2 of 9.  11 Q Uh-huh.  12 A So flip it back and --  13 Q Uh-huh.  14 A -- just -- the paragraph just before  15 the bolded area of "Healthcare use of services..."  16 Q Uh-huh.  17 A "Currently, lack of claims-based data is  18 a challenge for health services attempting to  19 estimate costs.  20 "However, the credibility of claims-based  21 sources to better understand the prevalence of  22 gender dysphoria and for related utilization and  23 cost studies will improve over time, especially as  24 health insurers begin to provide coverage for  25 related healthcare services.</p>	<p style="text-align: right;">Page 102</p> <p>1 data, it -- it -- they're not -- they're -- I -- I  2 don't see a, sort of, specific citation to what --  3 you know, why they're saying that.  4 Is it -- is -- is -- is there something  5 in here that you could point to that --  6 A So refer to the -- so back to the  7 sentence I just read --  8 Q Yup.  9 A -- I don't see anything that they're  10 referencing. I -- I -- this is based on their  11 experience.  12 Susan works in San Francisco, and she  13 has had -- and I think the City of San Francisco's  14 one of her clients.  15 She has a particular -- a professional  16 interest in the -- in the treatment and the -- the  17 cost of benefits for transgender individuals and  18 has likely -- I don't know this for a fact -- but  19 has likely done a fair amount of thinking about --  20 about what's available and what's not available.  21 And this is her reflections on -- on the -- kind  22 of, the state of the world and the cost of these  23 benefits.  24 Q And the City of San Francisco covers  25 treatments for gender dysphoria for its employees.</p>

Page 103

1 Correct?

2 A It does. And as I understand it -- I  
3 may be incorrect on this -- but I understand they  
4 were the first government entity to do so.

5 Q Do you know anything about their cost  
6 data?

7 A So there are things flowing around in my  
8 head from things that I have read and reviewed in  
9 the past.

10 They attempted to cost it, but had  
11 similar kinds of -- of issues in finding, you  
12 know, lack of really good data about how much  
13 things cost and how much they expect the  
14 utilization to be there was a and I believe  
15 there's a -- a hint of this in -- in some of the  
16 information that we reviewed today, that they put  
17 a -- a risk premium on it that ultimately, as  
18 their experience worked out, didn't turn out to be  
19 as high as what they originally put on there.

20 Q So I -- so the --

21 A That was said -- said poorly. But --

22 Q So -- so that their -- their actual  
23 costs ended up being well below the risk premium?

24 A So well- --

25 MR. ROTH: Objection. Vague.

Page 104

1 A -- well below --

2 MR. ROTH: You can --

3 A -- well below --

4 MR. ROTH: -- answer.

5 A -- is not well-defined here. So I can't  
6 make that statement.

7 BY MR. DUPUIS:

8 Q It -- well -- well, don't you tell me  
9 what you mean, and --

10 A I -- I -- so the -- so my -- so my  
11 recollections are vague, and I don't have specific  
12 information. But I have read -- so I -- these are  
13 interesting topics for me, as well --

14 Q Uh-huh.

15 A -- in -- in costing benefits. And I do  
16 recall reading that the experience showed not to  
17 be as high as what the risk premium that was  
18 attached to it originally you would have  
19 indicated.

20 Q And do you know what that risk premium  
21 was?

22 A I don't recall.

23 Q Okay. What about California?

24 A I don't have any specific information  
25 about California, in general.

Page 105

1 Q Do you know if California covers gender  
2 dysphoria benefits for treatment -- covers gender  
3 dysphoria treatment?

4 A So I don't know specifically. I have not  
5 reviewed their benefit design.

6 Q Okay. Obviously, Massachusetts does.  
7 You know that. Correct?

8 A I do know that Massachusetts does.

9 Q And do you know, did -- did they have a  
10 risk premium?

11 A I don't know who costed that.

12 Q Okay. So one other thing at -- on  
13 this -- at -- there's a bundle of services --  
14 and -- and this is on page 4 of 9 in Exhibit 5.

15 A Uh-huh.

16 Q Figure 1 has a bundle of services  
17 included in gender reassignment surgery. Did -- did  
18 this figure play any role in your determination of  
19 how to capture data from a -- a -- the treatment  
20 database?

21 A Not specifically. This a common -- I --  
22 I won't say "common." This is -- this is not an  
23 unusual way to think about it, particularly where  
24 you vaguely or -- or -- I'm not sure how to describe  
25 it.

Page 106

1 But -- but you're looking for codes that  
2 may or may not be specifically identifiable, and  
3 you're looking for ways to capture the cost of a  
4 benefit when you don't have all the definitions in  
5 the front of you. This is a not an uncommon  
6 process.

7 If anything, I read this. And I said,  
8 Oh yeah, that's kind of how we're approaching it,  
9 as well. But it wasn't the thing that kicked me  
10 off to say, This is the way I ought to do that.  
11 No.

12 Q Okay. So when you say the codes may  
13 not capture it, is that procedure codes or service  
14 codes? Or are you talking about diagnostic codes?

15 A Yes. All of those.

16 Q Okay. So in this case, part of the  
17 issue is that some of the same procedural codes  
18 are used for -- because the same procedure are  
19 used to treat conditions other than gender  
20 dysphoria?

21 A That's a different topic.

22 Q Okay.

23 A I -- I can see where, you know, that  
24 might be related. But it's not really a -- that's,  
25 kind of, a different issue --

28 (Pages 103 to 106)

Page 107

1 Q Okay.

2 A -- that we'd have to address in the  
3 database.

4 Q Okay. So what issue are you -- can you  
5 describe the -- the --

6 A So even though the Blue Cross Blue  
7 Shield Massachusetts list of codes that they have  
8 there feels like it's comprehensive, it probably  
9 isn't.

10 And so in order to capture the codes  
11 that are not listed in that document, you create a  
12 bundle to grab everything that happens, just  
13 assuming that everything that happens within the  
14 pro- -- the proximity of the -- of the surgical  
15 procedure is going to be related to that  
16 procedure.

17 Q Okay.

18 A So you grab all of those services. I'm  
19 going to say that's the -- that's the cost related  
20 to performing that -- that surgery.

21 Q So then -- but -- but again, would it --  
22 so that would include, say, procedural and service  
23 and other kinds of codes that would not necessarily  
24 be connected?

25 A But you have a diagnosis of F64 --

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1 A It's a common -- let me rephrase that.

2 It's a common way to -- or a -- it is often used as  
3 a way to -- to associate all the costs associated  
4 with an episode of care.

5 Q Okay. And common in -- is -- is -- is  
6 it particularly -- is that particular to surgical  
7 procedures?

8 A It could be other procedures, as well.

9 Q Okay.

10 A Let me give you another example. CMS  
11 has a bundle payment methodology that they're  
12 currently employing as payment methodology.

13 And their methodology uses a similar  
14 kind of -- of construct; that is, it starts a few  
15 days before -- a period before and goes -- I think  
16 it goes clear to 90 days after. And anything that  
17 happens within that has to be paid for --

18 Q In one --

19 A -- in -- as one bundle payment.

20 Q Okay. So one question about that: Does  
21 the 60 days, then, probably capture a lot of  
22 potential complications after the surgery, like  
23 infection -- that kind of thing?

24 A To the extent that those happen, that --  
25 it would capture those. Yes.

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1 Q Okay.

2 A -- related to -- in conjunction with  
3 the -- with the surgical procedures.

4 Q Okay.

5 A So you probably -- you have to assume  
6 that that surgical procedure is being done for that  
7 diagnosis.

8 Q Okay. And that -- and that's the --  
9 the bundle, basically, you're talking about is  
10 the -- the bundle of everything that happens seven  
11 days -- starting seven days before the surgery and  
12 continuing 60 days after the surgery?

13 A Correct.

14 Q Is that, at least presumptively, related  
15 to the reassignment surgery?

16 A Yes.

17 Q Okay. But this isn't what led you down  
18 that path. That was -- it -- it -- it was some  
19 other reason that you adopted that 7/60?

20 A Correct.

21 Q And -- and what was that?

22 A It -- it -- it's just a reasonable way to  
23 approach the -- the problem.

24 Q Reasonable -- on what basis do you say  
25 it's reasonable?

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1 Q Okay. And is that one of the reasons you  
2 to the 60 days after the procedure -- is to capture  
3 potential --

4 A Yeah. That's --

5 Q -- complications?

6 A -- considered part of it. Yeah. Yes.

7 Q Okay.

8 A So I'd like to point out that we may be  
9 missing some of those dollars. So -- because some  
10 of those complications may occur outside of the  
11 60-day window, as well, and not have the -- the  
12 diagnosis code related to it.

13 So, yeah, we could be missing -- we could  
14 be missing information that way, too.

15 Q Are there any specific items that you  
16 can think of in this -- for these types of services  
17 that would, more than likely, end up beyond the 60  
18 days?

19 A Well, people are very complicated.  
20 So -- and their health care can be quite  
21 complicated. It would be hard for me to speculate  
22 what those might be.

23 Q So you don't have anything in  
24 particular in mind that you think might be beyond  
25 60 days?

29 (Pages 107 to 110)

<p style="text-align: right;">Page 111</p> <p>1 A Not without looking at it specifically.  2 Q Okay. And the next item the Padula,  3 which I think we'll talk about separately later.  4 A Okay.  5 Q But might as well -- actually --  6 (Whereupon, Plaintiff's Exhibit  7 Williams No. 6, Article Entitled  8 "Societal Implications of Health  9 Insurance Coverage for Medically  10 Necessary Services in the U.S.  11 Transgender Population: A  12 Cost-Effectiveness Analysis," was  13 marked for identification.)  14 BY MR. DUPUIS:  15 Q So showing you what's been marked as  16 Exhibit 6. And so I take it you reviewed this  17 document primarily because it was referenced in Dr.  18 Budge's report. Is that correct?  19 A That's correct.  20 Q Okay. Well, I'll have more questions  21 about that later. But let's just set it aside for  22 the moment.  23 A Okay.  24 Q The Olyslager and the Conway article --  25 MR. DUPUIS: Let's mark that as</p>	<p style="text-align: right;">Page 113</p> <p>1 were being used in the community that they may have  2 read.  3 So it was the help put the reader into a  4 proper framework so they could see what the database  5 was doing.  6 Q Okay. So -- so basically, what this  7 helped you to see is both that prevalence is still a  8 not clear -- you know, they hadn't come to a clear  9 number of -- or, you know, general prevalence or  10 incidence rates -- correct? -- for gender  11 dysphoria?  12 A The paper does discuss, you know, some  13 of the pros and cons of the various  14 methodologies --  15 Q Right.  16 A -- for collecting the data and, you  17 know, some of the strengths and of weaknesses of  18 each of those.  19 Q Yeah.  20 A And -- and I think it is fair to say  21 that -- that, you know, there is some uncertainties  22 about, you know, where the prevalence and incidence  23 and actual utilization actually comes down.  24 Q Right. But -- but basically, it  25 confirmed for you or gave you some confidence that</p>
<p style="text-align: right;">Page 112</p> <p>1 Exhibit 7.  2 (Whereupon, Plaintiff's Exhibit  3 Williams No. 7, Article by Lemke  4 Olyslager and Lynn Conway Entitled,  5 "On the Calculation of the  6 Prevalence of Transsexualism," was  7 marked for identification.)  8 BY MR. DUPUIS:  9 Q How did -- how did this enter into your  10 report?  11 A If you recall, one of the things we  12 looked at was the prevalence of incidence. And in  13 the hierarchy of -- of, you know, that progression  14 of -- not everybody that has gender dysphoria  15 actually seeks services, either hormonal treatment  16 or -- or surgical benefits.  17 And it had a very nice -- it has a very  18 nice way to think about it. I'm on page 7.  19 Q Uh-huh.  20 A And I use that as, sort of, a mental  21 framework so that people could see how -- how the  22 in- -- incidence studies that they might review and  23 how the database work that we did might -- might end  24 up being less than what would be considered the  25 prevalence rate based on various techniques that</p>	<p style="text-align: right;">Page 114</p> <p>1 the fact that you were seeing significantly fewer  2 actual procedures than the estimated prevalence  3 of -- even the prevalence of the condition isn't  4 somehow undermining you're -- you're results.  5 Right?  6 MR. ROTH: Objection. Vague.  7 You can answer.  8 A Yeah. I -- I think that's a -- I think  9 that's a good way to say it. I -- you know, did we  10 make a direct connection between the two?  11 Probably not. But it gave us some -- at  12 least the framework -- again, the mental framework  13 to talk about how they might, you know, progress  14 down from a large number here to a smaller number  15 at this point and -- and, maybe give some hint about  16 what those relationships would look like.  17 BY MR. DUPUIS:  18 Q Okay. The Schatten/Vieira transgender  19 cost estimate, that is the Segal Consulting cost  20 estimate from January of 2017.  21 (Whereupon, Plaintiff's Exhibit  22 Williams No. 8, 1/23/17 Segal  23 Consulting Schatten/Vieira Cost  24 Estimate, was marked for  25 identification.)</p>

<p style="text-align: right;">Page 115</p> <p>1 BY MR. DUPUIS: 2 Q And I'm going to show you what was marked 3 as Exhibit 8. 4 A Uh-huh. 5 MR. DUPUIS: Sorry. 6 MR. ROTH: That's all right. 7 BY MR. DUPUIS: 8 Q Is -- is this what you're referring to in 9 your bibliography? 10 A Yes. 11 Q And again, it seems that you did use 12 this, in part, to just, sort of, verify for 13 yourself that estimates were in the the range of 14 reasonableness given what other people are saying? 15 A I did. 16 Q But you also used the numbers to 17 calculate your own per member per month cost that 18 they presented as a range of .05 to .13 -- well, 19 five cents to 13 cents per member per month. 20 Correct? 21 A Correct. 22 Q And you used their numbers to come up 23 with a point estimate of about eight cents? 24 A Roughly. Yes. .77 -- something like 25 that.</p>	<p style="text-align: right;">Page 117</p> <p>1 estimates of cost to the State of Wiscon- -- the 2 cost of benefits for treatment of gender dysphoria 3 to the State of Wisconsin until you produced your 4 report in this case. Correct? 5 A Correct. 6 Q And to your knowledge, Milliman never 7 provided information on the costs of this sort of 8 benefit to the State of Wisconsin until this 9 report? 10 A I'm not aware of any Milliman consultant 11 doing so. 12 Q Okay. So to your knowledge, in December 13 of 2016, the state could not have been relying on 14 your report in determining whether it was a 15 responsible exercise of their fiduciary duty to -- 16 to offer this benefit? 17 A This report was produced -- so in terms 18 of timing, this report was produced after -- 19 Q December, 2016. 20 A -- after December of 2016. 21 That's the date I'm looking for. 22 Q Yup. 23 A Yes. That's correct. 24 Q The standards of care, I'm also not going 25 to produce the entire document for you. But you've</p>
<p style="text-align: right;">Page 116</p> <p>1 Q And that was consistent with your point 2 estimate of roughly seven percent? 3 A Yeah. It was in the right range. Yup. 4 Q Okay. Are you familiar with Segal 5 report on -- for the -- the State of Maryland that 6 was provided to the State of Wisconsin when they 7 were initially considering whether to eliminate the 8 exclusion? 9 A I did. I did review that. Yes. 10 Q Okay. 11 A I didn't rely on that, but I did review 12 it. 13 Q Okay. Why did you -- did you -- would 14 you say you relied on the Segal Consulting, the -- 15 Exhibit 8? 16 A This one -- yes. I did I relied on it to 17 verify the range that we were looking at. 18 Q Okay. Did you -- well, why did you not 19 rely on the Maryland report? 20 A I -- I didn't use anything directly in 21 the report, I think. 22 Q Did -- did you view it as inconsistent 23 with your report in any way? 24 A No. 25 Q Okay. So you never provided your</p>	<p style="text-align: right;">Page 118</p> <p>1 cited specific pages of it. And I just want to make 2 sure that I'm understanding what -- how you used 3 this. 4 MR. DUPUIS: That's Exhibit 9. 5 (Whereupon, Plaintiff's Exhibit 6 Williams No. 9, Standards of Care, 7 was marked for identification.) 8 MR. DUPUIS: Actually, can I have 9 that back? 10 I don't know where I put -- oh, no. 11 Never mind. I've got it. 12 That's 9. Correct? I'm sorry. 13 Yeah. 14 THE WITNESS: Yeah. Okay. 15 BY MR. DUPUIS: 16 Q Would you take a look at Exhibit 9? 17 A Oh, okay. 18 Q And I -- in your report, I believe it's 19 a footnote that references these pages, pages 47 -- 20 A Yes. 21 Q -- to 50? 22 A Yes. 23 Q And I just want to clarify that you -- 24 what you used this for, it sounds like the -- the 25 primary purpose was to identify the types of</p>

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<p>1 treatment codes or pharmacy codes that would have 2 been associated with hormone treatment for gender 3 dysphoria? 4 A Correct. 5 Q In -- in preparing your cost estimates, 6 did you look for costs associated with gen- -- 7 hormone treatments that were not connected within 8 the 60 -- the -- the seven-to-60-day window for 9 surgical treatment? 10 A Yes, I did. 11 Q Okay. And that factored into your 12 overall 2,900-hundred-dollar -- 13 A Yes. 14 Q -- per transgen- -- or per -- per person 15 with hor- -- gender dysphoria -- that 16 2900-hundred-dollar cost included both the surgical 17 bundle and any other estrogen -- any -- any other 18 hormone therapies that were not necessarily 19 connected to a surgical bundle? 20 A I think I know what you're getting -- I 21 think I know what you're getting to. That was a 22 really long sentence. 23 Q Yes. It was a terrible question. 24 And -- and actually, if you can answer it with a 25 better answer than my question, that would be</p>	<p>1 Q Okay. 2 A Yes. 3 Q Okay. There -- was there any other use 4 you made of the standards of care in general? 5 I -- I don't want to produce -- you 6 know, have you look at the whole thing. It's also 7 another long document. 8 A It is another document that I read, at 9 least, most of to inform me, in general, of -- 10 of -- of the nature of the benefit and the people 11 that would be seeking it so that I was informed, 12 when I looked at the claims data, that -- or at the 13 treatment pieces that they were looking forward to 14 receiving. 15 Q But there was nothing specific, other 16 than the citation -- 17 A I can't -- 18 Q And if -- 19 A -- give -- I'm -- 20 Q -- you -- 21 A -- sorry. Correct. That's correct. 22 Q So then, let's look at a document -- 23 okay. I don't -- I don't think we actually need to 24 look at Dr. Budge's report. 25 So let's look at this Zucker article.</p>
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<p>1 wonderful. 2 A So what I can tell you is that, yeah, 3 the -- the hormone therapy is -- is listed 4 separately. 5 But it was also included in the 6 reassignment surgeries in -- it's not "also" as in 7 terms of a duplicate. But it is included in the 8 surgical for those surgical people that are having 9 surgical procedures done. 10 But there is -- but we looked at the 11 hormone therapy for the entire year for individuals 12 with those diagnoses -- 13 Q Okay. 14 A -- so that we captured everybody that 15 was in that bucket. Not -- not everybody that takes 16 that hierarchy -- not everybody that has hormone 17 therapy gets surgery, obviously. 18 So the -- the ones that aren't getting 19 surgery are left in that other bucket. 20 Q Okay. And is that -- the -- those who 21 are not getting surgery, are they included in your 22 seven-cent-per-member- -- 23 A Yes. 24 Q -- -per-month estimate? 25 A I'm sorry.</p>	<p>1 MR. DUPUIS: It should be in 2 this -- thank you. 3 THE COURT REPORTER: Sure. 4 (Whereupon, Plaintiff's Exhibit 5 Williams No. 10, Zucker Article, was 6 marked for identification.) 7 BY MR. DUPUIS: 8 Q Showing you what's been marked as Exhibit 9 10. So how did this article contribute to your 10 report? 11 A I looked at this because it was the most 12 recent epidemiology study on gender dysphoria that I 13 could find -- 2017. 14 So the recent publication I thought 15 would be useful, since many of the publications 16 that I was looking at are older -- quite a bit 17 older -- and I know that information about the -- 18 the prevalence and incidence has evolved quite a 19 bit over the years. So I -- I found this 20 interesting because of that. 21 The -- what I was particularly 22 interested in as I read this were the -- the 23 progression that he talked about about the various 24 ways that this data is collected in various 25 environments and the -- the range of the results</p>

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1 that can be achieved depending on the geo- --  
2 geograph- -- geography, the -- the social setting,  
3 the country, the various components that -- the  
4 various ways that they collect the data.

5 It also had some specific information  
6 that I reviewed in terms of -- of relationship to  
7 the -- to the prevalence and incidence rates that I  
8 was reviewing in other studies. And I just wanted  
9 to compare the two and see how close they were  
10 coming.

11 I don't -- I'll have to review it in  
12 terms of exactly what I used specifically. I do  
13 think I made a statement in here about some of  
14 the -- the uncertainties that are involved in  
15 collecting the data. And that may have been where I  
16 focused my -- my comments in the paper.

17 Q I believe there was a citation to Zucker  
18 on pages 9 and 10?

19 Or Zucker?

20 No. Zucker.

21 A Yeah. Yeah. So I quoted a paragraph:  
22 "The recent studies suggest that the prevalence of  
23 a self-reported transgender identity in children,  
24 adolescents, and adults range" -- "ranges from zero  
25 to 1.3 [sic], markedly higher than the prevalence

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1 rates based on the clinical" -- "clinic-referenced  
2 [sic] samples of data [sic]."

3 Oh, yes. I recall.

4 And "The stability of a self-reported  
5 transgender identity or a gender identity that  
6 departs" -- am I going too fast?

7 THE COURT REPORTER: (Nods head.)

8 A "The stability of a self-reported  
9 transgender identity or a gender identity that  
10 departs from the traditional male-female binary  
11 among nonclinic-based populations remains unknown  
12 and requires further study."

13 So I was trying to make the point here  
14 of two things; one is that, you know, the  
15 clinic-based reporting, that is, when they show up  
16 for treatment, is quite a bit less than when they  
17 ask for self-reported data --

18 BY MR. DUPUIS:

19 Q Uh-huh.

20 A -- and that there still remains a lot of  
21 further study in order to nail down the numbers.

22 Q And the "self-reported data," meaning --

23 A Survey --

24 Q -- self- --

25 A I'm sorry.

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1 Q Survey data, but self-reported incidence  
2 of transgender identity or of gender dysphoria?

3 A I -- that's a great question. And I  
4 think the way they ask the question becomes part of  
5 the issue.

6 Q All right. Okay. Okay. You can set  
7 that one aside for a moment.

8 So I'd like you to take a look at a  
9 couple of documents.

10 MR. DUPUIS: Looking for the  
11 actuarial -- -- oh, they're right there.

12 MS. KADRI KEELER: Thank you.

13 THE COURT REPORTER: You're  
14 welcome.

15 (Whereupon, Plaintiff's Exhibit  
16 Williams No. 11, Actuarial Standard  
17 Of Practice, was marked for  
18 identification.)

19 BY MR. DUPUIS:

20 Q I'm showing you what's been marked as  
21 Exhibit 11. Do you recognize this document?

22 A This specific document, no. This is an  
23 ASOP, an Actuarial Standard Of Practice.

24 Q Okay. Are you familiar with the A- --  
25 ASOPs, in general?

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1 A Yes.

2 Q Okay. And when you say you're not  
3 familiar with this one, you just mean you haven't  
4 read this one in --

5 A I haven't --

6 Q -- particular?

7 A -- read this one. That's correct.

8 Q Okay. Could you take a look at page 3  
9 of the actual ASOP, not the introductory front  
10 material, but page 3 of the actual document?

11 And there's a definition of  
12 "materiality" there. Is -- could -- could you take  
13 a look at that?

14 A Yes. I read it.

15 Q Okay. Is that definition something  
16 you're familiar with in your work?

17 A I'm familiar with the concept.

18 Q Okay. Is -- do you have any other  
19 understanding of the term "materiality" in the  
20 context of, for example, the pricing of benefits?

21 A That's a broad question. I'd need you to  
22 be more specific before I could answer a specific  
23 question.

24 Q All right. When you were talking about  
25 your areas of agreement or disagreement or, at

33 (Pages 123 to 126)

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1 least, questions for Joan Barrett -- about the Joan  
2 Barrett report --  
3 A Uh-huh.  
4 Q -- one of them had to do with the  
5 question of materiality.  
6 Does this change your answers with  
7 respect to your view of agreement or disagreement  
8 with Ms. Barrett's report with respect to  
9 materiality?  
10 A No.  
11 Q Okay. Under this definition of  
12 materiality, would you consider the cost -- cost per  
13 member per month of seven cents material?  
14 MR. ROTH: Objection. Vague. And I  
15 think it kind of calls for a legal  
16 conclusion.  
17 But you can answer.  
18 A That's not my decision. My decision is  
19 to calculate the seven percent.  
20 BY MR. DUPUIS:  
21 Q All right. And you would say the same, I  
22 take it, with regard to the risk premium -- or  
23 risk -- you -- you did -- you don't use the term  
24 "risk premium."  
25 A It's a factor. Yeah.

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1 Q Risk factor?  
2 A Yeah. Yes.  
3 MR. DUPUIS: Done with the -- this  
4 one.  
5 BY MR. DUPUIS:  
6 Q Are you familiar with the term  
7 "credibility procedures"?  
8 A I'm familiar with the concept of  
9 credibility. I'm not sure I'm fami- -- it's -- I'm  
10 not sure of a specific -- I'm not sure of a  
11 specific -- I'm -- I'm not familiar with the  
12 specific term "credibility procedures."  
13 Q Okay.  
14 MR. DUPUIS: Well, let's -- let's  
15 just mark this and talk about it that  
16 way.  
17 (Whereupon, Plaintiff's Exhibit  
18 Williams No. 12, Actuarial Standard  
19 Of Practice, was marked for  
20 identification.)  
21 MR. DUPUIS: Oh, you're ahead of  
22 me.  
23 BY MR. DUPUIS:  
24 Q I give you this. This is exhibit 12.  
25 And again, this is a -- another ASOP from the

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1 Actuarial Standards Board. And it deals with  
2 credibility procedures. You see that?  
3 A Yup. Yes.  
4 Q So do you -- and -- and actually, if you  
5 could look at little "i," little page "v" on this.  
6 A Okay.  
7 Q You'll see the credibility task force  
8 there includes Joan Barrett. See that?  
9 A Where is Joan Barrett?  
10 Ah, right at the top. Yes. I see it.  
11 Q Okay. So what is your understanding of  
12 credibility as a concept, as I think is what she  
13 said?  
14 A It -- there are various aspect --  
15 various aspects to credibility including the size  
16 and likely variance of the -- of the population;  
17 The underlying -- the nature of the underlying data  
18 that is being used to calculate the benefit cost  
19 and whether or not it is reliable; the material  
20 risk that it's applied to; meaning, how risky it is  
21 when it gets applied.  
22 Q How risky it --  
23 A So how risky -- so if you have a premium  
24 and if you miss that amount by a, you know, a -- a  
25 range, does it have material impact on -- on the

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1 fiduciary that's -- that's taking the risk.  
2 Those are the -- at the top of my head  
3 without thinking about it more clearly. That's --  
4 those are the kinds of things that I would think  
5 about.  
6 Q Okay. Was that concept something that  
7 factored into your work in this case.  
8 A It's in the back of my mind. It's --  
9 it's part of the -- the -- it's part of the work  
10 that we do.  
11 It's part of the work that I do in terms  
12 of judging the quality of the data, the potential  
13 size of the variability, the impact that it would  
14 have. Those are all things that are -- are  
15 considered.  
16 Q Okay. On page 2 of this, there's a  
17 definition of credibility. And it says, "A measure  
18 of the predicted value in a given application that  
19 the actuary attaches to a particular set of data."  
20 Would you say that's consistent with the  
21 definition you gave?  
22 A Yes. I think it is.  
23 Q Okay. What is "subject experience"?  
24 What does that mean?  
25 A It says here, "A specific set of data

34 (Pages 127 to 130)

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1 drawn from the experience under consideration for  
2 the purpose of predicting the parameter under  
3 study."  
4 Q Okay. Who is the subject, or what is the  
5 subject?  
6 A So that would be the -- in this case, it  
7 would be the -- the subset of individuals that --  
8 that we pulled from the large data set. So maybe  
9 200 individuals that would --  
10 Q With --  
11 A -- that are listed as having a diagnosis  
12 of gender dysphoria.  
13 Q Okay. Okay. I take it you didn't  
14 actually refer to either of these ASOPs in preparing  
15 the report?  
16 A Not -- no, I didn't.  
17 Q Okay.  
18 A I didn't --  
19 Q Do you know if the actuaries who reviewed  
20 the report may have looked at them?  
21 A Well --  
22 MR. ROTH: Objection. Calls for --  
23 BY MR. DUPUIS:  
24 Q Do you --  
25 MR. ROTH: -- speculation.

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1 BY MR. DUPUIS:  
2 Q -- do you know?  
3 A I do not know. However, I will say  
4 this: They're all actuaries and subject to these  
5 ASOPs. So they're familiar with them.  
6 Q All right. Let's go back to your  
7 report, Exhibit 2. Is there a way in which your  
8 work on automobile-re- -- in -- -accident related  
9 medical claims factored into your work here?  
10 A A broad question. Not specifically or  
11 directly. But the skill sets that are used to work  
12 with these large data sets and to understand the --  
13 the billing and the claim adjudication and -- and  
14 pricing of -- of health care -- financing of health  
15 care are all skill sets that were applied to my work  
16 here.  
17 Q So I just want to clarify. I mean, this  
18 is -- this is more about pricing a benefit from an  
19 insurance perspective.  
20 Is it fair to say that -- that -- that  
21 what you were doing in the automobile association  
22 cases was really pricing its fee-for-service  
23 pricing? Right?  
24 I mean, you're looking at the price of a  
25 particular set of services, but not -- it's not

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1 about risk-spreading?  
2 A No. It's not about risk-spreading. But  
3 it is about calculating all of the fees that were  
4 charged for all of the services that could be  
5 applied to any bene- -- any services provided to a  
6 member of USAA in terms of how much it would cost at  
7 the 80th percentile in calculating those amounts and  
8 determining whether or not those are reasonable or  
9 not.  
10 So there's a -- there's several skills  
11 that's sort of involved there. One is understanding  
12 the health care finance market, understanding the  
13 physician payment patterns, understanding the  
14 databases and the nuances of the databases that are  
15 used in order to produce those data sets. Those are  
16 all skill sets that are directly applicable to what  
17 we're doing here.  
18 Q All right. On page 3 of your report,  
19 item No. 6, I just want to clarify that you're  
20 adding not just a 50 percent risk margin, which is  
21 saying, building in 50 percent more utilization  
22 than your point estimate would lead you to, but  
23 also, a 50 percent cost per utilization. So  
24 it's -- it's effectively doubling the  
25 per-member-per-month cost?

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1 A Correct.  
2 Q Okay. So the per-member-per-month cost  
3 was in the hundred-and-fifty-,  
4 hundred-and-sixty-thousand-dollar -- not per member  
5 per month.  
6 The hundred -- it was a hundred and  
7 sixty thousand, roughly, total cost was your point  
8 estimate. With the risk factor, you would be  
9 adding -- you -- it would be essentially coming  
10 close to doubling it to 300,000 --  
11 A That -- that's correct.  
12 Q Okay.  
13 A I'm just trying to find the exact  
14 number. But yes, that's correct.  
15 Q And can explain why it doesn't actually  
16 end up actually doubling it? Is it be- -- is it  
17 because the utilization -- well, can you explain?  
18 A It -- it has to do with rounding. So  
19 we're using fairly precise -- and -- and they are  
20 artificially precise, I might add --  
21 Q Uh-huh.  
22 A -- numbers. And when you do the math,  
23 you turn out that, you know, one of them is  
24 probably rounded at seven-point-something. And  
25 then, when you apply -- apply the math, you end up

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<p>1 with 15. 2 Q Okay. 3 A So instead of it being just seven to 14, 4 it turns out to be 15. And it was probably 7.4. 5 And now, it's, you know, in the low 15. 6 Q Got you. So it's just -- it's just the 7 way the math works out? 8 A (Witness nods head.) 9 Q Okay. And it's the rounding? 10 A It has to do with -- it has to do with 11 how many decimal places you're actually working with 12 in the -- in the process. 13 Q Okay. So on page 4, you -- you summarize 14 the group benefit pricing approach. And in the 15 first paragraph you, sort of, describe the overall 16 approach. 17 And my -- my question about this is: 18 When insurers do this, do they typically do it -- 19 do -- are actuaries typically involved in that 20 process? 21 A It -- it -- it depends on who you work 22 for and -- and -- and -- and what you're doing. 23 Actuaries are often involved, but they don't 24 necessarily have to be. 25 Q Are there situations in which actuaries</p>	<p>1 Q And that's state by state? 2 A State by state. 3 Q In the next paragraph, you say, 4 "Regardless of who takes the risk, new health plan 5 benefits impose a cost." 6 Is that always true? 7 A So "always" is a big number. If there's 8 no utilization, then, there would be no cost. 9 Q Right. 10 A If there's utilization, there is a cost. 11 Q Do they impose -- would -- would you say 12 that any new benefit that is utilized imposes a cost 13 even if they're offsetting savings? 14 MR. ROTH: Objection. Vague. Calls 15 for speculation. 16 You can -- 17 BY MR. DUPUIS: 18 Q I'm just -- 19 MR. ROTH: -- answer. 20 BY MR. DUPUIS: 21 Q -- trying to get at, What do you mean by 22 cost? Do you mean that there is an other -- there 23 is an expense that's paid not considering 24 whether -- you know, for example, paying more some 25 preventive benefit may actually result in lower</p>
<p>Page 136</p> <p>1 have to be involved? 2 A Yes. If it requires an actuarial opinion 3 by statute. 4 Q Would pricing this benefit require an 5 actuarial opinion by statute in Wisconsin, if you 6 know? 7 MR. ROTH: Objection. Calls for a 8 legal conclusion. 9 But you can answer. 10 A I -- I -- I -- I don't think so. 11 BY MR. DUPUIS: 12 Q Okay. Is -- is that a state-by-state and 13 maybe even market-by-market type of statutory 14 requirement? 15 A So generally, pricing benefits is an 16 analytic exercise that actuaries are particularly 17 good at. In most cases, unless you're filing to the 18 DOI, they do not require a -- an actuary -- a -- an 19 actuarial opinion. 20 And if an actuary does it, then, they 21 have to follow the rules for the actuaries to 22 perform it. But it doesn't require a -- an 23 actuarial certification. 24 Q And "DOI" is Department of Insurance? 25 A Yeah.</p>	<p>Page 138</p> <p>1 costs to a provider than -- or to an insurer than 2 would be the case if -- if that benefit were not 3 provided? 4 MR. ROTH: Same objections. 5 You can answer. 6 A So the -- anytime you impose a -- 7 anytime you impose a benefit or you allow a 8 benefit, there is a cost associated with that. 9 There could be calculations where there might be an 10 offsetting savings in some form. 11 A lot of value-based, insurance-designed 12 concepts are built around that. It may be in that 13 year. It may be thirty years down the road. But 14 there's always a cost that's associated. There's 15 always a payment for the services that is being 16 provided. 17 When you're -- when you're pricing an 18 old benefit that has a longterm history, any costs 19 and offset savings are built into the database as 20 part of it, because both of those are occurring at 21 the same time. And when you do the calculations, 22 those numbers -- whatever that number turns out to 23 be is the combination of both of those concepts 24 together. 25 If you're pricing a brand new benefit,</p>

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1 then, typically, those are being considered as a --  
 2 might be considered in a ROI study or in a, you  
 3 know, whatever return on -- on investment might be  
 4 there.  
 5 And again, those might be short term, or  
 6 it may be very long term. That would play into the  
 7 decision that would -- that would be taking place.  
 8 But there's going to be a cost -- a cost component  
 9 that would be associated with it. That's a given.  
 10 BY MR. DUPUIS:  
 11 Q All right. It -- it's just that in the  
 12 overall scheme of things, there might be a net  
 13 benefit that outweighs the cost?  
 14 MR. ROTH: Same objections.  
 15 You can answer.  
 16 A Potentially.  
 17 BY MR. DUPUIS:  
 18 Q All right. But that's not the -- what  
 19 you're referring to here. You're just referring to  
 20 that initial -- the cost of actually covering a  
 21 procedure that is now covered?  
 22 A We calculated -- yes. We calculated the  
 23 cost of procedure that was not otherwise covered.  
 24 Yes.  
 25 Q But did not try to quantify any cost

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1 savings that might result from that?  
 2 A I did not identify any cost savings in my  
 3 research that would occur from that.  
 4 Q Is that because you think there aren't?  
 5 Or you are just not able to quantify them because  
 6 there is no data?  
 7 A I -- I -- I found no data to support  
 8 that.  
 9 Q Okay. Did you find data to contradict  
 10 it?  
 11 A I did not.  
 12 Q Okay. So on No. 4 -- item No. 4 under  
 13 the pricing approach, you talk about estimating the  
 14 number of relevant health care services using the  
 15 number of individuals with the disorder, how many of  
 16 those individuals might seek treatment, and the  
 17 average cost.  
 18 You don't include how often somebody  
 19 might actually seek the treatment. Is that --  
 20 is -- isn't, sort of, utilization pattern relevant?  
 21 A Absolutely. So read the whole sentence.  
 22 Estimate the number of relevant health care  
 23 services using -- first is how many individuals.  
 24 How many of these individuals might seek covered  
 25 treatments, procedures, services, supplies?

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1 So that's both of those components  
 2 together. The individual, and then, all of their  
 3 stuff -- if I can use "stuff" as a technical term --  
 4 that they might -- that they might seek in terms of  
 5 treatment.  
 6 Q I think what I'm getting at here is more  
 7 the question of -- so surgeries, at least some of  
 8 these surgical procedures, are basically once in  
 9 your lifetime. Right?  
 10 MR. ROTH: Objection. Vague.  
 11 You can answer --  
 12 A I don't --  
 13 MR. ROTH: -- if you --  
 14 A -- know the --  
 15 MR. ROTH: -- can.  
 16 A -- answer to that.  
 17 BY MR. DUPUIS:  
 18 Q So an orchiectomy would not be done twice  
 19 for a male-to-female transgender person?  
 20 A That's uncertain.  
 21 Q How is that uncertain?  
 22 A If the first one wasn't done correctly  
 23 or completely, then, a second one would be needed.  
 24 Q All right. But we're talking a finite  
 25 number. Correct?

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1 A I --  
 2 Q Un- -- unlike hormone therapy, which is  
 3 ongoing treatment. Correct?  
 4 A It -- it -- it -- so claims data is very  
 5 messy.  
 6 Q Yup.  
 7 A And people are very complicated. So  
 8 saying there would only be one done ever is, in my  
 9 experience, a stretch.  
 10 Q Okay. And -- and you think frequency of  
 11 service or how often a service is -- is captured in  
 12 what you've described here -- or if you did capture  
 13 it in some sense?  
 14 A I did.  
 15 Q Okay. Did that factor into your  
 16 assessment of the risk margin -- the likelihood of  
 17 a -- a second -- a need for a second surgery?  
 18 A Not specifically.  
 19 Q Okay. On page 5, you describe the  
 20 Truven database partly in a footnote, but  
 21 elsewhere, as well. And you say, "These data  
 22 contain inpatient, outpatient, and pharmacy claims,  
 23 and enrollment from large U.S. employers and health  
 24 plans."  
 25 How large are the employers, and does

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1 "large" modify "health plans," as well?  
 2 A Various sizes. I think there's a range  
 3 of sizes. But it includes -- well, I think it's  
 4 more useful to talk about it in terms of the total  
 5 size of around 24 million individuals. And there's  
 6 a variety of -- of employers and health plans that  
 7 contribute to that database.  
 8 I don't have any -- I don't have any  
 9 specific breakdowns of -- of frequency counts of --  
 10 by size --  
 11 Q Okay.  
 12 A -- right in front of me.  
 13 Q Well, it -- it -- let me -- let me  
 14 explain why I'm asking.  
 15 So one of the things you say is that, you  
 16 know, you're trying to find a universe of -- so  
 17 any -- any -- basically, you assume that any plan  
 18 that paid a claim for this kind of service covered  
 19 that service. Right?  
 20 A That's -- that's an assumption that I  
 21 made.  
 22 Q Okay.  
 23 A Yes.  
 24 Q And I assume you made the opposite or the  
 25 converse assumption about plans that had no claims

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1 paid?  
 2 A I did think about this. And, yes, I --  
 3 I -- I -- I -- I thought about that possibility.  
 4 Q Okay. So the number, the "N," which  
 5 affects the price per member per month could  
 6 actually be higher. Correct?  
 7 A It could be.  
 8 Q And did you -- did you -- did you  
 9 account for that? And if so, how did you account  
 10 for that?  
 11 A Well, I -- I think another way to say  
 12 that in terms of accounting for it is, Did I examine  
 13 the materiality of that assumption?  
 14 And I did do some variance analysis on  
 15 "What if I missed by a million people in the  
 16 denominator?"  
 17 Q Uh-huh.  
 18 A And it doesn't make a material difference  
 19 in that second sense.  
 20 Q So when you say -- what --  
 21 A And --  
 22 Q -- why did it -- what's material?  
 23 A A penny or two.  
 24 Q A penny or two?  
 25 A (Witness nods head.)

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1 Q So on the per-member-per-month count? Or  
 2 on -- figure --  
 3 A At the most. Yeah.  
 4 Q Okay. So a penny or two is, in your  
 5 view, not material?  
 6 A So it -- it is a source of variance that  
 7 does exist. And I -- and I do think we need to  
 8 acknowledge it.  
 9 But in terms of the general conclusions  
 10 that I draw in terms of what I'm stating in the  
 11 paper, it's consistent with the -- with the -- with  
 12 the -- my opinions doesn't change the -- the  
 13 overall opinion of -- of where I'm going with this.  
 14 Q So seven cents per member per month is  
 15 the point estimate. And 15 cents per member per  
 16 month with the -- with the risk --  
 17 A Yes.  
 18 Q -- factor?  
 19 A Yes.  
 20 Q Okay. I think we've already talked  
 21 about the surgical bundle approach. But I had one  
 22 additional question about that.  
 23 You talk about the Center for Medicare  
 24 Ser- -- this is on page 6 -- the Center for Medicare  
 25 Services using a similar method, this -- so the

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1 seven-to-60-day to calculate costs associated with a  
 2 surgical procedure.  
 3 Was that a specific surgical procedure?  
 4 Or is that a more generic kind of approach that they  
 5 take?  
 6 A They have specific procedures that they  
 7 are currently paying using that method. I don't  
 8 have the list of those procedures.  
 9 I do know that they include -- they have  
 10 started with defined procedures related to hip  
 11 replacement and knee replacements.  
 12 Q So high volume --  
 13 A There may be others.  
 14 Q So relatively high volume --  
 15 A High volume, high cost.  
 16 Q Sorry.  
 17 A I'm sorry.  
 18 MR. ROTH: No cross talk.  
 19 A They tend to be high volume, high cost,  
 20 and -- and -- and well- -- well-defined. There --  
 21 there's a surgical procedure with point that  
 22 starts. And then, they can calculate the end date  
 23 from there.  
 24 BY MR. DUPUIS:  
 25 Q So does that work as well in a situation

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1 like this where there's -- there's not as high  
2 volume?  
3 A Yeah. It works equally as well here.  
4 Yes.  
5 Q Okay. Is there a reason that they use  
6 that for the high volume situations and not --  
7 or -- or am -- am I over-interpreting what you  
8 said?  
9 Did they use it for low volume  
10 procedures, as well?  
11 A They picked those as well-defined, so  
12 that they could study it. It's in a study phase --  
13 Q Okay.  
14 A -- right now.  
15 Q So in the -- later on page 6, your  
16 "Gather Enrollment, or Exposure Data," that's where  
17 you talk about the assumptions that you made  
18 about -- that there is coverage, in fact -- if --  
19 if there are -- if there are claims that are paid  
20 that you're assuming that they're -- that the plan  
21 in question covered it, but not -- you're not  
22 making the opposite assumption. But you are -- you  
23 accept -- assess whether or not that was a material  
24 difference?  
25 A I -- I did look at it.

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1 Q Okay. But you didn't actually -- that  
2 wasn't part of your choice to re- -- to -- to, sort  
3 of -- I mean, you essentially took a midpoint  
4 between point one -- between four cents and ten  
5 cents. Correct?  
6 A Yeah.  
7 Q And that was not specifically to adjust  
8 for this possibility. Correct?  
9 A There are a lot of moving parts in -- in  
10 this. And that is one source of analysis that led  
11 me to do that. But it's not the only one.  
12 Q Okay. What else led you to -- to -- to  
13 take the midpoint?  
14 A Just the uncertainty of the -- the small  
15 numbers and the variability in costs between the  
16 patients.  
17 Q Okay. So I have one question about  
18 Table 1A and Table 1B and their relationship. So  
19 Table 1A has four hundred and -- it identifies 469  
20 individuals with surgery. And it has a total cost  
21 for the surgery for those people of 7,257,523 with  
22 a cost per person of 15,747. Correct?  
23 A Uh-huh.  
24 Q And then, in Table 1B, you've got  
25 reassignment surgery, four hundred sixty -- same 469

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1 individuals, I assume. Is that correct?  
2 A Yes.  
3 Q Fair assumption?  
4 A Yes.  
5 Q And the total cost number for surgery is  
6 higher?  
7 A Uh-huh.  
8 Q Do you know why that is?  
9 A Some of those costs are -- are teased  
10 out from the bundle or from the period around the  
11 reassignment surgery and placed back into the other  
12 categories that are listed there.  
13 So there's some -- there is some -- I'd  
14 have to examine the details that are underneath it.  
15 But there are -- well, let me -- let me phrase it  
16 this way. So the 469 is the total. But if you  
17 look at the individuals by each category, that  
18 obviously doesn't total --  
19 Q Right.  
20 A -- to 469.  
21 Q Right.  
22 A Because people are in multiple  
23 categories at the same time. And so I've -- I've  
24 identified the costs associated with the  
25 reassignment surgery in Table 1A. And then, I've

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1 identified the cost of the individuals that had --  
2 or the patients that had reassignment surgery --  
3 Q Right.  
4 A -- and the various things that happened  
5 to them, including the hormonal therapy and etc.  
6 So the numbers, you'll see, go up because of that.  
7 So it expands a little bit the -- the -- kind of,  
8 the -- the more broader perspective of -- of what's  
9 going on.  
10 Q So are those numbers being pulled out of  
11 these other categories, then, for this 469 -- this  
12 group of 469? Or are they double-counted?  
13 A No. They're not double-counted.  
14 Q All right.  
15 A I was careful -- I don't believe they are  
16 double-counted. There's a lot of complexity  
17 underneath here. But I don't believe they're  
18 double-counted. I took care to not double-count  
19 them.  
20 Q Okay. Did you do the calculations here  
21 with somebody else? Or was --  
22 A I did --  
23 Q -- somebody else --  
24 A -- them.  
25 Q -- doing them --

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1 A I did --  
 2 Q -- for you?  
 3 A -- them.  
 4 Q And was it, like, a particular software  
 5 package? Or you -- was it --  
 6 A It's a combination of -- of Sequel --  
 7 Q Which is a database?  
 8 A -- according -- which is a database.  
 9 Q Okay.  
 10 A And -- and Excel. But mostly, this was  
 11 done in Sequel.  
 12 Q Okay. Okay. So -- so that's not MARA.  
 13 It's a -- it's not -- it's a -- an artifact of  
 14 having people -- it -- this show -- the Table 1A is  
 15 capturing -- is not capturing some costs under the  
 16 reassignment surgery section that are captured in  
 17 Table 1B. But those aren't duplicated for those  
 18 people because they're --  
 19 A Right.  
 20 Q -- appearing -- but they are -- they're  
 21 not appearing in one of these other places,  
 22 presumably?  
 23 A Yes. That's correct.  
 24 Q As far as you know?  
 25 A To the best of my ability, that's what I

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1 did.  
 2 Q Okay.  
 3 A Yes.  
 4 Q Okay. And that -- would that be a  
 5 material difference if that were --  
 6 MR. ROTH: Objection. Vague.  
 7 You can answer.  
 8 A I -- I -- I -- I -- I don't know. I'd  
 9 have to -- if -- if I missed, I'd have to look and  
 10 see what that is. But I don't think -- I was pretty  
 11 careful not to miss.  
 12 BY MR. DUPUIS:  
 13 Q Okay. Well, I -- I'm saying if you  
 14 missed, would it be material?  
 15 A I don't know. I'd have to assess that.  
 16 Q Okay. Could you explain what you mean  
 17 in the -- the -- the one-sentence paragraph that  
 18 starts with "As discussed further below, the true  
 19 PMPM figure based on this data is somewhere between  
 20 four and ten cents, since each set of calculations  
 21 does not precisely track the coverage exclusion at  
 22 issue."  
 23 A Yes. So this another one of those, kind  
 24 of, vagaries in terms of how to define the benefit.  
 25 Q Okay.

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1 A So individuals that, for example, are  
 2 receiving hormone treatment therapy may or may not  
 3 elect to go on to surgery. I understand that they  
 4 may have to attest that they won't go on to receive  
 5 surgery.  
 6 But I do not necessarily know that they  
 7 can't change their mind later, for example. And so  
 8 the -- and then, there are issues about the  
 9 definitions of the -- of the surgery and the extent  
 10 of which it is, most of which we try capture in the  
 11 bundle, but some of which may be beyond that.  
 12 Also, some of the things that we capture  
 13 within the bundle, while they -- I believe that  
 14 they are all related to the surgery, there may be  
 15 other comorbid conditions that may have been  
 16 treated even if they had not received the surgery.  
 17 Q In -- in other words -- oh, okay. So  
 18 they -- they received the care and it would have  
 19 been covered?  
 20 A Right. Right. So there's -- there's,  
 21 kind of, gives and takes, you know, subtractions  
 22 and additions that you might consider when looking  
 23 at the details inside the database. Remember,  
 24 there's -- for this population, there's somewhere  
 25 in the neighborhood of 400- -- 450,000 records that

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1 we're looking at.  
 2 And so we're looking at ways to try to  
 3 distill that into numbers that make sense for  
 4 pricing a benefit. And then, we're trying to  
 5 isolate those that would actually -- anticipating  
 6 those that would actually be adjudicated in the way  
 7 it needs to be administered if the benefit were --  
 8 the exclusion were eliminated.  
 9 And so we've done our best to try to  
 10 isolate those. But there are still uncertainties in  
 11 our analysis that would show that there is variance  
 12 in there.  
 13 So by picking the midpoint of a range,  
 14 and I -- and if I pick the ranges appropriately,  
 15 then, I should be able to get at least, you know,  
 16 a, On average, this is about what I would expect in  
 17 any given year given all of the information that we  
 18 are a little bit uncertain about.  
 19 Q Okay.  
 20 A And that's just the nature of database  
 21 work and the way it works.  
 22 Q Okay. Table 1C includes, sort of, cost  
 23 ranges. And I assume it's -- and so the cost range  
 24 is zero to \$250 in a percentage of individuals who  
 25 had a diagnosis of gender dysphoria and had a cost

40 (Pages 151 to 154)

<p style="text-align: right;">Page 155</p> <p>1 between zero and \$250 for the year --</p> <p>2 A Uh-huh.</p> <p>3 Q -- was 2.3 percent. And then, the next</p> <p>4 range is actually 251 to a thousand?</p> <p>5 A Correct.</p> <p>6 Q Okay. So did you -- why did you choose</p> <p>7 these cutoffs?</p> <p>8 A They're somewhat arbitrary. You'll</p> <p>9 notice that it's sort of a -- a logarithmic scale.</p> <p>10 So this is based on judgment and just to give you</p> <p>11 a -- a finite number of categories to look at, but</p> <p>12 also, to give you a sense of range.</p> <p>13 Q Okay. It's not quite logarithmic.</p> <p>14 A It's not. It -- it -- if you -- if you</p> <p>15 actually did the math in your head, I'd be</p> <p>16 impressed.</p> <p>17 Q No, I didn't do the math.</p> <p>18 MR. ROTH: Let's see -- let's see</p> <p>19 what you have and how close you can get.</p> <p>20 MR. DUPUIS: I haven't actually</p> <p>21 calculated a log in --</p> <p>22 MR. ROTH: Since eighth grade --</p> <p>23 MR. DUPUIS: I had -- I had three</p> <p>24 semesters of calculus.</p> <p>25 MR. ROTH: Oh, okay.</p>	<p style="text-align: right;">Page 157</p> <p>1 Q Okay. So on page 10, you talk about the</p> <p>2 Naugle study a little bit.</p> <p>3 A Uh-huh.</p> <p>4 Q You searched the -- the -- and this is</p> <p>5 your colleagues at Milliman. In their data set,</p> <p>6 they searched a 2012 medical claims data set. Is</p> <p>7 this the -- that -- what you thought was the Truven</p> <p>8 data set?</p> <p>9 A This -- this was described to me as the</p> <p>10 Truven data set.</p> <p>11 Q Okay. So you didn't do it yourself,</p> <p>12 obviously?</p> <p>13 A I did not.</p> <p>14 Q Okay. And -- and if they found</p> <p>15 .004 percent of members had an insurance claim</p> <p>16 related to gender dysphoria, you -- you say, "This</p> <p>17 analysis likely underestimates the true rate of</p> <p>18 gender-dysphoria related claims." Why -- why do you</p> <p>19 say that?</p> <p>20 A Well, this was prior to the -- okay.</p> <p>21 Two things: Many employers have begun to remove</p> <p>22 the exclusions in the gender reassignment benefits.</p> <p>23 So part of it is that there may have been a number</p> <p>24 of claims that were done and paid for by the member</p> <p>25 themselves, as opposed to through a benefit and</p>
<p style="text-align: right;">Page 156</p> <p>1 BY MR. DUPUIS:</p> <p>2 Q I'm going to actually end up coming back</p> <p>3 to this, but I -- I'm going to pass on to another</p> <p>4 topic for a moment.</p> <p>5 So on page 10, I just want to check</p> <p>6 with -- I -- I assume that is a typo. But on --</p> <p>7 on -- you talk about "identifying as gender</p> <p>8 dysmorphic does not necessarily mean individuals</p> <p>9 seek related health care services."</p> <p>10 Is that --</p> <p>11 A Oh, on --</p> <p>12 Q You see that? This is on the second --</p> <p>13 A Oh.</p> <p>14 Q -- paragraph -- second real --</p> <p>15 A Then --</p> <p>16 Q -- paragraph -- "identifying as gender</p> <p>17 dysmorphic."</p> <p>18 See that?</p> <p>19 A Yes.</p> <p>20 Q I -- is that a term that you saw in the</p> <p>21 literature somewhere? Or is that an error?</p> <p>22 A It could be an error.</p> <p>23 Q Okay.</p> <p>24 A I don't recall what was in my mind when I</p> <p>25 actually typed -- typed that.</p>	<p style="text-align: right;">Page 158</p> <p>1 because it was not a covered benefit at the time.</p> <p>2 Q So it wouldn't be captured?</p> <p>3 A It wouldn't be captured.</p> <p>4 The other piece is, as I mentioned a</p> <p>5 little bit down there, is that the ICD-9 I don't</p> <p>6 think is quite as -- as -- I don't think people were</p> <p>7 coding gender dysphoria very well at the time,</p> <p>8 either.</p> <p>9 So I didn't talk about this in the</p> <p>10 report. But they -- I do think that there is -- was</p> <p>11 a reluctance to put the -- the diagnosis on the code</p> <p>12 in order for the -- sometimes for the payment to go</p> <p>13 through.</p> <p>14 So I don't think the diagnosis code was</p> <p>15 accurately reflecting what was happening in the</p> <p>16 claims database. I don't think they were always</p> <p>17 identified in those individuals.</p> <p>18 Q Do you have -- what is the basis for</p> <p>19 that?</p> <p>20 A I have -- that's -- that is pure</p> <p>21 speculation, pure --</p> <p>22 Q Okay. So at least part of your</p> <p>23 assessment that this is a likely underestimate is</p> <p>24 based on speculation about --</p> <p>25 A It --</p>

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1 Q -- claims behavior?  
 2 A And so the number is unusually low  
 3 compared to what I would expect. And I --  
 4 Q Expect compared to what --  
 5 A Con- --  
 6 Q -- you've seen in other --  
 7 A What I've seen in other -- in other  
 8 reports and in other -- and as you said --  
 9 mentioned before, the studies that I had done on  
 10 incidence and prevalence and, also, on the data  
 11 that we were seeing in 2016.  
 12 Q Can I just back up?  
 13 Incidence and prevalence of --  
 14 A Claims --  
 15 Q -- procedures or --  
 16 A Just --  
 17 Q -- the underlying condition?  
 18 A The underlying condition. So, for  
 19 instance, the -- the -- the report that we looked  
 20 at, the epidemiology study in 2017.  
 21 Q Zucker?  
 22 A Right.  
 23 Q Uh-huh.  
 24 A Zucker. So I'm looking for reasons why  
 25 the numbers in 2012 were -- you know, seemed so low

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1 compared to what we would expect.  
 2 Q And so what you expect is based more on  
 3 current what you've seen in the database?  
 4 A Yeah. We've learned a lot since 2012.  
 5 Correct.  
 6 Q But since there's -- since 2012, there's  
 7 also been -- because there's been an increase in  
 8 the number of exclusions, there might -- an in --  
 9 an increase in the removal of the exclusions,  
 10 therefore, more coverage availability, there might  
 11 be -- the -- this current time period might  
 12 actually be elevated because there was a pent-up  
 13 demand?  
 14 A Correct. Pent-up demand is one of the  
 15 things we talked about. Yes.  
 16 Q Yeah.  
 17 A It's possible.  
 18 Q So it's possible that it could return to  
 19 a mean that is lower than your estimate?  
 20 A That is one of the possibilities. Yes.  
 21 Q Unlikely to revert all the way back to  
 22 .004 percent, though?  
 23 A I would not anticipate it going back to  
 24 there.  
 25 Q So your estimate was .041 percent, which

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1 is essentially a hundred -- a hundred times for 2012  
 2 data?  
 3 A Correct.  
 4 Q And some of that may be pent-up demand?  
 5 A It's possible. I don't know that, but  
 6 it's possible.  
 7 Q Okay.  
 8 MR. ROTH: Is that -- is that a  
 9 hundred times? My math is a little off.  
 10 THE WITNESS: How many decimal  
 11 points did you move?  
 12 MR. ROTH: Just one.  
 13 BY MR. DUPUIS:  
 14 Q Oh.  
 15 MR. ROTH: Then, it's 10 points.  
 16 BY MR. DUPUIS:  
 17 Q Ten. Yup. Sorry. There are -- there  
 18 are a lot of zeroes in front of it, if you count  
 19 the ones before the -- so it's -- it's 10 times  
 20 the --  
 21 MR. ROTH: Yeah.  
 22 A I have to do the mental math too. So --  
 23 BY MR. DUPUIS:  
 24 Q Yeah. This is why I'm not an actuary.  
 25 Well, among many other reasons.

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1 So that when you -- in -- in the next  
 2 paragraph, you say, "While" -- this on page 11 --  
 3 "While the annual utilization figure found in the  
 4 database" -- which is the .041 percent --  
 5 correct? --  
 6 A Uh-huh.  
 7 Q -- "remains lower than the prevalence  
 8 rates from self-reported sources discussed  
 9 above..."  
 10 And there, you're talking more about  
 11 prevalence -- not of utilization, but prevalence of  
 12 the condition. Right?  
 13 A Correct.  
 14 Q Okay. So, I mean, this -- the -- the  
 15 way this is written, it suggests that you think  
 16 that the utilization rate should be closer to the  
 17 prevalence rate than it is even here?  
 18 A Well, so there may be -- so that there  
 19 may be some clarification here. So continue to  
 20 read: "The .41 percent utilization rate comes  
 21 closer to describing the expected method of  
 22 utilization for gender reassignment benefits than  
 23 self-reported prevalence studies."  
 24 So I was just reiterating my prior  
 25 observation that the self-reported studies are high

42 (Pages 159 to 162)

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1 and that we would expect the database to be low.  
 2 And this is --  
 3 Q Okay.  
 4 A -- verifying that fact.  
 5 Q Okay. And, again, the Schatten and  
 6 Vieira Segal report most- -- mostly just made use  
 7 of it as a check against the -- the -- another data  
 8 point to check your numbers against?  
 9 A Correct.  
 10 Q But you independently calculated per  
 11 member per month of .084 using the information  
 12 available in that report. Correct?  
 13 A I don't --  
 14 Q On --  
 15 A -- see the zero -- .084.  
 16 Q It -- it's not --  
 17 A Oh, there we go. Yes.  
 18 Q That's the eight cents --  
 19 A Oh, okay.  
 20 Q -- figure?  
 21 A Yup. Yup.  
 22 Q When you say you calculated using their  
 23 numbers, can you tell me -- show me what that  
 24 calculation was on Exhibit --  
 25 MR. DUPUIS: We did put that in,

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1 didn't we?  
 2 Yeah.  
 3 BY MR. DUPUIS:  
 4 Q Exhibit 8, what did -- what did you use  
 5 to get to that point? It wasn't just averaging --  
 6 or taking the midpoint?  
 7 MR. ROTH: It's in your --  
 8 THE WITNESS: Yeah.  
 9 (Whereupon, there was a discussion  
 10 off the record.)  
 11 BY MR. DUPUIS:  
 12 Q It wasn't just taking the midpoint?  
 13 A No. What I tried to do is I tried to use  
 14 the -- this is a -- I'm sure this took me much  
 15 longer, but this is an hour or two of exercise for  
 16 me.  
 17 The -- we used the information that they  
 18 had as key assumptions. And I tried to then apply  
 19 those to -- to find those key assumptions and apply  
 20 them to the table and their various components,  
 21 including the variances between prevalence of high  
 22 and low; their estimated cost; and then, the  
 23 resulting cal- -- calculations in the cost  
 24 estimate.  
 25 And -- and then, to basically compute

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1 for myself the math that they went through to go up  
 2 through -- to find the column in the low and high  
 3 and the cost estimate on the right of the table.  
 4 Q Okay.  
 5 A And then, added that up to come up with  
 6 the -- the number between .05 and .13. But  
 7 ultimately, I did come up with a number between  
 8 those two, but it was a little bit different than  
 9 the point estimate I think that they had found. But  
 10 anyway, it came out --  
 11 Q Actually, I don't think they -- I don't  
 12 think they had a point estimate, did they?  
 13 A Oh, maybe they didn't. Maybe they  
 14 didn't.  
 15 But so, I -- I -- ultimately, I concluded  
 16 that I was in the right range.  
 17 Q I -- I believe there was a point estimate  
 18 in the Maryland one. And it was, I think, lower  
 19 actually, than the .7 cents. Does that ring a  
 20 bell?  
 21 A It might have been. I don't recall  
 22 specifically.  
 23 Q I -- unfortunately, I didn't bring it.  
 24 You -- you say that there's no mention of  
 25 the definition of a benefit in the Segal

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1 Consulting, Exhibit 8.  
 2 And you say "The latter omission" -- you  
 3 said, "...or any adverse outcomes or co-morbidities  
 4 that may be associated with the procedures. The  
 5 latter omission" -- meaning, co-morbidities --  
 6 "could cause Segal to report to underestimate the  
 7 true costs."  
 8 You don't know if it did or didn't,  
 9 though, do you?  
 10 A I don't. So the cost of treatment, as  
 11 defined on page 2 of that report --  
 12 Q Uh-huh.  
 13 A -- information was provided at a very  
 14 high level from a national medical vendor. That's  
 15 their citation --  
 16 Q Uh-huh.  
 17 A -- which is vague enough that I -- I  
 18 would liked to have had more information about --  
 19 Q Uh-huh.  
 20 A -- the year and the nature of the  
 21 benefits they used to describe that and which  
 22 procedures were included and how often -- things  
 23 like that.  
 24 So it is lacking specificity for me to be  
 25 able to rely -- to not ask questions be -- and or at

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1 least ad- -- address it as a --  
 2 Q Okay.  
 3 A -- potential source of -- of variance,  
 4 even though I kind of relied on it for that midrange  
 5 point.  
 6 Q Okay. So you -- you -- I mean, you rely  
 7 on it in the sense that you have a footnote that --  
 8 A Footnote for --  
 9 Q -- gives that?  
 10 A -- it. Right.  
 11 Q But that's not your point estimate?  
 12 A It's not my point estimate.  
 13 Q Your point estimate based on the data  
 14 that you looked at is .7?  
 15 A Yes.  
 16 Q Or seven cents?  
 17 A I used this as a -- as a reference  
 18 point.  
 19 Q Right.  
 20 A And I tried to do a little due diligence  
 21 as to whether or not the reference point was a  
 22 reasonable reference point. But yeah, you're  
 23 correct. I did not rely on it.  
 24 Q So on page 12, in the -- the  
 25 paragraph -- the third paragraph says, "The

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1 implication of this wide range of average costs is  
 2 that the expected total cost for a population of  
 3 around 167,500" -- which is the -- the state  
 4 employee population. Correct?  
 5 A I -- I believe that was the number that  
 6 was provided to me. Yes.  
 7 Q Okay. And who provided that number to  
 8 you?  
 9 A It would have been Mr. Roth.  
 10 Q Okay. Do you remember what format he  
 11 provided that? Was it just a -- an E-mail he sent?  
 12 Or was it a document of some sort?  
 13 A I don't recall.  
 14 Q Okay. You say anyway that the -- the  
 15 wide range of average costs, the implication of that  
 16 is that total expected costs would be highly  
 17 variable in a population of around 167,500.  
 18 Correct?  
 19 A Correct.  
 20 Q And you talk about the possibility that  
 21 they couldn't -- in any given year, there could be  
 22 an adverse year of claims with more individuals  
 23 seeking surgery than predicted.  
 24 And one individual with a catastrophic  
 25 claim could significantly -- significantly raise

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1 average in total costs. I just want to confirm the  
 2 opposite could be true, as well. Right?  
 3 A It could be.  
 4 Q It could have fewer claims than  
 5 expected?  
 6 A Possible.  
 7 Q They could have lower costs than  
 8 expected?  
 9 A It could.  
 10 Q And, in fact, the chances of either are  
 11 pretty much equal.  
 12 A I don't know that.  
 13 Q What would you need to know to know  
 14 that?  
 15 A I would like to have many more years of  
 16 data to be able to calculate that.  
 17 Q Okay. So you talk about some of the  
 18 sources of variability of costs. And this is cost  
 19 per, sort of, person, I think. And one of them is  
 20 the level of reconstruction?  
 21 A Uh-huh. Yes.  
 22 Q So I just want to confirm some of these  
 23 procedures are -- would be covered for other  
 24 purposes, such as congenital anomalies, injury, post  
 25 cancer treatment -- that sort of thing?

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1 MR. ROTH: Objection. Speculation.  
 2 You can answer it if you can.  
 3 A Some of these are -- are covered  
 4 benefits. Some of them are sometimes excluded  
 5 benefits. But otherwise, yes. They could be for  
 6 things that -- other than for treating patients with  
 7 gender dysphoria.  
 8 BY MR. DUPUIS:  
 9 Q Okay. So in the paragraph that begins  
 10 with "For example" --  
 11 A Uh-huh. Yes.  
 12 Q -- "it's possible that in a given year,  
 13 an ETS population of around 175- -- 167,500, eight  
 14 individuals might submit claims for gender  
 15 reassignment surgery rather than three to four at  
 16 an average cost of 100,000 rather than the  
 17 calculated average cost of around 21,000."  
 18 Correct?  
 19 A That's what it says.  
 20 Q It's -- what are the odds of that  
 21 happening, do you know?  
 22 A I don't know the odds. I'm giving a  
 23 speculative example of -- of -- you might call it a  
 24 worst case scenario.  
 25 Q Uh-huh.

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1 A It's not unplausible. But it -- I don't  
2 know the exact odds, because I don't have enough  
3 years of data to be able to calculate it.

4 Q Okay. When you say, "In your  
5 professional experience, this would not be an  
6 unusual variance." Based on what do you say that?

7 A I've seen surprises of -- particularly  
8 with small numbers like this where you get a year  
9 where you have adverse experience that goes beyond  
10 the expectations of the plan and causes them to  
11 make some adjustments in their finances. So it  
12 might --

13 Q Can you think of an example?

14 A We have seen -- we have seen -- we have  
15 seen high cost cases in general be higher than  
16 expected on occasion. I can think of specific  
17 examples. I'm not going to give them to you with  
18 names, because they are clients.

19 Q No. I'm talking about like a  
20 procedure -- a comparable procedure.

21 A Yeah. So we have seen -- so -- so it --  
22 it's very common for high cost services -- high  
23 cost claims, for example, claims over -- let's pick  
24 a threshold of a hundred thousand dollars.

25 We often calculate an actual-to-expected

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1 variance for those services based on the -- and the  
2 expected is based both on the size of the  
3 population and on the -- on the types of high cost  
4 services that would -- you would expect.

5 And we do see -- we do see situations  
6 where for that employer group, they have high cost  
7 cases that exceed the expected values by a  
8 significant amount and -- and --

9 Q When you --

10 A -- challenge their -- and challenge  
11 their -- their finances.

12 Q When you say "expected amount," are you  
13 talking expected amount per service or expected  
14 amount for the service in general, including both  
15 frequency and cost?

16 A Frequency and cost. So it would be both  
17 the number of individuals that have exceeded the  
18 high cost threshold --

19 Q Uh-huh.

20 A -- and the intensity of those in terms of  
21 the average cost. Yeah. Well, and -- and also, the  
22 average cost per patient.

23 Q Okay.

24 A Yeah. We have seen both.

25 Q All right. What would -- I'm -- I'm

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1 having trouble understanding you. What would --  
2 what you would be disclosing, that wouldn't --  
3 I'm -- I'm not asking you to identify a plan or a  
4 place -- a place. And so it's -- like, what service  
5 are -- are we talking about that -- where this has  
6 happened?

7 A So I'm talking just a little bit  
8 generically and applying my experience generically  
9 to this particular example.

10 So high cost services could be  
11 everything from neonatal intensive care unit. So  
12 babies that are born prematurely and end up in  
13 the -- in the NICU. Or it could be cancer cases  
14 that have complications. Or it could be heart  
15 surgeries or a sudden onset of a -- of a -- of a  
16 rare disease that cause high cost claims.

17 So -- but any time you have a small  
18 number of rare disease or a small number of  
19 individuals -- one or two or three within a  
20 population -- the range of variance, given the --  
21 the potential for the types of services that could  
22 be incurred here is -- can be quite, quite large.  
23 So that in any given year, if you're expecting  
24 three, it's not unusual for you to end up with  
25 six --

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1 Q Uh-huh.

2 A -- or eight in a given year.

3 Now, does that happen every year? No.  
4 It does not happen every year.

5 But it's not unusual for you to end up  
6 with a -- a doubling or even a -- exceeding a  
7 doubling, and also, the average cost to go from a  
8 hundred thousand dollars to 400 or 800 thousand  
9 dollars for a -- a certain set of individuals that  
10 really stretch your -- your finances for that. So  
11 it's not unusual for that to happen, given the  
12 small numbers and the degree of variability.

13 Q But you're -- if -- if I'm understanding  
14 what you're saying correctly, you're aggregating,  
15 like, top -- all kinds of things that might hit some  
16 threshold of high cost. And what we're talking  
17 about here in -- in your report is one slice of  
18 that.

19 I mean, the state has a number of -- for  
20 things that it covers that might contribute to  
21 that. Correct?

22 I mean, you did these -- the unexpectedly  
23 complex cancer treatment or heart surgery. They're  
24 already covering those. Right? So how much are you  
25 talking about introducing a different variance

45 (Pages 171 to 174)

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1 here?

2 MR. ROTH: Objection. Vague.

3 A So we are -- I'm applying general

4 experience with rare conditions and high cost

5 cases, and I am applying that to a specific case

6 here. And I am making a judgment, and I'm stating

7 that even though it's a specific benefit that you

8 are -- are working with, the potential for

9 variability is quite high.

10 BY MR. DUPUIS:

11 Q Okay.

12 A And -- and it would not be unusual to --

13 to see the numbers be considerably higher than what

14 we stated here in our range. Do we expect it every

15 year? No. But it's -- it's a contingency that

16 people need to be aware of.

17 Q Okay. So the

18 seven-cent-per-member-per-month --

19 per-member-per-month cost that you calculated as

20 your point estimate is .01 percent of total

21 premium -- of the state's total premium. Correct?

22 A That sounds correct, although I can't

23 find it on the page that I'm on.

24 Q It's on page 13. Sorry. Are -- are you

25 on 13?

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1 A I am --

2 Q It's the second paragraph or first full

3 paragraph.

4 A I got it. Yes.

5 Q Okay. And you blended the Segal data

6 from the January 23rd, 2017, memo to increase the

7 total per surgery in your estimate. Is that

8 correct?

9 A I --

10 Q I mean, it looks like it's -- ends up at

11 the same number.

12 A It -- it does, which -- which was kind

13 of magical, which surprised me when I did the

14 calculation. But -- so the reason I did that is

15 because of -- it wasn't to increase it.

16 It was because -- I think there's just a

17 lot or uncertainty around -- so -- I want to

18 rephrase that. I think there's a lot of variance

19 around these numbers, and some of the numbers are

20 new.

21 And I've got a -- I've got people that

22 are knowledgeable over here saying something and

23 giving information. And I've got my own

24 information that I've been doing. And so I said,

25 Okay. What happens if I kind of combine the two of

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1 them together and, sort of, blend the experience of

2 two professionals working, you know, in different

3 areas that have written a report? What happens if

4 I combine the two?

5 I end up with the same result,

6 essentially. But I think that it sort of gives

7 power to --

8 Q Okay.

9 A -- to the -- to the numbers that

10 you've -- that I've predicted. But then, it

11 wasn't -- the intention wasn't necessarily to

12 increase it. It was to blend together, you -- you

13 know, two groups of individuals that are working,

14 kind of, in the same area and -- and see what

15 happened.

16 Q Okay. So is it fair to say that the -- I

17 mean, these sort of choices that you've made to do

18 these various -- some of these things are really

19 sort of ad hoc as -- and a function of the

20 uncertainty, because there hadn't been a lot of

21 claims data yet?

22 A It -- it -- so not having a lot of claims

23 data leads to further uncertainty. And so I'm

24 looking for ways to -- to strengthen -- to

25 strengthen or to, you know, sort of verify the --

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1 the results and -- and feel as -- as comfortable as

2 I can about them. Those were the -- the things I

3 was trying to do.

4 Q Okay. And -- and doing that here led you

5 to the same number?

6 A It did.

7 Q But you still felt like you needed to

8 add a 50-percent risk factor for utilization and

9 cost?

10 A I did. Yes.

11 Q Okay. On the -- at the last paragraph

12 before "other considerations," you said, "its

13 approach would cover most contingencies of high

14 claim costs associated with a gender reassignment

15 benefit, but it would result in excess revenue

16 during an average or below-average utilization

17 year."

18 That sounds to me like you're doing a

19 worst case scenario?

20 A I don't know if I would call it a worst

21 case scenario, but it's a bad-case scenario.

22 Q Okay.

23 A I don't know what --

24 Q Do you --

25 A -- worst case --

<p style="text-align: right;">Page 179</p> <p>1 Q -- do you --</p> <p>2 A -- scenario --</p> <p>3 Q -- do you know what the odds are of --</p> <p>4 of that -- of a scenario that would -- where you</p> <p>5 would reach, essentially, doubling from your point?</p> <p>6 A I don't have a way to calculate the</p> <p>7 odds. I don't have enough history of claims that</p> <p>8 I'd be able to calculate that.</p> <p>9 Q And then, you said "The risk margin</p> <p>10 would be reviewed and adjusted annually based on</p> <p>11 the financial position of the plan at the time and</p> <p>12 additional future claims data."</p> <p>13 So basically, what you're saying is if</p> <p>14 they have excess revenue as a result of this, they</p> <p>15 could consider adjusting the risk margin for the</p> <p>16 following year?</p> <p>17 A Yes.</p> <p>18 Q All right. And do you know of any other</p> <p>19 plans that have a -- built in a risk margin this</p> <p>20 large for this benefit -- or a comparable benefit, I</p> <p>21 should say?</p> <p>22 A I don't have any specific information on</p> <p>23 that.</p> <p>24 Q Do you have any general information on</p> <p>25 that?</p>	<p style="text-align: right;">Page 181</p> <p>1 January through December. And when you consider a</p> <p>2 60-day bundle, if you started that bundle on</p> <p>3 December 15th, you only have 15 days to run out for</p> <p>4 the bundle.</p> <p>5 And there's no additional data to support</p> <p>6 that. I didn't have the data going backwards with</p> <p>7 the --</p> <p>8 Q Truven.</p> <p>9 A -- I do have Truven data going</p> <p>10 backwards, but not with the same benefit coverages.</p> <p>11 So there was -- it started to become a</p> <p>12 apples-to-oranges to go outside of that particular</p> <p>13 calendar year to be able to go backwards with it.</p> <p>14 Q And did 2017 not exist yet? So you</p> <p>15 couldn't --</p> <p>16 A 2017 --</p> <p>17 Q -- have tried to capture it on the other</p> <p>18 end?</p> <p>19 A Correct. 2017 is not available yet.</p> <p>20 Q Okay. So the effect would be a possible</p> <p>21 slight increase in cost?</p> <p>22 A Yeah. So I may be underestimating this</p> <p>23 .7 slightly, because I'm not capturing all of the</p> <p>24 bundled services for --</p> <p>25 Q Would it --</p>
<p style="text-align: right;">Page 180</p> <p>1 A I don't.</p> <p>2 Q Okay. But you did indicate that the</p> <p>3 risk margin -- your recollection is that the risk</p> <p>4 margin for San Francisco ended up being higher than</p> <p>5 necessary. You just don't know what that margin</p> <p>6 was?</p> <p>7 A I don't recall what it was.</p> <p>8 Q Okay. "Other considerations," the --</p> <p>9 the -- on page 13, the first one is, you say it's</p> <p>10 possibility there was pent-up demand.</p> <p>11 So this is sort of acknowledging what we</p> <p>12 talked about before, is that the 2016 data might</p> <p>13 actually be an artifact of pent-up demand, and it</p> <p>14 could revert to a lower utilization. Right?</p> <p>15 A It's possible.</p> <p>16 Q Do you think that's likely?</p> <p>17 A Well, I've given it some thought, and I</p> <p>18 guess I don't know -- I really don't know the</p> <p>19 answer. I'm as curious as anybody to see --</p> <p>20 Q Okay.</p> <p>21 A -- 2017.</p> <p>22 Q Okay. Item No. 3 in your list, can you</p> <p>23 explain how that would affect things?</p> <p>24 A Oh, yeah. Yes. So the period of the</p> <p>25 database that we're looking at is 12 months --</p>	<p style="text-align: right;">Page 182</p> <p>1 A -- for the --</p> <p>2 Q -- be -- do --</p> <p>3 A -- for -- for --</p> <p>4 Q -- you --</p> <p>5 A -- for services that occurred af- --</p> <p>6 after 60 days, after November 1st.</p> <p>7 Q Do you think that it is likely a material</p> <p>8 amount or no?</p> <p>9 MR. ROTH: Objection. Vague.</p> <p>10 You can answer.</p> <p>11 A So I'm speculating, but I don't think it</p> <p>12 would be a -- a game-changer in the numbers that we</p> <p>13 calculated.</p> <p>14 BY MR. DUPUIS:</p> <p>15 Q And you -- it -- it -- its, sort of,</p> <p>16 threshold, you said it was a penny --</p> <p>17 A Yeah.</p> <p>18 Q -- per member per month?</p> <p>19 A A penny --</p> <p>20 Q Would it be --</p> <p>21 A Yeah. A penny or two. Yeah. We're</p> <p>22 going from .4 to --</p> <p>23 Q Yeah.</p> <p>24 A -- .13 -- or .14 --</p> <p>25 Q All right.</p>

47 (Pages 179 to 182)

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1 A -- something like that. So it's not a  
2 huge -- a --

3 Q Did -- did you do anything to look at how  
4 much of the cost in the bundles clustered around the  
5 date of the procedure?

6 A I may have looked at individuals to  
7 verify my methodology in an ad hoc fashion where I,  
8 you know, queried three, ten, a few people, and  
9 just looked at it to see what was happening there.

10 And so in that sense, I verified it.

11 But I couldn't give you any specifics. Those  
12 were -- those were things that I did to verify as I  
13 was going through the process.

14 Q Did -- do you have any -- do you have any  
15 recollection of whether the cost clustered around  
16 the surgery pretty significantly?

17 A To put that in context, I don't. But I  
18 will tell you that these individuals receive a lot  
19 of care. And so there's a lot of -- there's a lot  
20 of -- a lot happening with these individuals.

21 And sometimes, drawing a line in terms  
22 of what should have been included in that and what  
23 shouldn't have been included in that -- I felt  
24 comfortable that we were capturing the bulk of the  
25 surgical procedures related to that within the 60

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1 use as part of the study. So it was part of the --  
2 part of the Budge report.

3 Q Uh-huh.

4 A I think that there was some -- some  
5 sense that that was being used to estimate cost.  
6 So I looked at it to see if it would be useful for  
7 any of the costing that I would be doing. But I,  
8 as you can see from my description, I -- I couldn't  
9 find anything that I found useful to pull out and  
10 include it in my -- in my analysis.

11 Q And is that -- I mean, it seems you --  
12 one -- one of the things you say that it's -- that  
13 any sort of benefit is too far out -- that time  
14 horizon is too far out for benefit-pricing  
15 purposes.

16 What -- what do you mean by that? Can  
17 you explain what you mean by that?

18 A So we're calculating the benefit for one  
19 calendar year. And our -- and the measured outcome  
20 of this study is a Quality -- a Quality Adjusted  
21 Life Year, QALY -- Quality Adjust Life year. And  
22 it's at the five- and ten-year horizons.

23 So that was the endpoint measured for the  
24 study, which is too far out for our use in what we  
25 were doing here. It -- it wouldn't be -- it

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1 days. So I was comfortable within that framework.

2 I did see people that had multiple  
3 surgeries in a given year. And so they might have,  
4 you know, one step done in January; and another  
5 step done in March; and another step done in August  
6 or something like that. I believe we were  
7 capturing all three bundles. And in some cases,  
8 the bundles even overlapped. And so this is not,  
9 you know, a clean --

10 Q Uh-huh.

11 A -- pristine process.

12 Q Okay. Okay. So I'd like to look,  
13 again, at the Padu- -- well, actually, I don't  
14 think we need to look at the Padula article yet.

15 But taking a look at your description of  
16 it, you said that these types of studies, including  
17 the Padula study, which is a -- essentially, sort  
18 of, a cost effectiveness study. So --

19 A Yes.

20 Q -- you're -- you're not critiquing the  
21 study itself. Correct?

22 You're critiquing -- you're just saying  
23 it would not be used for purposes of pricing?

24 A So I was asked to look at that study to  
25 see if there was information in there that I could

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1 wouldn't be the way we would think about it in terms  
2 of pricing a benefit.

3 Q Now, you said that there are some times  
4 when this sort of cost effectiveness measure might  
5 be used for deciding whether to cover benefits.

6 But is -- is that just not part of a  
7 pricing, but it's part of a determination of  
8 whether to cover -- I'm trying to understand  
9 when --

10 A So --

11 Q -- like, the benefit -- the -- the --  
12 the possibility of benefit or the actualization of  
13 some financial benefit from providing --

14 A So you're --

15 Q -- pieces of --

16 A -- looking at this middle paragraph --

17 Q Yeah.

18 A -- "These types of things are not used in  
19 [sic] actuarial sciences" --

20 Q Yeah.

21 A -- "for benefit pricing purposes. It  
22 lacks sufficiently detailed information to match the  
23 costs" -- I'm doing this for the reporter -- "match  
24 the costs with the benefit descriptions for a  
25 specific time period."

48 (Pages 183 to 186)

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1 So these types of studies, I am familiar  
2 with them. But they are typically not used in  
3 benefit pricing exercises. They may have a  
4 different purpose when a new benefit is being  
5 introduced.

6 They are used more extensively in Europe  
7 to make a judgment as to whether or not the -- the  
8 benefit or the device or the pharmaceutical --  
9 whatever it is that's being introduced -- is a  
10 value to the patient and to the -- whatever -- who  
11 is -- whoever's paying for the service.

12 Q Uh-huh.

13 A It may include some cost offsets that  
14 have occurred to it. But it has more to do with  
15 a -- a threshold of how much it cost to produce  
16 the -- or how much it cost to pay for the benefit in  
17 relationship to how many life years it adds to the  
18 patient --

19 Q Uh-huh.

20 A -- and the relative cost of that to the  
21 life year that -- so to the quality of the life year  
22 that is being provided.

23 Q Okay.

24 A And -- but for pure costing exercises,  
25 it's -- it's not a lot of use.

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1 I would -- did look to see if the -- if  
2 the costing pieces of it -- if I could pull  
3 information out of that and, perhaps, use it. But  
4 their data is very old, and it was not well defined  
5 enough to be able to use effectively.

6 Q I don't think I asked this yet. Is there  
7 a reason you didn't just look at the actual  
8 experience in Massachusetts rather than using the  
9 Truven database?

10 A I don't have access to the GIC  
11 databases.

12 Q Okay. Well -- and why is that? Is that  
13 just --

14 A Those are --

15 Q They're not proprie- -- I mean, it's  
16 government. Right? Or is that --

17 A Those are still proprietary.

18 Q Okay. Well, actually, is Blue Cross  
19 Blue Shield of Massachusetts fully privatized at  
20 this point? Maybe they are. I don't know.

21 A Yeah. So because of HIPAA laws, you  
22 don't --

23 Q Oh, okay.

24 A -- those data -- those data stay within  
25 the firewalls of the health plan. In the case of

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1 the GI- -- I think what you're referring to is the  
2 GIC. And Dolores does -- I'm sorry. I do know a  
3 little bit about the GIC health plan.

4 They do collect the data from the  
5 various health plans for the peo- -- for vendors  
6 that they have in their -- in their employee  
7 benefits. But that data is kept within the GIC,  
8 and only people that are granted access for  
9 certain -- certain reasons are granted access to  
10 it. And I -- this would not be -- this would not  
11 be considered that.

12 Q Okay. Do you -- do you happen to know  
13 anything about their experience from other -- I  
14 mean, not from the data. But -- yeah, do they --  
15 have they published anything in -- in general terms  
16 about this?

17 A I don't know the answer to that in terms  
18 of published for -- for public -- I do not know the  
19 answer. I feel like I've read things from them.  
20 But I don't -- I don't know the answer.

21 Q Okay. So how did you identify the  
22 articles that you did end up using and referring to  
23 in your bibliography? Was that -- did you do a  
24 literature search?

25 A Two sources: One is if it was referenced

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1 to one of the other -- so to the chain of references  
2 from other documents, like, the Budge and the Padula  
3 re- -- report.

4 I did do a combination of a -- of a  
5 PubMed search and just a general Google search to  
6 see what I could find.

7 Q Okay. Did the codes you included in  
8 your -- the ICD codes include facial feminization  
9 and masculinization?

10 A I --

11 Q I -- I believe it did. But I -- it -- it  
12 was, I think, one of the questions that wasn't  
13 absolutely clear to me.

14 Yeah. I don't think Massachusetts --  
15 Massachusetts is the first one. I believe --

16 A So it did include blepharoplasties,  
17 rhinoplasties, chin reconstructions.

18 Q Okay. So it did include some of the --  
19 the --

20 A Yeah.

21 Q -- facial --

22 A Facelifts.

23 Q Okay.

24 A Tracheal shaves.

25 Q Okay. So the answer is s basically,

49 (Pages 187 to 190)

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1 Yes, maybe not everything. But --  
 2 A Yeah. And we do -- we did recognize and  
 3 we did state that that, you know, as comprehensive  
 4 as this list of procedures was, we do recognize that  
 5 it may not have been everything.  
 6 And we did try to take some steps to --  
 7 like, through the -- through the --  
 8 Q Through the bundling.  
 9 A Yeah. Partly. But we tried to take  
 10 steps to try to fold in as much of the -- of those  
 11 as we could.  
 12 Q Okay. Sorry to go back to this Table 1A  
 13 and Table 1B thing with the differential. I just  
 14 want to verify, you did use the higher number when  
 15 you ultimately did your calculations. Right?  
 16 A Yes. So the table 1B is what's reflected  
 17 for the --  
 18 Q Yeah.  
 19 A -- surgical patients. Yes.  
 20 Q Okay. So some of the -- the same  
 21 surgical procedures that we -- that you included  
 22 and talk about on page 12 are covered for treatment  
 23 of other conditions that are excluded for treatment  
 24 of gender dysphoria -- right? -- to the extent you  
 25 know?

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1 A So say that again?  
 2 Q So some of the same surgical procedures  
 3 that are listed and that you took into account in  
 4 querying the database are procedures that are  
 5 covered -- well, for treatment of other conditions  
 6 that are excluded for treatment of gender  
 7 dysphoria?  
 8 MR. ROTH: Objection. Calls for  
 9 speculation.  
 10 You can answer if you can.  
 11 A I don't know if I can answer that.  
 12 BY MR. DUPUIS:  
 13 Q So you didn't look at the entire  
 14 Wisconsin plan in terms of coverage or lack of  
 15 coverage?  
 16 A I -- so what do mean by that? If I look  
 17 at the plan --  
 18 Q I mean --  
 19 A -- in terms of the benefit description?  
 20 Q Yeah. The --  
 21 A Or --  
 22 Q -- general benefit description for  
 23 surgical procedures, for example.  
 24 A I did look at it. And it was quite a bit  
 25 less comprehensive than the procedures that we were

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1 using.  
 2 Q Right.  
 3 A And I don't know what -- I have no idea,  
 4 in terms of how they adjudicate those claims, and  
 5 what they would include in their benefit, what they  
 6 wouldn't.  
 7 So I -- I didn't have any knowledge of  
 8 that and had no way to discern that.  
 9 Q Okay. Well, let's -- let's talk about a  
 10 couple of specifics.  
 11 A mastectomy to treat breast cancer would  
 12 be covered. Correct?  
 13 MR. ROTH: Objection. Calls for  
 14 speculation.  
 15 A I -- I -- I -- don't know.  
 16 BY MR. DUPUIS:  
 17 Q Okay. Why -- why do you not know?  
 18 A I haven't read their benefit description  
 19 for --  
 20 Q That purpose?  
 21 A -- for that purpose.  
 22 Q Okay. Okay. Do you know, roughly, the  
 23 per member per month cost of mastectomy to treat  
 24 breast cancer?  
 25 A I don't right off the top of my head.

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1 No.  
 2 Q Would it be safe to say that it's more  
 3 than the per member per month cost of gender  
 4 confirmation surgery?  
 5 A I -- I -- I don't know.  
 6 Q What about hysterectomy for cancer or  
 7 fibroids, endometriosis, uterine prolapse? Do you  
 8 know the per member per month cost of those in a  
 9 typical plan?  
 10 A I -- I don't have that information in  
 11 front of me. I don't know.  
 12 Q Hysterectomy is more common for those --  
 13 treating those conditions than for treating gender  
 14 dysphoria, isn't it?  
 15 MR. ROTH: Objection. Calls for  
 16 speculation.  
 17 You can answer it if you can.  
 18 A It would depend on the population that  
 19 you're -- that you're looking at.  
 20 BY MR. DUPUIS:  
 21 Q Let -- let's say a standard state  
 22 employee plan.  
 23 MR. ROTH: Same objection.  
 24 BY MR. DUPUIS:  
 25 Q You're going to have more hysterectomies

50 (Pages 191 to 194)

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1 to treat cancer than you are --  
 2 A I didn't -- so I don't --  
 3 MR. ROTH: Same -- just --  
 4 A -- I don't want --  
 5 MR. ROTH: -- hold on.  
 6 A -- I -- I don't want to --  
 7 MR. ROTH: Same objection.  
 8 You can answer.  
 9 A -- I don't want to be -- I don't want to  
 10 be stubborn. But I really don't know the answer.  
 11 I think, in general, I think your statement's true.  
 12 But I would like to -- I would like to run the data  
 13 to be able to answer that.  
 14 BY MR. DUPUIS:  
 15 Q Okay. But what -- same thing for  
 16 mastectomy. I mean, it's more common for a  
 17 mastectomy for breast cancer than a mastectomy for  
 18 treating gender dysphoria?  
 19 MR. ROTH: Same objection.  
 20 A Same answer. So I would -- I would want  
 21 to look at the data and understand what the  
 22 differences are.  
 23 You may have a different utilization,  
 24 and you may have a different average cost. And  
 25 you -- you don't want to end up where the PMPM

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1 value would turn out to be important. I just don't  
 2 know.  
 3 BY MR. DUPUIS:  
 4 Q Okay.  
 5 A So you're asking about utilization but  
 6 you're not asking about cost. The cost has to be  
 7 part of the equation, too.  
 8 BY MR. DUPUIS:  
 9 Q Do you have any reason to think the cost  
 10 would be different for the same CPT code -- for the  
 11 same procedure for different -- treating gender  
 12 dysphoria as opposed to treating cancer?  
 13 A So I think what you're asking, the  
 14 answer would be, No, I don't -- wouldn't expect it  
 15 to be different for the procedure level. But I do  
 16 think the mix of procedures would be quite  
 17 different.  
 18 Q Okay. So it's going to be the same  
 19 answer [sic], but breast reconstruction post  
 20 mastectomy?  
 21 MR. ROTH: Same objection.  
 22 BY MR. DUPUIS:  
 23 Q Pro- -- probably higher utilization, but  
 24 you'd want to know?  
 25 A Yeah. Generally, I would accept that.

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1 But I'd want to -- I'd want to -- I'd reserve the  
 2 right to be able to look --  
 3 Q Quantify it?  
 4 A -- at it and quantify it.  
 5 Q Yeah. Yup.  
 6 A I mean --  
 7 Q And what about orchiectomy for  
 8 testicular cancer?  
 9 MR. ROTH: Same objection.  
 10 A Ooh, that one's less -- less certain.  
 11 BY MR. DUPUIS:  
 12 Q You mean, the other ones that I  
 13 mentioned, it's -- I'm probably right. Correct?  
 14 MR. ROTH: Objection. Misstates  
 15 testimony.  
 16 BY MR. DUPUIS:  
 17 Q I mean, it's probably higher utilization  
 18 and probably similar cost, at least at the  
 19 procedure level, for those other -- for mastectomy  
 20 for breast cancer? hysterectomy?  
 21 A I -- I'm not ready to concede --  
 22 MR. ROTH: Same --  
 23 A -- that.  
 24 MR. ROTH: -- same objection.  
 25

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1 BY MR. DUPUIS:  
 2 Q Okay. All right. And for orchiectomy  
 3 for testicular cancer, you're just saying maybe  
 4 utilization isn't all that different?  
 5 A No. I didn't say that.  
 6 Q Okay.  
 7 A I didn't say that it -- it -- it's going  
 8 to be different. I'm -- I'm certain it would be  
 9 different. I just don't know how different it would  
 10 be.  
 11 Q Okay. So your risk premium calculation  
 12 or risk factor calculation, how did you arrive at  
 13 the 50 percent utilization and 50 percent cost,  
 14 respectively?  
 15 A It was a judgment, a judgment decision.  
 16 Given the -- the small numbers -- two, three, four;  
 17 the balancing between pent-up demand and an  
 18 expected kind of increase in utilization over time,  
 19 as we've discussed in various parts of this  
 20 deposition, the variance that you might expect from  
 21 that, in my judgment, could vary by 50 percent.  
 22 Could it have been higher? Yes. Could  
 23 it have been lower? It depends. But it was a  
 24 judgment call in terms of -- reflective of the --  
 25 of the degree of variance that is there and the

51 (Pages 195 to 198)

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1 other factors that are implicit with the data set  
2 that we were looking at, the newness of the data,  
3 and the uncertainty about what we might expect in  
4 the next year or two.

5 Q So would a -- a risk factor like this be  
6 used for, like, long benefits that have been covered  
7 for a longer period of time that are simple -- also  
8 rare?

9 A They could be. Just the nature of the  
10 variance in small numbers. Yes.

11 Q So are -- I mean, in your experience,  
12 have you done that with -- with similar -- other  
13 procedures that are more commonly covered but are,  
14 in fact, just as variable because of the  
15 infrequency?

16 A Not specifically. No.

17 Q Okay. Why not?

18 A A lot those decisions are made at a more  
19 aggregate level. So they are -- are things that  
20 are looked at. But then, the final decision for  
21 the risk factor incorporates ano- -- particularly  
22 when you've had a benefit in for a long time, we'll  
23 typically aggregate a number of those uncertainties  
24 into a single risk factor that encompasses many  
25 different benefits all at once.

1 mean, a -- a risk margin?

2 A Un- -- uncertain. Depending on a number  
3 of factors.

4 Q You want to tell me what those factors  
5 are?

6 A I knew you were going to ask that.

7 So we -- I would -- I would want to know  
8 things like, you know, how -- how many people may  
9 be -- how many other health plan -- how many other  
10 employers in the area, for example, are offering  
11 this benefit.

12 If everybody's offering the benefit as a  
13 uniform benefit overall, then -- then, you're not  
14 being to get a big increase.

15 But if they're one of the few or if the  
16 benefits are generous for this particular benefit,  
17 then, you're going to attract more people in, which  
18 is going to increase. People are going to come and  
19 be employed.

20 Q So it's the welfare magnet?

21 A Kind of --

22 Q I mean --

23 A -- like that, yes. And we've seen  
24 that -- we have seen that for certain benefits --  
25 and certain other benefits. So that's one factor.

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Page 202

1 So it's just a general -- it is a  
2 general risk factor associated with a number of  
3 different uncertainties underneath the data.

4 Q So why not just aggregate that year?  
5 Why not just aggregate the -- the -- I mean, this  
6 is a highly volatile unpredictable service like  
7 many others -- right? -- that are covered. And why  
8 not -- why not just aggregate it here?

9 A Well, when -- when a benefit is new,  
10 it -- people like to understand -- the people  
11 that -- that are paying for it, like, understand the  
12 nature and the extent of the risk that they're  
13 taking.

14 So they will -- they will endeavor to  
15 understand that as best they can before they make  
16 their final decisions. Or if they knew your  
17 decisions have already been made, they will use it  
18 to -- to judge how much they need to plan for  
19 additional payments that need to be made and/or  
20 additional administrative issues that might come up  
21 associated with the benefits, so they could  
22 understand that.

23 Q How long would you say it's -- it is to  
24 a -- it's a -- would be appropriate to factor in  
25 pent-up demand in figuring a risk benefit -- I

1 There may also be just a general  
2 increase in the acceptance or the -- the -- or  
3 patients seeking those benefits over time as they  
4 become more acceptable. So that would be another  
5 thing that we'd want to monitor and see how that --  
6 how that is evolving over time.

7 So those would all be, kind of, offsets  
8 to the pent-up demand. And then, I'd also be  
9 curious to see, you know, if there was a pent-up.

10 Or if they occurred in the first year,  
11 or if maybe people wait a year or two to go through  
12 the -- the transitioning process and -- and live  
13 as -- as their desired gender for a year or two or  
14 three, and then, decide to do the surgeries, in  
15 which case that pent-up demand may take not just  
16 one year. But it might take one year or two years  
17 or three years or more to finally peak before it  
18 comes down. So there are a number of different --

19 Q But then, it would be smaller in the  
20 middle. Correct? I mean --

21 A You -- you -- you -- yeah. Then, it  
22 would be -- yeah. So there -- there's competing  
23 kinds of -- of things that are going on.

24 Q And you haven't seen any data any of  
25 those --

52 (Pages 199 to 202)

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1 A I haven't --  
 2 Q -- three factors?  
 3 A -- had any data on any of those factors.  
 4 And I don't know how to answer the question, because  
 5 it's just still evolving as a benefit.  
 6 Q So these are hypothetical reasons it  
 7 might --  
 8 A I am --  
 9 Q -- take longer?  
 10 A -- purely speculating. Yeah.  
 11 Q So I think we've already covered this.  
 12 But you were not able to estimate the odds or the  
 13 likelihood of a 50-percent increase in utilization  
 14 over the point estimate?  
 15 A I don't have enough data.  
 16 Q All right. Same is true for cost per  
 17 service? The 50-percent estimate, you don't have  
 18 data to --  
 19 A I have more data on that, because we do  
 20 have a range of cost for one year. But I don't  
 21 have -- I would like to see that for more years to  
 22 see if that range of cost holds up.  
 23 Q Okay. So on -- on page 12 -- yeah.  
 24 Twelve. It's the last full paragraph. You -- you  
 25 hypothesize this average cost of a hundred thousand

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1 Could you have calculated the -- the  
 2 hundred percent cutoff -- or the  
 3 hundred-thousand-dollar cutoff with the data you  
 4 had? Or was there some sort of limits on the data?  
 5 A There's some limits of the data. If we  
 6 were to do that, we would -- we would do a Monte  
 7 Carlo simulation to determine a -- how often we  
 8 might expect individuals to exceed that threshold  
 9 based on the distribution that currently exists.  
 10 So the two things that would -- the two  
 11 things that would help that vary would be if that  
 12 one year's worth of data that created that  
 13 distribution was inaccurate. Then, you would,  
 14 likewise, have an inaccurate result in your Monte  
 15 Carlo si- -- Monte Carlo simulation. So -- and I  
 16 don't see that one year of data with that  
 17 distribution is -- is credible enough --  
 18 Q All right. So --  
 19 A -- to be able to do that study  
 20 effectively.  
 21 Q Okay. So isn't there an equal  
 22 likelihood that the costs will be lower than your  
 23 best estimate -- the .7 percent -- or .7 cents per  
 24 member per month?  
 25 A That would assume a normal distribution.

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1 dollars rather than the calculated average of about  
 2 21,000. Right?  
 3 A Yes.  
 4 Q Isn't it true that only about 5.6  
 5 percent, based on 1C -- Table 1C -- I think it was  
 6 1C?  
 7 A Yeah. I believe that's right.  
 8 Q Yeah. I'm sorry. Yeah. Table 1C --  
 9 A Table 1C.  
 10 Q -- only about 5.6 percent of all costs  
 11 for surgical claims exceeded \$75,000?  
 12 A You're interpolating between the 11.3 and  
 13 the 4.3. But sounds reasonable. So that seems like  
 14 a reasonable number.  
 15 Q So that's -- is that about the odds --  
 16 about 5.6 percent chance that you actually end up  
 17 with an average cost that high?  
 18 A Yes.  
 19 Q So that's a pretty low likelihood?  
 20 A Yeah. It's five percent.  
 21 Q Uh-huh.  
 22 A Five, six percent. Something like that.  
 23 Q Well, actually, that's not a hundred  
 24 thousand. It's seven -- 75,000, rather than a  
 25 hundred thousand.

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1 And I don't believe this distribution is normal. So  
 2 I would have to say, No.  
 3 Q Okay. And so do you think there's a tail  
 4 toward the high end?  
 5 A Yes.  
 6 Q Would that alter whether you should be  
 7 using averages or medians?  
 8 A It wouldn't -- it wouldn't alter the  
 9 results that we'd produce here. No.  
 10 Q Is there a way to test whether these  
 11 risk -- risk adjustments were accurate after the  
 12 fact?  
 13 MR. ROTH: Objection. Vague.  
 14 A Well, you can certainly look at the  
 15 results and see how close you came. So  
 16 empirically, you can look at the results of the next  
 17 year and see if it matched your results from the  
 18 prior year.  
 19 BY MR. DUPUIS:  
 20 Q Have they -- have these risk margins been  
 21 tested in other contexts?  
 22 MR. ROTH: Same objection.  
 23 A So every year, you produce a -- when you  
 24 do a cost -- when you do benefit pricing --  
 25

53 (Pages 203 to 206)

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1 BY MR. DUPUIS:

2 Q Uh-huh.

3 A -- you always look and see what you  
4 started with last year and see what you ended up  
5 with and see what the difference is.

6 So in that respect every year, you -- you  
7 mea- -- measure, to some extent, the results of your  
8 guess from last year to see how it turned out to be  
9 in the next year.

10 Q Do you do that on a, sort of,  
11 service-by- -- or diagnosis-by-diagnosis basis like  
12 this in other settings? Or is it mostly that kind  
13 of bumbling?

14 A It depends --

15 Q Or aggregating?

16 A -- on how --

17 Q I'm sorry.

18 A -- detail you're getting -- it depends on  
19 how much detail or how much time you want to spend  
20 digging around.

21 But it's not unusual to look at a --  
22 drivers in the -- in the cost increases and to drill  
23 down into those cost drivers and understand the  
24 specifics of what's driving it. So that's not  
25 unusual.

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1 But do we do it exhaustively and boil the  
2 ocean to find out every -- every ICD-9 code?  
3 Probably not.

4 Q Do you know how they fare, in general --  
5 these risk adjustments -- in terms of, like, when  
6 they -- when you've looked at them after the fact?  
7 Has there been a tendency to over- -- overestimate  
8 risk?

9 MR. ROTH: Objection. Vague.

10 You can answer.

11 A I don't know how to answer that.

12 Have there been studies that --

13 BY MR. DUPUIS:

14 Q Yes.

15 A -- determine -- so that's an inter-rater  
16 reliability study based on the individual that's  
17 doing the study. And I haven't seen any studies  
18 like that.

19 So if you have a health -- if you have  
20 an actuarial group that is consistently overpricing  
21 or consistently underpricing, I haven't seen any  
22 stu- -- or individuals that are doing that, I  
23 haven't seen any studies like that.

24 Q So there's no -- and -- and -- I guess  
25 I'm not looking at -- at the individual level, but

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1 this, sort of, process of building in a risk  
2 margin, which doesn't happen with every service.  
3 Right? I mean, you only build it -- or -- or is  
4 there a risk margin for every covered service in  
5 some sense?

6 A There's usually not an implicit or an  
7 explicit margin built into every single service.

8 But there is an understanding of what  
9 your risks that you're taking up -- taking on when  
10 you're introducing a benefit. They often will ask  
11 for a -- a -- an understanding of what their  
12 variances are and what they're expected and what  
13 their risks are.

14 That -- and the risk -- that risk factor  
15 that -- that contingency is a way to describe, in  
16 general, what you would expect the benefits to be  
17 and what your, you know, what you need to prepare  
18 for for a contingency if you're off by a little  
19 bit.

20 So that's not unusual at all. In fact,  
21 it's expected. It's kind of a fiscal -- it's  
22 fiscally responsible to understand those -- those  
23 risks that you're taking.

24 Q Okay. And then, the question then is,  
25 in -- in -- have there been general studies of, you

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1 know, when new benefits are introduced and there's  
2 a risk margin, of whether those risk margins, in  
3 retrospect, turn out to be high, low, or right on?

4 A I haven't seen those studies.

5 Q Okay.

6 A If there are any.

7 MR. DUPUIS: Can we take a short  
8 break?

9 MR. ROTH: Absolutely.

10 BY MR. DUPUIS:

11 Q Okay. So I just want to ask a few more  
12 questions about how you came up with the 50-percent  
13 utilization risk margin and 50-percent  
14 cost-per-service risk margin? Is it really more  
15 accurate to say "cost per person"?

16 A No. It's -- it would be on the -- on the  
17 aggregate benefit of PMPM.

18 Q Okay. So did -- did you quantify, in any  
19 way, the contri- -- I mean, it seems like there  
20 are uncer- -- there's uncertainty in prevalence of  
21 the condition.

22 But that didn't really factor into your  
23 analysis. Is that right? Is that fair to say?

24 A I think the uncertainty cer- --  
25 certainly -- under --

54 (Pages 207 to 210)

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1 Q Uncertainty of --  
 2 A -- all that --  
 3 Q -- prevalence of -- of -- of having  
 4 gender dysphoria. Because your analysis is on  
 5 utilization. Not --  
 6 A I think it's fair to say that it --  
 7 the -- in the end, the prevalence did not factor  
 8 into the -- -to the final result that I produced in  
 9 the expert report.  
 10 I certainly reviewed it. But I don't  
 11 think it was the -- I don't think it was the basis  
 12 for the report.  
 13 Q Did it -- did it -- did the possibility  
 14 that --  
 15 A Excuse me.  
 16 Q Sorry.  
 17 -- that there was -- that there was error  
 18 in the underlying prevalence of gender dysphoria  
 19 lead you to add a risk -- add some component of  
 20 risk?  
 21 A Not specifically. But I -- I think the  
 22 general -- I have to think of how to say this.  
 23 I think the general descriptions of  
 24 prevalence incidence and utilization for these  
 25 individuals has been varied enough and vague enough

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1 at all levels that it contributes to a level of --  
 2 of additional risk in terms of where we may end up  
 3 in the -- in subsequent years with the -- with the  
 4 utilization.  
 5 So it's not these specific factors, but  
 6 the variances of the uncertainties around being  
 7 able to count individuals is a contributing factor  
 8 in general, but not a specific factor.  
 9 Q Okay. And did -- so is it fair to say  
 10 that you didn't quantify the contribution of  
 11 prevalence in coming to your 50-percent risk  
 12 margin?  
 13 A I did not quantify it specifically.  
 14 Q Okay. And there's uncertainty in  
 15 utilization. Correct?  
 16 A Correct.  
 17 Q Did you quantify that in coming up with  
 18 this 50 percent? Could you say how much of the  
 19 50 percent was a utilization uncertainty?  
 20 A I wouldn't be able to accurately quantify  
 21 it, unless I had multiple years of data in those  
 22 databases, which don't exist. I would have liked to  
 23 have, but I didn't have the information available to  
 24 me.  
 25 So no, I -- I didn't quantify it

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1 specifically. I have one year's worth of  
 2 utilization data to base this off of, which, in and  
 3 of itself, is a source of uncertainty.  
 4 Q Okay. Did you quantify the uncertainty  
 5 in the cost per service -- I mean, it -- that is one  
 6 of your stipu- -- that's the 50 percent is the cost  
 7 of the service. Right?  
 8 A So I -- I added a 50-percent risk margin  
 9 to the cost in addition to the utilization. That is  
 10 correct.  
 11 Q And did -- were -- were there factors  
 12 that you quantified the con- -- are there factors  
 13 that went into that you could quantify, like, what  
 14 proportion of the 50 percent is attributable to that  
 15 risk factor or that variance?  
 16 A So -- so one of the informing pieces of  
 17 information in the report is that distribution of  
 18 costs from zero to 500,000. So that gives me -- I  
 19 have to apologize.  
 20 Q No. That's all right. I --  
 21 A It's not -- it's not a -- it's something  
 22 else.  
 23 But anyway, the -- so that did inform me  
 24 that there's a wide range of possible outcomes that  
 25 could -- that could occur for those surgical

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1 benefits, which does not surprise me. That --  
 2 that's not a surprising outcome to me.  
 3 And so that does inform me a little bit  
 4 that it's not un- -- it wouldn't be unusual or  
 5 necessarily unexpected or find individuals at or  
 6 above the 100- or even 200-thousand-dollar threshold  
 7 or even higher.  
 8 And it's not implausible for a number of  
 9 people to also exceed that threshold  
 10 simultaneously. So --  
 11 Q But it wasn't quantified in terms of This  
 12 distribution leads me to say, that there's a  
 13 50-percent risk that I'm going to end up with costs  
 14 that are out- --  
 15 A I didn't --  
 16 Q -- outside --  
 17 A -- do a mathematical calculation between  
 18 the distribution and the 50 percent.  
 19 Q Okay.  
 20 A I guess it's a statistical distribution.  
 21 Q Right. It's a --  
 22 A Not mathematical.  
 23 Q So it -- it -- it was a -- it's basically  
 24 a judgment?  
 25 A It's a judgment. It's an informed

55 (Pages 211 to 214)

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1 judge- -- it --  
 2 Q Right.  
 3 A -- it -- it is an informed --  
 4 Q Could -- do you believe an actuary would  
 5 have been able to sign this report?  
 6 A What do you mean "be able to sign this  
 7 report?"  
 8 Q And still comply with the Actuarial  
 9 Standards Of Practice.  
 10 MR. ROTH: Objection. Calls for  
 11 speculation.  
 12 A So that report was reviewed by  
 13 actuaries. And I am not qualified to make a  
 14 judgment as to whether or not it meets all of the  
 15 standards.  
 16 But it does meet our internal standards  
 17 for reports of this nature.  
 18 BY MR. DUPUIS:  
 19 Q Do you -- are those collected  
 20 anywhere -- the internal standards -- in writing?  
 21 A There are risk management guidelines for  
 22 us to follow that are in writing.  
 23 Q Are those considered proprietary?  
 24 A Yes.  
 25 Q Okay. Do you have any personal views on

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1 the rights of transgender people?  
 2 MR. ROTH: Objection. Vague.  
 3 A I don't, actually. I -- I am aware of  
 4 the controversies, and I'm aware of the  
 5 societally -- societal transformations that are  
 6 occurring.  
 7 But I don't have any specific opinions  
 8 about whether or not they should be getting  
 9 benefits related to this. I have no opinions that  
 10 way.  
 11 BY MR. DUPUIS:  
 12 Q Do you have any -- do you belong to any  
 13 organizations that have taken a position one way or  
 14 the other on rights of transgender people?  
 15 A Can you be more specific?  
 16 Q Any advocacy organizations, religious  
 17 groups, community groups.  
 18 A So I'm a member of a church. And you may  
 19 have -- you may view that as a -- as a society. But  
 20 I'm not aware of any specific policies on  
 21 transgender individuals as a member of that church.  
 22 Q Any advocacy organizations --  
 23 A No.  
 24 Q -- you belong to?  
 25 A No.

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1 Q Okay. I'm done.  
 2 MR. ROTH: I have no questions.  
 3 (Whereupon, the deposition was  
 4 concluded at 5:42 p.m.)  
 5  
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23	Sanders, Gale & Russell for production.)	
24		
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1                    C E R T I F I C A T E

2                    I hereby certify that I am a Notary Public,

3                    in and for the State of Connecticut, duly

4                    commissioned and qualified to administer oaths.

5                    I further certify that the deponent named in

6                    the foregoing deposition was by me duly sworn, and

7                    thereupon testified as appears in the foregoing

8                    deposition; that said deposition was taken by me

9                    stenographically in the presence of counsel and

10                   reduced to typewriting under my direction, and the

11                   foregoing is a true and accurate transcript of the

12                   testimony.

13                   I further certify that I am neither of

14                   counsel nor attorney to either of the parties to

15                   said suit, nor am I an employee of either party to

16                   said suit, nor of either counsel in said suit, nor

17                   am I interested in the outcome of said cause.

18                   Witness my hand and seal as Notary Public

19                   this 19th    day of    June, 2018.

20

21                   *San Edwards*

22                   \_\_\_\_\_

23                   San Edwards

24                   Notary Public

25                   My commission expires: 11/30/2021



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1                    J U R A T

2

3                    I have read the foregoing 220 pages and hereby

4                    acknowledge the same to be a true and correct record

5                    of the testimony.

6

7

8

9

10                   \_\_\_\_\_

11                   DAVID VAUGHN WILLIAMS

12

13                   Subscribed and sworn to

14                   \_\_\_\_\_.

15                   Before me this    day of   ,

16                   2017.

17

18

19

20

21                   \_\_\_\_\_

22                   Notary Public

23                   My Commission Expires:

24

25

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