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

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs,

v. Case No. 17-CV-0264

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

Defendants.

STATE DEFENDANTS' ADDITIONAL PROPOSED FINDINGS OF FACT

Defendants State of Wisconsin Department of Employee Trust Funds, State of Wisconsin Group Insurance Board, and Robert J. Conlin, Secretary of the Department of Employee Trust Funds ("State Defendants") submit the following additional proposed findings of fact in support of their motion for summary judgment. These proposed findings begin at entry 119, so that they run consecutively with State Defendants' original proposed findings, which ended at entry 118.

I. Opinions of State Defendants' medical expert, Dr. Lawrence Mayer.

119. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, gender identity is not an innate or immutable characteristic. (Dkt. 90, Mayer Report ¶¶ 3–11; Dkt. 112, Mayer Dep. 87:1–6 ("There are societies that value all sorts of different definitions of femininity

and beauty. That's what I don't understand. How can someone be born with this idea of femininity or beauty or masculinity when you're not born with anything. It's a clean slate."), 137:18–24 ("Children grow up and they're curious about their gender identity, so they often identify with being a little girl, and later with a little boy. They play with different genders. So I don't know what you mean by fixed. Gender identity, the struggle for gender identity is a fluid struggle when children are growing up.").)

120. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, no studies show that the incidence of gender dysphoria goes down as a function of plastic surgery or reassignment surgery. (Dkt. 112, Mayer Dep. 49:21–50:15 ("There is not a single study that shows the incidence of gender dysphoria goes down as a function of plastic surgery or reassignment surgery. . . . In other words, gender dysphoria isn't about people feeling better. . . . Gender dysphoria is a very serious illness leading to a high risk of suicide, for example. You need to cure that dysphoria. . . . [W]e do not have long-term follow-up studies of what percentage of them are still dysphoric."), 35:25–36:4 ("[L]et's say [the AMA] said that surgery was a major treatment for the dysphoric part of being transgender. That may be true, but where is the evidence? I couldn't find any evidence. I searched and searched."), 88:6–8 ("[T]here has been no demonstration that they're safe and effective. There's argument, but there is no demonstration."), 100:10–21

("There was an extensive search I did of the literature, probably a thousand papers. I probably reviewed the biography of 500 of them in the abstract, and probably read 200 of them over the course of four years now trying to find studies on gender dysphoria. Q. So you are saying there are no studies about efficacy and safety of treatment for gender dysphoria? A. I wouldn't say there are no studies. I'd say there are no decent studies. There's not a simple controlled study in which gender dysphoria is actually measured.").)

121. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, no studies show the relative efficacy of hormone therapy and reassignment surgery versus other treatments. (Dkt. 112, Mayer Dep. 62:21–63:14 ("Q. Do you believe . . . that hormone therapy is medically necessary for treating gender dysphoria in adults with long-standing gender dysphoria? A. Well, I have to know what its relative efficacy is versus other treatments. I don't know, because we don't have the data, we don't have the analysis. Is this an effective treatment? I would like to see people given hormones and people given the reassignment surgery, and follow them up in 20 years or whatever length of time, and see how well they're doing compared to another group. Science is about comparison. Where are the transgender people who then don't undergo hormone therapy to have a comparison group?").

122. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, studies cited by Plaintiffs' experts are flawed: "[Many studies] don't actually measure the gender dysphoria, they don't actually break it down into the incident rate, and they don't show, which is clinical trials 101, a significant difference between people who get the treatment and people who don't in terms of risk of being gender dysphoric. So . . . [the patients] improve body image, feel better about themselves, [and have a] more positive outlook in life, those are fine [outcomes]. . . . [F]or surgery. They aren't fine in psychiatry. The question is, are these people having serious life adjustment problems, and are those problems alleviated by the surgery?" (Dkt. 112, Mayer Dep. 178:10–21.)

123. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, a placebo effect that could explain why subjects of Plaintiffs' favored studies show improved well-being: "[T]o do a study of giv[ing] people $50,000 worth of plastic surgery and then ask[ing] them if they feel better about themselves is a little bit silly. The outcome has got to be dysphoria. And we've got to look at the treatment versus an active control. I bet anybody you do $50,000 worth of cosmetic surgery on feels better about themselves." (Dkt. 112, Mayer Dep. 42:6–14.)

124. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, it would be a good idea to conduct reliable, well-designed studies regarding the safety and efficacy of surgical treatments for gender dysphoria. (Dkt. 112, Mayer Dep. 42:20–43:1 ("[O]ne of the things we should do is we should have studies about what treatments are safe and effective. What are comparative statics of this treatment versus other treatments? And I'm not seeing studies. If you are depressed and you have gender dysphoria, is this an effective way versus directly treating your depression?"), 56:5–9 ("What I would like is some very conservative people on this issue, some very liberal people on this issue to meet in the middle and let's get together and decide on how to help this population of people. That is my sincere desire."); 130:8–18 (Q. So you are saying without an expert in the clinical treatment of gender dysphoria, you would not be able to design the study to decide whether or not hormone therapy or surgery is more effective than talk therapy? A. It's beautifully said. I envision a table. Schechter is there. Bailey who is an advocate is there. You are there. Someone on design is there. A clinical psychiatrist. And we decide to resolve this by having a definitive multi-site clinical study. . . . I would donate my time.").)

125. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, although gender reassignment surgery may be safe and effective as surgery, studies do not show it is safe and effective treatment for gender dysphoria. (Dkt. 112, Mayer Dep. 65:9–66:5 ("It's as safe and effective as surgery. That is what the studies say. There are no studies . . . [that] show the incidence and prevalence rate of gender dysphoria is significantly decreased by hormone or reassignment surgery compared to other modalities of treatment. So if you mean, if it works as well as a 10 cent pill, is that safe and effective? No. The fact is that all surgery has side effects. The fact is that all medicines have side effects. Is the risk of those side effects warranted? We just don't have the research; we don't have the publications. We have studies telling people feel better, they like the way they look, they have less burden. None of that is dysphoria. . . . Better body [image], but do they actually have a decreased risk of dysphoria, I do not know that."), 71:25–72:3 ("Safe and effective in surgery means safe and effective as surgery. You can't mean it's safe and effective treatment of dysphoria if you don't have any evidence."), 87:16–88:1 ("Q. What do you mean by safe? A. Well, safe to mean that the risk associated with the treatment for gender dysphoria is worth it. So let's suppose you had surgery on positive outcomes for most people, and some people you have negative outcomes. Well, is the risk worth it?

So safe always means, is the risk of that procedure worth it. Effective means both medically effective and financially effective.").)

126. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, a 2004 study showed a high level of uncertainty regarding various outcomes after sex reassignment surgery, making it difficult to find clear answers about the effects on patients of reassignment surgery. (Dkt. 90, Mayer Report App. D:109.)

127. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, a 2011 study showed that "post-surgical mental health" among post-operative transsexuals "was quite poor, as indicated especially by the high rate of suicide attempts . . . . [T]his study suggests that sex-reassignment surgery may not rectify the comparatively poor health outcomes associated with transgender populations in general." (Dkt. 90, Mayer Report App. D:110–11.)

128. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, a 2009 study "found considerably lower general life satisfaction in post-surgical transsexuals as compared with females who had at least one pelvic surgery in the past." (Dkt. 90, Mayer Report App. D:111–12.)

129. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, a 2010 study found only "'very low quality evidence' that sex reassignment via hormonal interventions 'likely improves gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life.'" (Dkt. 90, Mayer Report App. D:112.)

130. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, "[t]he scientific evidence summarized suggests we take a skeptical view toward the claim that sex-reassignment procedures provide the hoped for benefits or resolve the underlying issues that contribute to elevated mental health risks among the transgender population." (Dkt. 90, Mayer Report App. D:112.)

131. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, "therapeutic interventions for children must take into account the probability that the children may outgrow cross-gender identification." (Dkt. 90, Mayer Report App. D:106.)

132. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, one method for treating gender dysphoria is to help patients achieve a better body image, partly through talk therapy, in a way that helps them better function in their daily lives. (Dkt. 112, Mayer Dep. 90:8–91:19 ("Q. So what is -- what if the individual explains that their dysphoria is about the incongruence in their body? A. Why -- Q. What is the optimal treatment

for that? A. Well, that's very interesting, because I'd have to go back to something Paul McHugh said, and that is for anorexic. We don't put them on a diet. We try to give them better body image. We try to give them better body image. We try to help people feel better about themselves. Dysphoria is full of a feeling of helplessness, a feeling of hopeless, a feeling of despair. Of course you try to help them with all those. That is what psychiatry is. Q. So you're saying that gender dysphoria is just like body dysmorphia disorder? A. No. I don't believe that. It has some characteristics, though. And that is it's a psychiatric disorder. Where you wouldn't change their body to try to change that disorder. You try to change their attitude to themselves. You try to give them a healthy attitude about themselves. Isn't that what it's about? You try to stop the demoralization. Q. And how would talk therapy address or stop someone whose dysphoria is about the incongruence in their body? A. Well, when you go to these clinics, they have young people in there. They're not old enough for hormone therapy, they're not old enough for surgery. They talk to them about being accepting. They talk to them about a supportive environment, how important it is to be around people who accept them, people who understand them. It is not just talk therapy. First of all, talk therapy is very powerful therapy. But the fact is, you want to make them feel better. You want to make them better able to function in their daily life.").

133. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, another possible method for treating gender dysphoria is to prescribe medication for anxiety or depression, possibly including hormone therapy. (Dkt. 112, Mayer Dep. 92:25–93:17 ("Q. So you're saying we should just help someone who is facing distress about their body -- A. Right. Q. -- because it doesn't match who they are? A. Who they think they are, yes. Q. That we should simply try to make them comfortable with their body? A. Well, I think you're demeaning it. I think making them comfortable with their body versus $50,000 worth of surgery makes a lot of sense. What in the world -- why are they uncomfortable? They identify with being a female, and this is the body they have. They are transgendered, why do they need to look like something else. I don't understand it. Yes, I would try to make them feel comfortable. I might give them medication for anxiety, for depression. And maybe I would give them hormone therapy.").)

134. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, "transgender" means a person for whom there is an incongruity between the gender identity they understand themselves to possess and their biological sex. (Dkt. 90, Mayer Report App. D:94 n.*.)

135. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, a person's gender (or their sex, for that matter) is not "assigned at birth." (Dkt. 90, Mayer Report ¶¶ 3, 10–11.)

136. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, the concept of "transitioning" is inapt when discussing transgender individuals, since the only requirement for adopting a gender identity that differs from one's sex is "a long-term identification" with that gender identity, "not any particular body configuration." (Dkt. 112, Mayer Dep. 76:24–77:11 ("If you're born with that gender, why do you need a transition? . . . Because they keep talking about gender transition being necessary. The other thing that's interesting is that a gender transition seems to be culturally defined. What it means to transition to be more male or more female is a cultural definition. So I really don't know what they're saying, all this need for transition. They can be -- to me, they can weigh 280 pounds and be very masculine and claim they are a woman. They need to have a long-term identification, not any particular body configuration."), 126:4–12 ("[I] tell you my experience with these clinics, and I read their literature and stuff. If you come in and you are transgender, they very much support that you're dysphoric and try to get in treatment. They call it "treatment to transition." And I don't want to see treatment to transition. There is nothing people have to transition. I want to see society be accepting of these people as they are.").)

137. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, people with gender dysphoria have high suicide rates, whether or not they obtain gender reassignment surgery. (Dkt. 112, Mayer Dep. 53:17–54:1 ("Q. And wouldn't that indicate the seriousness of the condition, that it's a life or death situation? A. Well, for some patients. I thought you meant as public health, is this a significant problem. The suicide rate or self-harm rate is so high among transgenders, I don't know how you separate it out. So they're denied the surgery and then they go kill themselves. And some have the surgery and kill themselves. The problem is they kill themselves. This is a crisis. Let's do something about it."), 54:18–25 ("These transgender or gender dysphoric people have very high suicide rates, treated or not. You're saying there are people . . . who can show, had they not had treatment, they would have been suicidal. I do not know of that study. I would be interested if you'd send it to me."), 126:13–16 ("But if it causes them serious dysphoria, if they're suicidal, of course that has to be treated one way or the other. But I don't know what the best way to treat them is. We have too little data.").)

138. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, any consensus among professional medical organizations like the American Medical Association and the American Psychological Association regarding the safety and efficacy of surgical treatments for gender dysphoria does not establish that those treatments are, in fact, safe and efficacious

when used for that purpose. (Dkt. 112, Mayer Dep. 41:16–19 ("And whatever clinical guidelines it has, I'm not here to argue about clinical guidelines. But those guidelines have got to be based on scientific studies, and where are the studies?"), 77:14–25 ("Q. Assuming that what I said is true that the AMA supports hormone therapy and surgeries as treatment for gender dysphoria, would you agree that that is the correct position? A. I agree the AMA supports it. I can't second-guess the APA. I don't know that much about what their position is. I would have to read the whole document, but if they are saying that's been demonstrated that it's a significant factor in reducing dysphoria, I would have a great deal of difficulty with that statement."), 97:21–98:1 ("[T]he AMA has been wrong so many times. Remember, the AMA believed that being gay was a disorder. The AMA believed that the answer to domestic violence was never to leave your husband. The AMA supported smoking. The AMA is a trade union. They've made all sorts of mistakes."), 155:12–17 ("[T]onsillitis is another example. AMA took out millions of tonsils in this country when no tonsils virtually were taken out in Europe. And we did it so we wouldn't have recurrent sore throats. And we quit taking tonsils out, there was no increase in sore throats. Nobody has their tonsils out.").)

139. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, clinician practice alone does not establish that a particular procedure is safe and effective for treating gender dysphoria. (Dkt. 112, Mayer Dep. 55:10–56:4 ("Q. Isn't it standard . . . that when the standards of care for treating a condition such as gender dysphoria are established, that they look at the research as well as clinical experience? A. Well, sometimes they do, but the Cochrane Review that studied OB/GYN procedures found that two-thirds of the things we do, including holding babies up by their feet and spanking their butts are actually harmful. So there is a great deal of folklore in what we do in medicine. . . . The other example that I worked on were VBACs. A VBAC is a vaginal birth after cesarean delivery. We'd forbid them in the United States. The AMA said they were dangerous. And yet when we finally did a study of Canadian experiences versus ours, we found out that VBACs were safe. That is the importance of doing research.").)

140. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, "gender transition seems to be culturally defined. What it means to transition to be more male or more female is a cultural definition." (Dkt. 112, Mayer Dep. 77:3–11.)

141. In the opinion of State Defendants' medical expert, Dr. Lawrence Mayer, "the characteristics that we identify as being male or female are very culturally dependent." (Dkt. 112, Mayer Dep. 48:14–18.)

II. Opinions of State Defendants' financial expert, David Williams.

142. In the opinion of State Defendants' financial expert, David Williams, the study on which Budge relies for her cost-effectiveness opinion is of a type that is "not used in the actuarial sciences for benefit pricing purposes" and contains "study design elements [that] would [not] be used in a current pricing of medical benefits." (Dkt. 91, Williams Report 14; Dkt. 111, Williams Dep. 185:18–186:2 ("[W]e're calculating the benefit for one calendar year. And . . . the measured outcome of this study [cited in Budge's report] is a . . . Quality Adjusted Life Year . . . . And it's at the five- and ten-year horizons. So that was the endpoint measured for the study, which is too far out for our use in what we were doing here. . . . [I]t wouldn't be the way we would think about it in terms of pricing a benefit."), 188:4–6 ("[T]heir data is very old, and it was not well defined enough to be able to use effectively.").)

143. In the opinion of State Defendants' financial expert, David Williams, the concept of materiality in the actuarial sense is inapplicable to the decision by a fiduciary about whether to add a new benefit. (Dkt. 111, Williams Dep. 83:9–19 (Q. So . . . would you say there's no definition of materiality that . . . actuaries would generally apply in a situation like this? . . . A. I don't know of standards specific to materiality. There may be. But in terms of whether or not to add a benefit, I think that

those are fiduciary decisions that need to be made by those that are taking the risk and expected to pay the costs.").)

144. In the professional experience of State Defendants' financial expert, David Williams, large state employers with insurance plans with a total size of around $1 billion have analyzed benefits that cost as little as $20,000 to determine whether to add them. (Dkt. 111, Williams Dep. 84:3–23 ("I have seen employers scrutinize costs at this amount or less very, very carefully before they decide how and if they are going to provide the benefit."), 85:18–86:10 ("[A]s part of our role . . . actuaries and consultants for these groups, we frequently monitor and point out areas that . . . a benefit may be increasing beyond what their budget amount was down to the 200,000-, 300,000-dollar levels. And in many cases, they will consider modifying the benefit in order to . . . keep those costs under control. . . . [I]t's a fiduciary responsibility to monitor all the aspects of the benefit . . . and our job is to point out where those increases are occurring. And it's their job to decide whether or not they want to maintain that benefit . . . and pay for it -- or whether they want to introduce changes to the benefit that will keep those costs under control.").)

III. Other facts about gender dysphoria.

145. For a male-to-female transition, World Professional Association for Transgender Health (WPATH) recommends plastic surgery including genital surgeries, breast augmentation, facial feminization (such as rhinoplasty, reduction of the Adam's apple, and face-lifts), contour modeling of the waist, liposuction, and gluteal (i.e. buttock) augmentation. (Roth Decl. Ex. S (WPATH Standards of Care (SOC) 57–58, 63–64).)

146. For a female-to-male transition, WPATH recommends plastic surgery including genital surgeries, mastectomies, liposuction, and pectoral implants. (Roth Decl. Ex. S (WPATH SOC 57–58, 63–64).)

147. WPATH states that "*most* professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic" and concedes that "opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered *purely* reconstructive." (Roth Decl. Ex. S (WPATH SOC 58 (emphasis added)).)

148. WPATH recommends against genital surgery for minors and it advocates chest surgery for minors in some circumstances, but its position on other forms of surgical treatment for minors short of genital surgery remains unstated. (Roth Decl. Ex. S (WPATH SOC 21).)

149. WPATH concedes that "there is greater fluidity and variability in outcomes" in children and that "formal epidemiologic studies on gender dysphoria—in children, adolescents, and adults—are lacking." (Roth Decl. Ex. S (WPATH SOC 11).)

150. Studies cited in the WPATH SOC indicate that gender dysphoria persists into adulthood for only 12–27% of children. (Roth Decl. Ex. S (WPATH SOC 11).)

151. Stephanie Budge, Plaintiffs' expert witness, defines sex and gender differently. (Dkt. 101-1:8–9 (Budge Expert Decl.).)

152. Not all transgender people have gender dysphoria. (Roth Decl. Ex. S (WPATH SOC 5–6); Dkt. 112, Mayer Dep. 37:13–22 ("[P]art of the treatment for gender identity disorder was to treat people for being transgender. Now, we fought hard. I supported the fight that it, just like gay, it shouldn't be a diagnosis. Being transgender should not be a diagnosis. These are perfectly healthy human beings, and society needs to accept these human beings. So the fact of the matter is, we don't treat gender identity disorder, we treat gender dysphoria."), 38:6–19 ("Q. The diagnoses for the condition of gender identity disorder are very similar to the diagnoses for gender dysphoria, are they are not? A. No. They are absolutely different because it takes out being transgender. We fought hard for this. Transgender is not part of the diagnosis any longer. So gender identity disorder was

anybody struggling with their identity. Why do they have a disorder? Why should a woman who identifies -- let's say she's biologically a woman in my terminology – identifies with being a man, a sincere persistent identification, why shouldn't she be treated with respect. What does it have to do with whether or not she's transgendered or not. The social stigma is a real problem."), 39:1–6 ("A. Why should a transgender person be treated? What are you treating them for? We fought to get -- the same with gay. Gay is a diagnosis we fought for 20 years to get rid of that diagnosis. Being transgender is not a condition that needs to be treated.").)

153. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5") notes that, with respect to children, rates of persistence of gender dysphoria may be low, which indicates that treatments aimed at aligning one's gender identity with their biological sex may be successful at ending (i.e. treating) gender dysphoria. (Dkt. 90, Mayer Report App. D:106.)

154. The DSM-5 defines gender dysphoria as "incongruence between one's experience/express gender and assigned gender," as well as "clinically significant distress or impairment in social, occupational, or other important areas of functioning." (Dkt. 90, Mayer Report App. D:94.)

155. The WPATH guidelines on which Plaintiffs rely state that "[s]urgery . . . is often the last and the most considered step in the treatment process for gender dysphoria." (Roth Decl. Ex. S (WPATH 54).)

IV. Facts relevant to transgender status as a purported protected class.

156. During the Obama administration, the federal government enacted measures meant to protect transgender rights. 45 C.F.R. Part 92 (Section 1557 of the Affordable Care Act); (Roth Decl. Ex. U (*Dear Colleague Letter on Transgender Students*)).

157. Several states and cities have enacted legislation to protect gender identity and prohibit discrimination based on gender identity in either employment, housing, or public accommodation. (Roth Decl. Ex. V (Know Your Rights: Transgender People and the Law, FAQ No. 1); Roth Decl. Ex. W (Equality Maps, Transgender Law Center).) *See also* Roth Decl. Ex. X (chart outlining these state legislative enactments).

158. Many non-governmental organizations devote significant resources to promoting transgender rights. (Roth Decl. Ex. Y (Transgender Law Center); Roth Decl. Ex. Z (National Center for Transgender Equality); Roth Decl. Ex. AA (ACLU); Roth Decl. Ex. BB (Lambda Legal); and Roth Decl. Ex. CC (Movement Advancement Project).)

159. Editorial boards of prominent, nation-wide newspapers support transgender rights. (Roth Decl. Ex. DD (Trump's Heartless Transgender Military Ban Gets a Second Shot); Roth Decl. Ex. EE (Trump's transgender troop ban is as insidious as ever); Roth Decl. Ex. FF (Time for transgender rights opponents to give up the fight).)

V. Miscellaneous facts.

160. The Uniform Benefits define "medically necessary" as follows:

> "A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the HEALTH PLAN and/or PBM: 1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and 2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and 3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and 4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

(Dkt. 82-1:25 (Uniform Benefits at 112).)

161. Some GIB members believe that every additional benefit provided in a health insurance plan imposes some cost on a health insurance program and exclusions contain costs. (Dkt. 53, Farrell Dep. 165:1–166:16; Dkt. 79, Wieske Dep. 89:8–9, 20; 90:6–7.)

162. Coverage decisions must rest, in part, on whether the treatments at issue have been shown to be safe and efficacious. (Dkt. 103-23:23 (Defs.' Resp. Interrog. No. 10) (explaining that Exclusion was put in place in 1994 because the surgeries were seen as experimental).)

163. Minor dependents of state employees are covered by the Uniform Benefits. (Dkt. 82-1:21, 27, 29 (Uniform Benefits at 108, 114, 116) (definitions of "dependent," "participant," and "subscriber").)

164. In May 2016, HHS issued final regulations prohibiting provisions like the Exclusion, to go into effect Jan. 1, 2017. (Roth Decl. Ex. GG (Federal Register); 45 C.F.R. Part 92).

165. Since GIB had expected the HHS regulations to be enjoined by a federal district court in Texas, it acted on December 30, 2016, to restore the status quo by reinstating the Exclusion. GIB chose that date and used a contingent vote because the Exclusion was scheduled to be removed on January 1, 2017, and GIB hoped to act to reinstate the Exclusion before that date. (Dkt. 53, Farrell Dep. 28:7–13, 56:4–7, 61:21–22 ("[I]t was our understanding that the injunction was going to occur and, because of that, voted to reinstate the exclusion."), 71:5–6; Dkt 79, Wieske Dep. 96:2–6.)

166. Those HHS regulations were enjoined by a federal district court in Texas on Dec. 31, 2016, the day after GIB's special meeting. (*Franciscan All., Inc. v. Burwell*, No. 16-cv-00108, 227 F. Supp. 3d 660 (N.D. Tex. Dec. 31, 2016).)

167. The Uniform Benefits exclude coverage for bariatric surgery. (Dkt. 82-1:51 (Uniform Benefits at 138).)

168. The Uniform Benefits exclude coverage for infertility services, where the person is merely diagnosed as infertile. (Dkt. 82-1:53 (Uniform Benefits at 140).)

169. GIB member J.P. Wieske testified that "insurers put that in place in part to administratively simplify the way that they were administering gender reassignment coverage issues and that administratively having the exclusion made the policies clearer because their medical folks, their medical review did not provide coverage for the gender reassignment treatment." (Dkt. 79, Wieske Dep. 32:12–19.)

170. ETF explained that the Exclusion was "was included in the Uniform Benefits [in 1994] by the Group Insurance Board (GIB) because the . . . benefits and services were generally accepted by health insurance companies and health care providers to be experimental and not medically necessary." (Dkt. 103-23:24 (Defs.' Resp. Interrog. No. 10).)

171. Wieske also understood that insurers "were finding these [gender dysphoria services] consistently not medically necessary" and that, even without a blanket exclusion, gender reassignment surgery "wouldn't end up being covered because it wouldn't fall under their . . . their medical necessity." (Dkt. 79, Wieske Dep. 49:1–2, 90:21–23.)

172. GIB member Michael Farrell testified that "there [are] multiple reasons for including exclusions, including the fact that they would create cost for a plan" and that Wisconsin avoids costs by having the Exclusion here. (Dkt. 53, Farrell Dep. 165:19–166:16.)

173. Wieske testified explicitly that "[t]here was a discussion about costs being a factor" regarding reinstating the Exclusion and that "when you're adding a benefit, there is going to be a cost that attaches to it." (Dkt. 79, Wieske Dep. 89:8–9, 97:12–14, 98:14 ("I think cost was a factor.").)

174. Farrell testified that "medical necessity is the basis for most coverage decisions -- for all coverage decisions with health insurance plans. (Dkt. 53, Farrell Dep. 53:1–4.)

175. Wieske testified that "[w]hen a consumer or an insured person applies for any certain types of medical treatment, that is subject to an additional layer of review by the insurer and they typically use a medical provider to review that. They base those on the medical records that are provided by the medical doctor, as well as any research that the particular

company has done in order to make a determination on the benefits." (Dkt. 79, Wieske Dep. 32:24–33:7.)

Dated this 29th day of June, 2018.

Respectfully submitted,

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