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

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs, Case No. 17-cv-0264

v.

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

Defendants.

RESPONSE TO PLAINTIFFS' SUPPLEMENTAL PROPOSED FINDINGS OF FACT IN RESPONSE TO STATE DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

State Defendants submit the following responses to the Plaintiffs' Supplemental Proposed Findings (Dkt. 114) filed in response to State Defendants' motion for summary judgment:

I. Efficacy of Treatment for Gender Dysphoria

1. The consensus in the medical and psychological community is that a post-pubescent person's gender identity is immutable. (Supplemental Expert Report of Dr. Stephanie Budge ("Budge Supp. Rep.") at 12).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith.

Notwithstanding and without waiving this objection, dispute this proposed fact (Dkt. 88, DFOF ¶¶ 83–86; Dkt. 121, DFOF ¶ 119), but assert that this is not a dispute of material fact, since the purported immutability of gender identity does not suffice to entitle transgender persons to heightened equal protection scrutiny or otherwise entitle them to the insurance coverage they seek.

2. The medical profession recognizes gender confirmation surgery as reconstructive, not cosmetic, and the WPATH standards of care emphasize that such treatment is not elective. (Budge Supp. Rep. at 1, Supplemental Expert Report of Dr. Loren Schechter ("Schechter Supp. Rep.") ¶ 4).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge and Schechter for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith.

Notwithstanding and without waiving this objection, dispute this proposed fact. The World Professional Association for Transgender Health (WPATH) itself opines that gender reassignment surgery requires "altering anatomically normal structures." (Dkt. 123-1:61.) WPATH further acknowledges that "[i]n ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self-image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender

dysphoria, because these conditions are thought not to apply." (Dkt. 123-1:61.) WPATH guidelines also concede that "in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic." (Dkt. 123-1:64.)

But assert that this is not a dispute of material fact because whether Plaintiffs' experts call these surgeries "cosmetic," "reconstructive," or "elective," they would not be covered by the Uniform Benefits. Surgical procedures meant to treat gender dysphoria create a new appearance meant to match "cultural stereotypes, norms, and traits." (Dkt. 101-1:9.) The Uniform Benefits exclude this type of surgery to treat psychological conditions, regardless of Plaintiffs' preferred term. (Dkt. 88, DFOF ¶ 71.) Likewise, these terms have nothing to do with Dr. Mayer's opinion that adequate evidence of safety and efficacy is lacking. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.)

3. Depression is not an indication for cosmetic surgery, and cosmetic surgery is not a treatment for depression. (Schechter Supp. Rep. ¶ 1).

RESPONSE: State Defendants OBJECT to the additional opinions of Schechter for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. FURTHER OBJECT to any opinions by Schechter regarding

proper diagnosis and treatment of depression. Schechter is a plastic surgeon and his curriculum vitae does not reveal any expertise in diagnosing or evaluating the efficacy of treatments for psychiatric conditions such as depression. His expert report lacks foundation to support these opinions.

Notwithstanding and without waiving this objection, do not dispute that cosmetic surgery is not a treatment for depression. State Defendants assert that, for similar reasons, surgical treatments have not been proven safe and effective to treat gender dysphoria. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.) Depression and gender dysphoria manifest through similar symptoms. Gender dysphoria is not characterized solely by a person's "perception of her body," but primarily by "her inability to function day-to-day." (Dkt. 112, Mayer Dep. 121:18–19.) Similarly, the "underlying features" of gender dysphoria are "depression, anxiety, alienation, [and] withdrawal" (Dkt. 112, Mayer Dep. 88:16–25), and the goal of treatment should be to "make them [i.e. gender dysphoric patients] more comfortable, reduce their anxiety, [and] reduce their depression." (Dkt. 112, Mayer Dep. 119:16–17.) Even Budge agrees that gender dysphoria "can often lead to depression, anxiety, [and] suicidality." (Dkt. 119:5.) (*See also* Dkt. 101-1:26, 31 (Boyden's gender dysphoria is associated with "significant depression and anxiety"; Andrews' gender dysphoria is associated with "depress[ion] and suicidal[ity]").)

4. Cosmetic and elective surgeries performed to enhance self-esteem and self-confidence should not be performed to treat or improve psychological disorders, and research has not shown this surgery to benefit patients with pre-existing psychological or personality problems. (Budge Supp. Rep. at 3-4).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith.

Notwithstanding and without waiving this objection, do not dispute that cosmetic surgery is not a treatment for depression. State Defendants assert that, for similar reasons, surgical treatments have not been proven safe and effective to treat gender dysphoria. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.) Gender dysphoria is a psychiatric condition set forth in the DSM-V that is characterized by psychological distress. (Dkt. 88, DFOF ¶ 77.) None of the Plaintiffs' experts provide a reasoned explanation why, from an insurance coverage perspective, gender dysphoria should be treated differently from all other psychological conditions. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.) Depression and gender dysphoria manifest through similar symptoms. Gender dysphoria is not characterized solely by a person's "perception of her body," but primarily by "her inability to function day-to-day." (Dkt. 112, Mayer Dep. 121:18–19.) Similarly, the "underlying features" of gender dysphoria are "depression, anxiety, alienation, [and] withdrawal"

(Dkt. 112, Mayer Dep. 88:16–25), and the goal of treatment should be to "make them [i.e. gender dysphoric patients] more comfortable, reduce their anxiety, [and] reduce their depression." (Dkt. 112, Mayer Dep. 119:16–17.) Even Budge agrees that gender dysphoria "can often lead to depression, anxiety, [and] suicidality." (Dkt. 119:5.) (*See also* Dkt. 101-1:26, 31 (Boyden's gender dysphoria is associated with "significant depression and anxiety"; Andrews' gender dysphoria is associated with "depress[ion] and suicidal[ity]").)

5. For some patients, hormone therapy and gender confirming surgeries prevent the severe emotional and physical harms associated with gender dysphoria. (Budge Supp. Rep. at 9-10 (research demonstrates relationship between transition-related care and a reduction in suicidal ideation and improved quality of life); Dkt. # 112, Deposition of Dr. Lawrence Mayer ("Mayer Dep."), at 150:1-5 (acknowledging "certainly there are some cases in which it [gender confirming treatment] is called for")).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. This proposed fact should only be considered if State Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely opinion from Plaintiffs' expert.

Notwithstanding and without waiving this objection, dispute. Medical and surgical treatments have not been demonstrated to be safe and effective for gender dysphoria. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.) The quoted deposition testimony from Dr. Mayer came in the midst of his

testimony regarding a Centers for Medicare and Medicaid Services document; this one ambiguous statement does not undermine Dr. Mayer's consistently-expressed opinion that there is inadequate scientific evidence to support the safety and efficacy of surgical gender dysphoria treatments. (Dkt. 88, DFOF ¶¶ 101–04; Dkt. 121, DFOF ¶¶ 120–39.)

6. Defendants also cover surgeries such as kidney and heart transplants. (Dkt. # 103-5, 2017 Uniform Benefits, at 31-33).

RESPONSE: For purposes of summary judgment only, do not dispute.

7. Gender dysphoria, the medical and psychiatric term for psychological distress caused by the incongruence between a transgender person's gender assigned at birth and their gender identity, is distinct from anxiety and mood disorders. (Pls.' PFOF ¶ 30; Budge Supp. Rep. at 4-5).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. State Defendants further OBJECT that the phrase "is distinct from" is vague and ambiguous.

Notwithstanding and without waiving this objection, do not dispute that gender dysphoria is not identical to anxiety and mood disorders. However, gender dysphoria is a psychiatric condition set forth in the DSM-V that is characterized by psychological distress and share attributes of anxiety and mood disorders. (Dkt. 88, DFOF ¶ 77.) Depression and gender dysphoria manifest through similar symptoms. Gender dysphoria is not characterized

solely by a person's "perception of her body," but primarily by "her inability to function day-to-day." (Dkt. 112, Mayer Dep. 121:18–19.) Similarly, the "underlying features" of gender dysphoria are "depression, anxiety, alienation, [and] withdrawal" (Dkt. 112, Mayer Dep. 88:16–25), and the goal of treatment should be to "make them [i.e. gender dysphoric patients] more comfortable, reduce their anxiety, [and] reduce their depression." (Dkt. 112, Mayer Dep. 119:16–17.) Even Budge agrees that gender dysphoria "can often lead to depression, anxiety, [and] suicidality." (Dkt. 119:5.) (*See also* Dkt. 101-1:26, 31 (Boyden's gender dysphoria is associated with "significant depression and anxiety"; Andrews' gender dysphoria is associated with "depress[ion] and suicidal[ity]").) None of the Plaintiffs' experts provide a reasoned explanation why, from an insurance coverage perspective, gender dysphoria should be treated differently from all other psychological conditions. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.)

8. The term "dysphoria" on its own is not a diagnosis, and it is not the same as depression. (Budge Supp. Rep. at 4-5).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith.

Notwithstanding and without waiving this objection, do not dispute that dysphoria, on its own, is not a DSM-V diagnosis, and that it is not identical to depression. Depression and gender dysphoria manifest through similar symptoms. Gender dysphoria is not characterized solely by a person's "perception of her body," but primarily by "her inability to function day-to-day." (Dkt. 112, Mayer Dep. 121:18–19.) Similarly, the "underlying features" of gender dysphoria are "depression, anxiety, alienation, [and] withdrawal" (Dkt. 112, Mayer Dep. 88:16–25), and the goal of treatment should be to "make them [i.e. gender dysphoric patients] more comfortable, reduce their anxiety, [and] reduce their depression." (Dkt. 112, Mayer Dep. 119:16–17.) Even Budge agrees that gender dysphoria "can often lead to depression, anxiety, [and] suicidality." (Dkt. 119:5.) (*See also* Dkt. 101-1:26, 31 (Boyden's gender dysphoria is associated with "significant depression and anxiety"; Andrews' gender dysphoria is associated with "depress[ion] and suicidal[ity]").)

9. Surgeons generally consider surgeries performed to treat gender dysphoria as reconstructive, even when the same surgical procedures may be considered "cosmetic" when performed on someone without a gender dysphoria diagnosis. (Budge Supp. Rep. at 2).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith.

Notwithstanding and without waiving this objection, dispute as applied to "[s]urgeons generally," and note that even the WPATH guidelines concede that "in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic." (Dkt. 123-1:64.)

But assert that this is not a dispute of material fact because whether Plaintiffs' experts call these surgeries "cosmetic" or "reconstructive" they would not be covered by the Uniform Benefits. Surgical procedures meant to treat gender dysphoria create a new appearance meant to match "cultural stereotypes, norms, and traits." (Dkt. 101-1:9.) The Uniform Benefits exclude this type of surgery to treat psychological conditions, regardless of the preferred terminology used by Plaintiffs' experts. (Dkt. 88, DFOF ¶ 13.) Likewise, these terms have nothing to do with Dr. Mayer's opinion that adequate evidence of safety and efficacy is lacking. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.)

10. While anxiety and mood disorders may accompany gender dysphoria, they are not the same thing. (Budge Supp. Rep. at 4).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. Notwithstanding and without waiving this objection, do not

dispute for purposes of summary judgment only. (*See also* Dkt. 122, State Defs.' Resp. to PSFOF ¶¶ 7–8.)

11. According to the standards of care for transgender patients, surgeries to treat gender dysphoria are only to be undertaken after a qualified mental health professional has assessed the patient and documented that they have met the criteria for such treatment. (Budge Supp. Rep. at 3).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. Notwithstanding and without waiving this objection, do not dispute for purposes of summary judgment only.

12. Studies using control groups have found that hormone therapy is effective for reducing gender dysphoria. (Budge Supp. Rep. at 7).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. This proposed fact should only be considered if State Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely critique from Plaintiffs' expert.

13. Studies have also indicated that transgender persons undergoing gender confirmation surgery have reduced suicidal ideation and improved quality of life, compared to those who did not have surgery or hormones. (*Id*. at 9-10).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. This proposed fact should only be considered if State Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely critique from Plaintiffs' experts.

14. Cosmetic and elective surgeries performed to enhance an individual's self-esteem are not treatments for psychological disorders, and studies indicate that cosmetic surgery does not improve outcomes for patients with depression, anxiety, or body dysmorphic disorder. (Budge Supp. Rep. at 2-4).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. This proposed fact should only be considered if State Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely critique from Plaintiffs' experts.

15. Cosmetic surgery is not recognized as a treatment for depression, and individuals suffering from depression may not be candidates for cosmetic surgery unless their depression is being treated. (Schechter Supp. Rep. ¶ 1).

RESPONSE: State Defendants OBJECT to the additional opinions of Schechter for the reasons stated in *State Defendants' Rule 37 Motion to Strike*

Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter, filed herewith. This proposed fact should only be considered if State Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely critique from Plaintiffs' expert. Further, any opinions by Schechter regarding proper diagnosis and treatment of depression are objectionable. Schechter is a plastic surgeon and his curriculum vitae does not reveal any expertise in diagnosing or evaluating the efficacy of treatments for psychiatric conditions such as depression. His expert report lacks foundation to support these opinions.

16. Schechter is unaware of any studies in which individuals with depression were treated with cosmetic surgery. (*Id.*)

RESPONSE: State Defendants OBJECT to the additional opinions of Schechter for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. This proposed fact should only be considered if State Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely critique from Plaintiffs' expert. Further, any opinions by Schechter regarding proper diagnosis and treatment of depression are objectionable. Schechter is a plastic surgeon and his curriculum vitae does not reveal any expertise in diagnosing or evaluating the efficacy of treatments for

psychiatric conditions such as depression. His expert report lacks foundation to support these opinions.

17. Nor is cosmetic surgery considered a treatment for suicidal ideation in cisgender individuals. (Budge Supp. Rep. at 10).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. This proposed fact should only be considered if State Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely critique from Plaintiffs' expert.

18. Surgeries such as breast reconstruction following mastectomy, a commonly-covered benefit, includes both a reconstructive and a cosmetic component, and is intended to help restore the recipient's sense of femininity and improve self-esteem and well-being. (Schechter Supp. Rep. ¶¶ 2-3).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith.

For purposes of summary judgment only, do not dispute, and assert that under the Uniform Benefits, such surgery would be covered only if "associated with covered reconstructive surgery due to an ILLNESS or accidental INJURY." (Dkt 82-1:58–59.) Surgery for gender dysphoria, on the other hand, would be for a psychological reason, which is excluded under the Uniform

Benefits, just as it is for any cisgender individuals seeking surgery for a psychological reasons. (Dkt.82-1:58–59.)

19. Gender confirmation surgery is similar to reconstructive surgeries provided to non-transgender persons to correct conditions such as congenital absence of the vagina or reconstruction of the vagina/vulva following oncologic resection, traumatic injury, or infection. (Dkt. # 106, Expert Report of Dr. Loren Schechter ("Schechter Rep."), at 11).

RESPONSE: Dispute. If a healthy biological male is born without a vagina, there is nothing to reconstruct—it must be constructed first. This principle difference between gender reassignment surgery and reconstruction surgery due to congenital defects, illness or accidental injury is acknowledged by WPATH: "In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply." (Dkt. 123-1:61.) Surgery for gender dysphoria would be for a psychological reason, which is excluded under the Uniform Benefits, just as it is for any cisgender individuals seeking surgery for a psychological reasons. (Dkt. 82-1:58–59.) Likewise, in the context of cancer, traumatic injuries, or infections, the vaginoplasty is being used as a well-accepted treatment for a physical malady that caused damage to the normally-functioning vagina. (Dkt. 106:11.) Any cisgender or transgender state employee could enjoy coverage when the vaginoplasty is

used for that purpose—no discrimination exists in that regard. (Dkt. 82-1:31, 33 (Uniform Benefits cover surgical services found to be "medically necessary" by third-party health plans).)

20. The exclusion bars chest reconstruction surgery for transgender men and women, while chest reconstruction surgery is covered for cancer and other medical conditions. (Schechter Rep. 7, 11; Dkt. # 103-5, 2017 Uniform Benefits, at 130; see also Schechter Supp. Rep. ¶ 2).

RESPONSE: State Defendants OBJECT to the additional opinions of Schechter for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. Notwithstanding and without waiving this objection, do not dispute that the Exclusion would not provide coverage for surgery to treat gender dysphoria, and that under the Uniform Benefits, chest reconstruction surgery may be covered if "associated with covered reconstructive surgery due to an ILLNESS or accidental INJURY." (Dkt. 82-1:58–59.).

21. The "gender reassignment" exclusion in the Uniform Benefits is entirely separate from the "cosmetic surgery" exclusion. (*Compare* 2017 Uniform Benefits at 41 (gender reassignment exclusion) *with* 47 (exclusion for treatment for "cosmetic or beautifying purposes")).

RESPONSE: Dispute. While the Exclusion for surgery for gender reassignment is specifically set forth on Page 138 of the Uniform Benefits, it is encompassed in a broader exclusion on Pages 145–46 of the Uniform Benefits that excludes coverage for "[t]reatment, services and supplies for cosmetic or beautifying purposes," even if for "psychological reasons." (Dkt. 82-1:51,

58–59.) Surgery for gender dysphoria would be for a psychological reason, which is excluded under the Uniform Benefits, just as it is for any cisgender individuals seeking surgery for a psychological reasons. (Dkt. 82-1:58–59.)

II. Defendants' Expert Dr. Lawrence Mayer

22. Mayer is not licensed to practice medicine in the United States, has never practiced medicine or psychiatry, and has no specific training dealing with gender dysphoria. (Mayer Dep. 6:22-7:6).

RESPONSE: Do not dispute that Dr. Mayer is not licensed to practice medicine in the United States. Dispute the remainder of this proposed fact. Dr. Mayer supervised residents in teaching hospitals such as Johns Hopkins for the last 25 years (Dkt. 112, Mayer Dep. 12:20–22, 13:14–18), where his focus was supervising rounds in psychiatry. (Dkt. 112, Mayer Dep. 15:19–22.) Dr. Mayer's role would be the clinical epidemiologist trying to determine how results in the epidemiological literature can be used in analysis of specific patients. (Dkt. 112, Mayer Dep. 13:4–7.) As a clinical epidemiologist, he was part of a medical team that provided research concerning individual transgender patients, which involved seeing patients regularly. (Dkt. 112, Mayer Dep. 14:4–16.)

Dr. Mayer's "expertise is to review the literature and say, what does biology have to say, and to review these different models of the relationship between gender and sex, and try to figure out what . . . the best data says." (Dkt, 112, Mayer Dep. 23:11–19.) Dr. Mayer is "an expert in the epidemiology

of gender dysphoria, having reviewed a tremendous amount of literature on what the science has to say." (Dkt. 112, Mayer Dep. 32:25–33:3.) He has reviewed over a thousand studies on gender dysphoria. (Dkt. 112, Mayer Dep. 100:10–15.) Dr. Mayer is qualified to opine that the scientific studies available do not support that surgery is a safe and effective treatment for gender dysphoria. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.)

23. Instead, he has reviewed research papers on gender dysphoria, but acknowledges that "reading the papers alone wouldn't make you an expert in anything." (Mayer Dep. 62:12-20).

RESPONSE: Do not dispute that Dr. Mayer has reviewed research papers on gender dysphoria, but dispute the characterization of Dr. Mayer's quote. Dr. Mayer explained that he did not just review research papers on gender dysphoria: "I spent two years dissecting the studies. I went back to the original data. I spent two years day in and day out trying to find the best studies and figure out what those studies said. It was far greater -- I mean, you could say my whole career has been reviewing and evaluating research papers. That is what I do; I try to extend methodology." (Dkt. 112, Mayer Dep. 62:12–18.) This experience can be contrasted with a plastic surgeon like Dr. Schechter, Plaintiffs' medical expert, "[who] obviously knows no epidemiology." (Dkt. 112, Mayer Dep. 61:25–62:1.)

24. When asked whether hormone therapy is a medically necessary treatment for adults with gender dysphoria, Mayer stated, "I'm not an expert in what is medically necessary," and that a determination of whether something is "medically necessary" must be determined by looking at a specific patient. (Dr. Mayer 64:1-7; *see also* 85:11-16 (if a psychiatrist said reassignment surgery was "absolutely critical" to resolve a certain patient's dysphoria, he would not dispute that conclusion); 86:4-13 (same)).

RESPONSE: Do not dispute, but assert that Dr. Mayer went on to explain that, "[t]here are no studies -- let me make it clear -- I'm willing to bet Dr. Schechter would 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. None of it is dysphoria. Better body imagine, but do they actually have a decreased risk of dysphoria, I do not know that. I do not know it. I wish I did. (Dkt. 112, Mayer Dep. 65:14–66:6.) As for Dr. Mayer's statement that he would not argue with a clinical recommendation that reassignment surgery was "absolutely critical" (Dkt. 112, Mayer Dep. 85:11–16), that reflects his role as an epidemiologist rather than a treating physician. This statement does not modify his core

opinion about the lack of sufficient evidence regarding the safety and efficacy of surgical treatments for gender dysphoria.

25. When asked for the basis of the opinions stated in his report, Mayer replied, "Most of the opinions come from first principle. They don't come from research, because there isn't any good research on the treatment of gender dysphoria." (Mayer Dep. 99:19-22).

RESPONSE: Do not dispute that Dr. Mayer made this statement, but assert that it was taken out of context. Dr. Mayer testified that that his opinions were based on "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." (Dkt. 112, Mayer Dep. 100:10–15.) He also testified that he "spent two years dissecting the studies. I went back to the original data. I spent two years day in and day out trying to find the best studies and figure out what those studies said." (Dkt. 112, Mayer Dep. 62:12–18.)

26. Mayer's expert report cites to his own amicus brief filed in *Gloucester County School Board v. G.G. ex rel Grimm*, No. 16-273 (U.S.) as support for his conclusions on the safety and efficacy of treatments for gender dysphoria, but in that brief, Mayer explicitly stated that he was "leav[ing] aside all questions about how best to treat gender dysphoria in adults." (Mayer Dep. 103:5-14).

RESPONSE: Do not dispute, but this case concerns both adults and children, because beneficiaries of the Wisconsin Group Health Insurance Plan include both state employees and their minor children. (Dkt. 121, DFOF ¶ 163.)

The state of the medical evidence regarding both children and adults is thus relevant to this case.

27. Mayer contends that gender dysphoria is the same as any other depression, and should be treated the same. (Mayer Dep. 121:17-122:2).

RESPONSE: State Defendants OBJECT to this proposed fact because the evidentiary materials cited to do not support these assertions. Dr. Mayer made no such broad assertions in the cited testimony about the nature of every case of gender dysphoria or what the proper treatment would be. Rather, he opined that psychiatrists might be able to help patients with gender dysphoria in the same way that they help patients with depression. (Dkt. 112, Mayer Dep. 121:13–122:01 ("[W]hy in the world would their [i.e. transgender persons'] depression be different -- treatment be different than any other depression? There's something going on they're depressed about. The key is try to help them be less depressed. So do we know that psychiatrists have an effect? Yes. It's very marginal, but we know they have an effect with people with depression in general. Is there a study in particular with transgenders? No, because it would have to be advocates of transgenders, these clinics that have enough patients to do these studies, and they don't do the studies. I don't know why they don't do the studies.").)

28. Mayer concedes that because he is not a clinician, he cannot offer an opinion as to whether hormone therapy or surgical treatment are appropriate treatments for the Plaintiffs, and that such treatments may be appropriate for them. (Mayer Dep. 157:21-158:10).

RESPONSE: Do not dispute that Dr. Mayer is not a clinician, but OBJECT to the remainder of this proposed fact as not supported by the evidentiary materials cited. Dr. Mayer's opinion is that the scientific studies available do not demonstrate that surgery is a safe and effective treatment for gender dysphoria. (Dkt. 88, DFOF ¶¶ 101–05; Dkt. 121, DFOF ¶¶ 120–39.) Dr. Mayer's inability to opine on treatments for specific patients has nothing to do with his ability to evaluate the overall state of the evidence on this issue.

Moreover, Dr. Mayer never testified that these treatments "should be covered," contrary to Plaintiffs' misstatement in their brief that cites this proposed finding. (Dkt. 115:25.) He disclaimed any opinion about the availability of insurance coverage for the treatments at issue. (Dkt. 112, Mayer Dep. 45:1–2 ("I know very little about who pays the bill"), 95:2–3 ("[W]ho should pay? I really don't know about those issues.").)

29. Mayer testified that he could not design a study to test the effectiveness of treatments for gender dysphoria because he is "not an expert in the field." (Mayer Dep. 128:20-129:2; *see also* 129:15-18 (he is not an expert in gender dysphoria)).

RESPONSE: State Defendants OBJECT to this proposed fact because the evidentiary materials cited to do not support these assertions. Dr. Mayer testified that he is an expert in study design, but that he would need assistance

from an expert on the clinical side of gender dysphoria. (Dkt. 112, Mayer Dep. 129:16–18.) He clarified that, "I can design a study. I can't run a study. I'm not a clinician," (Mayer Dep. 130:25–131:1.), that he has "designed hundreds of studies," and that "[t]his is what I've done for 45 years. Yes, I could design that study. Do I need clinical people to run that study? Yes." (Dkt. 112, Mayer Dep. 131:6–13.)

30. Mayer testified that he did not see studies about what treatments for gender dysphoria are safe and effective. (Mayer Dep. 42:20-43:2; *see also* Mayer Dep. 36:1-4 (he "searched and searched" but could not find any evidence that surgery is a major treatment for gender dysphoria); 49:20-24 (claiming there is "not a single study that shows the incidence of gender dysphoria goes down as a function of plastic surgery or reassignment surgery")).

RESPONSE: Do not dispute with the clarification that Dr. Mayer has not seen any specific studies that are well-controlled or well-designed. (Dkt. 112, Mayer Dep. 98:7–8.). Dr. Mayer explains that, "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." (Dkt. 112, Mayer Dep. 100:18–21.)

31. There are studies that measure gender dysphoria as a specific outcome of transition-related care that have found that gender dysphoria is significantly reduced after the medical interventions, including gender confirmation surgery and hormone therapy. (Budge Supp. Rep. at 6-7).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike*

Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter, filed herewith. This proposed fact should only be considered if State Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely critique from Plaintiffs' expert.

32. Mayer maintains that a proper study to measure the effect of interventions on gender dysphoria must include an active control. (Mayer Dep. 42:6-13).

RESPONSE: Do not dispute with the clarification that the study must actually measure the dysphoria—not just whether or not a person "feels better about themselves." (Dkt. 112, Mayer Dep. 42:6–14.) Dr. Mayer has not seen any specific studies that are well-controlled or well-designed. (Dkt. 112, Mayer Dep. 98:7–8.). Dr. Mayer explains that, "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." (Dkt. 112, Mayer Dep. 100:18–21.)

33. Many studies have researched the effect of hormone therapy on gender dysphoria using control groups and found these interventions to be effective. (Budge Supp. Rep. at 7).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. This proposed fact should only be considered if State

Defendants' expert, Dr. Mayer, is given leave to submit his report responding to this untimely critique from Plaintiffs' expert.

34. It is not possible to perform a single-blind study in the context of gender reassignment surgery or hormone therapy, because there is no way for the patient to be unaware of whether they are receiving a placebo or the true intervention. (Budge Supp. Rep. at 8).

RESPONSE: State Defendants OBJECT to the additional opinions of Budge for the reasons stated in *State Defendants' Rule 37 Motion to Strike Plaintiffs' Supplemental Expert Witness Reports of Drs. Budge and Schechter*, filed herewith. Notwithstanding and without waiving this objection, dispute. According to Dr. Mayer, such a study could be conducted. (Dkt. 112, Mayer Dep. 96:4–16 ("You can approximate by doing single-blinding. For example, you can bring transgenders in that are dysphoric, and you could say -- you have to have an active control, not a passive control. We're going to give you $50,000 worth of surgery, or we're going to give you $50,000, and we're going to flip between them. I think a lot of people would be willing to be in that trial. You either get $50,000 worth of cosmetic surgery, or we give you $50,000. The coin is flipped, and now we compare the two groups in terms of gender dysphoria. One group gets surgery, the other group doesn't. They're both gender dysphoric, and we would have the answer.").)

III. Defendants' Expert David V. Williams

35. Defendants' expert David V. Williams is not an actuary. (Williams Dep. 24:14-16).

RESPONSE: Undisputed, but immaterial. First, Plaintiffs have not filed a *Daubert* motion seeking to exclude Williams' testimony on the basis that he is not qualified as an expert.

In any event, Williams' professional experience qualifies him as "an expert in the cost of benefits, whether it be gender dysphoria or other benefits." (Dkt. 111, Williams Dep. 27:18–20.) He has worked as a Director of Medical Economics for two health plans, which entailed work on "pricing, market research, client reporting, . . . [and] member and revenue forecasting." (Dkt. 111, Williams Dep. 34:2–4, 35:5–9.) In that work, Williams did not consult with actuaries. (Dkt. 111, Williams Dep. 36:20–24.) Further, Williams was the lead consultant for the State of Connecticut employee benefits program, producing reports "related to the price of . . . medical benefits." (Dkt. 111, Williams Dep. 41:6–23.) In Williams' experience, "[w]orking for an actuarial firm, you're frequently taught in actuarial science concepts . . . and approaches, both formally and informally." (Dkt. 111, Williams Dep. 24:8–11.) Williams' work in this case was subject to his firm's guidelines, which "generally follow the Actuarial Standards of Practice." (Dkt. 111, Williams Dep. 68:23–69:1.)

He has had "clients that have asked for benefits to be added related to gender dysphoria" and has "reviewed the cost for those benefits . . . in the past." (Dkt. 111, Williams Dep. 29:1–4.) As part of that analysis, Williams "discussed sources of data and the cost related to gender dysphoria" and "supplied information back to the clients related to that." (Dkt. 111, Williams Dep. 29:18–20.)

Moreover, Williams worked with actuaries at Milliman in producing the report at issue in this case. (Dkt. 111, Williams Dep. 56:23–57:23, 62:7–63:6.)

36. Williams is not an expert in the medical necessity, safety, and efficacy of treatments in general nor treatments for gender dysphoria specifically. (Williams Dep. 72:4-11).

RESPONSE: Undisputed, but immaterial. Williams' report does not rely on any expertise regarding the medical necessity, safety, and efficacy of treatments in general or treatments for gender dysphoria specifically. Rather, it rests on his qualification as "an expert in the cost of benefits, whether it be gender dysphoria or other benefits." (Dkt. 111, Williams Dep. 27:18–20.)

37. In calculating the cost of the exclusion, Williams opined that a "risk margin" that would effectively double the total cost estimate was "reasonable," but at deposition he conceded that this risk margin represented a "bad case," if not a "worst case" scenario and admitted that he was aware of no other similar risk margins for comparable benefits. (Williams Dep. 178:18-21; 179:18-23; *see also* 170:20-171:3 ("I'm giving a speculative example of – of – you might call it a worst case scenario")).

RESPONSE: Undisputed that Williams applied a 100% risk margin, that he testified that this could represent a "bad case" scenario, that that he was not aware of similar risk margins for comparable benefits. But the cited evidentiary materials do not show that he called his best estimate a "worst case" scenario—rather, he called his hypothetical adverse year of claims totaling $800,000 a "worst case" scenario, not his best estimate of $300,000 a year. (Dkt. 111, Williams Dep. 170:12–24.) Williams explained how he arrived at this risk margin:

> It was a judgment, a judgment decision. Given . . . the small numbers -- two, three, four [people using the services]; the balancing between pent-up demand and an expected kind of increase in utilization over time, as we've discussed in various parts of this deposition, the variance that you might expect from that, in my judgment, could vary by 50 percent. Could it have been higher? Yes. Could it have been lower? It depends. But it was a judgment call . . . reflective of the . . . degree of variance that is there and the other factors that are implicit with the data set that we were looking at, the newness of the data, and the uncertainty about what we might expect in the next year or two.

(Dkt. 111, Williams Dep. 198:11–199:4.) Similarly, his risk margin rests on the "small numbers" of patients who seek surgical benefits, "balancing between pent-up demand and an expected . . . increase in utilization over time," the "potential for variability [that is] quite high" in cost and utilization of services, and "newness of the data, and . . . uncertainty about what we might expect in the next year or two." (Dkt. 111, Williams Dep. 175:8–9, 198:15–199:4.)

38. Williams conceded the 2016 Truven database data he relied upon to make his fifty percent risk factor adjustment could possibly contain "pent-up data" and not be a fully accurate representation of likely future health insurance claims for transgender individuals. (Williams Dep. 180:11-19).

RESPONSE: Undisputed that Williams acknowledged that "pent-up demand"[1] could affect utilization rates. (Dkt. 111, Williams Dep. 180:11–19.) But the cited evidence does not support the proposed finding that Williams' risk factor was not a "fully accurate representation of likely future health insurance claims for transgender individuals." Rather, Williams noted that his risk factor adjustment considered and factored in the possibility of pent-up demand. (Dkt. 111, Williams Dep. 198:11–199:4.)

39. Williams does not have enough data to estimate the odds or likelihood that the utilization rate would exceed his point estimate by 50%. (Williams Dep. 203: 11-22).

RESPONSE: Undisputed but immaterial. The risk factor itself is "associated with a number of different uncertainties underneath the data." (Dkt. 111, Williams Dep. 200:1–3.) In any event, the lack of long-term data that could support a more precise cost estimate cuts in State Defendants' favor, as it merely establishes greater uncertainty about the cost of benefits affected by the Exclusion.

[1] Plaintiffs misquote this passage in their proposed finding as "pent-up data [sic]."

40. Plaintiffs' expert Joan Barrett, when reviewing Williams' report, recommends an additional risk factor of twenty-five percent compared to Mr. Williams' fifty percent. "Our recommendation would be to use a 25% margin, resulting in a $0.09 PMPM. This would support a scenario where there was one additional reassignment surgery and 16 additional non-surgical patients. The net impact to the State Plan would be $175,000 or 0.02% of total costs." (Barrett Rep. p. 8).

RESPONSE: Undisputed but immaterial. The choice of a particular risk factor is a matter of professional judgment (Dkt. 111, Williams Dep. 198:11–199:4), and Barrett does not demonstrate that her more conservative risk factor is more appropriate than the one Williams chose. In any event, State Defendants are entitled to rely on Williams' reasonable cost estimate rather than the one offered by Plaintiffs.

41. Barrett noted that, "Even at Mr. Williams' estimate of $0.15, the removal of the Exclusion rounds to 0.0%, so it is clearly immaterial. It is standard actuarial practice to assume that any benefit that is 0.1% of total costs or less is immaterial for several reasons, but mostly because it is considered a rounding error." (Barrett Rep. p. 7).

RESPONSE: Undisputed that Barrett's report contains that analysis, but the analysis is immaterial. As Williams explained, the appropriate way to judge the materiality of the cost of a benefit is "not really for me to decide. That's really for the . . . fiduciaries of the state or whoever's taking the risk to decide that. . . . [M]y job is to produce what the cost would be. And if that's material, that would be for . . . them to decide. . . . [I]n 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." (Dkt. 111, Williams Dep. 83:1–19.)

42. Williams found no data to support or contradict potential cost savings in removing the exclusion. (Williams Dep. 140:2-11).

RESPONSE: Undisputed. This finding undermines Plaintiffs' assertion that removing the Exclusion would save money, since the only expert in this case who has looked at actual data—Williams—found nothing to support that proposition. Plaintiffs' actuarial experts did not examine any data, and the only basis on which they opine that removing the Exclusion could reduce costs is the opinion of Dr. Budge (who is a counseling psychologist, not an actuary or benefits pricing professional), and Dr. Budge relied on a study that would "not [be] used in the actuarial sciences for benefit pricing purposes." (Dkt. 91:18.)

IV. Defendants Conlin and ETF

43. ETF Secretary Robert Conlin, with input from the GIB chair, made the final determination that the contingencies for reinstatement of the exclusion were met and issued a memo to GIB stating that the exclusion would be reinstated and that "No Board action is required." (Conlin Dep. 32:4-10, 53:2-8, 157:18-21, 167:21-24, 168:17-20 ("Q: You had determined all of the contingencies were met? A: That is what the memo is telling the board, yes"); Dkt. # 83-15, Jan. 30, 2017 Conlin Memo to GIB).

RESPONSE: Dispute that Secretary Conlin "determin[ed]" to reinstate the Exclusion. GIB had directed ETF to decide whether the four contingencies set forth in GIB's December 30, 2016, decision had been met. (Dkt. 54, Conlin Dep. 157:18–158:1 ("Q. At this point were you anticipating that the GIB

would meet again to determine whether or not the contingencies were met? A. No. There was some question about whether the board had intended that -- or not the board intended it, but I think Lisa Ellinger, that was her leading. I understood the motion that the board made and approved to kind of be self-executing once the conditions were met.") As ETF's Secretary, Secretary Conlin had a legal obligation under state statute to administer and execute GIB's decisions. (Wis. Stat. § 40.03(2)(a); Dkt. 88, DFOF ¶¶ 35–36, 110–11.) But it was GIB that made the decision to reinstate the Exclusion, not Conlin. (Dkt. 88, DFOF ¶¶ 61, 66.) Neither ETF nor its Secretary has any statutory authority to make final decisions on the Uniform Benefits' content. (Dkt. 88, DFOF ¶ 21.)

44. Although the elimination of the exclusion was most directly precipitated by the issuance of HHS rules implementing Section 1557 of the ACA, ETF's initial memorandum to the GIB in June 2016 recommending elimination noted that employers "will generally be prohibited from discriminating on the basis of sex, gender identity, or sexual orientation under Title VII and EEOC regulations." (Dkt. # 103-9, Pray Mem. at 3-4).

RESPONSE: Do not dispute that the elimination of the Exclusion was most directly precipitated by the issuance of HHS rules implementing Section 1557 of the ACA or that the quoted passage is contained in ETF's memorandum, but State Defendants OBJECT to this assertion to the extent Plaintiffs seek to establish the legal opinions of ETF attorneys as facts.

45. ETF's general counsel rebutted the Wisconsin DOJ's assertion that the section 1557 regulations did not require Defendants to rescind the exclusion in part by noting that the EEOC had taken the position that discrimination based on gender identity constituted sex discrimination. (Dkt. # 103-6, Nispel Mem. at 4-5 (citing U.S. DOJ *Title VII Legal Manual*)).

RESPONSE: Do not dispute that the quoted passage is contained in ETF's memorandum, but State Defendants OBJECT to this assertion to the extent Plaintiffs seek to establish the legal opinions of ETF attorneys as facts.

Dated this 9th day of July, 2018.

Respectfully submitted,

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