

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

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs,

Case No. 17-cv-264

v.

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

Defendants.

**PLAINTIFFS' RESPONSES TO STATE DEFENDANTS'
ADDITIONAL PROPOSED FINDINGS OF FACT**

Plaintiffs, Alina Boyden and Shannon Andrews, submit these Responses to State Defendants' additional proposed findings of fact in support of their motion for summary judgment. (Dkt. #95).

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.”.)

RESPONSE: Disputed. Dr. Lawrence Mayer is not qualified to provide expert testimony on this topic. (Dkt. # 83-17, Mayer Rep. ¶ 1 (“I am a research physician, epidemiologist and biostatistician and one of the few physicians with training in clinical epidemiology and a M.S. and Ph.D. in Mathematics and Statistics”); Dkt. # 112, Deposition of Lawrence Mayer (“Mayer Dep.”) 7:3-6 (Mayer is not an M.D. and has never practiced medicine), 12:18-20 (has never practiced psychiatry).) Moreover, Dr. Mayer agreed that a transgender person’s gender identity is very resistant to change and that it is very rare that a transgender person’s gender identity would change back. (Mayer Dep. 119:20-120:5, 138:13-23). In the opinion of Plaintiffs’ expert Dr. Stephanie Budge, based on her clinical experience with transgender patients, review of relevant research and the consensus in the medical and psychological community with respect to post-pubescent children and adults, gender identity is immutable. (Dkt. # 119, Supplemental Expert Report of Dr. Stephanie Budge, (“Budge Supp. Rep.”) at 11-12). Curiosity about gender and gender non-conforming behaviors among young children are not the same as a transgender identity or gender dysphoria and research cited to support the notion that children outgrow cross-gender identification is often misunderstood and has significant design flaws. (Second Supplemental Expert Report of Dr. Stephanie Budge (“Second Budge Supp. Rep.”) at ¶ 2).

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.”).)

RESPONSE: Disputed. First, gender dysphoria is a condition diagnosed by determining whether an individual manifests particular symptoms over at least a six-month period and demonstrates clinically significant distress or impairment in areas of functioning. (Dkt. # 101.1, Expert Report of Dr. Stephanie Budge (“Budge

Rep.”) at 13-14). Gender dysphoria is not the same as “depression,” and there is no general diagnosis of “dysphoria.” (Budge Supp. Rep. 4-5). Second, gender confirmation surgery provided as treatment for individuals with gender dysphoria is reconstructive and different from cosmetic surgeries performed to enhance an individual’s self-esteem and self-confidence, which should not be performed to treat or improve psychological disorders. (Dkt. # 119, Supplemental Expert Report of Dr. Stephanie Budge (“Budge Supp. Rep.”) at 3-4; Dkt. # 116, Supplemental Expert Report of Dr. Loren Schechter (“Schechter Supp. Rep.”) at ¶ 4).

There are studies that measure gender dysphoria as a specific outcome of transition-related care, and these studies have found that gender dysphoria is significantly reduced after medical intervention. (Budge Supp. Rep. 6). Contrary to Dr. Mayer’s statement, a number of studies have used control groups to research the effectiveness of these treatments. (*Id.* at 7). A body of research has also demonstrated a relationship between transition-related care, including hormones and gender confirmation surgery, and a reduction in suicidal ideation. (*Id.* at 9-10). As for Dr. Mayer’s statement that there are no “long-term follow-up studies” of the effect of these treatments on gender dysphoria, Dr. Budge confirms that longitudinal studies show decreases in anxiety, depression, and other psychological symptoms with the use of hormones. (Budge Rep. 17).

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?”).

RESPONSE: Disputed. Numerous studies have shown the efficacy of hormone therapy and gender confirmation surgery. (*See* Pls. Resp. to Defs.’ Additional FOF ¶ 120). In direct contradiction to Dr. Mayer’s statements, some of these studies have involved control groups of transgender individuals using hormone therapy and those not using hormone therapy, and found depression decreased for those using hormone therapy. (Budge Supp. Rep. 7). Further, Plaintiffs’ expert Dr. Budge observes that Dr. Mayer’s proposed study, a randomized controlled trial with a group of participants who do not receive treatment, is unethical and such studies of surgical treatments are not feasible, since participants will be aware of which intervention they are receiving. (Budge Supp. Rep. 8-9). In addition, psychotherapy and anti-depressant medications alone do not treat the underlying gender dysphoria, but only co-morbid psychological or psychiatric conditions. (Second Budge Supp. Rep at ¶ 2). Further, WPATH’s Standards of Care states that in some

instances surgery can be the *only* option for treating gender dysphoria. (WPATH SOC v. 7 p.8, 54-55) ("While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage & Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.").

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).

RESPONSE: Disputed. As Dr. Budge explains, studies on the efficacy of hormone therapy examined the effect of treatment on gender dysphoria using a validated gender dysphoria scale and showed a statistically significant decrease in gender dysphoria over time for those receiving hormone therapy. (Budge Supp. Rep.

7). One study did compare control groups of transgender individuals using hormone therapy versus those not using hormone therapy, and found those not using hormone therapy were four (4) times more likely to report depressive symptoms. (*Id.*) Other studies comparing transgender individuals who underwent hormone therapy and gender confirmation surgery to transgender individuals who did not found decreased suicidal ideation, not merely that the individuals felt “better” about themselves. (*Id.* at 9).

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).

RESPONSE: Disputed. First, the cited testimony does not say that the improved well-being of individuals in these studies experienced a “placebo effect.” Second, studies that examine the impact of treatments including hormone therapy and gender confirmation surgery on gender dysphoria have been conducted, and found treatment to improve a patient’s gender dysphoria, not merely make patients “feel better about themselves.” (*See* Pls.’ Resp. to Defs.’ Additional FOF ¶ 120). There have also been studies conducted on hormone therapy using an active control that

have found a decrease in symptoms for individuals using that therapy. (Budge Supp. Rep. 7).

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.”).)

RESPONSE: No dispute that Dr. Mayer testified as to his desire to conduct such studies, but disputed to the extent this fact is meant to state that no studies on the effect of hormone therapy and gender confirmation surgery have been conducted that measure the effect of such treatments on gender dysphoria and depression. (*See*

Pls. Resp. to Defs.’ Additional FOF ¶¶ 120-123). Dr. Mayer further testified that he is not an expert in what treatments for transgender persons are medically necessary because he is not a clinician, and he could not design a study to test the effectiveness of treatments for gender dysphoria because he is not an expert in the field. (Pls.’ Supp. FOF ¶¶ 24, 28-29).

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.”.)

RESPONSE: Disputed. This statement is inadmissible pursuant to Fed. R. Evid. 702 as it is not based on sufficient facts or data, because Dr. Mayer is simply ignoring the studies that have been performed on the efficacy of hormone treatment and gender confirmation surgery that measure depressive symptoms and gender dysphoria in propounding his opinion that there is “no evidence” of the efficacy of those treatments. *See MDG Int’l, Inc. v. Australian Gold, Inc.*, 2009 U.S. Dist. LEXIS 55652 at *10 (S.D. Ind. June 29, 2009) (“When an expert ‘ignores critical data’ in forming his opinions, he fails to satisfy *Daubert*.”) (internal citations omitted). Studies examining whether hormone therapy and gender confirmation surgery are effective treatments for individuals with gender dysphoria and/or depression do exist and have shown such treatment to be effective. (*See* Pls.’ Resp. to Defs.’ Additional FOF ¶¶ 120-123). Moreover, Mayer admits that other treatments that are recognized in the medical community do not have any greater support than gender confirmation surgery. Mayer Dep. 80:22-81:11.

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).

RESPONSE: Disputed. The cited evidence does not support this proposed fact. First, the purported “2004 study” was not a study, but follow-up of a 1997 literature review of studies of “post-operative-transsexuals,” and Dr. Mayer’s paper cites not to this study but to a summary of the study published in *The Guardian*, a newspaper, not a medical journal. (Dkt. # 83-17, Mayer Expert Rep. App. D:109). Second, in his deposition, Dr. Mayer made the following statement regarding his citation of this article:

Q. Now, why would you rely on an article in a newspaper to support your views?

A. Let me say something. I'm an academic, so when I cite things, I'm not regurgitating what other people said. These are my opinions, and to support my opinions or elaborate my opinions, I often cite something that I find of interest. I'm not citing any of these as being the end-all and be-all of my opinion. It's to give an example of what other people are out there doing. So I think it's perfectly fine -- I notice in the early part of this I cited the work of feminists and things like that. We're all over the map. Also, it's a popular text and all that. That's what you do. If you mean did my conclusions fall from a Guardian newspaper, of course they didn't.

(Mayer Dep. 141:21-142:10). More recent studies have demonstrated the effectiveness of gender confirmation surgery on transgender individuals. (Budge Rep. 16-18). Further, there are considerable flaws in this report, which was published in 1997 and 2004, and which criticizes studies that were conducted in 1979, 1968, 1987, and 1990. (Second Budge Supp. Rep. ¶ 1). Many of the criticisms in this report, such as the lack of studies using a control group and low follow-up rate, have been addressed with more recent studies. (*Id.*)

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).

RESPONSE: Disputed. Dr. Mayer conceded at his deposition that the 2011 study by Dr. Cecelia Dhejne did not address the effectiveness of sex reassignment as treatment for transsexualism. (Mayer Dep. 142:14-17). Further, this study compared transgender persons to cisgender persons, and did not include a control group of transgender persons who desired to have gender confirmation surgery but did not receive it. (Mayer Rep. App. D:110). Mayer has claimed that only studies using control groups can be used to determine the efficacy of such treatments. (*See* Defs.’ Additional FOF ¶ 121). Dr. Mayer’s paper conceded that this study’s design “precludes drawing inferences ‘as to the effectiveness of sex reassignment as a treatment for transsexualism.’” (Mayer Rep. App. D:111).

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).

RESPONSE: Disputed. Dr. Mayer conceded that this study compares transgender persons receiving surgery with cisgender women, and does not compare

patients with gender dysphoria, which Dr. Mayer has stated is the only way to determine the efficacy of treatments such as gender confirmation surgery. (*Compare* Mayer Dep. 142:23-143:6 *with* Defs.' Additional FOF ¶¶ 120-122).

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).

RESPONSE: Disputed. The cited evidence states that researcher Mohammad Hassan Murad found, after conducting a literature review and not a study, "low quality evidence" that hormonal interventions improved gender dysphoria, psychological functioning, and overall quality of life. (Mayer Rep. App. D:112). Plaintiffs dispute Defendants' suggestion that this review shows that hormone treatment is ineffective in treating gender dysphoria, since the study actually indicated that gender reassignment with the use of hormone therapies was associated with "improvements in gender dysphoria, psychological functioning and comorbidities, lower suicide rates, higher sexual satisfaction and overall, improvement in the quality of life." Mohammad Hassan Murad, Mohamed B. Elamin, Magaly Zumeata Garcia, Rebecca J. Mullan, Ayman Murad, Patricia J. Erwin, *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*, 72 *Clinical Endocrinology* 214, 229 (2010). Additional studies cited by Dr. Budge demonstrate improvements in gender

dysphoria among those using hormone therapy. (Budge Supp. Rep. 7). Studies on the efficacy of hormone therapy examined the effect of treatment on gender dysphoria using a validated gender dysphoria scale and showed a statistically significant decrease in gender dysphoria over time for those receiving hormone therapy. (*Id.*) One study did compare control groups of transgender individuals using hormone therapy versus those not using hormone therapy, and found those not using hormone therapy were four (4) times more likely to report depressive symptoms. (*Id.*)

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).

RESPONSE: No dispute that this is Dr. Mayer's opinion based on the evidence summarized in his non-peer-reviewed *New Atlantis* article, but disputed that the scientific evidence concerning gender confirmation surgery and hormone therapy supports a "skeptical view" of the benefits provided by such treatment. Plaintiffs' expert Dr. Budge opines that many studies have demonstrated the benefit of these medical interventions for transgender individuals with gender dysphoria, demonstrating decreases in gender dysphoria, depression, and suicidal ideation. (Pls.' FOF ¶¶ 33, 35, 37; Pls.' Supp. FOF ¶¶ 5, 12, 31, 33).

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).

RESPONSE: No dispute that this is Dr. Mayer’s opinion, but disputed to the extent Defendants claim this opinion supports an opinion that gender identity can change for adults and post-pubescent children. (Budge Supp. Rep. 11-12.) In addition, experts in the health care of transgender individuals recognize that among post-pubertal adolescents and adults a person’s gender identity is highly resistant to outside efforts to change it and that efforts to do so are harmful and unethical. (Budge Rep. 19-20). Moreover, medical treatments (hormones and surgery) for children and adolescents are highly regulated and very carefully considered. (Second Budge Supp. Rep. ¶ 2). It is highly unlikely that a youth who goes through an extensive psychological evaluation and is assessed by multiple health care providers over a long period of time would be “misdiagnosed” with gender dysphoria or inappropriately prescribed irreversible treatment. (*Id.*) The WPATH SOC v.7 have strict guidelines surrounding the medical treatment protocols for children and adolescents with gender dysphoria. (*Id.*)

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.").

RESPONSE: Disputed. The cited evidence does not support the proposed fact and is inadmissible pursuant to Fed. R. Evid. 702, as it is not based on sufficient facts or data, nor is it the product of reliable principles and methods, as Dr. Mayer's statements on the treatment of body dysmorphic disorder have not been shown to

have any bearing on proper treatments for gender dysphoria. (Budge Supp. Rep 3-4). In contrast to the research supporting the efficacy of GCS and hormone therapy for gender dysphoria, research indicates that there is either no benefit or worse outcomes for individuals with depression, anxiety, personality disorders, or body dysmorphic disorder for cisgender individuals receiving cosmetic surgeries. (*Id.*) Body dysmorphic disorder is entirely different from gender dysphoria. (Budge Supp. Rep. 3-4). Moreover, unlike reconstructive surgical treatments for gender dysphoria, which are effective, surgical treatments for body dysmorphic disorder are ineffective. (*Id.*) Appropriate treatments for body dysmorphic disorder are psychotherapy and psychiatric medications, which, on their own, are not effective at treating gender dysphoria. (*Id.*; Second Budge Supp. Rep. ¶ 2).

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.”.)

RESPONSE: Disputed. The cited evidence does not support the proposed fact and is inadmissible pursuant to Fed. R. Evid. 702, as it is not based on sufficient facts or data, nor is it the product of reliable principles and methods, as Dr. Mayer has not provided any underlying support for this position, and has conceded that he is not licensed to practice medicine, has never practiced medicine or psychiatry, and has no specific training dealing with gender dysphoria. (Dkt. # 113, Pls.’ Supp. FOF ¶ 22). In addition, gender dysphoria is not synonymous with mood disorders such as depression, although gender dysphoria can lead to mental health concerns such as depression, anxiety, and suicidality. (Budge Supp. Rep. 5). Treating only comorbid diagnoses of depression will not treat the gender dysphoria. (*Id.*; *see also* Budge Rep. 13 (failure to treat gender dysphoria can lead to other mental health concerns). Dr. Budge’s clinical experience shows that psychotherapy is not effective as the sole treatment for individuals who indicate the need for medical changes to their bodies to reduce gender dysphoria. (Second Budge Supp. Rep. ¶ 2).

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.*).

RESPONSE: Disputed. Transgender identity is the incongruence between a person’s gender assigned at birth and their gender identity. (Budge Rep. 9). “Gender

assigned at birth” is sometimes also referred to as “sex assigned at birth,” and is usually based on an assessment of an infant’s genitals and/or a chromosome analysis. (*Id.* at 8).

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).

RESPONSE: No dispute that this is Dr. Mayer’s opinion, but there is evidence that gender is immutable. (*See* Budge Rep. 8, Budge Supp. Rep. 11-12). Even Dr. Mayer agrees that the condition is very resistant to change and that it is very rare that a transgender person’s gender identity would change back. (Mayer Dep. 119:20-120:5, 138:13-23).

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.”).)

RESPONSE: Disputed. Dr. Mayer misunderstands the meaning of “transition.” A social transition is “any aspect of identifying and expressing one’s gender identity,” including coming out, using pronouns congruent with gender identity, and wearing clothing associated with their gender identity. (Budge Rep. 9). A medical transition, any medical procedure that “assist[s] a transgender individual with achieving primary or secondary sex characteristics that are closely assigned with their gender identity,” is not desired or needed by all transgender individuals. (*Id.* at 9-10). The language of “gender transition” is common in the transgender community, and denotes the changes that are made to align one’s body with one’s gender identity (for example, the changes from hormone therapy or surgery) or changes that are made socially (for example, a name change or change in haircut). (*Id.* at 9-10, 15). Within the psychological and medical communities, the term gender confirmation is often used to clarify that the procedures confirm one’s gender. (*Id.* at 10).

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.”).)

RESPONSE: No dispute that the suicidal ideation rates for transgender persons remain higher than in the general population. (Budge Supp. Rep. 9). Plaintiffs dispute this fact to the extent Defendants claim gender confirmation surgery has no effect on the suicidal ideation of transgender persons, as studies have found that the relative risk of suicide is reduced for transgender persons who have undergone surgery. (*Id.* at 9-10).

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.”).)

RESPONSE: Disputed. Dr. Mayer concedes in the cited testimony that he does not know the APA’s position and that he would “have to read the whole document,” and this opinion is therefore not based on sufficient facts or data, because Dr. Mayer concedes he has not reviewed the information about which he is opining. Moreover,

Dr. Mayer stated that he does not disagree with the APA's position that "social transition hormone therapy and sex reassignment surgery is appropriate and medically necessary care for some people with gender dysphoria," saying that he has "no doubt" that some people benefit from the treatment. (Mayer Dep. 72:15-19). The clinical guidelines set by AMA and APA for treatment of gender dysphoria are based on studies. (*See* Budge Rep. 19 (APA guidelines for psychological practice for transgender people discusses importance of reviewing research literature on hormones and gender confirmation surgery); Second Budge Supp. Rep. ¶ 3).

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.”).)

RESPONSE: No dispute, except to the extent Defendants claim clinician practice alone is the sole evidence of the safety and efficacy of treatments for gender dysphoria. Many studies have demonstrated the safety and efficacy of hormone therapy and gender confirmation surgery to treat gender dysphoria. (*See* Pls.’ Resp. to Defs.’ Additional FOF ¶¶ 120-122).

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).

RESPONSE: Disputed. While “gender” refers to social, cultural, and psychological characteristics that are considered masculine or feminine based on cultural stereotypes, norms, and traits, a “gender transition” is a transition for an individual to identify and express their gender identity, through a social transition and/or a medical transition. (Budge Rep. 8-9). Moreover, the primary and secondary sex characteristics altered by GCS and hormone therapy are not culturally dependent; while social roles may vary by culture, a penis and testicles are associated with a male gender in all cultures and a vagina and breasts are associated with a female gender in all cultures. (Second Budge Supp. Rep. ¶ 4).

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).

RESPONSE: Disputed. While some aspects of gender expression, such as social roles and expectations, may be culturally dependent, the primary and secondary sex characteristics associated with a male or female gender and altered by GCS and hormone therapy do not vary by culture. (Second Budge Supp Rep. ¶ 4; *See also* Pls.’ Resp. to Defs.’ Additional FOF ¶ 119).

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.”).)

RESPONSE: No dispute, however Williams also testified that cost-benefit analyses of these sorts may be consulted in determining whether to cover a benefit. (Williams Dep. 185:1-187:11).

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.”).)

RESPONSE: Disputed. The testimony cited does not support Defendants' proposed fact. Williams stated that the materiality of a cost for adding a benefit is a decision to be made by the fiduciary who will be paying the costs rather than the actuary offering an opinion, not that it is inapplicable. (Williams Dep. 83:1-19). Plaintiffs' expert Joan Barrett has opined that costs below 0.1% of total program costs are actuarially immaterial, because such small costs amount to a rounding error and have never in her experience been the reason for a decision not to cover a benefit. (Dkt. # 105, Expert Report of Joan Barrett (“Barrett Rep.”) at 8). Defendant Herschel Day, also an actuary, agreed that costs of 0.1% or 0.2% are negligible. (Dkt. # 51, Deposition of Herschel Day (“Day Dep.”) 53:1-10).

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.”.)

RESPONSE: No dispute that this is Williams’ testimony, but Plaintiffs’ expert has stated that in her decades of experience as a health care actuary, no employer had made a benefits decision based on cost for a benefit that is less than 0.1%. (Barrett Rep. 8).

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).)

RESPONSE: Disputed. WPATH states that, “surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care,” because the Standards of Care “allow for an individualized approach to best meet a patient’s health care needs.” (Dkt. # 123-1, WPATH Standards of Care, at 56-58). The Standards of Care state that “surgical procedures may include the following” for male-to-female or female-to-male transitions, but do not “recommend” those procedures. (*Id.* at 57-58). Rather, the Standards of Care set forth criteria to be met before such procedures are performed. (*Id.* at 58-61).

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).)

RESPONSE: Disputed. *See* Pls.’ Resp. to Defs.’ Additional FOF ¶ 145.

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)).)

RESPONSE: No dispute that this quote appears in WPATH, but the fact that these gender conforming surgeries may not be "purely reconstructive" does not distinguish them from other reconstructive surgeries for which Defendants do provide coverage. Many reconstructive surgeries have both functional and cosmetic

purposes. (See Second Supplemental Expert Report of Dr. Loren Schechter at 2) (“no particular surgery is inherently cosmetic or inherently reconstructive; rather, the underlying diagnosis determines whether the procedure is considered cosmetic or reconstructive.”).

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).)

RESPONSE: Disputed. WPATH recommends that “extensive exploration of psychological, family, and social issues should be undertaken” before any physical interventions are considered for adolescents, and that such interventions should proceed through stages (fully reversible interventions, partially reversible interventions, irreversible interventions) to keep options open. (*Id.* at 18; *see also* Second Budge Supp. Rep. ¶ 2 (noting that medical treatments for children and adolescents are highly regulated and carefully considered, and the WPATH Standards of Care have strict guidelines for children and adolescents with gender dysphoria)).

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).)

RESPONSE: No dispute that these words appear in the SOC, but Plaintiffs note that “the persistence of gender dysphoria into adulthood appears to be much higher for adolescents.” (*Id.* at 11.) In addition, many of the studies on gender identity in children conflate children who exhibit gender nonconforming behavior with children who have a persistent transgender identity and/or gender dysphoria, making the conclusions about fluidity and persistence of gender identity or gender dysphoria in young children difficult. (Second Budge Supp. Rep. ¶ 2).

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).)

RESPONSE: No dispute that these figures appear in the SOC, but Plaintiffs note that these are studies of pre-pubertal children, not post-pubertal children. (*Id.*) Moreover, the studies cited for these persistence rates included many children who are considered “gender non-conforming,” which is not the same as children who have gender dysphoria. All of these studies used criteria for gender identity disorder that are no longer considered critical aspects of a gender dysphoria diagnosis (for example, language regarding the type of toys children play with and the type of clothing they wear). The current criteria requires that children/adolescents identify with a gender that is different from their assigned gender, which was not the case for all of the studies that are cited to indicate whether or not a youth will experience gender dysphoria in the future. Reparative or conversion therapies are widely considered harmful and unethical. (Second Budge Supp Rep. ¶ 2).

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

RESPONSE: No dispute.

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.”).)

RESPONSE: No dispute that not all transgender people have gender dysphoria, but disputed as to Dr. Mayer's statements about "gender identity disorder" and "gender dysphoria." The DSM-5 has been updated to identify "gender dysphoria" rather than "gender identity disorder" as a mental health disorder to reflect the understanding that gender identity is not a disorder, but distress related to the incongruence between a person's gender assigned at birth and gender identity is diagnosable. (Budge Rep. 12-13).

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).

RESPONSE: No dispute that the DSM-5 states that persistence of gender dysphoria in prepubescent natal males has ranged from 2.2% to 30%, and has ranged from 12% to 50% in natal females, but the DSM-5 does not state that "treatments aimed at aligning one's gender identity with their biological sex may be successful at ending (i.e. treating) gender dysphoria," nor does Mayer's *New Atlantis* article make this representation. WPATH observes that "Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success, particularly in the long term. Such treatment is no longer considered ethical." (Dkt. # 123-1, WPATH Standards of Care, at 16 (internal citations omitted); see also Budge Rep. 19-20 (citing additional

sources regarding attempts to change gender identity being ineffective and unethical)).

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).

RESPONSE: Disputed. The “A” criteria quote is “marked incongruence between one’s experienced/expressed gender and assigned gender of at least 6 months’ duration, as manifested by at least two of the following,” and lists six additional criteria. No dispute as to the “B” criteria quote. (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition, Arlington, VA: American Psychiatric Association, 2013).

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).)

RESPONSE: No dispute.

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*)).

RESPONSE: No dispute that the Obama administration issued this *Dear Colleague* letter, but Plaintiffs note that the Trump administration withdrew this letter on February 22, 2017. (Madden SJ Reply Decl. Ex. C, Feb. 22, 2017 Dear Colleague letter, accessed at <<https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201702-title-ix.pdf>>, last accessed July 5, 2018).

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).

RESPONSE: No dispute, but Plaintiffs object that Ex. X, a screenshot of a Wikipedia article, is inadmissible hearsay evidence pursuant to Fed. R. Evid. 802.

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).)

RESPONSE: Disputed. None of the evidence cited supports Defendants' proposition that these organizations "devote significant resources" to transgender rights, and in fact make *no* statements as to the resources used on these causes.

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).)

RESPONSE: No dispute that these three editorials published by the New York Times and Washington Post opposed the proposed ban on transgender troops, and that the Los Angeles Times editorial from 2015 supported a California law that clarified California anti-discrimination policies in the state education code.

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).)

RESPONSE: No dispute.

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).

RESPONSE: No dispute.

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).)

RESPONSE: Disputed. The cited evidence does not support Defendants’ proposed fact, but only states the reason that Defendants excluded coverage for transition-related care in 1994.

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”).)

RESPONSE: No dispute.

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).

RESPONSE: No dispute.

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).

RESPONSE: No dispute that Farrell and Wieske testified they understood that an injunction would be issued enjoining the HHS regulations and that this was the reason they voted to reinstate the exclusion. (Farrell Dep. 28:7–13, 56:4–7, 61:21–22, 71:5–6; Wieske Dep. 96:2-6). The remainder of the factual statement is disputed, as the evidence cited is silent on whether the action was taken with the intention of reinstating the exclusion before it was removed on January 1, 2017. Plaintiffs further note that GIB’s action did not reinstate the exclusion effective January 1, 2017, because ETF Secretary Conlin did not determine that the contingencies had been met until January 30, 2017. (Dkt. # 83-15, Conlin Dep. Ex. 17 – GIB Correspondence (finding GIB’s four contingencies had been met and reinstating the exclusion effective February 1, 2017)).

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).)

RESPONSE: No dispute.

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

RESPONSE: No dispute.

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).)

RESPONSE: No dispute.

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).

RESPONSE: No dispute that Wieske provided this testimony, but the statements of unnamed “insurers” as to the medical necessity of treatment including gender confirmation surgery and hormone therapy for transgender individuals is disputed as inadmissible hearsay.

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).)

RESPONSE: No dispute.

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).

RESPONSE: See Pls.’ Resp. to Defs.’ Additional FOF ¶ 169.

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).

RESPONSE: No dispute, though Plaintiffs note that Farrell made this statement in general about exclusions, and not specifically about the exclusion in this case. Farrell also conceded that the Segal memo found the costs of removing the exclusion in this case to be “minimal.” (Farrell Dep. 167:12-25).

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.”).)

RESPONSE: Disputed. Wieske could not identify anyone who spoke about costs, or what was said about it. (Wieske Dep. 89:11-17). Lisa Ellinger, Tara Pray, and Nancy Thompson did not recall discussion of costs as a factor for removing or reinstating the exclusion. (Pls.’ Resp. to Defs.’ FOF ¶ 67).

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).

RESPONSE: No dispute that this was Farrell’s testimony, but Farrell also testified that he was “not familiar with the science” related to medical necessity for transition-related health care. (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).

RESPONSE: No dispute.

Dated this 9th day of July, 2018.

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