Exhibit 1

From:	Bedard, Stephanie
To:	Ele Hamburger; Omar Gonzalez-Pagan; Jenny Pizer; Daniel Gross; Matt Terry; Theresa Redfern; Stacy Hoffman
Cc:	Payton, Gwendolyn; Neeleman, John; Rountree, Ian
Subject:	[External] CP v. BCBSIL (No. 3:20-cv-06145-RJB) - BCBSIL"s Rule 26(a)(2) Expert Disclosures
Date:	Friday, June 24, 2022 2:22:39 PM
Attachments:	image002.png C.P. et al. v. BCBSIL - 2022.06.24 Rule 26 Disclsoure of Dr. Laidlaw.PDF C.P. et al. v. BCBSIL - 2022.06.24 Rule 26 Disclosure of Dr. Burns.PDF C.P. et al. v. BCBSIL - BCBSIL"s Rule 26(a)(2) Expert Disclosures.pdf

Counsel,

Pursuant to Federal Rule of Civil Procedure 26(a)(2) and the Court's April 4, 2022 Order (ECF No. 48), please find enclosed BCBSIL's expert disclosures and the report for Dr. Burns. Dr. Laidlaw is disclosed for rebuttal purposes only.

Thank you,
Stephanie

KILPATRICK TOWNSEND
ATTORNEYS AT LAW

Stephanie Bedard
Kilpatrick Townsend & Stockton LLP
Suite 2800 | 1100 Peachtree Street NE | Atlanta, GA 30309-4528
office 404 815 6039 | fax 404 541 3153
sbedard@kilpatricktownsend.com | My Profile | vCard

Exhibit 2

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard and PATRICIA PRITCHARD,

Plaintiffs,

vs.) No. 3:20-cv-06145-RJB

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

MICHAEL LAIDLAW

9:00 a.m.

September 2, 2022

REPORTED BY: Pat Lessard, CCR #2104

P R O C E E D I N G S

THE VIDEOGRAPHER: One moment, please.

We are on the record at 9:07 a.m. on September 2nd, 2022. This is the video-recorded deposition of Dr. Michael K. Laidlaw in the matter of C.P. by and through his parents, et al., versus Blue Cross Blue Shield of Illinois.

No. 3:20-cv-06145-RJB in the United States District Court at Tacoma.

This deposition is being held virtually and was noticed by plaintiff.

Counsel, please introduce yourselves and state whom you represent.

MR. Gonzalez-Pagan: Good morning. Omar Gonzalez-Pagan, Lambda Legal, for the plaintiff.

MS. HAMBURGER: I'm Eleanor Hamburger, Sirianni Youtz Spoonemore Hamburger, also for the plaintiff.

MS. PAYTON: I'm Gwendolyn Payton and I represent Blue Cross Blue Shield of Illinois.

THE VIDEOGRAPHER: My name is Patrick Norton and I am the legal videographer. The court reporter is Pat Lessard. We are with Seattle Deposition Reporters.

MICHAEL LAIDLAW, being duly sworn, testified upon oath, as follows:

E X A M I N A T I O N

BY MR. GONZALEZ-PAGAN:

Q. All right. I think we're good to proceed.

Good morning, Dr. Laidlaw, thank you for joining us today. It's afternoon for me; I'm in New York.

A. Okay.

Q. Are you in California today?

A. Correct.

Q. Okay. So as you might have heard, I represent the plaintiffs in this matter and I will be asking you some questions about your opinions in this case.

A. Okay.

Q. First I just want to go over some ground rules for the deposition which will make it easier for everyone and most importantly for our court reporter.

You understand that you're under oath today, is that correct?

A. Yes.

Q. We cannot speak at the same time because the court reporter needs to be able to take down what each of us says.

Q. And that's in Canada, is that correct?
A. Correct.
Q. Did you testify at deposition or trial in this matter?
A. I did not testify. I only wrote a report.
Q. Did this matter have to do with gender dysphoria or transgender issues?
A. Yes.
Q. What is the subject matter of this case?
A. It was a minor person having a mastectomy surgery.
Q. What was the substance of your expert opinion in that case?
A. The substance was similar, that the patient could not consent, didn't have the judgment capacity to consent for the surgery given her age.
And that was pretty much the substance of it.
Q. You used the "given her age."
If it was a mastectomy this would have been for a transgender male, is that right?
A. Yes, correct.
Q. Any reason why you used the female pronoun for a transgender male?
A. I did not interview the patient so I don't

know the background as to the exact -- the patient was clinically diagnosed through a psychiatrist or a psychologist.

Q. But you did not interview the patient, is that right?

A. I did not interview the patient.

Q. Do you know the outcome of the case?

A. I don't recall. I don't think it was -- let's see. I don't believe it went in favor of the plaintiff.

Q. Who was the plaintiff in that matter?

A. I believe it was the mother of the person seeking surgery.

Q. And the mother was objecting?

A. Yes. Well, the mother wanted it. I think it was the mother wanted -- it's been a while, but I think the mother wanted to obtain medical records regarding the case -- I don't remember all of the specifics -- and was being blocked because the minor was -- there was a question whether they were emancipated or whether the mother could look at the records, that sort of thing.

Q. Let's turn to DH and DOE v Snyder. That's the next one over.

That's pending in federal court in Arizona,

on existing publications and preexisting data.

I think that's the distinction that you were drawing in your answer as well, is that correct?

A. Yes.

Q. So would you be comfortable with that understanding, that shared understanding of -- do you know what I mean by primary research?

A. Yes, I understand your meaning.

Q. Have you performed any primary research?

A. Yes.

Q. On what? On what matters?

A. There were two studies. One was a magnesium study that had to -- we're looking for an association of low magnesium leading to osteoporosis.

And the other study was regarding thyroid cancer where we were looking at thyroid globulin tumor markers and how they correlated with ultrasound findings of the neck.

Q. And when did you perform this research?

A. This was during my -- it may have begun during my -- I think it began during my residency and then I continued into fellowship.

Q. Have you performed any primary research regarding gender dysphoria?

A. No.

Q. Have you performed any primary research relating to transgender people?

A. No.

Q. Have you performed any primary research relating to gender identity?

A. No.

Q. Do you have any peer-reviewed publications?

A. Yes.

Q. Do you have a copy of your CV with you?

A. No.

Q. I will show you what's been marked as Exhibit 2.

A. Okay.

Q. And this is a copy of your CV, right?

Well, it's not showing yet. This is a copy of your CV, right?

A. Yes. It's the one we looked at earlier.

Q. And you have here a section titled "Research, Publications, and Expert Witness Work," is that right?

A. Yes.

Q. And we can scroll through it but just go area by area.

Can you tell me which the -- within the screen showing right now which of these publications

listed here are peer-reviewed?

MS. PAYTON: Object to the form of the question. And the blue print on the question on the screen here, I'm not sure that's easy to follow.

But go ahead and answer.

THE WITNESS: Understood.

Q. (By Mr. Gonzalez-Pagan) Dr. Laidlaw, you have marked in your CV some of these as expert witness --

A. Yes.

Q. -- brief of Amicus Curiae, Expert Witness, et cetera, is that correct?

A. Yes.

Q. Okay. So there's a publication listed for 2021 --

A. Uh-huh.

Q. -- it's a Letter to the Editor --

A. Uh-huh.

Q. -- titled "Erythrocytosis in a Large Cohort of Trans Men Using Testosterone: A Long-Term Follow-Up Study on Prevalence, Determinants and Exposure Years," is that right?

A. Yes.

Q. It's a Letter to the Editor pertaining to that separate article, is that correct?

A. That's right.
Q. And is a Letter to the Editor a peer reviewed publication?
A. I don't know. It has to be accepted before they publish it, so I don't know what process they go through. It may be or it may not be.
Q. There's another listing or a publication in 2020 titled "Correction Transgender Surgery Provides No Mental Health Benefit," is that right?
A. Yes.
Q. And you're a coauthor of this piece, is that right?
A. Yes.
Q. It was published in the Public Discourse, is that correct?
A. That's correct.
Q. Is this a peer-reviewed publication?
A. Not to my knowledge.
Q. There's another publication just below it, in 2020, titled Gender-Affirmation surgery conclusion lacks evidence (letter)."
And you're a coauthor of this publication, is that right?
A. That's right.
Q. This was another letter, is that correct?

A. Yes, it's a Letter to the Editor.
Q. Okay. Is this peer-reviewed?
A. I don't know. It has to be accepted for publication, like I said, so I don't know what process they go through.
Q. Below that there's another publication titled "The Pediatric Endocrine Society's Statement on Puberty Blockers isn't just Deceptive. It's Dangerous."
And you're the sole author of this publication, is that right?
A. Yes.
Q. And it was published in Public Discourse, is that correct?
A. That's correct.
Q. And the next page, the next publication listed is "The Right to Best Care for Children does Not Include the Right to Medical Transition," is that right?
A. Yes.
Q. And you're a coauthor of this piece?
A. Yes.
Q. And this is an opinion piece, is that correct?
MS. PAYTON: Object to the form.

A. My understanding is it's a peer-reviewed piece, but that's the one I would say has to be peer-reviewed to be published but I don't know their process.

Q. (By Mr. Gonzalez-Pagan) But is it an opinion piece or is it a research piece?

MS. PAYTON: Object to the form.

A. I mean it's the Journal of Bioethics, so it's not -- if you're asking is it based on primary research? Because there's two different things. You could have a peer-reviewed -- peer review doesn't necessarily mean it's primary research, to my understanding.

Q. No. Understood.

I'm asking the question is the Journal of Bioethics a peer-reviewed publication?

A. That's my understanding, yes. I mean all the medical journals that you have listed are peer reviewed publications. The exact process they use, I don't know.

Q. And this piece in 2019 for which you are a coauthor in the American Journal of Bioethics is not a piece of original research, is that correct?

A. When you say that, do you mean did we have patients doing -- collecting data on individual

patients? Is that what you mean by that?

Q. Yes. Do you have an understanding of what primary research meant? So I guess I would ask it that way.

Is this article based on primary research you conducted?

A. It's not based on primary research I conducted.

Q. Thank you. There's another publication. It's a Letter to the Editor, "Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline," is that correct?

A. Correct.

Q. And you're a coauthor of this piece?

A. Yes.

Q. And this is another Letter to the Editor, correct?

A. Yes.

Q. Just below that there's a publication titled "The Gender Identity Phantom," and you are the sole author, is that right?

A. Correct.

Q. And it appears to be published in the gdworkinggroup.org, is that right?

A. Yes, I think so.
Q. What's the gdworkinggroup.org?
A. They're a collection of different psychologists, psychiatrists and other mental health professionals, and there may have been other physicians, but who were writing pieces with concerns or criticisms about the care of people with gender identity conditions.
Q. Is this a publication posting on a discussion board?
A. Could you repeat that?
Q. Is this a publication posting within a discussion board?
A. No. Are you asking me like can you just post something as part of a discussion or are you asking can people discuss the topic below your article? Is that what you're asking?
Q. I'm asking if it's a discussion forum for professionals where you are set up, made a post, or whether it's an article.
A. Oh, it's an article against -- each author can write -- you have to be a member to be an author and you have to be an author to put something up there.
So not just any general member of the public

could write something, if that clarifies it.
Q. Okay. Is this peer-reviewed?
A. No.
Q. The next publication is titled "Gender Dysphoria and Children: An Endocrinologist's evaluation of 'I am Jazz,'" and you're the sole author, is that right?
A. That's correct.
Q. And it was published in Public Discourse, is that correct?
A. Yes.
Q. Are there any other publications that you have in relation to gender dysphoria or transgender issues?
A. Not that I can think of. I did have this -- I think I put it somewhere with my subpoena response, but there's gendersanity.org where I explained myself and coauthors explained the most recent Letter to the Editor.
Q. Sorry? What is that?
A. Gendersanity.org I believe is the name.
Q. And is that a self-published website?
A. Yes.
Q. We've established that three of your publications are for Public Discourse, is that

correct?

MS. PAYTON: Object to the form.

A. Yeah. Three -- I think it was three, yeah, three publications for Public Discourse.

Q. (By Mr. Gonzalez-Pagan) Who publishes, Public Discourse?

A. I believe at the time I submitted my articles that -- I don't know who the publisher is but the editor was Ryan Anderson, I believe.

Q. Are you familiar with the Witherspoon Institute?

A. Only that I saw their name associated with Public Discourse.

Q. I'm going to show you what's been marked as Exhibit 4.

A. Okay.

(Marked Deposition Exhibit No. 4.)

Q. (By Mr. Gonzalez-Pagan) Do you see the document in front of you?

A. Yes.

Q. This is the Mission Statement for Public Discourse, is that right?

A. It says "Our Mission," so I suppose it is.

Q. Okay. And just to clarify, this is a printout on September 2nd, 2022, 8:30 a.m., off the

website www.thepublicdiscourse.com/our mission, is that correct?

MS. PAYTON: Object to the form, foundation.

A. You are posting -- or I can see on the screen a mission statement from Public Discourse as of today. Today is the first time I've ever seen it.

Q. (By Mr. Gonzalez-Pagan) Yes. On the screen?

A. Yeah.

Q. And do you understand Public Discourse to be an online journal?

A. Yes.

Q. And are you aware that their mission is to enhance public understanding of the moral foundations of free society?

MS. PAYTON: Object to the form.

A. You know, I'm looking at it now and I can say you just read what is on there. But I don't have any affiliation with them in particular.

I think, but I don't recall exactly, that anything I publish at the bottom, I think, says something like "This does not necessarily represent the views of the Public Discourse," so --

Q. Is there any reason why you chose to publish in the Public Discourse?

THE VIDEOGRAPHER: We're going off the record at 10:00 a.m.

(Recess.)

THE VIDEOGRAPHER: We're back on the record at 10:07 a.m.

Q. (By Mr. Gonzalez-Pagan) We left off discussing your publications. Do you recall that, Dr. Laidlaw?

A. Yes, I do.

Q. Just to sum up, none of your publications pertaining to gender dysphoria are based on original primary research, is that correct?

A. That's correct.

Q. And with the exception of the piece in the Journal of Bioethics none of your publications pertaining to gender dysphoria are peer-reviewed?

A. Well, a number are published in peer-reduced journals.

Q. Sorry. The Letters to the Editor, is that right?

A. The Letters to the Editors are in peer-reviewed journals, yes.

Q. We've established that you have a private practice dedicated to endocrinology, is that correct?

A. That's correct.

Q. As part of your practice do you treat any pediatric patients?

A. I have some patients who are under the age of 18, so later teens or mid teens.

Q. What percentage of your practice are patients under the age of 18?

A. Probably, like, less than five percent.

Q. Have you ever provided care to a transgender patient?

A. Yes.

Q. Have you provided them with care relating to their gender dysphoria?

A. Only once.

Q. What care did you provide that one patient?

A. The patient needed a refill of estrogen.

Q. Did you provide them with the refill?

A. Yes.

Q. About how many transgender patients have you treated for other conditions besides this one patient for gender dysphoria?

A. So I would say that in my practice I have patients with, I would use a more general term and say "gender incongruence," who I'm seeing for other conditions.

For example, they may have a pituitary

A. Or there would be one who had -- well, I would say two because the detransition person I am treating as a consequence of gender dysphoria. So I would say two.

Q. Okay. So there's the one person who has detransitioned and then the one person who you provided a refill for estrogen, is that correct?

A. Those are two patients who received hormones related to a gender incongruence condition.

Q. How old was the patient that detransitioned?

A. In his 20s. He was diagnosed in his early teens.

Q. Do you know how this patient came about connecting with you?

A. He has had a very difficult time finding an endocrinologist who will treat him. He had an orchiectomy or testicles removed and vaginal plasty.

He had a difficult time finding a physician who would prescribe testosterone so he had made a search and somehow found me.

Q. Have you ever diagnosed any patient with gender dysphoria?

A. Being that it's a psychological diagnosis, I do not make psychological diagnoses, so no.

Q. Have you ever diagnosed a person with gender

identity disorder?

A. The same answer. A psychological, you know, diagnosis that I do not make.

Q. Just to clarify, for the patient who detransitioned, you're not providing care for treatment of gender dysphoria, is that correct?

A. Well, I guess it depends how you define treatment for gender dysphoria.

Q. Well, what do you understand gender dysphoria to be?

A. Well, this would be a discomfort arising from a person's, you know, true feeling of their gender identity versus their physical body.

So I don't think this person has fully resolved that issue within himself, but he feels very poorly not receiving testosterone so I'm treating him. So in a sense I am treating his gender -- I mean he feels better. He's doing better.

So I believe I am treating his gender dysphoria. That's not my primary purpose but it's a secondary consequence.

Q. Are you working in conjunction with a mental health therapist or mental health provider in providing this care to this individual?

A. He just moved to Southern California and in

my understanding is he's found some mental health help in his location.

Q. Did you require a mental health assessment of this individual prior to providing testosterone that would be in keeping with his desire to have a more masculine body?

A. He had received some testosterone at some point so I continued the treatment.

Q. So let me restate the question, though.

Did you ask for, did you ascertain whether this person had received a mental health assessment prior to providing testosterone in order to -- in keeping with his desire to have a more masculine body?

A. I discussed with him his mental health condition during the course of my visit.

Q. Are you a mental health provider?

A. No.

Q. And is the answer "No" to the question as to whether did you request a mental health assessment by a mental health provider?

A. He had already been seen by a mental health provider.

Q. Did you discuss the care with the mental health provider?

A. He moved to a different location since that

Q. In paragraph ten of your report you mentioned that you reviewed Dr. Kim Reed's deposition, him being the medical director for Blue Cross Blue Shield of Illinois, is that right?

A. Yes.

Q. Do you disagree with Dr. Reed's testimony?

A. Yes.

Q. With what do you disagree in Dr. Reed's testimony?

A. Dr. Reed -- my reading of Dr. Reed is that he relies on WPATH pretty much exclusively to determine coverage, whereas I disagree that insofar as the WPATH is an advocacy organization with some medical people there and doesn't represent the broad view of gender dysphoria, gender incongruence.

Q. Are you aware that Dr. Reed testified as the corporate representative for Blue Cross Blue Shield of Illinois?

A. I didn't -- well, if you're telling me that's his capacity, then now I know. But I wasn't -- I don't know all the lingo, put it that way.

Q. Okay.

A. I didn't think he was testifying in his own behalf, for example. I assumed it was some representative form.

Q. Did you disagree with Blue Cross Blue Shield of Illinois's gender affirming care policy?

A. I would say "Yes."

Q. What do you disagree about with regards to Blue Cross Blue Shield of Illinois's gender affirming care policy?

MS. PAYTON: I'm going to object to the form of the question. The document is not in front of him.

Q. (By Mr. Gonzalez-Pagan) You may answer.

A. Okay. I don't have it in front of me, but my main two considerations were, first, the WPATH which I just discussed. Second is ability for minors to consent to procedures that can result in sterility, lack of sexual function and ability to breastfeed.

I don't believe that minors can make that decision so it's a problem of medical consent.

Q. Do you disagree that there's a scientific basis for the provision of that care as far as Blue Cross Blue Shield of Illinois's medical policy?

A. I think Blue Cross Blue Shield of Illinois's medical policy, from what I've read, is based on a single source of care, the WPATH, which really has no grading of quality of their evidence or recommendations, so it's a poor scientific document.

Q. Do minors provide consent for medical care?

intervention or medication, surgery, et cetera.

Q. I will refer to the minor plaintiff in this case as C.P. with his initials. I just want to --

A. Yes.

Q. -- I just want to continue that, but do you understand of whom I'm talking about when I use the initials C.P.?

A. Yes.

Q. Have you met with C.P. or his parents?

A. No.

Q. Have you spoken to C.P. or his parents?

A. No.

Q. Did you examine C.P.?

A. No.

Q. Have you evaluated C.P.?

A. I have evaluated the medical records only.

Q. But have you evaluated him, done a physical evaluation?

A. I have not done a physical evaluation or a history, anything like that.

Q. Have you treated C.P. in any form?

A. No.

Q. And you have reviewed the medical records of C.P., is that right?

A. I reviewed the medical records that were

testosterone deficiency. Many times it's not covered or it has to be authorized or things like that.

So if the insurance company says it's not authorized it doesn't mean that it's not medically necessary for that patient. I still -- sometimes they have to pay out of pocket or they use a coupon or something like that. It doesn't affect my decision making.

Likewise, if something is covered but I don't -- but I feel that it may be harmful, I may not prescribe it simply because it's covered or even recommended.

Q. (By Mr. Gonzalez-Pagan) Thank you. Just to clarify, you previously stated that you did not read the Catholic Health Initiative's contract with Blue Cross Blue Shield of Illinois, correct?

A. Correct.

Q. Okay.

A. I was simply aware there was an exclusion.

Q. So you're not aware of what the rationale for the exclusion is, right?

A. I did not read it. I guess my understanding or impression was that it was -- I don't know the reason why. I mean it could be a religious objection or it could be because of concerns about the

DSM-5 diagnosis.

MS. PAYTON: Are you finished, Dr. Laidlaw, with your answer?

THE WITNESS: Yes.

MS. PAYTON: Okay. We can go off.

THE VIDEOGRAPHER: We're going off the record at 11:27 a.m.

(Discussion off the record.)

THE VIDEOGRAPHER: One moment, please.

We're back on the record at 11:28 a.m.

Q. (By Mr. Gonzalez-Pagan) Dr. Laidlaw, you mentioned that gender dysphoria is a diagnosis within the DSM5, is that correct?

A. Yes.

Q. And it is the diagnosis pertaining to a clinically significant distress -- the significant clinical distress that a person experiences based on the incongruence between their gender identity and you said their body characteristics.

A. I mean there's a full definition in the DSM-5 but that's a summary that I would agree with.

Q. Okay. So the diagnosis pertains to the distress, not to whether -- every person has a gender identity, would you agree with me on that?

A. Every person has a gender identity? I have

last two sentences. It states "WPATH claims to be a scientific organization while explicitly acting as an advocacy group. These are incompatible goals."

A. Yes.

Q. What is the basis for your opinion that a scientific organization cannot engage in advocacy?

A. I think a scientific organization can -- for example, the American Cancer Society, which we talked about earlier, they can advocate for eliminating cancer or better treatments for cancer. But they would not -- one would expect them not to exclusively follow one, say, politically based point of view.

There could be a variety of points of view within the American Cancer Society, I'm just giving you an example, or Endocrine Society. Whatever the society is should be open to a variety of points of view.

And what I've seen is that the WPATH is not.

Q. You're not a member of WPATH, is that right?

A. That's correct.

Q. Do you know, are you privy to the debates that occur within WPATH?

A. I've seen some online debates. I've spoken to a psychologist who was a member and quit basically because of this problem.

Q. But you're not privy to the actual internal conversations of WPATH, is that correct?
A. I've spent time looking at the WPATH standards of care.
Q. That wasn't my question, though. Have you participated in any WPATH conferences?
A. I do not participate in WPATH conferences. I'm not a member.
Q. Have you participated in internal discussion forums?
A. I do not participate with WPATH. I'm not a member.
Q. So what is the basis for your opinion that there are no diverse -- no differences of opinion within WPATH?
A. I'm basing it on their standards of care.
Q. The Endocrine Society has a variety of clinical practice guidelines, is that not correct?
A. They do.
Q. Some people disagree with many of those variety of clinical practice guidelines, is that not correct?
A. Are you saying that the members of the Endocrine Society disagree with practice guidelines?
Q. Yes.

allowed for a variety of viewpoints in my opinion.

Q. (By Mr. Gonzalez-Pagan) And I'm asking whether you know whether, know from a first hand basis whether WPATH allows for a variety of opinions?

A. My impression is that they do not.

Q. What's the basis for your impression?

A. Their standards of care and my conversation with the psychologist that I mentioned.

Q. So the standards of care itself is proof there's no debate?

A. Right. Because it doesn't offer any alternatives.

Q. Let's turn to page 31 -- sorry, paragraph 31 of your report.

A. Okay.

Q. There you state -- is there an echo? There you state that the assertion by Dr. Etner that a growing assemblage of research documents that gender identity is immutable and biologically based lacks scientific support and therefore impairs the credibility of Dr. Etner's opinions?

A. Yes.

Q. Okay. Are you saying that gender identity is not biologically based?

A. I'm saying there's no evidence of it at this

A. I'm not sure. I think some of the earlier studies were in the United States but I'm not a hundred percent sure.

Q. Are you aware that the desistance studies only involve youth that were diagnosed or were sub threshold for gender identity disorder rather than gender dysphoria?

A. Well, the gender dysphoria diagnosis was not, you know, hadn't been published at that point, so.

Q. It didn't exist at that time, is that correct?

A. Well, I mean it may have existed but it didn't exist as a term in the DSM.

Q. Sure. What I'm trying to say, the gender dysphoria diagnosis as contained within the DSM-5 did not exist at the time that these studies were conducted?

A. Yes.

Q. Okay. And the diagnostic criteria of gender identity disorder contained in the DSM-3 and 4 is different than the diagnostic criteria for gender dysphoria in the DSM-5, is that correct?

A. At that time I believe they had a term gender identity disorder.

Q. Yes. And I'm asking whether the diagnostic criteria are different.

A. There were different diagnostic criteria, to my knowledge.

Q. I'm going to show you what's been marked as Plaintiffs' Exhibit 6.

(Marked Deposition Exhibit No. 6.)

Q. (By Mr. Gonzalez-Pagan) I apologize. This is actually a pretty enormous PDF.

Can you see my screen?

A. Yes.

This is a publication titled "Understanding the Well-Being of LGBTQI Populations," from 2020, published by the National Academies of Sciences, Engineering and Medicine.

Do you see that?

A. I see it.

Q. Are you familiar with this document?

A. Only briefly looking at it this morning but I had not heard of it before.

Q. Okay. And in your report you relied on reported reviews from the United kingdom, Sweden and Finland relating to the scientific evidence of the care of gender dysphoria, is that right?

A. Yes.

A. Yes.
Q. Do you know whether the report pertaining to the United Kingdom was peer-reviewed?
A. Which report are you referring to?
Q. You refer to a Kass review within your report, is that right?
A. Yes.
Q. Do you know whether that was peer-reviewed?
A. My assumption is yes.
Q. It's actually a preliminary report, is that right?
A. The one I refer to, I don't know if the final reports come out or not.
Q. Okay. Are you certain that it was peer-reviewed?
A. I'm certain that the NIH -- sorry, NHS, is involved with the reports. So, you know, then again, it depends how you define peer-reviewed. I presume if the NHS is involved then they have peers looking at the report before it's published. That's just my assumption.
Q. Peer-review has a particular meaning within the scientific literature, does it not?
A. If you're talking about publication in a scientific journal?

Q. Yes.
A. Then an article is submitted, appropriate peers are selected, have a look and decide whether, you know, the arguments are valid or, you know, the data is valid. That sort of thing.
Q. Essentially the publication goes out to external reviewers who may have some expertise in the area and may have some comments or not on the publication, is that right?
A. That's my understanding.
Q. Okay. Do you know whether it happened with the Kass review?
A. I don't know. I'm not part of the review.
Q. Do you know whether the report from Sweden was peer-reviewed?
A. Well, if it's not in a scientific publication -- and what my -- the reason that I think these are important is because peers within their public health system have looked at it and decided it should be published. So it's not a scientific --
Q. I understand that. I guess I'm asking an underlying threshold question for my edification which is --
A. It's --
Q. -- whether they were externally

peer-reviewed or not.

MS. PAYTON: Please don't talk over each other.

A. Because it's not published in a journal it would not have a journal type peer review.

Q. (By Mr. Gonzalez-Pagan) Does that hold true also for the report pertaining to Finland?

A. That's my assumption.

Q. Do you know what the percentage of desistance is among transgender adolescents?

A. Now, if you could -- I think that's a difficult question to answer because when did they come to -- when did they come to see a medical or psychological health professional. When did they come to seek treatment and how long had they had the dysphoria.

So are you asking me someone who's had dysphoria since age four and presents at age 13, for example?

Q. Well, I guess what I'm asking is you made a statement about desistance on your report --

A. Uh-huh.

Q. -- and you referenced particular studies --

A. Yes.

Q. -- and we've established that those studies

looked at primarily up to age twelve population.

So I'm asking if you know any desistance rates or studies pertaining to desistance rates, you know, above age twelve?

A. Well, I don't -- well, let's say from the age of 13 to 18 I'm not aware of any study that looks at desistance.

Q. Do you know of any study that looks at desistance above age 18?

A. I don't know if there's any published study. I know there was a professor in the UK who wanted to publish something and he was obstructed from doing that. I don't remember his name, Caspin, I think.

So I'm not aware that there's any out there.

Q. (By Mr. Gonzalez-Pagan) I'm going to refer you again to Exhibit 6. This is the National Academies study report. I'm on page 302 of the document.

And it states that while interest in the so-called desistance of transgender identity has been informed by studies suggesting that as high as 80 percent of prepubertal youth presenting to pediatric gender clinics ultimately do not identify as transgender, many of the youth included in the studies did not meet full DSM criteria for a gender

identification.

It sounds like they're speculating about what might have happened.

Q. Do you know where the recruitment occurred in Lisa Littman's article?

A. I know it was an online recruitment.

But having a question about medical care doesn't, you know, invalidate their opinion. But it could be a skewed sample, I would say that that is correct.

Q. Okay. Turn to paragraph 65 of your report.

A. Yes.

Q. In that paragraph you refer to various approaches for modalities of treatment for gender dysphoria, is that right?

A. Yes.

Q. One of these is -- one is psychosocial treatment that helps the young person align their internal sense of gender with their physical sex, is that right?

A. Yes.

Q. And the other one would be to watch and wait and allow time and maturity to help the young person align sex and gender through natural desistance.

A. Yes.

Q. And the third option is referred to as gender affirming, affirmative therapy, or GAT, and is the approach recommended by WPATH, is that right?

A. Yes.

Q. Okay. Is the first approach using psychosocial treatment to help the young person align their internal sense of gender with their physical sex, is that which you would refer -- to which other people would refer as reparative therapy?

A. I don't know.

Q. And you cite to Zucker. Is that Ken Zucker?

A. Ken Zucker, that's correct.

Q. Do you know what model Dr. Ken Zucker uses as a form of treatment for gender dysphoria?

A. I don't know if he's actively treating children for gender dysphoria currently.

Q. Do you know what model of treatment he used previously?

A. I know that it included -- I would say the first two, although I'm not an expert on Ken Zucker's approach. But I know that he believed that desistance was possible.

That, like the DSM states, that many of these children would grow up to be, say, gay or Lesbian, and that, therefore, medical treatments to

change their bodies would not be something that should be approached in early childhood.

Q. Just to clarify children, you're referring to those studies in the 80s and 90s prior to the diagnosis of gender dysphoria being in existence, is that right?

A. Can you repeat that?

Q. When you say these children are you referring to those that were studied in the 80s and 90s up to the age of twelve prior to the existence of the diagnosis of gender dysphoria?

A. These are children who came to their clinic with what we would call now gender incongruence.

Q. But you don't know if they were children that showed up or would have met the criteria for gender dysphoria?

A. There would be no way to know that.

Q. I'm going to show you what's been marked as Exhibit 8.

(Marked Deposition Exhibit No. 8.)

Q. (By Mr. Gonzalez-Pagan) Can you see the screen?

A. Yes.

Q. This is an article "Gender nonconforming youth: current perspectives."

It is authored by Diane Ehrensaft, published in 2017 in the Journal Adolescent Health, Medicine and Therapeutics, is that right?

A. Yes.

Q. Are you aware of who Dr. Ehrensaft is?

A. Yes.

Q. She's a psychologist, is that right?

A. I believe so.

Q. Are you familiar with the Journal of Adolescent Health, Medicine and Therapeutics?

A. I have probably seen it. I don't read it on a regular basis.

Q. Is that a peer-reviewed journal?

A. Presumably.

Q. I'm going to turn to page 61 of the exhibit.

This article is discussing here the "live in your own skin" model.

Do you see that?

A. Yes.

Q. Okay. "As mentioned earlier, this model was developed by Drs. Susan Bradley and Ken Zucker at the Center for Alcoholism and Mental Health gender clinic in Toronto. The treatment goal of facilitating a young child accepting the gender identity matching the sex assigned to that child at birth is based on the

supposition that younger children, in contrast to older youth, have a malleable gender brain, is tied to a medical-social rationale."

And then, later, it states, "If by the arrival of puberty a child is still exhibiting cross-gender identifications and expressing a cross-gender identity, that child should be supported in transitioning to the affirmed gender, including receiving puberty blockers and hormones, once it is assessed through clinical interviews and psychometric testing that the affirmed gender identity is authentic."

Did I read that correctly?

A. Yeah.

Q. This is a description of the "live in your own skin" model developed by Dr. Zucker, is that right?

A. You know, I don't know. 'Live in your own skin,' is that something Dr. Zucker -- is it a quote from Dr. Zucker? I don't know.

Or is that Dr. Ehrensaft's interpretation? I haven't come across it.

Q. Well, she's describing the model used, the modality of treatment used by Dr. Ken Zucker.

A. She's describing it with her own words, as

far as I can tell. Because I don't -- a malleable gender brain? I don't know what that is. I don't know what she's talking about.

Q. Do you have any reason to dispute that under Dr. Zucker's own modality of treatment by the arrival of puberty there is the provision of puberty blockers and hormones if the person is exhibiting cross-gender identity?

A. Can you repeat that, please.

Q. Sure. Do you have any reason to dispute that under Dr. Zucker's modality of treatment puberty blockers and hormones are provided once there is the arrival of puberty and the child is still exhibiting cross-gender identification?

A. So what you're saying is that under Dr. Zucker's model if the person has not -- hasn't aligned, say, their gender identity with their physical body, that under Dr. Zucker's model the next step would be puberty blockers and hormones?

Is that what you're asking me?

Q. That's what the article says and I'm asking do you have any reason to dispute that?

A. If by the arrival of puberty -- it's the same problem. This is the problem with the psychological literature is that they confuse puberty

and adolescence. Dr. Ehrensaft has the same problem.

So, you know, I think Dr.Zucker uses age twelve, so some of them had already arrived at puberty. So I don't think that statement is correct.

Q. Okay. In your statement that Dr. Zucker uses age twelve as the marker, if by age twelve a child continued to exhibit cross-gender identification, would Dr. Zucker -- under Dr. Zucker's model would puberty blockers and hormones be provided?

A. I don't know that that would be the case every time. I believe they had used that at their clinic, or at least referred. The problem is Dr. Zucker and Dr. Ehrensaft don't prescribe puberty blockers. They can't.

Q. Both Dr. Zucker and Dr. Ehrensaft worked in multidisciplinary clinics, is that right?

A. I guess so. I don't know for sure.

Q. The second method described is the watch and wait method, is that right?

A. Yes.

Q. Is this also known as the watchful waiting model?

A. Sometimes.

Q. And in speaking of the watchful waiting model are you talking about the model developed at the

Amsterdam clinic?

A. No.

Q. To what model are you referring to?

A. Just the gender approach to watching and waiting with observation and psychological support to see what will happen with a person's gender identity. It's just a general medical terminology.

Q. Okay. Are you aware that the watchful waiting model has been described as the one designed by members of the interdisciplinary team at the Amsterdam Center for Expertise on Gender Dysphoria, under the leadership of Dr. Peggy Cohen-Kettenis?

A. Dr. Kettenis, what are you saying? She did what now?

Q. She is the lead in the center that developed the watchful waiting model.

A. Okay. What's the question about it?

Q. Well, I'm just asking you about the watchful waiting model. It's a very specific term but it's used in reference to the model applied at this center in Amsterdam.

A. Okay.

Q. And I'm just asking you if you disagree with that statement?

A. I know that from the Dutch study they had

waited to age twelve to start puberty blockers, if that's what you're referencing.

Q. Okay. So under this model, the Dutch watchful waiting model, they would wait until age twelve and if-cross-gender identification persisted at that period of time they would initiate medical care, is that right?

A. No.

Q. No?

A. No, that's not right.

Q. Why?

A. Because it depends on other factors, psychological condition of the child, home situation. There are a lot of other factors involved before they went on to prescribe puberty blockers.

Q. I'm going to read some more description of the model by Dr. Ehrensaft. If a child's cross-gender identification and affirmation are persistent over time, interventions are made available for a child to consolidate a transgender identity, once it is assessed through therapeutic intervention and psychometric assessment as in the best interests of the child. These interventions include social transition, the shift from one gender to another, including possible name change, gender marker change,

gender pronoun changes, puberty, blockers and later hormones and possible gender affirming surgeries.

Is that right, did I read that correctly?

A. You read it correctly.

Q. Okay. Is that consistent with your understanding of the watchful waiting model?

A. I'm rereading this. I would say these interventions "may" include these things.

So I think the sentence needs to be clarified. It's not 100 percent.

Q. Let me ask you this. You say that the watch and wait model allows time and maturity to help the young person align sex and gender from natural desistance.

At what point in time in the watch and wait model that you described is medical intervention appropriate?

A. Well, I mean, just to be clear, I'm not -- I'm not using the watch and wait as a term that's synonymous with the Dutch approach. I'm using it as a general medical term for any sort of condition where you watch with observation and support, not simply leaving a person in the lurch, so to speak. Yeah.

Q. I get -- I'm not trying to cut you off.

A. Okay.

Q. I get that. My question is under your description of a watch and wait model at which point in time is medical intervention appropriate?

A. I would say it could be considered once they reach -- a person reaches the age of majority.

Q. So no person before the age of majority under that model would be ever able to obtain medical care for gender dysphoria?

MS. PAYTON: Object to the form.

A. These people could obtain medical care, but if you're talking about puberty blockers, cross-sex hormones, surgeries, there's not good evidence and there are certainly risks of harm so that they should not -- they would not be able to do that, to consent to the types of harm, the sterilization, you know, inability to breastfeed, until they reach the age of majority.

Q. (By Mr. Gonzalez-Pagan) Okay. So just to clarify, under the watch and wait model as you've described it --

A. Yes.

Q. -- no person under the age of majority would be prescribed puberty blockers, hormones or surgery as treatment for gender dysphoria?

A. Correct.

Q. To what scientific literature do you cite in support of this model?

A. Pretty much my whole declaration is in support of this model.

Q. Yes. What I'm asking is any peer-reviewed article, clinical guideline, anything in scientific literature that recommends and describes this model.

A. This would be an opinion of myself based on my clinical experience and research on the topic.

Q. And your clinical experience is limited to -- in the treatment of gender dysphoria is limited to one person for whom you prescribed estrogen and one person which you've been seeing since May for detransition, is that right?

A. Well, the issue -- I mean there's -- the reason I opine on this topic is because as an adult endocrinologist patients can, and one already has, come to me who's been through these medical interventions.

So I have to A, be aware of them, B, be aware of any type of side effects or complications, endocrine complications, anatomical complications that result from that.

So I have to make that assessment. In other words, if someone comes to me who is, say, age 20, on

this treatment I have to know was it assessed properly and what are the risks to them for the future. And so as I make this assessment, which is really what I'm saying in my report, the evidence is poor and the risk of harms are great, and so that's why it's best to watch and wait.

Q. Okay. But you mentioned in your response the presentation of somebody aged 20 to you.

A. Okay.

Q. Would you not provide or would you object to the provision of medical treatment such as hormones or surgery for their gender dysphoria?

A. I would have to look on a case-by-case basis.

Q. And aside from that one person that required estrogen, has anybody presented to you requesting the provision of hormone treatment or puberty blockers for their gender dysphoria?

A. I have not, like, done a history and physical for such a patient but I'm prepared for such a patient.

Q. So in your opinion it hasn't occurred?

A. Right.

Q. And the first mode of treatment that you discussed was the psychosocial treatment that helps

the young person align their internal sense of gender with their physical sex, right?

A. Yes.

Q. And I believe I asked this question and you answered this question but please remind me.

A. Okay.

Q. I honestly don't recall the answer.

So is this what some would term reparative or conversion therapy?

A. I don't know.

Q. Are you aware that the American Psychiatric Association opposes conversion therapy efforts?

A. What -- I don't know, conversion therapy, what -- could you explain that further? Or do you have a quote that I can look at or something?

Q. I'm going to show you what's been marked as Plaintiffs' Exhibit 9.

(Marked Deposition Exhibit No. 9.)

Q. (By Mr. Gonzalez-Pagan) Do you see the screen?

A. Yes.

Q. It's a Position Statement on Conversion Therapy on LGBTQ Patients adopted by the American Psychiatric Association, is that right?

A. Yes.

Q. Okay. And it was approved by the Assembly of the American Psychiatric Association November 2018 and the Board of Trustees on December 2018, is that right?

A. Yes.

Q. The third point of the resolution states that the American Psychiatric Association encourages psychotherapies which affirm individuals' sexual orientations and gender identities.

Is that right?

A. That's what it says.

Q. It also states, "Along a similar vein, gender diverse patients have been shown to benefit from gender-affirming therapies, and given the documented harm of 'reparative' or conversion therapies regarding sexual orientation, it would likely be seen as unethical to research reparative therapy outcomes with gender diverse populations."

Do you see that?

A. I see that.

Q. I'm going to show you what's been marked as Plaintiffs' Exhibit 10.

(Marked Deposition Exhibit No. 10.)

Q. (By Mr. Gonzalez-Pagan) This is a resolution by the American Psychological Association

on gender identity change efforts and it was adopted in February 2021.

Do you see that?

A. Yes.

Q. And it describes gender-identity change efforts as referring to a range of techniques used by mental health professionals and nonprofessionals with the goal of changing gender identity, gender expression or associated components of these to be in alignment with gender role behaviors that are stereotypically associated with sex assigned at birth.

Is that right?

A. Yes. That's what it says.

Q. And then it states on the third page that "Be it therefore resolved that consistent with the APA definition of evidence-based practice, the APA affirms that scientific evidence and clinical experience indicate that gender identity change efforts put individuals at a significant risk of harm."

Did I read that correctly?

A. Yes. You read it correctly.

Q. Then "Be it further resolved that the APA opposes gender identity change efforts because such efforts put individuals at significant risk of harm and encourages individuals, families, health

professionals and organizations to avoid gender identity change efforts."

Did I read that correctly?

A. Yes.

Q. So the American Psychiatric Association and the American Psychological Association both oppose a modality of treatment that seeks to encourage a young person to align their gender identity with their sex assigned at birth?

Is that right?

A. Can you repeat that?

MS. PAYTON: I'll object to the form.

Go ahead.

Q. (By Mr. Gonzalez-Pagan) Based on what we have discussed. would you agree that the American Psychiatric Association and the American Psychological Association oppose a modality of treatment that encourages young people to align their internal sense of gender with their sex assigned at birth?

MS. PAYTON: Object to the form of the question.

A. I mean my understanding of this is that people are opposed to, as they should be, like electroshock treatments or shaming people or, you know, forcing girls, ripping trucks out of their hands

and putting Barbies in their hands. And I would agree with all of those things. Those are bad.

But if the idea is that we're going to wait a few years and see if on their own, not through any effort but watching and waiting, a child or adolescent gender identity on its own changes, I don't know that they are opposed to that based on what I've read.

Q. (By Mr. Gonzalez-Pagan) Okay. But that wasn't my question, Dr. Laidlaw.

To be clear, I'm asking not about the wait and see model.

A. Okay.

Q. I'm asking you about the first model of treatment that you described, which is the psychosocial treatment that helps the young person align their internal sense of gender with their physical sex.

And you've described that as one of the modalities of treatment. And I'm asking if, based on what we have reviewed, the American Psychiatric Association and the American Psychological Association oppose the very modality of treatment that you discuss as the first of three modalities of treatment in that paragraph?

MS. PAYTON: Object to the form of the

question.

A. I think the thing is what you presented to me is not in a peer-reviewed journal, if we want to go down that road. It's not peer-reviewed that I can tell.

It's some committee probably wrote it up and purports to represent thousands and thousands of people across the country that may have never looked specifically at this situation.

So I don't put much credence into this.

Q. (By Mr. Gonzalez-Pagan) I understand that you don't put much credence. That's not my question.

The question is does the APA, as in the American Psychiatric Association, the American Psychological Association, oppose the very first modality of treatment that you described on paragraph 65?

A. Well, I don't think they're describing the same thing.

Q. You're describing psychosocial treatments that help the young person align their internal sense of gender with their physical sex.

A. Right.

Q. Are you talking about active encouragement or are you talking about letting them wait and see?

A. Well, it's their internal sense of gender which for a young person is going to be ambiguous.

That's different than saying someone who is, you know, 24 -- throwing out a number -- 24, natal female has a gender identity of a male. I think it's two different situations.

Q. What's your reason for stating that a young person's internal sense of gender is not firm or set?

A. Because it can change over time, just like a lot of things. They might think they're a butterfly for a while. I was the $6 million man for a little while.

It's just the nature of kids.

Q. Is there any peer-reviewed literature that you can cite to in support of that opinion?

A. It's just an observation that anyone would see, I think, with children.

Q. You spoke to a model and I just want to make sure I understand your opinion as to what you would recommend.

And I just want to clarify, is that the case?

A. My purpose there was to list three different types of approaches to -- more so kids or young people with gender dysphoria. I'm not advocating any

particular position in that statement.

Q. Do you believe that adults, so people above the age of majority, should not be able to have access to gender affirming medical treatment such as hormones or surgery?

A. Would you repeat that, please.

Q. Sure. Do you believe that adults, people above the age of majority, should not be able to access medical treatment in the form of hormones or surgery as treatment for gender dysphoria?

MS. PAYTON: Object to the form.

A. I don't believe adults should be obstructed or blocked from receiving, you know, gender affirmative hormones or surgeries provided -- provided, again, they have capacity to consent. They have co-morbid psychiatric, you know, conditions examined and so forth.

Q. (By Mr. Gonzalez-Pagan) Are you aware that the exclusion at issue in this case applies regardless of age?

A. Yes, that's my understanding.

Q. Do you think it is appropriate for coverage to be denied for people -- do you think it is appropriate for coverage for medical treatment of gender dysphoria to be denied for people above the age

of majority?

MS. PAYTON: Object to the form of the question.

A. I would say with adults, as I just said earlier, I have not actively sought to, you know, prevent adults from getting hormones and surgeries for gender dysphoria.

However, people can make a case, a medical case for adults as well that there could be a harm from this treatment. But I'm not opining on that specifically.

Q. (By Mr. Gonzalez-Pagan) So you're not providing an opinion one way or the other with regards to adults?

A. With regard to adults I'm not making a policy decision for adults.

Q. No. I understand that.

I guess -- let me just clarify because I just want to be clear on the transcript. I think you may have used the term "policy decision," and I'm not asking you to do that.

I'm just asking about whether you're providing an opinion about whether that care should be provided or not with regards to adults?

A. I'm not providing an opinion on that.

Q. Turn to paragraph 213. In the second sentence and the third you state as follows, "C.P. had not had enough time and maturity to grasp this complication. Thirteen-year-old girls are generally not thinking about their future family planning as they are still children themselves under the care of another."

I just wanted to clarify, are you referring to C.P. as a girl?

MS. PAYTON: Object to the form.

A. The problem with this -- well, one of the many problems with the medical care in this circumstance is that there was no known mental health evaluation at the onset to determine if the patient had gender dysphoria.

So therefore, knowing that a large portion of minors will desist, therefore, and knowing that C.P. is a natal female, therefore, probability-wise the person would have otherwise identified as a girl.

Q. (By Mr. Gonzalez-Pagan) C.P. identifies as a boy, is that correct?

A. C.P. has undergone puberty blockers and testosterone so this complicates the situation.

Q. Not my question. My question is, C.P. identifies as a boy?

A. That's my understanding.
Q. Okay. Is there any reason why you wouldn't refer to him as a boy?
A. Well, the comparison is really about biological function, because C.P. was born with eggs. And if C.P. is to become pregnant in the future this will be because C.P. has eggs which can be fertilized by sperm, which is what happens to, let's see, natal females when they eventually become adults, which would be girls.
MS. PAYTON: Omar, we can't hear you. Omar, we couldn't hear you.
Q. (By Mr. Gonzalez-Pagan) I said let's go to paragraph 222 of your report.
A. Okay.
Q. The last sentence states, "Again, from the records it does not appear that C.P. had an adequate assessment by a qualified psychiatrist or psychologist prior to signing a consent form for a mastectomy procedure."
Did I read that correctly?
A. Yes.
Q. To what guideline do you refer to in requiring an assessment by a psychiatrist or a psychologist?

testosterone use."

Did I read that correctly?

A. Yes.

Q. Are you familiar with the Goldwater Rule?

A. The Goldwater Rule?

Q. Yes.

A. No.

Q. I'm going to show you what's been marked as Exhibit 18.

(Marked Deposition Exhibit No. 18.)

Q. (By Mr. Gonzalez-Pagan) Can you see this?

A. Yes.

Q. It is an American Psychiatric Association Ethics Committee Opinion, is that right?

A. Yes. I don't know which document this comes from but --

Q. It comes from the APA Ethics Committee and it was published on March 15, 2017.

Do you see that?

A. Where is it published?

Q. The APA has it on its website.

A. Well, where is the website?

Q. I represent to you that I obtained this from the APA's website.

A. Okay. I'd like to have a reference, please.

Q. I'm going to read from the Answer. "Section 7.3 of the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (sometimes called 'The Goldwater Rule') explicitly states that psychiatrists may share expertise about psychiatric issues in general but that it is unethical for a psychiatrist to offer a professional opinion about an individual based on publicly available information without conducting an examination. Making a diagnosis, for example, would be rendering a professional opinion. However, a diagnosis is not required for an opinion to be professional. Instead, when a psychiatrist renders an opinion about the affect, behavior, speech or other presentation of an individual that draws on the skills, training, expertise and/or knowledge inherent in the practice of psychiatry, the opinion is a professional one. Thus, saying that a person does not have an illness is also a professional opinion."

Do you disagree with that statement?

A. I don't have an opinion on it.

Q. In your report is there any discussion about medical necessity in reference to Catholic Health Initiative's' contract definition of medical necessity?

MS. PAYTON: Object to the form.

A. I don't think I have a reference to the Catholic -- I'm sorry, I forgot the name you just said, but I don't have a reference in there.

Q. (By Mr. Gonzalez-Pagan) In your report you do not discuss medical necessity in reference to the Blue Cross Blue Shield of Illinois gender assignment and reassignment policy, is that right?

A. Correct.

Q. You were not asked for an opinion as to whether Blue Cross Blue Shield of Illinois's medical policy -- well, scratch that.

MR. Gonzalez-Pagan: I'm about to finish. Let's take a very short five-minute break just to see and we'll come back.

Let's go off the record.

THE VIDEOGRAPHER: We're going off the record at 3:15 p.m.

(Recess.)

THE VIDEOGRAPHER: One moment, please.

We're back on the record at 3:18.

MR. Gonzalez-Pagan: Dr. Laidlaw, thank you for your patience. I have literally less than a handful of questions and then we're done.

So I appreciate your patience. I know it's

Exhibit

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard and PATRICIA PRITCHARD,

Plaintiffs,

vs.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

No. 3:20-cv-06145-RJB

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

LAWTON BURNS

9:54 a.m.

September 9, 2022

REPORTED BY: Pat Lessard, CCR #2104

LAWTON BURNS, being duly sworn, testified upon oath, as follows:

E X A M I N A T I O N

BY MS. HAMBURGER:

Q. Good morning, Dr. Lawton. It's nice to meet you. My name is Ele Hamburger.

Can you state and spell your name for the record, please.

A. Yes. Lawton, L A W T O N, Robert Burns, B U R N S.

Q. What's your address?

A. Work or home?

Q. Both.

A. My work address is Department of Health Care Management at the Wharton School, W H A R T O N, the Wharton School at University of Pennsylvania. 3641 Locust Walk, Philadelphia, PA 19104.

Home address is 933 Muirfield, M U I R, Field, one word, Muirfield Road in Bryn Mar, Pennsylvania 19010.

Q. Have you been deposed before?

A. Yes.

Q. About how many times?

A. At least 20.

Q. Okay. So I'm going to give you the short

motion in any way in forming your opinions in this case?

A. No.

Q. Okay. And when were you sent the CHI Summary Plan description?

A. I don't recall that, either. I can't tell you the approximate time I received anything.

Q. Did you receive it after you wrote your report or before?

A. I don't recall.

Q. The reason I'm asking, sir, is that it was not identified as a document upon which you relied when writing your report.

Do you recall relying upon the CHI Summary Plan Description when writing your report?

A. I don't recall.

Q. Just to close the door, are there any other documents that you brought with you today?

A. No.

Q. And did you receive any documents from Ms. Payton today?

A. Well, I don't have Internet connection here. Ms. Payton said that she forwarded me some documents late last night but I can't pull them up right now because I don't have an internet connection.

Q. You were asked to prepare a declaration. Were you asked to do any other work in this matter?
A. Show up for today.
Q. Okay. Other than that, anything else?
A. I don't think so.
Q. Okay. And you testified, I think, that you reviewed your report, your declaration, right?
A. Yes, I reread it. That's right.
Q. Okay. And do you have any corrections to it?
A. I have one that I can think of.
Q. And what is that?
A. I think it says somewhere in my declaration that I reviewed depositions. That is incorrect.
Q. Okay. Anything else come to mind that you would want to correct?
A. Not that I can think of, no.
Q. Okay. Did you write the report?
A. Yes, I did.
Q. Did anyone assist you in the writing of the report?
A. No, I wrote the report.
Q. Okay. All right. Let's look at the CV that you provided.
That CV says February 2022, correct?

Q. Okay. Other that, those changes, is this CV accurate?

A. Well, the CV is accurate. It's just a question of whether or not it includes everything that's happened since February.

And I have another article coming out this fall. I don't want if it's on there or if it's moved to -- under submission to publication. Things like that.

Q. Let's go to the beginning of your report. I'm turning now to paragraph six.

Do you see that?

A. Yes.

Q. And let me just say, we have been using a definition for the term "gender-affirming care" which -- hold on, I have to pull it up and I want to make sure we're on the same page when we use that term.

MS. HAMBURGER: Let's go off the record.

THE VIDEOGRAPHER: We're going off the record at 10:14 a.m.

(Recess.)

THE VIDEOGRAPHER: One moment, please. We're back on the record at 10:15 a.m.

Q. (By Ms. Hamburger) Dr. Burns, are you

familiar with the term gender-affirming case?

A. I've heard it before.

Q. I'm going to read you a definition that we've been using in this case for gender-affirming care, okay?

It refers to any healthcare, physical, mental or otherwise, administered or prescribed for the treatment of gender dysphoria, related diagnoses such as gender identify disorder, gender incongruence or transsexualism or gender transition. This includes but is not limited to the administration of exogenous endocrine agents to induce feminizing or masculinizing changes, commonly referred to as hormone replacement therapy, gender affirming or sex reassignment procedures and other medical services for preventative medical care provided to treat gender dysphoria or related diagnoses as outlined in the World Professional Association for transgender health, standards of care for the health of transsexual, transgender and gender nonconforming people, Seventh Version, 2012.

Did you hear that definition?

A. I heard it.

Q. Okay. Are you comfortable when I refer to gender-affirming care that that's what I mean?

MS. PAYTON: Object to the form.
A. Well, what you read to me sounds like a huge tent or umbrella concept under which lots of things are subsumed. So when you use the title gender-affirming, I have no idea what that specifically means or refers to, but I understand it's a big tent and there's a lot of stuff inside.
Q. Okay. Have you ever done any research related to gender-affirming care?
MS. PAYTON: Object to the form.
A. No.
Q. (By Ms. Hamburger) Have you ever written any articles related to gender-affirming care?
A. No.
Q. Have you ever given any lectures related to gender-affirming care?
A. No.
Q. Have you ever analyzed the cost of delivering gender-affirming care?
A. I haven't specifically analyzed it myself but I've read articles about the cost.
Q. And what articles have you read about the cost?
A. I can't remember anything specific. All I know is, you know, I read pretty widely and I've come

across those articles before.

Q. And did you refer to them in any way when developing your opinions in this case?

A. No.

Q. All right. I'm going to share the screen again, back with paragraph six of your declaration. All right.

Do you see paragraph six?

A. Yes, I do.

Q. Okay. And paragraph six lists a range of research that you have performed in the past, right?

A. Yes.

Q. And it states "I have focused much of my research on the hospital industry and the medical profession," correct?

A. Yes.

Q. Is that still true?

A. Well, it says "much." It doesn't say "all." I mean I actually cover a huge chunk of the entire health care ecosystem. That goes way beyond hospitals and doctors.

Q. But is it true that you have focused much of your research on the hospital industry and medical profession?

A. A good chunk of it, that is true. Just not

all of. It's not the totality of it.

Q. Okay. And it states here in this paragraph that you received an award for your study on physician-hospital relationships.

Do you see that?

A. Yes. That was 30 years ago.

Q. And then in paragraph seven it discusses management topics that you have focused much of your attention on, is that right?

A. Yes.

Q. Okay. And those management topics did not include benefit design of gender-affirming care, did it?

MS. PAYTON: Object to the form.

A. No, it did not.

Q. (By Ms. Hamburger) And then the next sentence says that you have focused on "governance decisions," horizontal and vertical integration, diversification, strategic alliances and networks, and value-chain alliances.

Is that still true?

A. Yes.

Q. And none of that addresses coverage of gender-affirming care, does it?

MS. PAYTON: Object to the form.

A. It covers health insurers and their plan designs but not plan designs concerning gender-affirming care.

Q. (By Ms. Hamburger) Okay. And in paragraph eight it discusses healthcare topics that you have focused your attention on, is that right?

A. It says I focused much of my attention on organized delivery systems as one of those topics, yes.

Q. And again, here in paragraph eight, none of this attention that you have focused on organized delivery systems specifically concerns gender-affirming care, is that right?

A. Yes. All that -- a lot of that research was conducted during the 1990s before this topic, I believe you know, really became, you know, well known.

Q. So none of this addresses coverage of gender-affirming care, is that right?

A. That's right.

Q. And then in paragraph nine it states that you have written extensively on healthcare related topics.

Do you see that?

A. Yes.

Q. And none of those topics have related to

gender-affirming care, is that right?

A. That is correct.

Q. In paragraph ten it says you have two new books.

Do you see that?

A. Yes.

Q. And those are the two books we discussed earlier in this deposition, right?

A. No.

Q. Okay. Those are two different books?

A. Yes. Those books in paragraph ten were both published last year.

Q. Okay. And in paragraph ten did either of those books address gender-affirming care?

A. Well, they both addressed the health insurance sectors but they did not include gender-affirming care.

Q. So nothing in those books addressed gender-affirming care, is that right?

A. That's correct.

Q. Okay. And in the two new books that you have published that we talked about at the beginning of the deposition, neither of those books address gender-affirming care, is that right?

A. That is correct.

Q. Okay. And it states here in paragraph eleven you published 150 articles and books and chapters on these topics.

Do you see that?

A. Yes.

Q. And none of those 150 books and articles and book chapters address gender-affirming care, is that right?

A. That is correct.

Q. In section two it states the Summary of Work Performed.

Do you see that?

A. Yes, I do.

Q. Okay. And in paragraph twelve it says you have been asked to analyze the effect of Blue Cross of Illinois, but I think you meant Blue Cross Blue Shield of Illinois.

A. Yes, it says BCBSIL.

Q. Okay. Their practice of administering self-funded health plans that contain exclusions for gender-affirming care.

Do you see that?

A. Yes, I do.

Q. And so is it fair to say that -- so can you tell me, you know, "effect" is rather broad. So I'm

Q. And I think you had identified that you considered four stakeholders: The insurance company administering the exclusion, the employers, the enrollees/employees and society in general.

Is that correct?

A. Yes, that's what I said.

Q. Okay. And what was the methodology that you used for evaluating the effect of Blue Cross Blue Shield's administration of this exclusion on those four stakeholders?

A. Well, I don't have an empirical knowledge of that. But I've learned over time that there are lots of stakeholders and all of the decisions are made in healthcare, both upstream and downstream, with whoever is making the decision.

And I've just learned over time through extensive experience that you have to kind of do a 360 degree analysis of who's affected by these things and which issues are important to them.

So if there's a methodology it's trying to do that.

Q. So your methodology consisted of using your general experience and knowledge to do a 360-analysis of who is affected by the exclusion, is that right?

A. Well, it's a little bit more detailed than

that. I've spent the last 25, 30 years studying what I call the healthcare value chain, which is basically all the upstream and downstream relationships that every party in the healthcare ecosystem has.

You know, you might consider that more simply as who are your buyers, who are your suppliers, who are your competitors.

And I've learned to do that for most of the healthcare players in the healthcare ecosystem. And so in this case I was using that sort of general approach for Blue Cross Blue Shield of Illinois.

Q. Okay. And did you review any data related to the costs and benefits of administering such an exclusion?

A. No.

Q. Did you look at any surveys related to the administration of gender-affirming care?

A. I've seen articles on the topic. I don't know if you would call those surveys, but I've seen research articles or publications in professional journals on employers who do this or don't do this and what are some of the issues involved.

So I've seen data on it but I didn't personally conduct those surveys.

Q. And you did not review those articles or

those surveys and incorporate them or rely upon them in your report, in your declaration?

A. Well, I've seen this material before and so I think my report talked about this is not, you know, an unusual occurrence. So I'm drawing on that.

In other words, it's the case that there could be any, you know, any number of employers offering any number of health plans, some of which have or have not these exclusions.

So I was drawing on that. That's based on published work. Not my own published work, but the published work of others.

Q. So you're drawing on your general experience related to general healthcare exclusions when you analyzed the effect of Blue Cross Blue Shield's practice of administering gender-affirming care exclusions, is that right?

MS. PAYTON: Object to the form.

A. No.

Q. (By Ms. Hamburger) Please tell me what's wrong.

MS. PAYTON: Object to the form.

A. I think I had mentioned that I have actually seen research on employers' coverage or noncoverage of these, of what you call gender-affirming care.

Now whether or not your definition matches what's taking place in those articles, I'll never be able to figure out what you described, it's so omnibus. But I've seen research articles on whether or not this sort of practice of including versus excluding coverage is common or typical.

Q. And did you identify those articles in your declaration?

A. No.

Q. Did you produce them in response to the subpoena that we sent you?

A. No.

Q. Can you tell me the names of those articles?

A. I have them at home. I could dig them up for you.

Q. Did you review them when writing your declaration?

A. No. As I said, I didn't rely on them in writing my report. I just remember having seen things like this in the past.

Q. And do you remember articles or reports talking about the cost benefit of covering gender-affirming care?

A. I don't remember. I wasn't specifically looking for or thinking about cost-benefit analysis

when I wrote my report.

Q. You weren't thinking about the cost-benefit analysis when you wrote your report?

MS. PAYTON: Object to the form of the question.

A. I don't know if I was thinking about it but I didn't write about it in my report.

Q. (By Ms. Hamburger) Okay. So do you think, when you're asked to analyze the effect of the practice of administering an exclusion, that that does not include whether the exclusion incurs both costs or benefits to the various stakeholders in the healthcare system?

MS. PAYTON: Object to the form.

A. Well, it's possible, but I didn't do a cost-benefit analysis or look for research on the cost-benefit analysis of including versus excluding that specific coverage.

I was asked to talk about the employer's viewpoint on coverage or noncoverage. Whether or not they did a cost-benefit analysis, I don't know.

Q. So part of what you were asked was to talk about the employer's viewpoint on coverage or exclusion of gender-affirming care?

A. I was asked to talk about, you know, what

what's the right thing for them.

And what I'm here focusing on is the benefits to the employer of having that choice.

Q. My question was, sir, did you look at the benefits to employers and consumers if Blue Cross Blue Shield is unable to implement a gender-affirming care exclusion?

A. You'll have to repeat the question. I didn't follow everything you just asked.

MS. HAMBURGER: Pat, could you.

THE COURT REPORTER: "Question. My question was, sir, did you look at the benefits to employers and consumers if Blue Cross Blue Shield is unable to implement a gender affirming care exclusion?"

A. Well, as I said, there can be benefits in the sense that employees have a choice of plans that allow them to get that coverage.

But at the same time there can be benefits to the employees of choosing plans that don't have that coverage.

Q. (By Ms. Hamburger) Sir, I'm trying to understand -- I hear you're saying that today.

But in your report did you analyze the benefit -- the possible benefits to employers and to consumers if Blue Cross Blue Shield of Illinois is

unable to implement a gender-affirming care exclusion?

A. Well, in the sense that employees have free choice. And so the employees are free to choose which of those plan designs they want, so that is basically answering your question.

Q. Is your analysis in response to the question posed in paragraph 13, is it limited to employers and consumers in the affected plans only, or are you talking about the benefit to employers and consumers generally?

MS. PAYTON: Object to the form of the question.

A. Well, by the consumers here, these are the enrollees in the plan. There are also employees in the other plans offered by that employer, so it could be expanded to include them as well.

Q. (By Ms. Hamburger) Okay. I'm just trying to understand the scope of your opinion here.

Is it limited to the people enrolled in the plans in which Blue Cross Blue Shield of Illinois is administering them --

MS. PAYTON: Object to the form.

Q. (By Ms. Hamburger) -- or are you talking about healthcare consumers in general?

MS. PAYTON: Object to the form of the

Q. Sure. The second one, number 13, if Blue Cross Blue Shield is required to refrain from administering gender-affirming care exclusions, you were asked to opine on the potential harm to employers and consumers, is that right?

A. Well, I would probably restate it as the following, that is that Blue Cross Blue Shield is acting as the third-party administrator for these ERISA self-funded health plans, some of which include the gender-affirming care, some of which have designs that exclude the gender-affirming care and what would be the effect of not allowing the ERISA health plans from excluding gender-affirming care.

Q. Okay. And there are no other questions that you were asked to opine upon, is that right?

MS. PAYTON: Object to the form, asked and answered.

A. No. These are the two questions.

Q. (By Ms. Hamburger) Okay. And how much time did you spend conducting research for this declaration?

A. Well, I'm not sure what you mean by research. I didn't collect any data or do any surveys.

You know, I went back through a lot of what

I've written about ERISA health plans, the sponsors of ERISA health plans and their using third-party administrators and that relationship.

And then in terms of the specific case I do recall having come across articles in the past about employers who do or don't cover certain things. I didn't do specific research on that but I recall those kinds of articles.

So that's basically what I was doing here. So in terms of the research that was what I did.

Q. How much time did you spend researching for this declaration?

MS. PAYTON: Object to the form.

A. I don't know. I have a timesheet at home that I keep a log of, you know, how much time I spent.

I don't recall, to be honest.

Q. (By Ms. Hamburger) How much time have you spent on this project in its entirety?

A. That would be on my timesheet. I don't have that here with me.

MS. HAMBURGER: Counsel, that has not been produced. We would like that produced.

Q. (By Ms. Hamburger) Do you have an estimate of how much time you spent on this project?

A. No, I do not. This is ongoing.

litigation. Do you see that?

A. Yes.

Q. And tell me what documents produced in this litigation that you relied upon to reach your opinions in this matter.

A. I think I may have sent that to counsel. We talked about the documents that I have with me here today. So it usually starts with the complaint and then goes on from there, but I don't have a list of those things with me right now.

Q. Did you rely on any specific documents produced in this litigation in order to answer the questions in paragraphs 12 and 13?

A. Well, I obviously considered the complaint itself and what the complaint was about.

But it's drawing on my knowledge of ERISA healthcare plan sponsors, employers' self-funded plans, the third-party administrators they contract with to help administer those plans and what they've done and those dynamics and then relationship between both of those parties with the enrollees in these health plans.

So it's drawing on my general knowledge of all that.

Q. Okay. So sitting here today, other than the

complaint you can't identify any document produced in this litigation that you relied upon to reach your opinions in this matter?

A. Well, as I've mentioned before, I recall reading academic papers on the whole topic of employers' coverage or noncoverage of specific benefits. They weren't produced, as far as I know, in this litigation, but I do remember reading those so I drew on that as well.

Q. But just going back to my question, sir, sitting here today, other than the complaint you can't identify any documents produced in this litigation that you relied upon to reach your opinions in this matter?

A. Well, I also, I think, mentioned that one of the documents I brought along today had to do with a specific healthcare plan design so I looked at that as well.

Q. You believe you looked at that -- earlier you testified you didn't know when you looked at that.

Are you saying now that you looked at that as part of forming your opinions in the declaration?

A. You know, I don't -- I can't give you a timeline of what I looked at, when I looked at it and when I wrote the report. I can't give you that

timeline. I know I looked at it.

Q. Okay. And then (e) you say "The broader literature on medical groups, professional service agreements, including prior research and rulings and advisories by the FTC."

Do you see that?

A. Yes.

Q. Rulings and advisories -- and FTC means Federal Trade Commission, correct?

A. Correct.

Q. What rulings and advisories by the FTC did you rely on for your opinions in this matter?

A. Well, I've been working with the FTC for quite a bit of time going back 20 years.

And so oftentimes that involves insurance companies, third-party administrators and providers contracting with one another. So I'm going back to that knowledge, the general knowledge of that portion of the healthcare ecosystem.

Q. So (e) is really a statement relating to your general knowledge described in (a), (b) and (c), is that correct?

A. Yes, it's another portion of that.

Q. Okay. There's no specific rulings or advisories by the Federal Trade Commission that you

relied upon in this matter, is that right?

A. That is correct.

Q. Okay. Let me take this off the screen.

Were you aware that at some point Blue Cross Blue Shield of Illinois had a gender-affirming care exclusion in its insured plans?

A. Well, I think they do for some of their plans.

Q. Okay. So I just want to make sure we're clear. For their insured plans, did you discuss --

A. Oh, sorry. The self-funded plans.

Q. Correct. Were you aware that at one point, I think it was before 2015, Blue Cross Blue Shield of Illinois had gender-affirming care exclusions in their insured plans?

A. I don't recall.

Q. Were you aware or informed that there was a point in time when Blue Cross Blue Shield of Illinois removed the gender-affirming care exclusions in its insured plans?

A. I don't recall. My report focuses on their self-funded plans.

Q. I understand that, sir.

But it seems to me that if you're looking at the effect of removing such an exclusion when it's

administered by Blue Cross Blue Shield of Illinois that the impact of removing such an exclusion in Blue Cross Blue Shield of Illinois's insured plans would provide some insight to that effect.

Do you agree?

A. I don't know. I wasn't asked to look at that.

Q. Okay. Did you ask Blue Cross Blue Shield for any data related to its coverage of gender-affirming care in its fully insured plans?

A. No.

Q. Did you ask Blue Cross Blue Shield of Illinois if its premium rates increased as a result of removing the gender-affirming care exclusion in its fully insured plans?

A. No, I did not ask.

Q. Did you ask Blue Cross Blue Shield of Illinois for any data related to the self-insured plans that removed gender-affirming care exclusions and the impact of such removal on premium cost?

A. I do remember seeing information on what percentage of plans that Blue Cross Blue Shield of Illinois was administering that had these coverage exclusions but I'm not sure if I looked at the impact.

Q. What percentage of Blue Cross Blue Shield of

A. I meant the number. I don't know the exact percentage.

Q. And so you did not ask Blue Cross Blue Shield of Illinois for any data related to the self-insured plans that removed gender-affirming care exclusions and the impact of such coverage on premium costs or deductibles or copays or anything?

A. No, I did not ask them.

Q. And they did not provide that information to you, did they?

A. No.

Q. Okay. Let's turn to your Summary of Opinions in the declaration. Let me go back and share it.

Under your Summary of Opinions, do you see that, sir?

A. Yes, I do.

Q. Okay. "Plan designs that contain various iterations of exclusions for gender-affirming care are common."

Do you see that?

A. Yes.

Q. And what is the basis for that opinion?

A. I think I just mentioned that there were 398 such plans administered by Blue Cross Blue Shield that

But what I was trying to state was I know that there are plans offered by the same employer that have with or without coverage. People can really choose which of those options they prefer, so they're not harmed.

Q. Do you believe that all 398 plans that have an exclusion of gender-affirming care that are administered by Blue Cross Blue Shield of Illinois offer an alternative plan to their enrollees that would cover it?

A. I don't know. I haven't looked at all 398 plans.

Q. Okay. Did you look at the Catholic Health Initiatives' Summary Plan Description?

A. Here again, I received some documentation on Catholic Health Initiatives but I don't recall what it says.

Q. Are you aware that Catholic Health Initiatives did not provide an alternative plan that would allow the plaintiff in this matter, C.P., to have access to gender-affirming care?

A. I don't know. I am aware that Catholic Health Initiatives is a Catholic organization and on religious grounds it didn't want to cover the specific benefit.

motion. You were not provided the order on the motion to dismiss in this case, were you?

A. I don't recall. I don't have it with me here.

Q. Okay. So then in your opinion number iii, "Eliminating the ability to purchase health plans with gender-affirming care exclusions would be harmful to consumers."

Your opinion is that it's harmful to the consumers in the relevant health plans, is that right?

A. It's harmful to the extent that -- if you could put it up again.

Q. Oh, sure.

A. Just so I'm --

Q. Absolutely.

A. Just so I have it in front of me.

Q. Number iii.

A. If you did not allow the employees to purchase health plans with this exclusion, that the health plans would likely cost those consumers more money because they have more benefits to cover and that's the manner in which those consumers would be harmed.

Q. Okay. So the only harm that you identified is an economic harm?

A. That's the major one here. You want -- it's also a matter of choice. You want to allow people free choice as well as to choose the benefit plan that's right for them, that's customized to them.

And basically, what employees make are tradeoffs when they purchase a plan between access and cost, and so you're denying people the ability to make the tradeoff that's customized to their preferences.

Q. Do you object to the essential health benefits in the Affordable Care Act because they deny people choice?

MS. PAYTON: Object to the form of the question.

A. Those are the EHBs. I don't have an opinion either way about whether I find them good or bad. I mean they give people access to more types of coverage, but those things are mandated by patient protection in the Affordable Care Act. It's a matter of law.

Q. And so if this coverage, if gender-affirming care coverage is a matter of law, that would have to be provided, just like the EHBs, is that right?

A. Well, gender-affirming coverage I don't think is included in the essential health benefits.

And I'm not an expert on the law and so you

A. No.

Q. And you believe the Brad Herring article is after the Affordable Care Act?

A. I know it was published. I don't know what the timeframe of his study was.

Q. All right.

A. What I wrote here in point 19 is widely known and understood.

Q. Okay. So based on what you've written here and your general knowledge about exclusions, you assume that adding gender-affirming care coverage would result in greater premium payments for insured plans and greater employer expenses by self-funded plans, is that right?

A. That's not what point 19 is about. Point 19 is more general. This is what happens when the costs of healthcare in employer plans go up. Those costs get passed along to the end consumers starting with their employees.

Q. Okay. So paragraph 19 is more general and is not about gender-affirming care specifically?

A. It applies, but the paragraph doesn't talk about gender-affirming care.

Q. Okay. Why do you think it applies to gender-affirming care?

broadly snows that when you add more benefits you get more expenditures. Those expenditures get baked into higher premiums. Those higher premiums get passed to the employees the next year.

Q. (By Ms. Hamburger) Okay. And you did not look at this with a specific lens for gender-affirming care, correct?

A. Correct.

Q. Are you aware of what the cost of gender-affirming care generally is?

MS. PAYTON: Object to the form of the question.

A. As we established earlier on this it's an umbrella concept which includes lots of different things inside that tent. I don't know the price of the services for each one of those things, though.

Q. (By Ms. Hamburger) Did you ask Blue Cross Blue Shield of Illinois for claims information related to gender-affirming care?

A. No, I did not.

Q. And you use the term "gender-affirming care" in your declaration, do you not?

A. It's in there. I don't know how often I used it but it's in there.

Q. And I want to make sure we're talking about

the same thing when we refer to gender-affirming care.

Do you have a different definition than what I read to you earlier today?

A. Well, what you read to me earlier today was this umbrella concept which included lots of different things and I didn't necessarily have that in mind when I wrote my report. I was probably thinking a little bit more narrowly in terms --

Q. When you what?

A. Well, in terms of gender transitioning or dealing with what, gender dysphoria.

Q. What is your definition of gender-affirming care in this declaration?

A. Well, I don't think I put one in there and I can't give you one off the top of my head.

Q. Is it fair to say that your definition is subsumed in the one that I read to you earlier?

A. It's probably a subset. But here again, I don't know for sure what you -- I can't recall everything you read to me earlier but it just seemed to be this omnibus thing.

Q. I'm going to draw your attention to Exhibit 6.

(Marked Deposition Exhibit No. 6.)

Q. (By Ms. Hamburger) This is titled "Fifth

Supplemental Responses and Objections to Plaintiffs' Second Discovery Requests to Defendant Blue Cross Blue Shield of Illinois."

Do you see that?

A. Yes.

Q. Okay. I'm going to scroll through it.

I believe you testified earlier that you received this from the defendants and brought it here today, is that right?

A. I received it from counsel, not the defendants.

Q. Okay. From counsel.

And did you rely on this when writing your declaration?

A. I don't recall when I received this.

Q. Okay. So you don't know if you received this before or after writing your declaration, is that right?

A. That's right. Here again, I can't remember the time line of receipt of this or writing of that.

Q. Okay. Do you recall reading in here in response to Interrogatory No. 8 that Blue Cross Blue Shield of Illinois had identified 505 members who had received a denial based upon a gender-affirming care exclusion?

A. Yes, I see that.
Q. Okay. And the total of the claims submitted by those 505 members is approximately 1.3 million.
Do you see that?
A. Yes, I see that.
Q. And did you use that information to determine whether those costs spread over all of the plans would result in an increase in premium payments by the employers or the employees?
MS. PAYTON: Object to the form of the question.
A. No. My statement in my declaration was based more generally on what happens when you add more benefits to a plan design.
Q. (By Ms. Hamburger) Do you know the total population of the ERISA group plans that Blue Cross Blue Shield administers that contains a gender-affirming care exclusion?
A. Not off the top of my head, no.
Q. Were you told that by defense counsel?
A. Well, I think I recall seeing some data on enrollees and plans but that's about all I can remember.
Q. Would it surprise you to know that it's approximately 400,000 in any given year?

MS. PAYTON: Object to the form.
A. I have no way of knowing whether that's surprising or not. I don't have a benchmark to relate that to.
Q. (By Ms. Hamburger) All right. So you didn't analyze whether the charges of 1.3 million spread out over the 398 ERISA self-funded plans that Blue Cross Blue Shield of Illinois administers with gender-affirming care exclusions, whether that is so de minimus as to not cause any change in expenses?
MS. PAYTON: Object to the form.
A. Well, I'm not sure you stated that correctly. I think that figure pertained to the 200 plans of the 398.
Q. (By Ms. Hamburger) Yes. Were you aware that the other approximately 198 plans had no claims for gender-affirming care?
MS. PAYTON: Object to the form of the question. Misstates the testimony.
A. All I know is what was in that document.
Q. (By Ms. Hamburger) All right. So you don't know whether or not the remaining 198 plans had no claims for gender-affirming care exclusions?
MS. PAYTON: Object to the form. Mischaracterizes the evidence.

A. No. You'd probably have to put that exhibit back up because that's the only thing I saw.

Q. (By Ms. Hamburger) Okay. I'm going to show you another report. I'm going to show you what has been marked as -- sorry, that's the wrong one.

I'm going to show you what's been marked as Exhibit 7.

(Marked Deposition Exhibit No. 7.)

Q. (By Ms. Hamburger) Are you familiar with the Rand Corporation?

A. Yes.

Q. What is the Rand Corporation?

A. Well, it's what we call a think tank. And they've got -- their original base was, I think, Los Angeles. Now they have a branch in D.C. and maybe elsewhere.

Q. Are their reports a reliable source of information?

A. They can be. They're respected.

Q. Are they reputable?

A. Yes. I can't say that everything they've done is correct but the ones I've read they're decent, yes.

Q. Do you rely on Rand studies in your work?

A. I have before.

Q. And this is a report called "Assessing the Implications of Allowing Transgender Personnel to Serve Openly."

Do you see that?

A. Yes.

Q. And did you review this as part of forming your opinions in this matter?

A. No.

Q. I'm just going to show you here on page three. It says that this report was done to assist the Department of Defense in identifying the potential implications of allowing transgender persons to serve openly.

Do you see that?

A. I see that in the first sentence of that middle paragraph, yes.

Q. Okay. All right. In this study -- I'm going to go down to page 53 here.

One of the questions that Rand was asked to consider by the Department of Defense is what are the costs associated with extending healthcare coverage for gender transition related treatments.

Do you see that?

A. Yes.

Q. Is that a similar question you were asked to

Sorry about it.

A. Okay.

Q. (By Ms. Hamburger) All right. And so I want to have you take a look at this table that they put together, actuarial estimated costs of gender transition related health care coverage from the literature.

Do you see that?

A. Yes.

Q. Okay. Now you did not do an actuarial estimated cost of gender transition coverage, right?

A. That is correct.

Q. And you didn't research any data related to the cost of the benefit of adding gender-affirming care to coverage, correct?

A. As I stated before I didn't do any cost-benefit analysis.

Q. Okay. All right. And here in the public employer data, two public employers had no increase in their healthcare budget when they added gender transition related healthcare coverage.

Do you see that?

A. This is for public employers. I assume that means municipal firms. I haven't read this report so it's hard for me to evaluate this.

Q. It says City of San Francisco --
A. Okay.
Q. -- had zero increase in its healthcare budget when it added gender-affirming care.
Do you see that?
A. I see the line, yes.
Q. And the same, University of California, zero increase in the healthcare budget.
Do you see that?
A. Yes.
Q. City of Portland, 0.8 percent in the healthcare budget.
Do you see that?
A. Yes.
Q. So a very small increase, you would agree?
A. Well, that's what these data say and that's for public employers. Catholic Health Initiatives is not a public employer. I don't know if these estimates apply.
Q. Okay. And the City of Seattle had a .19 percent increase.
Do you see that?
A. Yes.
Q. Okay. All of these were less than one percent increase, correct?

A. Yes.
Q. And you didn't look at this?
MS. PAYTON: Object to the form, asked and answered.
A. I already told you I did not review this report.
MS. HAMBURGER: Okay. Let me get another report.
THE WITNESS: By the way, is it possible we can take a break if we're going to go longer?
MS. HAMBURGER: Sure. We can take a break.
Gwendolyn, what do you want to do? Do you want to take a break for lunch? Do you want to take a five-minute break and keep going?
MS. PAYTON: What's your time estimate?
MS. HAMBURGER: I think we have an hour or less.
MS. PAYTON: Okay.
THE WITNESS: Well, let's just go because I have --
MS. PAYTON: Professor Burns has a healthcare obligation of his own, so if we could do that that would be great.
MS. HAMBURGER: Do you want to just take a five-minute break?

MS. PAYTON: Yes.

MS. HAMBURGER: Let's go off, then.

THE VIDEOGRAPHER: We're going off the record at 11:48 a.m.

(Recess.)

THE VIDEOGRAPHER: We're back on the record at 11:53 a.m.

Q. (By Ms. Hamburger) Dr. Burns, I'm just going to return to Exhibit 7 again.

A. Okay.

Q. Looking at the same chart on actuarial costs, do you see here it looks at private employer data? Do you see that?

A. Yes.

Q. And the private employer data all shows zero actuarial costs to adding the benefit to under one percent.

Do you see that?

A. Well, the middle line says approximately one percent increase in premiums for two firms.

Q. All right. And those firms were very small size.

Do you see that?

A. Well, here again, I don't know it's relative to what.

Q. Compared to the size of some of these other ones, they're a lot smaller, correct?

A. Well, you know, the other ones up above are all the employees of the city. And the ones down below are firms of 5,000. They're big firms.

Q. You mean in terms of large groups, is that what you mean?

A. Yes, large-sized firms, yes.

Q. Okay. But nothing is more than one percent increase in premiums.

Do you see that?

A. Yes.

Q. Okay.

A. But it supports what I said earlier, it would lead to an increase in premiums.

Q. Does it? I believe in your report you cite -- let's go back to your report, sir -- a report by Baicker of UCLA and Chandra of Harvard.

Do you see that?

A. Yes.

Q. That is a report from before the Affordable Care Act, correct?

A. Yes.

Q. So it doesn't take into account changes in the law or the financing of healthcare since the

Affordable Care Act, correct?

MS. PAYTON: Object to the form of the question.

A. Well, how could it take account of it because it was published before it. But I don't think health economists believe that just because the Affordable Care Act was passed that this dynamic has changed.

Q. (By Ms. Hamburger) So what they reported is if you had a ten percent increase in insurance premiums you would see a 1.2 percent possible reduction in employment and a 1.9 percent reduction in working full-time instead of part time and a 2.4 percent in hours worked and a possible 2.3 percent decrease in wages.

Do you see that?

A. I see those statistics.

Q. Is that accurate?

A. Well, that's what they reported.

Q. Okay. And the percentage of increase related to gender-affirming care that was identified in the Rand study is one percent or less, is that right?

A. Well, that's what the Rand study reported.

Look, I haven't read the Rand study report

so I'd have to go back and look at it more specifically.

Q. So that's a percentage increase less than one-tenth of what was discussed in the Baicker and Chandra study, correct?

A. Well, I would be careful about comparing these reports and drawing any conclusions from them, especially because I haven't read the report from the Rand study, and I haven't looked at the Baicker and Chandra report recently.

So I'd have to go back and look at them, but I would be wary about drawing comparisons between them.

Q. Okay. Let me draw your attention to Exhibit 4. I'll put it up on the screen.

(Marked Deposition Exhibit No. 4.)

Q. (By Ms. Hamburger) Can you see it?

A. Yes.

Q. "Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis."

Have you reviewed this article?

A. No. But it may be one of the things that Gwendolyn Payton received last night. She showed me

some of the things she received last night and this may be one of them, but I haven't reviewed it.

Q. So when you testified earlier that you looked at studies or articles about the cost-effectiveness related to transgender health coverage you did not refer to this article?

A. Well, I think you've misstated my prior testimony. I didn't say I reviewed studies on the cost-effectiveness of these services.

Q. So you have not reviewed studies on the cost-effectiveness of transgender health coverage, is that right?

A. That's more accurate.

Q. Okay. And you've never seen this article before?

MS. PAYTON: Object to the form. Mischaracterizes testimony.

A. Well, I don't recall. I know that Ms. Payton showed it to me today, but whether or not I've seen it before I don't know. I don't think so.

Q. (By Ms. Hamburger) Okay. I just want to draw your attention to, under "Key Results" on this page it says "The budget impact of this coverage is approximately 0.016 per member per month."

Do you see that?

A. Yes. It's tiny print and I'm having trouble seeing it but I see the line you're pointing to, yes.

Q. Okay. So that is approximately two cents per member per month, is that right?

A. According to the line you just read that's what it's saying. But here again, I haven't read the article so I don't know specifically what they're measuring.

Q. All right. Let me zoom in so you can see it. I want to make sure you're able to see it. That's not the right one.

"The budget impact of this coverage is approximately 0.016 per member per month."

Can you see that now?

A. Yes. And then the next line may also be relevant.

Q. "Although the cost for transitions is $10,000 to $22,000 and the cost of provider coverage is $2175 per year, these expenses hold good value for reducing the risk of negative end points -- HIV, depression, suicidality, and drug use. Results were robust to uncertainty."

So that's saying that there's not only cost involved with providing the coverage but a benefit for avoiding other kinds of medical treatment, is that

right?

A. Well, it says value. I don't know how they're defining value. And it says "the risk of negative end points," so I don't know what specifically -- what specific metrics they're looking at there for those four conditions.

But the thing that catches my attention is that cost for the transitions is between $10,000 to $22,000 and then you have the cost of provider coverage is $2175. Those costs don't seem to be non-negligible.

Q. Do you know the incidence of the people who are transgender in the general population?

A. No.

Q. So even though these might be significant costs to any individual patient personally, if they're spread out across a general insured population they might be very negligible, correct?

A. Yeah, I don't know that for a fact. I don't know if they're concentrated or disbursed. And we're talking about self-funded healthcare plans here in this case and so you would probably want to be looking at that population.

Q. Absolutely. And you never looked at the total population of any of the plans in this case, did

you?

MS. PAYTON: Object to the form.

A. I was not asked to do that.

Q. (By Ms. Hamburger) Did you consider the ways in which adding gender-affirming care might save money for an employer?

A. No.

Q. It's possible that providing medically necessary gender-affirming care might avoid more costly treatment?

A. You know, I don't know how to answer that because I'm not sure what medically necessary gender-affirming care is.

As I understand there's some debate in the medical community about this procedure, so there's some -- I don't know if there's a consensus on medical necessity and so I don't know the literature on all that. I just know that there's some debate.

Q. How do you know that there's debate?

A. I've seen it in print.

Q. What have you seen it in?

A. I don't recall. I just know that I've seen it in print, that there's no medical consensus on this.

Q. Well, sir, I'm not sure what you're reading

A. Well, it's consistent with it. Whether or not that comes directly from that statistic, I don't know, but it's consistent with it.

Q. Okay. And then you say "I also understand from Blue Cross Blue Shield that many of these employers also offer a plan design to employees that includes coverage for these services, so that employees can choose what plan design is right for their circumstances."

Do you see that?

A. Yes.

Q. And you don't know what number of the 398 plans offer an alternative plan design that covers gender-affirming care?

A. I do not have those statistics.

Q. Do you know whether any offer a plan design that's an alternative, apart from what you've been told by counsel?

MS. PAYTON: Object to the form of the question.

A. It's my understanding that Blue Cross Blue Shield of Illinois is administering plans for lots of ERISA healthcare sponsors, one of which is Catholic Health Initiatives. And I don't know across all of those employers that Blue Cross Blue Shield of

Illinois is acting as TPA, you know, what percentage do or don't offer a dual choice plan.

Q. (By Ms. Hamburger) Do you know if any offer a dual choice plan?

A. No, I do not.

Q. And just so we know in the record, when you say "dual choice" you mean a choice of gender-affirming care and a plan that has an exclusion of gender-affirming care?

A. Correct. Giving employees the option.

Q. Okay. All right. Turning to the second paragraph 27.

A. Uh-huh.

Q. Okay. Again, paragraph 27 is a statement in general about exclusions and adding coverage, is that right?

A. That is correct.

Q. It is not specific to gender-affirming care, correct?

A. It's not specific to but it could encompass it.

Q. And you have not seen any data that shows that removing a gender-affirming care exclusion will result in higher premium?

A. Well, you showed me some data from the Rand

Corporation that shows that it leads to higher premiums so I'm aware of the data that you showed me today. But prior to today, no.

Q. You did not review any data yourself in forming this opinion that adding gender-affirming care translates into higher premiums?

A. That is correct.

Q. And the data I showed you today from the Rand Corporation shows that sometimes it translates into no impact on an entity's health budget, correct?

MS. PAYTON: Object to the form of the question.

A. That specific finding was for public employers. That's not the case here.

Q. (By Ms. Hamburger) And even for the private employers, sometimes it had no impact on the health budget and sometimes it was one percent or less, correct?

A. Well, I'd have to go back to that table to see exactly what it said for the private employers, so I can't affirm what you just said.

Q. Well, let me help you, then.

Here it says that many employers reported no actuarial cost to adding the benefit. Estimates range from zero to .2 percent.

about the harm to consumers when they are asked to pay more for a benefit to be added to their health plan, is that right?

A. The enrollees of a health plan that are required to offer certain benefits will probably face higher costs of that coverage.

Q. And you conclude that that is a harm to those consumers?

A. Well, if they're paying more than they otherwise would. That's why it's good if the enrollee has a choice between a plan with or without that coverage.

Q. But the enrollee might benefit from that coverage if they use it?

MS. PAYTON: Object to the form of the question, asked and answered.

A. Yes. But then they will select the health plan that offers that coverage and employees who don't want that benefit will not select that plan and they too will benefit.

Q. (By Ms. Hamburger) Isn't there a societal benefit to having a baseline of coverage that everybody receives so that everybody bears the cost of those benefits?

A. You know, that's more of a philosophical

Exhibit

October 24, 2022

Gwendolyn Payton, ESQ
Kilpatrick Townsend & Stockton
Suite 3700
1420 Fifth Avenue
Seattle, WA 98101

Dear Gwendolyn:

This letter serves as my invoice for expert witness services on the Pritchard case from 6/23/22 through 9/9/22. I have worked 13.5 hours, as follows: 5 hours on 6/23 spent preparing my report, 2.5 hours on 9/8 in deposition preparation, and 6.0 hours on 9/9 for more preparation and the actual deposition. At our agreed-upon rate of $900/hour, my bill is thus 13.5 * $900 = $12,150.00.

Please make the checks payable to the address below. My SSN is [redacted]. Thank you for handling this.

Best regards,

Lawton R. Burns
P.O. Box 222
Gladwyne PA 19035