

Exhibit 11



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

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BACKGROUND: Recently, the Massachusetts Group Insurance Commission (GIC) prioritized research on the implications of a clause expressly prohibiting the denial of health insurance coverage for transgender-related services. These medically necessary services include primary and preventive care as well as transitional therapy.

OBJECTIVE: To analyze the cost-effectiveness of insurance coverage for medically necessary transgender-related services.

DESIGN: Markov model with 5- and 10-year time horizons from a U.S. societal perspective, discounted at 3 % (USD 2013). Data on outcomes were abstracted from the 2011 National Transgender Discrimination Survey (NTDS).

PATIENTS: U.S. transgender population starting before transitional therapy.

INTERVENTIONS: No health benefits compared to health insurance coverage for medically necessary services. This coverage can lead to hormone replacement therapy, sex reassignment surgery, or both.

MAIN MEASURES: Cost per quality-adjusted life year (QALY) for successful transition or negative outcomes (e.g. HIV, depression, suicidality, drug abuse, mortality) dependent on insurance coverage or no health benefit at a willingness-to-pay threshold of \$100,000/QALY. Budget impact interpreted as the U.S. per-member-per-month cost.

KEY RESULTS: Compared to no health benefits for transgender patients (\$23,619; 6.49 QALYs), insurance coverage for medically necessary services came at a greater cost and effectiveness (\$31,816; 7.37 QALYs), with an incremental cost-effectiveness ratio (ICER) of \$9314/QALY. The budget impact of this coverage is approximately \$0.016 per member per month. Although the cost for transitions is \$10,000–22,000 and the cost of provider coverage is \$2175/year, these additional expenses hold good value for reducing the risk of negative endpoints—HIV, depression, suicidality, and drug abuse. Results were robust to uncertainty. The probabilistic sensitivity analysis showed that provider coverage was cost-effective in 85 % of simulations.

CONCLUSIONS: Health insurance coverage for the U.S. transgender population is affordable and cost-effective,

and has a low budget impact on U.S. society. Organizations such as the GIC should consider these results when examining policies regarding coverage exclusions.

KEY WORDS: transgender health; cost-effectiveness analysis; budget impact analysis; preventive care; health law; health insurance coverage.

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INTRODUCTION

U.S. health insurance plans categorically deny transgender enrollees coverage for medically necessary services such as transition-related and preventive care.¹

In 2013, the Commonwealth of Massachusetts Group Insurance Commission (GIC), the state's administrator of employment-based health benefits to 420,000 subscribers, prioritized research on whether the cost-effectiveness of providing benefit coverage for transgender enrollees would support the removal of exclusions of coverage for transition-related services. Current evidence indicates that transition-related care is medically necessary and effective for transgender patients.^{2,3} Furthermore, recent changes in federal and state laws may place health insurer accreditation status at risk based on absence of coverage for transition-related care.^{4,5} Since negative health outcomes are associated with denial of these services, it may be in payers' financial interests to cover transgender health benefits.² Payers could increase net monetary benefit and avoid noncompliance with regulations by offering coverage in accordance with guideline-recommended care.³

The American College of Physicians' position on the health care of transgender persons is that all services should be covered as they would for other beneficiaries, and that coverage should not discriminate on the basis of gender identity.⁶ However, health insurance policies frequently prohibit coverage for transgender people under a clause expressly prohibiting coverage for transitional care, or based on carriers' contract interpretation.⁷ Transgender exclusions result in denial of coverage when subscriber gender marker and physiology are incongruent.⁸

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In 2014, the U.S. Department of Health and Human Services lifted a 33-year ban on coverage of transitional care for Centers for Medicare and Medicaid Services (CMS) beneficiaries, citing that existing literature demonstrates the efficacy, safety, and effectiveness of “sex reassignment surgery” and that “exclusions of coverage are not reasonable.”^{4,5} This stance stemmed from the U.S. Department of Justice’s interpretation of Title VII of the Civil Rights Act that sex discrimination prohibitions extend to health benefits of transgender people.⁹ This federal decision could influence how public and commercial payers define medically necessary services.

The most effective approach to transition uses individualized treatment plans,¹⁰ which may require hormone replacement therapy (HRT), mastectomy, phalloplasty, vaginoplasty, psychotherapy, or other services.⁸ The prevalence of sex reassignment surgery is 1:100,000 population, or approximately 3000–9000 in the U.S.^{4,8} In 2001, 866 male-to-female (MTF) primary surgeries (bottom surgery) and 336 female-to-male (FTM) primary surgeries (top surgery) were documented in the U.S., and the prevalence has likely increased since then, despite considerable under-reporting.^{4,8,11} These procedures are costly to uninsured patients. In addition, many costs for gender-specific preventive care (i.e., prostate screening, mammograms) are not covered by insurance if a patient legally changes their sex on their birth certificate.^{11,12} According to Gorton et al., providing insurance coverage would appear cost-effective,² whereas negative outcomes associated with denial of coverage could be costly to payers because of increased morbidity.¹³ For instance, studies by Lundstrom and by Kuiper and Cohen-Kettenis estimated that suicidality in transmen dropped from 20 % to 1 % after treatment.^{14,15} No studies, however, have measured the economic benefit of health insurance coverage to transgender enrollees for medically necessary and preventive services.

Our objective was to analyze the cost-effectiveness of health insurance coverage for medically necessary and preventive services compared to no coverage in the U.S. adult transgender population. This study was designed from a U.S. societal perspective and evaluated outcomes over 5- and 10-year periods.¹⁶ We hypothesized that provider coverage is cost-effective.

METHODS

Study Design

Using a Markov model, we compared the cost-effectiveness of health insurance for provider coverage (i.e., access to primary, secondary, and tertiary services provided by a physician and/or advanced practitioner) of medically necessary services in the U.S. adult transgender population.^{17,18} Model parameters were extracted from the National Transgender Discrimination Survey (NTDS) of adults,¹ and provider costs for transition-related care were extracted from the Healthcare Bluebook.¹⁹

Costs were adjusted to 2013 U.S. dollar values and discounted at 3 % along with utilities, and analyzed over 5 and 10 years.¹⁶

The analysis was conducted from a U.S. societal perspective. Effectiveness was measured as quality-adjusted life years (QALYs) derived from EuroQol Group EQ-5D index scores.²⁰ Patient costs in the provider coverage arm were considered along with probabilities for negative outcomes and any associated costs for psychiatric rehabilitation. Patients in the provider coverage arm were assumed to receive individualized transition therapy.⁷ With no health benefit, patients were assumed to have lower upfront costs, but higher risks for negative outcomes, long-term costs, and lower life expectancy.

Model

The Markov model (Fig. 1) was built using TreeAge (TreeAge Software, Inc., Williamstown, MA, USA; 2009). With provider coverage, 100 % of patients were modeled to have authorized transitional therapy care in accordance with the World Professional Association for Transgender Health (WPATH) standards of care.³

Patients could experience a continuous progression of outcomes in escalating stages over 1-year cycles for up to 10 years. Patients in escalated states required costly rehabilitation to cycle through job loss/depression in order to return to a preferable baseline state. Patients who cycled into escalated states had increased risk of drug abuse, suicidality, and HIV.²¹ The risk of death included all-cause mortality²² and specific mortality rates from suicide and drug overdose.^{23–25} Following transitional therapy, the model included costs for provider coverage to reduce negative outcomes.

No Health Benefit

The structure of the no health benefit arm accounted for denial of coverage to transgender patients for medically necessary and preventive care, as well as adverse implications. Patients began either at baseline or a job loss/depression state according to the unemployment rate associated with anti-transgender bias.¹ Patients at baseline and in the job loss/depression state were modeled as having high rates of escalating issues, including death.¹ Alternatively, patients at baseline accrued no cost.

Provider Coverage

Patients with health insurance with provider coverage could navigate through transitional therapy or denial. Patients denied coverage following a mental health evaluation transitioned to baseline or escalated states. This sub-tree accounted for variations in policy and practice, including barriers raised through insurance claims and coding processes. For example, if a female-to-male (FTM) patient changed his legal gender marker and then submitted billing for a Pap smear, coverage was modeled as denied based on his gender marker despite the provider’s adherence to WPATH guidelines.

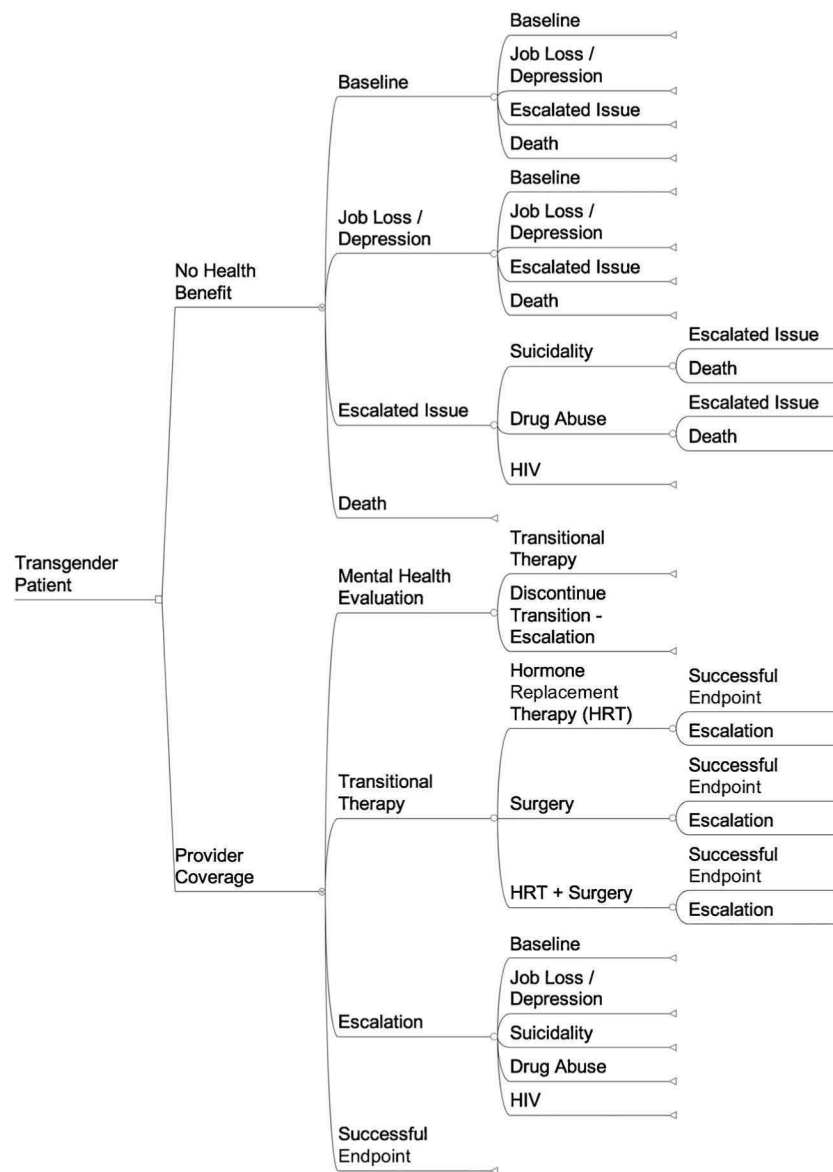


Figure 1 A simplified Markov diagram comparing no health benefit to provider coverage of medically necessary services for the U.S. transgender population.

Provider coverage was modeled as having higher costs and improved quality of life. The model also incorporated probabilities for negative health outcomes. Most patients were assumed to receive a full range of services indicated by WPATH, including reconstructive procedures.^{3,7}

Assumptions

The model included several assumptions. First, provider coverage paid for the following procedural combinations: surgery, HRT, surgery and HRT, discontinued transition, and costs associated with baseline prevalence of job loss/depression. Second, costs for provider coverage were equivalent to reimbursed rates for procedural diagnosis-related groups (DRGs). Third, transitional therapy would maintain its baseline utility.

Data Collection

Data were collected from a systematic review of over 30 randomized controlled trials, observational data, and case series detailing types of gender-confirming care, whether transphobic-related events triggered negative outcomes, and the existence of a defined outcome for each related state. Many probabilities were from the NTDS (Table 1).¹

Costs

Transition costs were gathered from the GIC public record and the literature (Table 2).¹¹ Existing DRGs weighted by procedural prevalence were used for initial and incremental costs of services. Thus, costs were reflective of the most common procedures (e.g. mastectomy) compared to rare procedures

Table 1 Probabilities for the cost-effectiveness analysis

Probabilities	Base Case	Range for Sensitivity Analyses	Source
<i>No Health Benefits</i>			
Baseline	0.74	0.629–0.851	1
Baseline	0.7	0.595–0.805	1
Job Loss/Depression*	0.199	0.169–0.229	1
Escalation	0.1	0.085–0.115	1
Suicidality*	0.82	0.697–0.943	1
HIV	0.048	0.039–0.053	1
Drug Abuse	0.13	0.1105–0.1495	1
Death	0.00012	0.000102– 0.000138	22
Active	0.26	0.221–0.299	1
Baseline	0.58	0.493–0.667	1
Active	0.26	0.221–0.299	1
Escalation	0.13	0.1105–0.1495	1
Suicidality*	0.739	0.628–0.849	1
HIV	0.101	0.086105– 0.116495	1
Drug Abuse	0.16	0.136–0.184	1
Death*	0.00012	0.000102– 0.000138	22
Death	0.00012	0.000102– 0.000138	22
Suicidality			
Job	0.47	0.399–0.541	1
Loss/Depression*			
Suicidality	0.33	0.281–0.380	24
Drug Abuse	0.08	0.068–0.092	1
Death	0.12	0.102–0.138	24
Drug Abuse			
Job	0.383	0.326–0.441	1
Loss/Depression*			
Drug Abuse	0.448	0.381–0.515	1
HIV	0.026	0.022–0.030	1
Suicidality	0.14	0.119–0.161	23–25
Death	0.0017	0.0014–0.0019	23–25
<i>Provider Coverage</i>			
<i>Mental Health Evaluation</i>			
Denied Coverage	0.07	0.059–0.081	1
HRT	0.62	0.527–0.713	1
Escalation	0.66	0.412–0.841	1
Surgery*	0.31	0.264–0.357	1
Escalation	0.0895	0.076–0.103	23
MTF	0.5		Assumed
w/HRT	0.8	0.68–0.92	1
w/no HRT*	0.2	0.17–0.23	1
FTM	0.5		Assumed
w/HRT	0.69	0.586–0.793	1
w/no HRT*	0.03	0.025–0.034	1

* Represents a remainder so that all probabilities add up to 1.0; FTM female-to-male transition, HRT hormone replacement therapy, MTF male-to-female transition

(e.g. phalloplasty).^{11,17} There were no costs attributed to baseline state or death. Depression, suicidality, and drug abuse states resulted in rehabilitative costs.^{26–28} The U.S. cost of illness for HIV was extracted from Walensky et al.²⁹

Cost of provider coverage was dependent on combinations of surgery and HRT. HRT was a fixed cost. The MTF group represented combinations of penectomy, breast augmentation, labiaplasty, and vaginoplasty. The FTM represented combinations of mastectomy, hysterectomy, abdominoplasty, and genital augmentation. Under provider coverage, there was an annual cost of \$2175 associated with medically necessary services and preventive care.

Other treatment costs were based on DRGs. Escalated states following baseline were based on employment status. The NTDS found that 78 % of respondents who successfully transitioned reported improved job performance.¹ Conversely, respondents who experienced job loss were 70 % more likely to abuse substances than employed respondents. HIV rates among the transgender population were 400 % higher than in the general population, and doubled with unemployment.

Utilities

QALYs were extracted from U.S.-based sources (Table 3). Baseline utility was taken as the U.S. average according to Sullivan et al.²⁰ This index also provided utilities for depression (ICD-9 311) and suicidality (assumed as ICD-9 296). Utility for HIV was referenced from Wu et al., and Coffin et al. provided utility data for drug abuse.^{30,31} Surgery had a disutility.³² Benefit coverage for transition and successful endpoints were weighted as 0.867 QALYs, given primary preferences for these outcomes aligned with the U.S. population average.^{30,31}

Sensitivity Analyses

Univariate and multivariate sensitivity analyses were used to test model uncertainty. These sensitivity analyses were performed by varying all base case estimates by reported distributions (e.g., confidence intervals, standard deviations) or by varying estimates ± 15 % of the mean when distributions were not reported.

In one particular univariate analysis, the probability of patients starting in job loss/depression ranged from 0–29.9 % in the provider coverage arm, since the model assumed some baseline prevalence of depression or unemployment not negated by transition therapy, leading to downstream escalations.

A Bayesian multivariate probabilistic sensitivity analysis applied distributions for each variable to characterize uncertainty on all parameters simultaneously using 10,000 Monte Carlo simulations. Beta distributions were used for probabilities and utilities (i.e., values of 0.0–1.0), and gamma distributions were used for costs (i.e., positive values).

Budget Impact Analysis

The budget impact of transgender coverage was measured relative to the total U.S. population, thereby gauging equity of absorbing costs of coverage in a small population.³³

Budget impact was calculated on a per-member-per-month basis for an approximate 2014 U.S. population of 320 million (U.S. Census Bureau, 2014). The calculation assumed that following implementation of blanket provider coverage, there would be an influx of about 30,000 transgender persons seeking transitional care in the first 5 years (i.e., 6000/year taken as the midpoint of 3000–9000 procedures per year according to

Table 2 Costs for the cost-effectiveness analysis

State	Cost Type	ICD-9 Code	Base Case Costs (\$)	Range for Sensitivity Analyses	Source
Baseline		n/a	n/a		Anchor
Job Loss – Depression	Annual	311	565.06	63.00–3781.10	28
Attempted Suicide	Annual	296	21,671.00	18420.35–24921.65	27
HIV (generic therapy)	Annual	042	11,600.00	9860.00–13340.00	29
Drug & Substance Abuse	Annual	304	11,448.00	9730.80–13165.20	26
Cost for Mental Health Evaluation	Fixed	n/a	2175.00	1848.75–2501.25	19
HRT	Fixed	n/a	4350.00	3697.50–5002.50	19
Surgery					
MTF w/HRT	Fixed	n/a	22,025.00	18721.25–25328.75	19
MTF w/o HRT	Fixed	n/a	17,675.00	15023.75–20326.25	19
FTM w/HRT	Fixed	n/a	14,658.00	12459.30–16856.70	19
FTM w/o HRT	Fixed	n/a	10,308.00	8761.80–11854.20	19
Cost for Continuous Coverage	Annual	n/a	2175.00	1848.75–2501.25	19
Death		n/a	n/a		Anchor

FTM female-to-male transition, HRT hormone replacement therapy, MTF male-to-female transition

Walsham).³² The additional cost would be the difference in cost of benefit coverage from the model.

RESULTS

Expected Cost and Effectiveness

Provider coverage resulted in higher cost and greater effectiveness, and was cost-effective relative to no health benefits at 5 and 10 years from a willingness-to-pay (WTP) threshold of \$100,000/QALY (Table 4). These results were driven by the cohort without health benefits, which had less favorable outcomes, including depression, HIV, and death. The 5-year incremental cost effectiveness ratio (ICER) was greater than that at 10 years, since upfront costs for transitional therapy were not yet offset by costly long-term endpoints of excluded coverage (e.g., HIV, drug abuse).

The 5-year budget impact analysis determined a cost of \$0.016 per member per month, meaning that if U.S. society

assumed the role of paying an additional \$10,614 for each person seeking benefit coverage, the U.S. population could absorb these costs for just cents per month.

Sensitivity and Threshold Analyses

Variations in expected values of all cost, probability, and utility estimates did not change expected results. Univariate sensitivity analyses indicated that the model was most sensitive to (1) probability of suicidal death, (2) probability of drug abuse, and (3) utilities of baseline, depression, and drug abuse. However, univariate and two- and three-way sensitivity analyses did not alter results.

The results did not change in sensitivity analysis of patients with provider coverage starting at a baseline with job loss or depression. The maximum probability of 29.9 % job loss/depression produced a 10-year ICER of only \$20,942/QALY.

The probabilistic sensitivity analysis showed that provider coverage was cost-effective compared to no health benefit in 8477 of 10,000 Monte Carlo simulations at a mean ICER of \$8655/QALY (median ICER of \$8593/QALY). In 389 of these simulations, provider coverage dominated the alternative (Fig. 2).

Table 3 Utilities for the cost-effectiveness analysis

Utilities	ICD-9 Code	Base Case Utility	Range for Sensitivity Analyses	Source
Baseline*	n/a	0.867	0.737–0.997	20
Job Loss – Depression	311	0.732	0.622–0.842	20
Attempted Suicide	296	0.693	0.589–0.797	20
HIV	042	0.800	0.680–0.920	31
Drug & Substance Abuse	304	0.800	0.730–0.900	30
Hormone Replacement Therapy (HRT)	n/a	0.867	0.737–0.997	Assumed
Surgery (transition utility from baseline)	n/a	−0.155	−0.178 to −0.132	32
End-State	n/a	0.867	0.737–0.997	Assumed
Death	n/a	0.0	0.0–0.0	Anchor

*The benefit of having transitional therapy is no disutility from baseline status

DISCUSSION

These findings suggest that the removal of transgender exclusions is affordable and efficient with respect to the U.S. population. Provider coverage is a cost-effective policy at a willingness-to-pay threshold of \$100,000/QALY. The ICER of provider coverage for medically necessary services and preventive care at 10 years is about \$9300/QALY, which suggests that this policy would be comparatively efficient on a per-patient basis. Even at 5 years, this type of program still holds good value. These findings appear robust to model uncertainty according to sensitivity analyses. In addition, the results of the budget impact analysis imply that this policy is affordable, with a cost of only about \$0.016 per member per month.

Table 4 Expected results of the base case cost-effectiveness analysis

	Cost (USD 2013)	Δ Cost	Health Utility (QALYs)	Δ Utility	ICER (\$/QALY)
<i>5-Year Time Horizon</i>					
No Health Benefit	10,712.00		3.71		
Provider Coverage	21,326.00	10,614.00	3.98	0.27	39,311.11
Male-to-Female (MTF)*	22,545.00	11,833.00	3.98	0.27	43,825.93
Female-to-Male (FTM)*	20,107.00	9395.00	3.98	0.27	34,796.30
<i>10-Year Time Horizon</i>					
No Health Benefit	23,619.00		6.49		
Provider Coverage	31,816.00	8197.00	7.37	0.88	9314.77
Male-to-Female (MTF)*	33,034.00	9415.00	7.37	0.88	10,698.86
Female-to-Male (FTM)*	30,597.00	6978.00	7.37	0.88	7929.55

(*) Compared to no health benefit; QALY quality-adjusted life year

This case presents an economical coverage policy that can be likened to patients in the U.S. facing similar challenges of access to necessary care, such as those with rare diseases who have access to necessary health technology as a result of the Orphan Drug Act of 1983.³⁴ For instance, cystic fibrosis (CF) affects a population of only 30,000 individuals in the U.S., but has evolved into a successfully treatable chronic disease with the availability of new pharmaceuticals.³⁵ While the cost of ivacaftor for CF (\$300,000/year) is neither affordable nor efficient (ICER > \$1 million/QALY), this act makes it available

to CF patients.³⁶ By the absorption of the cost of ivacaftor across the U.S. population for people who are uninsured or have annual incomes less than \$150,000, the budget impact is only about \$0.05 per member per month.³⁷

While justice, legality, and a desire to avoid discrimination should drive decisions about benefit coverage, this case for the transgender population also appears economically attractive. The budget impact analysis calculates the expected value of costs for a state with an average population of 700 instances of transition therapy each year. Thus, if state governments require

Incremental Cost-Effectiveness, Provider Coverage v. No Health Benefits

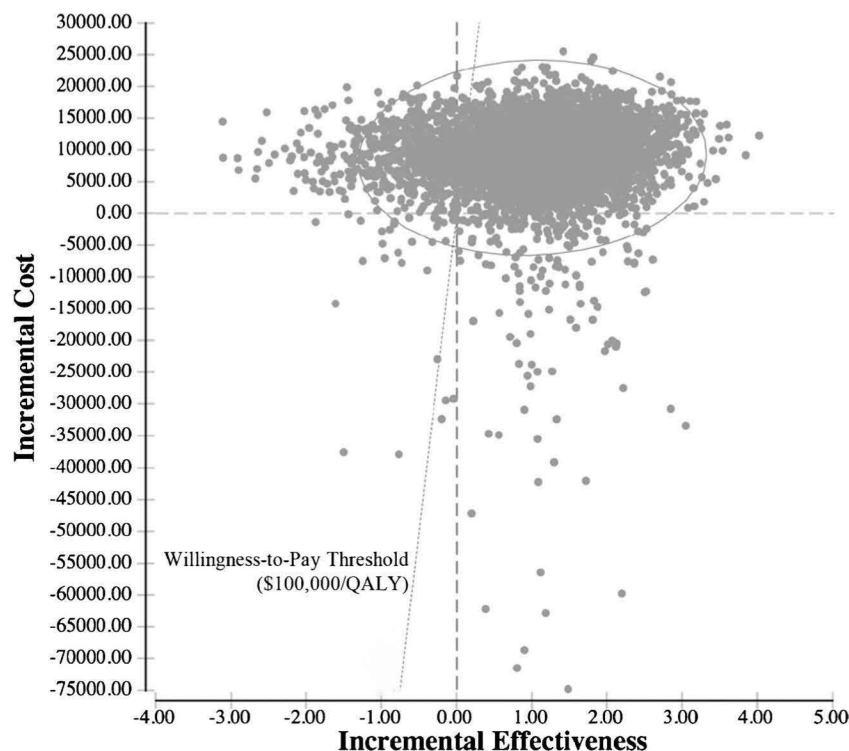


Figure 2 A scatter plot of a Bayesian multivariate probabilistic sensitivity analysis measuring the incremental cost-effectiveness ratios (ICERs) of 10,000 Monte Carlo simulations. Under no health benefit, people who are transgender navigate issues such as employment discrimination and depression, which can escalate to more severe health states such as suicidality, drug abuse, and HIV, according to the 2011 National Transgender Discrimination Survey. A lack of provider coverage under this arm increases the risk of these issues. In the other arm, provider coverage improves access to primary and preventive care, as well as medically necessary services that in most cases lead to transitional therapy such as hormone replacement therapy and surgery. The majority of people with provider coverage achieve preferred health states with greater utility, at an increased cost per year of about \$2175. The risks of escalated issues such as depression and suicidality still exist for the provider coverage arm, since not all people qualify for all benefits, and transitional therapy does not completely insulate against these issues.

that payers offer coverage, insurance companies need to account for approximately \$7.5 million per state. While cost-effective on a societal level, there is some upfront investment required of payers. A return-on-investment (ROI) calculation for this figure shows that it would take a payer approximately 63 years to break even on an investment in this type of benefit program.

However, legal and administrative barriers can hinder the implementation of new policy informed by these results. First, commercial payers are accustomed to negotiating contracts and benefit packages in ways that may resist change. It may be difficult to instantaneously adopt changes in provider coverage when exclusions are enforced by a third party or if state law defines health services to exclude transgender benefits.³⁸ Fortunately, transgender exclusions were recently removed by states, commercial payers, and CMS.^{4,7}

According to the Human Rights Commission, 57 of the approximately 200 major employers offering at least one transgender-inclusive health care coverage plan were law firms, possibly reflecting the growing legal consensus that transgender exclusions are discriminatory in practice.^{7,39} At least 17 major insurance carriers administer or provide coverage for at least one employer or student plan offering transgender benefits (e.g., Aetna, Cigna, Harvard Pilgrim, United Healthcare, and Blue Cross Blue Shield Massachusetts).⁴⁰ Additionally, numerous public employers offer provider coverage (e.g., University of California, University of Michigan, City of Minneapolis, City of New York, and City of San Francisco).^{15,40} However, most U.S. health insurance policies still contain transgender exclusions, even though treatment of gender identity disorder is neither cosmetic nor experimental.^{40,41}

This study has several limitations. First, data were lacking on whether transition-related therapy completely prevents negative endpoints such as depression/suicidality, or whether a baseline prevalence still exists. Second, some data in this analysis were representative not of the transgender population, but of the general population. Third, no empirical evidence exists on the time-dependency of escalated issues, so expert opinion guided transition probabilities. Fourth, no true health utilities were available for outcomes triggered by anti-transgender bias.¹¹ Fifth, some costs were derived from an ad hoc survey of provider affiliates to the GIC. Although these results should be widely applicable to most institutions, some insurance carriers have third-party payers or self-payers that could change the relevance of these results. Sixth, while depression and job loss are grouped together in the model, there may be some element of exclusivity in these two states that cannot be well-discerned by health utility. Seventh, HIV and drug abuse represent two of many possible negative outcomes; the choice to highlight these in the model was based on reported prevalence in the NTDS.

Finally, this study did not include children or adolescents, and focused on an adult-only population, based on the age of respondents in the NTDS. According to de Vries et al., young

adults experience alleviation of gender dysphoria and improvement in psychological functioning following gender reassignment.⁴² Given this promise, the field could benefit from additional outcomes research among youth.

Another challenge of this study involves the premise that outcomes research is able to justify transgender benefit coverage. QALYs in this study come from societal preferences for chronic conditions. People are not asked to consider a state of being for a transgender person who is depressed or HIV-positive, for example, nor are transgender individuals represented. According to Lyons et al., there is a stigma attached to the inclusion of transgender-stratified preferences and outcomes in trials and observation,⁴³ which speaks to the broader issue of gaining consensus within U.S. society in accepting that unique services covered by transgender benefits are as necessary as care for people not seeking a transition.

By removing transgender exclusions, society could change the trajectory of health for all transgender persons. It is worth considering that other costly surgeries (e.g., breast reduction, spinal fusion for chronic back pain), procedures (e.g., in vitro fertilization), and health technologies (e.g., drugs such as sildenafil citrate for erectile dysfunction) that consensus dictates as not medically necessary are still covered by payers. Overall, payers may provide the motivation for progress in a field when there is the potential of reimbursement for improved performance. This concept could be likened to poor outcomes of phalloplasty in MTF transitions: surgeons might invest in trials that improve outcomes of these complicated procedures if they knew they would be reimbursed.⁴⁴ A law protecting transgender benefit coverage is not only medically necessary, but is morally imperative.

Ultimately, removing a clause expressly prohibiting coverage for medically necessary care in the transgender population is economical at a U.S. societal level. State laws that define "health services," thereby dictating benefit exclusions, should be amended to reflect contemporary medical evidence.^{4,38,45} Affiliated contracting agencies and bodies should remove their corresponding exclusions given that provider coverage is affordable, efficient, and equitable.

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Compliance with Ethical Standards

Conflict of Interest: The Authors have no conflicts of interest to declare. Authorship of this manuscript follows ICMJE guidelines; each author is associated with conceptualization, writing, final approval, and accountability for the work.

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Exhibit 12

HONORABLE JUDGE ROBERT J. BRYAN

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**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA**

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

Plaintiff,

vs.

BLUE CROSS BLUE SHIELD OF
ILLINOIS,

Defendants.

Case No. 3:20-cv-06145-RJB

**FIFTH SUPPLEMENTAL RESPONSES
AND OBJECTIONS TO PLAINTIFFS’
SECOND DISCOVERY REQUESTS TO
DEFENDANT BLUE CROSS AND BLUE
SHIELD OF ILLINOIS**

TO: Plaintiffs C. P., Patricia Pritchard, and Nolle Pritchard.

AND TO: SIRIANNI YOUTZ SPOONEMORE HAMBURGER PLLC and LAMBDA
LEGAL DEFENSE AND EDUCATION FUND, INC., their attorneys.

Pursuant to Federal Rules of Civil Procedure 26, 33, and 34, Defendant Blue Cross Blue
Shield of Illinois (“BCBSIL”) hereby objects and responds to Plaintiffs’ Second Discovery
Requests (the “Requests”) as follows:

A. GENERAL OBJECTIONS

1. BCBSIL objects to the Requests to the extent they are overly broad, unduly
burdensome, oppressive, redundant, vague, ambiguous, and/or seek to impose on BCBSIL
obligations greater than or different from those imposed by the Federal Rules of Civil Procedure.

2. BCBSIL objects to the Requests to the extent they impose a burden on it that is

1 date of January 1, 2019, attached as Appendix A to the Amended Complaint (Doc. 38, the
2 “Complaint”).

3 **D. REQUESTS FOR ADMISSION**

4 **REQUEST FOR ADMISSION NO. 1: Admit that there are at least 40 persons who
5 fit the class definition found at paragraph 91 of the Amended Complaint (Dkt. No. 38).**

6 INITIAL ANSWER: BCBSIL objects to this Interrogatory in that the class definition is
7 vague, ambiguous and not easily ascertainable. BCBSIL is still investigating this request and will
8 supplement this response upon completion of the investigation.

9 SUPPLEMENTAL ANSWER: BCBSIL objects that the class definition found at
10 Paragraph 91 of the Amended Complaint is vague, ambiguous, and not easily ascertainable.
11 BCBSIL specifically objects that the proposed class definition hypothetically includes all
12 individuals who “will be participants” and who “will be denied pre-authorization of coverage.”

13 Notwithstanding the foregoing objections, BCBSIL admits that there are at least 40 persons
14 who may fit the class definition found at paragraph 91 of the Amended Complaint.

15
16 **E. INTERROGATORIES**

17 **INTERROGATORY NO. 6: Please identify any other plans for which BCBSIL
18 administers a gender-affirming care exclusion.**

19 INITIAL ANSWER: BCBSIL objects to this Interrogatory as overly broad, unduly
20 burdensome, and not reasonably calculated to lead to the discovery of admissible evidence in
21 seeking “any other plans” for which BCBSIL administers a “gender-affirming care exclusion,”
22 without regard to the materiality of such plans to the fact as issue in this lawsuit as alleged in the
23 Complaint.

24 Notwithstanding the foregoing objections, BCBSIL states that it will produce responsive
25 Documents sufficient to show the relevant language and number of ERISA self-funded group
26 health plans pursuant to Rule 33(d) of the Federal Rules of Civil Procedure.

27 SUPPLEMENTAL ANSWER: BCBSIL objects to this Interrogatory as overly broad,

1 unduly burdensome, and not reasonably calculated to lead to the discovery of admissible evidence
2 in seeking “any other plans” for which BCBSIL administers a “gender-affirming care exclusion,”
3 without regard to the materiality of such plans to the fact as issue in this lawsuit as alleged in the
4 Complaint.

5 Notwithstanding the foregoing objections, BCBSIL preliminarily states that there are 398
6 ERISA self-funded group health plans for which BCBSIL administers a gender-affirming care
7 exclusion. Discovery is ongoing.

8 SECOND SUPPLEMENTAL ANSWER: *See* revised Addendum A.

9 THIRD SUPPLEMENTAL ANSWER: BCBSIL incorporates by references its prior and
10 supplemental responses to Interrogatory No. 6. **BCBSIL further states that of the 398 ERISA self-**
11 **funded group health plans for which BCBSIL administers a gender-affirming care exclusion,** some
12 employers who offer a plan containing a gender-affirming care exclusion offer one or more plans
13 in the same year that do not contain a gender-affirming care exclusion. *See, e.g.,*
14 BCBSIL_CP_0020053-BCBSIL_CP_0020593.

15
16 **INTERROGATORY NO. 7: Please identify the total population of enrollees, by year,**
17 **in the CHI Plan and each of the plans identified in the responses to Interrogatories Nos. 3**
18 **and 6.**

19 INITIAL ANSWER: BCBSIL incorporates by reference its responses and objections to
20 Interrogatory Nos. 3 and 6. Notwithstanding the foregoing objections, BCBSIL states that it will
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1 meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the
2 complaint.

3 SUPPLEMENTAL ANSWER: BCBSIL states that the average number of enrollees in the
4 CHI Medical Plan is as follows:

5	January 2016-December 2016	35,802
6	January 2017-December 2017	34,437
7	January 2018-December 2018	34,224
8	January 2019-December 2019	34,883
9	January 2020-December 2020	37,641
10	January 2021-December 2021	37,222

11 *See* BCBSIL_CP_0010824.

12
13 **INTERROGATORY NO. 8: Please identify the total number of unique enrollees in**
14 **each plan administered by BCBSIL that contains a gender-affirming care exclusion as**
15 **identified in response to Interrogatory No. 6, or an exclusion that is the same or similar to**
16 **the Transgender Reassignment Surgery exclusion as identified in response to Interrogatory**
17 **No. 3, who have received a denial based on such exclusion from BCBSIL at any time since**
18 **November 23, 2014.**

19 INITIAL ANSWER: BCBSIL incorporates by reference its responses and objections to
20 Interrogatory Nos. 3 and 6. BCBSIL further objects to the term “same or similar” as vague and
21 ambiguous. BCBSIL also objects to the time frame set forth in this Interrogatory as seeking
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1 irrelevant information beyond the applicable statute of limitations. For the reasons stated above,
2 BCBSIL will conduct and produce discovery from November 23, 2016 to the present.

3 Notwithstanding the foregoing objections, BCBSIL states that it will produce responsive
4 Documents sufficient to show the requested information from November 23, 2016 to the present,
5 to the degree it exists.

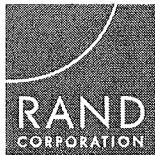
6 SUPPLEMENTAL ANSWER: BCBSIL incorporates by reference its responses and
7 objections to Interrogatory Nos. 3 and 6. BCBSIL further objects to the term “same or similar” as
8 vague and ambiguous. BCBSIL also objects to the time frame set forth in this Interrogatory as
9 seeking irrelevant information beyond the applicable statute of limitations. For the reasons stated
10 above, BCBSIL will conduct and produce discovery from November 23, 2016 to the present.

11 Notwithstanding the foregoing objections, BCBSIL preliminarily states that of the ERISA
12 self-funded group health plans BCBSIL administers, there are approximately 505 unique members
13 of 200 plans who have received a denial based on such an exclusion, for a total claim count of
14 1,952 claims and a total billed charges amount of \$1,326,779.00. BCBSIL reasonably anticipates
15 that these numbers are overinclusive. Discovery is ongoing, and BCBSIL will supplement these
16 preliminary numbers as its internal review and investigation proceeds.

17
18 **INTERROGATORY NO. 9: For each of the plans identified in response to**
19 **Interrogatories Nos. 3 and 6, please identify all individuals who participated in any way in**
20 **the creation, drafting and/or preparation of the Benefit Program Application provision on**
21 **coverage of treatment for gender dysphoria and/or the gender-affirming care exclusion,**
22 **whether employed by BCBSIL or another entity.**

23 ANSWER: BCBSIL incorporates by reference its responses and objections to
24 Interrogatory Nos. 3 and 6. BCBSIL objects that the terms “creation” and “preparation” are vague
25
26
27

Exhibit 13



Assessing the Implications of Allowing Transgender Personnel to Serve Openly

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Srikanth Kadiyala, Jennifer Kavanagh, Charles C. Engel,
Kayla M. Williams, Amii M. Kress

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Preface

U.S. Department of Defense (DoD) policies have rendered both the physical and psychological aspects of “transgender conditions” as disqualifying conditions for accession and allow for the administrative discharge of service members who fall into these categories. However, in July 2015, Secretary of Defense Ashton Carter announced that DoD would “create a working group to study the policy and readiness implications of welcoming transgender persons to serve openly.” In addition, he directed that “decision authority in all administrative discharges for those diagnosed with gender dysphoria¹ or who identify themselves as transgender be elevated to the Under Secretary of Defense (Personnel and Readiness), who will make determinations on all potential separations” (DoD, 2015b).

It is against this backdrop that DoD is considering allowing transgender personnel to serve openly. To assist in identifying the potential implications of such a change in policy, the Office of the Under Secretary of Defense for Personnel and Readiness asked the RAND National Defense Research Institute to conduct a study to (1) identify the health care needs of the transgender population, transgender service members’ potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness implications of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly. This report documents the findings from that study. This research should be of interest to DoD and military service leadership, members of Congress, and others who are interested in the potential implications of allowing transgender personnel to serve openly in the U.S. armed forces.

This research was sponsored by the Office of the Under Secretary of Defense for Personnel and Readiness and conducted within the Forces and Resources Policy Center of the RAND National Defense Research Institute, a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint

¹ *Gender dysphoria* is “discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth” (World Professional Association for Transgender Health, 2011, p. 2).

iv Assessing the Implications of Allowing Transgender Personnel to Serve Openly

Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community.

For more information on the RAND Forces and Resources Policy Center, see www.rand.org/nsrd/ndri/centers/frp or contact the director (contact information is provided on the web page).

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6,630 transgender personnel serving in the active component (AC) and 830–4,160 in the Selected Reserve (SR). Combining survey evidence from multiple states and adjusting for the male/female distribution in the military gave us a midrange estimate of around 2,450 transgender personnel in the AC and 1,510 in the SR.

How Many Transgender Service Members Are Likely to Seek Gender Transition–Related Medical Treatment?

We developed two estimates of demand for gender transition–related medical treatments based on private health insurance data and self-reported data from the National Transgender Discrimination Survey (NTDS). Based on our analyses of available private health insurance data on transition-related health care utilization, we expect only a small number of AC service members to access transition-related health care each year. Our estimates based on private health insurance data ranged from 0.022 to 0.0396 annual claimants per 1,000 individuals. Applied to the AC population, these estimates led to a lower-bound estimate of 29 AC service members and an upper-bound estimate of 129 AC service members annually utilizing transition-related health care, out of a total AC force of 1,326,273 in FY 2014.

We also projected health care utilization using the estimated prevalence of transgender service members and self-reported survey data from the NTDS describing the proportion of the transgender population seeking transition-related treatments by age group. Based on these calculations, we estimated, as an upper-bound, 130 total gender transition–related surgeries and 140 service members initiating transition-related hormone therapy (out of a total AC force of 1,326,273 in FY 2014). To put these numbers in perspective, an estimated 278,517 AC service members accessed mental health services in FY 2014. Hence, we expect annual gender transition–related health care to be an extremely small part of the overall health care provided to the AC population.

What Are the Costs Associated with Extending Health Care Coverage for Gender Transition–Related Treatments?

To determine the budgetary implications of gender transition–related treatment for Military Health System (MHS) health care costs, we again used data from the private health insurance system on the cost of extending coverage for this care to the transgender personnel population. We estimate that AC MHS health care costs will increase by between \$2.4 million and \$8.4 million annually—an amount that will have little impact on and represents an exceedingly small proportion of AC health care expendi-

tures (approximately \$6 billion in FY 2014)¹ and overall DoD health care expenditures (\$49.3 billion actual expenditures for the FY 2014 Unified Medical Program; Defense Health Agency, 2015, p. 22). These estimates imply small increases in annual health care costs; results that are consistent with the low prevalence of transgender personnel and the low annual utilization estimates that we identified.

What Are the Potential Readiness Implications of Allowing Transgender Service Members to Serve Openly?

Similarly, when assessing the readiness impact of a policy change, we found that less than 0.0015 percent of the total available labor-years would be affected, based on estimated gender transition–related health care utilization rates.² This is because even at upper-bound estimates, less than 0.1 percent of the total force would seek transition-related care that could disrupt their ability to deploy.³ Existing data also suggest a minimal impact on unit cohesion as a result of allowing transgender personnel to serve openly. However, we caution that these results rely on data from the general civilian population and foreign militaries, as well as previous integration experiences in the military (e.g., gays, lesbians, women), which may not hold for transgender service members.

What Lessons Can Be Learned from Foreign Militaries That Permit Transgender Personnel to Serve Openly?

There are 18 countries that allow transgender personnel to serve openly in their militaries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom (Polchar et al., 2014). Our analysis focused on the policies of the four countries—Australia, Canada, Israel, and the United Kingdom—with the most well-developed and publicly available policies on transgender military personnel. Several common themes emerged from our analysis of their experiences:

- The service member’s gender is usually considered to have shifted to the target gender in areas such as housing, uniforms, identification cards, showers, and restrooms when a service member publicly discloses an intention to live as the target

¹ AC beneficiaries make up less than 15 percent of TRICARE beneficiaries (Defense Health Agency, 2015).

² We define a labor-year as the amount of work done by an individual in a year.

³ We note that the ability to deploy is not exactly equivalent to readiness. A service member’s readiness could be measured by the ability to participate in required training and exercises, which could be affected by treatments as well. Our estimates include days of inactivity due to medical treatments, which could also apply in these settings.

CHAPTER FIVE

What Are the Costs Associated with Extending Health Care Coverage for Gender Transition–Related Treatments?

In this chapter, we provide estimates for the costs associated with extending health care coverage for gender transition–related treatments. We focused on transgender service members in the AC because they have uniform MHS access. We did not include reserve-component service members in our analyses, but their MHS utilization and the associated cost will be negligible, given their highly limited military health care eligibility. Likewise, we did not include retirees or dependents in the cost analyses because we did not have information on age and sex distribution within these beneficiary categories. Some of these beneficiary categories also have limited eligibility for health care provided through MTFs and may receive their health care through TRICARE coverage in the purchased care setting or through other health insurance plans. Given these unknowns, it was only feasible to estimate the costs of gender transition–related care for AC service members; however, we recommend expanding these analyses in the future to include reserve-component members, as well as all individuals eligible for treatment under TRICARE. For the following analyses, we used demographic characteristics of the 2014 AC population to estimate the cost of providing such services.

Private Health Insurance Cost Estimates

To determine the potential costs of covering gender transition–related health care for transgender service members, we collected information on private health insurers' experiences with covering this care from two sources (Herman, 2013b; State of California, 2012). These actuarial estimates represent the expected increase in health care costs from covering a new set of treatments or a new group of beneficiaries. If employers decide to provide coverage for a particular treatment, these actuarial estimates are translated into premium increases for covered employees. These estimates should be thought of as the expected costs of extending coverage for gender transition–related care to transgender AC service members. Moreover, we note that the military may already be incurring the cost of some transgender treatments, as some patients and their providers use “omissions and ambiguities” to acquire needed care (Roller, Sedlak, and Draucker, 2015, p. 420). For example, a currently serving female-to-male patient

who had undergone a hysterectomy reported taking only the testosterone and not the estrogen prescribed as part of hormone therapy with his endocrinologist’s knowledge and tacit support, while another was trying to get breast reduction surgery due to back pain rather than GD (Parco, Levy, and Spears, 2015, pp. 235–236).

Table 5.1 presents available data from public employers and private firms on the actuarial costs of covering gender transition–related care. It identifies the particular institution, the number of employees and dependents covered, and the identified premium increases due to expanding benefits.

Data from Table 5.1 show, generally, that the actuarial estimates of providing benefits for gender transition–related care increased total premiums (employee + employer share) by only a small fraction of a percent—and, in the most extreme cases, by only approximately 1 percent. Taking a weighted average of most of the information,¹ we estimated that extending insurance coverage to transgender individuals would increase health care spending by 0.038 percent. Applying this figure to total AC health care spending of \$6.27 billion,² we find that covering gender transition–related care will increase AC health care spending by approximately \$2.4 million (see Table 5.2).

The data in Table 5.1 suggest that the University of California, with 100,000 enrollees in its health plan, is one of the key drivers of the 0.038-percent weighted

Table 5.1
Actuarial Estimated Costs of Gender Transition–Related Health Care Coverage from the Literature

Public Employer Data	Actuarially Calculated Premium Increase	Total Contribution (employees + dependents)
City of Seattle	0.19% increase in health care budget	23,090
City of Portland	0.08% increase in health care budget	18,000
City of San Francisco	0% increase in health care budget	100,000
University of California	0% increase in health care budget	100,000
Private Employer Data	Estimate	Total Contribution (employees + dependents)
22 firms	Many employers reported no actuarial costs to adding benefit; estimates range from 0 to 0.2%	Mix of firm sizes
2 firms	Approximately 1% increase in premiums	5,800
1 firm	Much less than 1% increase in premium	77,000

SOURCE: Estimates are from Herman, 2013b, and State of California, 2012.

¹ We did not use information about the firm with 77,000 enrollees because it is not clear what “much less than 1 percent” implies with respect to the premium increase.

² Pharmaceutical and direct and purchased care inpatient and outpatient data calculated from TRICARE costs in Defense Health Agency, 2015.

average result. In addition to the actuarial increases, the University of California also reported a realized increase in health care spending of 0.05 percent, so we recalculated the weighted average figure by replacing the 0-percent estimate with the 0.05 percent estimate. This new calculation raised the overall cost estimate from 0.038 percent to 0.054 percent, or from \$2.4 million to \$3.4 million when applied to the AC. To summarize, our baseline estimates regarding expected gender transition–related health care costs in the AC are between \$2.4 million and \$3.4 million.

Sensitivity Analyses

To understand the potential full range of cost effects in the AC population, we conducted two additional sensitivity analyses similar to those described for our utilization ranges in Chapter Four. We used these sensitivity analyses to account for the skewed male/female distribution in the military population and for the possibility that transgender prevalence is higher in the military population. As in the utilization case, we were not able to identify any sex-specific effects on the premium increases. Thus, as in our utilization analysis, we assume that cost estimates are linearly related to prevalence,³ and cost estimates for male-to-female transitions are twice the cost estimates for female-to-male transitions. Using this relationship, we again calculated natal male– and natal female–specific estimates from the aggregate estimates.

Given the assumption about differing cost effects, we calculated a natal male–specific cost estimate of 0.05 percent and a natal female–specific cost estimate of 0.025 percent for the aggregate premium estimate of 0.038 percent. Applying these sex-specific estimates to the AC male/female distribution increased our initial premium estimate from 0.038 percent to 0.047 percent. A similar calculation can be performed for our realized cost estimate of 0.054 percent. Assuming that gender transition–related health care costs are twice as large for male-to-female transitions as for female-to-male transitions, we calculated a natal male–specific cost effect of 0.072 percent and a natal female–specific cost effect of 0.036 percent. Applying these sex-specific estimates to the AC male/female distribution increased our initial premium estimate from 0.054 percent to 0.067 percent. Applying these newly calculated health care costs to the 2014 AC health care expenditures (\$6.27 billion) increased our estimate of costs from the initial range of \$2.4–3.4 million to a range of \$2.9–4.2 million.

Finally, as noted previously, Gates (2011) and Gates and Herman (2014) calculated that transgender prevalence in the military is approximately twice that in civilian

³ We also note that built into this linearity assumption and how it is applied in the two sensitivity analyses is the assumption that the cost of male-to-female transitions is the same as the cost of female-to-male transitions. Since there is no sex-specific information in the private health insurance cost data, the validity of the cost per case being equivalent is unknown. Padula, Heru, and Campbell (2015) estimated that a male-to-female surgical case is 33 percent more expensive than a female-to-male surgical case, but these estimates were not based on private employer data, so we did not directly incorporate this result into our calculations.

populations. Assuming that this estimate is valid, and, again, assuming that health care costs are linearly related to underlying prevalence, this would increase the above calculated value of \$2.9 million to \$5.8 million and the calculated value of \$4.2 million to \$8.4 million. Table 5.2 summarizes the results from the calculations described in this section.

To better understand the relative importance of our estimates regarding expected AC annual gender transition–related health care spending, we compared our cost estimates to the MHS spending on mental health in 2012 and to total AC health care spending in FY 2014. As Figure 5.1 shows, gender transition–related health care spending is expected to be extremely small compared with MHS spending on mental health (Blakely and Jansen, 2013) and overall AC health care expenditures (Defense Health Agency, 2015).

Summarizing the Estimates

A direct application of estimates from the private health insurance system implies a baseline spending range between \$2.4 million and \$3.4 million for AC gender transition–related health care. Sensitivity analyses that attempt to account for the fact that the male/female distribution in the AC population skews more heavily male than the civilian population and that transgender prevalence might be higher in the military increase this initial range to \$5.8 million to \$8.4 million. The implication is that even in the most extreme scenario that we were able to identify using the private health insurance data, we expect only a 0.13-percent (\$8.4 million out of \$6.2 billion) increase in AC health care spending.⁴

Table 5.2
Estimated Annual MHS Costs of Gender Transition–Related Health Care, Active Component

Analysis Type	Calculations Using Only Actuarial Premium Estimates 0.038% (actuarial)	Calculations Using Actuarial Premiums and Realized Values 0.054% (actuarial + realized)
Baseline	\$2.4 million	\$3.4 million
Sensitivity analysis 1: Adjusts for the male/female distribution in the AC population	\$2.9 million	\$4.2 million
Sensitivity analysis 2: Adjusts for the male/female distribution in the AC population and the assumption that transgender prevalence is twice as high in the military compared to the civilian population	\$5.8 million	\$8.4 million

SOURCE: RAND analysis.

⁴ AC beneficiaries make up less than 15 percent of total TRICARE beneficiaries (Defense Health Agency, 2015).

CHAPTER NINE

Conclusion

By many measures, there are currently serving U.S. military personnel who are transgender. Overall, our study found that the number of U.S. transgender service members who are likely to seek transition-related care is so small that a change in policy will likely have a marginal impact on health care costs and the readiness of the force. We estimate, based on state-level surveys of transgender prevalence, that between 1,320 and 6,630 transgender personnel may be serving in the AC, and 830–4,160 may be serving in the SR. Estimates based on studies from multiple states, weighted for population and the gender distribution in the military, imply that there are around 2,450 transgender service members in the AC and 1,510 in the SR.¹

However, only a small proportion of these service members will seek gender transition–related treatment each year. Employing utilization and cost data from the private health insurance system, we estimated the potential impact of providing this care to openly serving transgender personnel on AC health care utilization and costs. Directly applying private health insurance utilization rates to the AC military population indicated that a very small number of service members will access gender transition–related care annually. Our estimates based on private health insurance data ranged from a lower-bound estimate of 29 AC service members to an upper-bound estimate of 129 annually using care, including those seeking both surgical and other medical treatments.

Using estimates from two states and adjusting for the male/female AC distribution, we also estimate a total of 45 gender transition–related surgeries, with 50 service members initiating transition-related hormone therapy annually in the AC.² We estimate 30 gender transition-related surgeries and 25 service members initiating hormone therapy treatments in the SR. These are likely to be upper-bound estimates, given the nonrepresentative sample selection procedures used in the NTDS. Furthermore, the best prevalence estimates that we were able to identify were from two of the more transgender-tolerant states in the country, and the empirical evidence that trans-

¹ Estimates are based on FY 2014 AC and SR personnel numbers.

² For hormone therapy recipients, the number of treatments and recipients is the same, and these estimates can be treated as counts of individuals.

gender prevalence is higher in the military than in the general population is weak. As a point of comparison, we also compared these estimated values to mental health utilization in the AC population overall. Using data from McKibben et al. (2013), we calculated that approximately 278,517 AC service members accessed mental health care treatment in 2014, the implication being that health care for the transgender population will be a very small part of the total health care provided to AC service members across the MHS.

With respect to health care costs, actuarial estimates from the private health insurance sector indicate that covering gender transition–related care for transgender employees increased premiums by less than 1 percent. Taking a weighted average of the identified firm-level data, we estimate that covering transgender-related care for service members will increase the U.S. military’s AC health care spending by only 0.038–0.054 percent. Using these baseline estimates, we estimate that MHS health care costs will increase by between \$2.4 million and \$8.4 million. These numbers represent only a small proportion of FY 2014 AC health care expenditures (\$6.27 billion) and the FY 2014 Unified Medical Program budget (\$49.3 billion). This is consistent with our estimate of relatively low AC rates of gender transition–related health care utilization in the MHS.

Similarly, when considering the impact on readiness, we found that using either the prevalence-based approach or the utilization-based approach yielded an estimate of less than 0.0015 percent of total labor-years likely to be affected by a change in policy. This is much smaller than the current lost labor-years due to medical care in the Army alone.

Even if transgender personnel serve in the military at twice the rate of their prevalence in the general population and we use the upper-bound rates of health care utilization, the total proportion of the force that is transgender and would seek treatment would be less than 0.1 percent, with fewer than 130 AC surgical cases per year even at the highest utilization rates. Given this, true usage rates from civilian case studies imply only 30 treatments in the AC, suggesting that the total number of individuals seeking treatment may be substantially smaller than 0.1 percent of the total force. Thus, we estimate the impact on readiness to be negligible.

We conclude with some general recommendations and insights based on the experiences of foreign militaries that permit transgender individuals to serve openly—specifically, Australia, Canada, Israel, and the United Kingdom. Our case studies provide some guidance that policymakers should consider as they develop policies to govern the employment of transgender personnel in the U.S. military. These cases also suggested a number of key implementation practices if a decision is made to allow transgender service members to serve openly:

- Ensure strong leadership support.
- Develop an explicit written policy on all aspects of the gender transition process.

- Provide education and training to the rest of the force on transgender personnel policy, but integrate this training with other diversity-related training and education.
- Develop and enforce a clear anti-harassment policy that addresses harassment aimed at transgender personnel alongside other forces of harassment.
- Make subject-matter experts and gender advisers serving within military units available to commanders seeking guidance or advice on gender transition-related issues.
- Identify and communicate the benefits of an inclusive and diverse workforce.

Exhibit 1

Transcript of the Testimony of

Frank G. Fox, Ph.D.

Date: 9/12/2022

C.P. vs BLUE CROSS BLUE SHIELD OF ILLINOIS



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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C.P., by and through his)	
parents, PATRICIA PRITCHARD)	
AND NOLLE PRITCHARD; and)	
PATRICIA PRITCHARD,)	
)	No. 3:20-cv-06145-RJB
Plaintiffs,)	
)	
vs.)	
)	
BLUE CROSS BLUE SHIELD OF)	
ILLINOIS,)	
)	
Defendant.)	

REMOTE
VIDEOTAPED DEPOSITION UPON ORAL EXAMINATION OF
FRANK G. FOX, Ph.D.
September 12, 2022

Taken remotely
Witness location: Seattle, Washington

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Frank G. Fox, Ph.D.

9/12/2022

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9/12/2022

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FRANK G. FOX, Ph.D. - September 12, 2022

I N D E X

EXAMINATION BY: Page(s)

Atty. Payton 5

* * *

EXHIBITS FOR IDENTIFICATION:

Exhibit 1	Declaration of Frank G. Fox	15
Exhibit 2	Amended Deposition Notice	23
Exhibit 3	Quinn Study	72
Exhibit 4	Williams Institute study	79

Frank G. Fox, Ph.D.

9/12/2022

1 Q. (By Atty. Payton) I'm sorry, I didn't hear your
2 answer.

3 A. On net, they go up.

4 Q. Do you know that because you performed the
5 calculation with the correct data set?

6 A. That's correct.

7 Q. Okay. Did you produce that to counsel?

8 A. No, I did not.

9 Q. Do you intend to?

10 A. If so asked.

11 Q. So essentially, your Table 4 is outdated, right?
12 In Exhibit 1?

13 A. That would be correct.

14 Q. It needs to be updated with the correct data?

15 A. It needs -- if we wanted to update to 2022 Williams
16 Institute figures, that would be updated, yes.

17 Q. Hold on a second, because I want to close out that
18 issue. So I'm jumping ahead, because I was going to get to
19 that later. Bear with me a moment. I'm finding where in my
20 outline I wanted to talk about that discrepancy.

21 Dr. Fox, was that just a mistake?

22 ATTY. HAMBURGER: Object as to form.

23 THE WITNESS: I don't know that I would

24 characterize it as a mistake. We received the -- or we

25 obtained the 2022 Williams report after I initially prepared

Frank G. Fox, Ph.D.

9/12/2022

1 these tables. And so I updated it in the sources underneath
2 that table, but I didn't update the numbers themselves.
3 They're still valid numbers. They're just not updated to
4 the most recent Williams Institute figures, they're still
5 valid.

6 Q. (By Atty. Payton) When did you receive the '22
7 update?

8 A. Would have been sometime this summer. I believe
9 late this summer, but I don't have the precise date.

10 Q. Okay. Okay. For purposes of today, we'll continue
11 to do the deposition based on your old Table 4, but I do
12 understand that Table 4 is outdated and you have an update,
13 correct?

14 A. I do have an updated Table 4, yes.

15 Q. When you did the update to Table 4, did you change
16 your methodology at all, how you calculated it?

17 A. No, I did not.

18 Q. When did you do the update on Table 4?

19 A. This weekend.

20 Q. And what led you to do that?

21 A. I was reviewing my expert report.

22 Q. And your expert report is dated August 19, '22,
23 correct?

24 ATTY. HAMBURGER: Object as to form.

25 THE WITNESS: I don't remember the precise

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 25)

Exhibit 15

Exhibit 1

From: [Payton, Gwendolyn](#)
To: [Omar Gonzalez-Pagan](#); [Bedard, Stephanie](#); [Neeleman, John](#); [Rountree, Ian](#); [Phelps, Zoe](#)
Cc: [Ele Hamburger](#); [Jenny Pizer](#); [Daniel Gross](#); [Stacy Hoffman](#)
Subject: RE: [External] C.P. v. BCBSIL (No. 3:20-cv-06145-RJB) - Request for consent to file consolidated Daubert Motion
Date: Wednesday, October 26, 2022 1:29:40 PM

That is fine.

Gwendolyn Payton

Kilpatrick Townsend & Stockton LLP

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From: Omar Gonzalez-Pagan <ogonzalez-pagan@lambdalegal.org>
Sent: Wednesday, October 26, 2022 1:28 PM
To: Bedard, Stephanie <sbedard@kilpatricktownsend.com>; Payton, Gwendolyn <GPayton@kilpatricktownsend.com>; Neeleman, John <JNeeleman@kilpatricktownsend.com>; Rountree, Ian <IRountree@kilpatricktownsend.com>; Phelps, Zoe <ZPhelps@kilpatricktownsend.com>
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Subject: C.P. v. BCBSIL (No. 3:20-cv-06145-RJB) - Request for consent to file consolidated Daubert Motion

Counsel,

I am writing to ask if defendant objects to our filing a single consolidated motion to exclude expert testimony (up to 30 pages in length, less parts excluded under LCR 7(e)), rather than filing three separate motions. We would appreciate a response by 5pm PT today.

Thank you in advance for your consideration.

Omar

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