THE HONORABLE ROBERT J. BRYAN

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,

Plaintiffs,

vs.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

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

BLUE CROSS BLUE SHIELD OF ILLINOIS'S RESPONSE TO PLAINTIFFS' CONSOLIDATED MOTION TO EXCLUDE EXPERT TESTIMONY OF MICHAEL LAIDLAW, M.D., LAWTON R. BURNS, Ph.D., and SCOTT CARR, Ph.D.

ORAL ARGUMENT REQUESTED

NOTE ON MOTION CALENDAR: NOVEMBER 18, 2022

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

I. INTRODUCTION

The Court should deny Plaintiffs' consolidated motion to exclude the expert testimony of Michael Laidlaw, M.D., Lawton R. Burns, Ph.D., and Scott Carr, Ph.D. in its entirety. All three experts offer opinions they are qualified to give that are relevant to the issues in this litigation.

Dr. Laidlaw demonstrates that there is legitimate ongoing debate in the medical community regarding transgender-related services. Dr. Burns demonstrates the impacts of rising health care costs on consumers and the benefits of plan choice for employees. Dr. Carr's rebuttal report was timely disclosed and is relevant to rebut the unreliable methodology and conclusions concerning numerosity proffered by Plaintiffs' expert, Dr. Frank Fox.

II. FACTUAL BACKGROUND

A. Dr. Laidlaw.

Dr. Laidlaw is a board-certified endocrinologist who evaluates and treats patients with hormonal and/or gland issues. Payton Decl., Ex. A ("Laidlaw Report") at ¶¶ 2, 5. He has expertise regarding the appropriate treatment of people with gender dysphoria. Dr. Laidlaw rebuts the opinions proffered by Plaintiffs from Dr. Randi Ettner, Dr. Dan Karasic, and Dr. Loren Schechter that there is uniform consensus in the medical community about the appropriate treatment for people with gender dysphoria, and thus the only explanation for transgender exclusions in employer-sponsored health plans is animus.

Dr. Laidlaw disagrees with the opinions of these experts that gender dysphoria is an immutable, permanent condition. In contrast, Dr. Laidlaw shows that "that is not the consensus in the relevant community and there is much debate and disagreement about whether gender dysphoria is always permanent." *Id.* ¶ 15. Dr. Laidlaw shows that there is "ongoing debate and study in the medical community regarding gender affirmative treatment," and the "medical community is divided on many issues related to the appropriate medical care for gender identity and the necessity or value of gender affirmative care." *Id.* ¶ 14. The ongoing debate in the medical community is "especially true for minors," and the "quality of care received by minors who undergo irreversible gender-affirming treatments" is a "recurring problem." *Id.* ¶¶ 14-16. This

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

problem results in part, because "gender dysphoria treatments are so entangled with advocacy." *Id.* ¶ 16.

Dr. Laidlaw opines that treatment interventions on behalf of individuals diagnosed with gender dysphoria must be held to the same scientific standards as other medical treatments – *i.e.*, that they must be optimal, efficacious, and safe. *Id.* ¶ 11. For minors in particular, Dr. Laidlaw opines that "any treatment which alters biological development in children should be used with extreme caution and regarded as a last resort." *Id.* Dr. Laidlaw disagrees that the surgery done on C.P. was appropriate given the lack of informed consent. *Id.* ¶¶ 206-18.

B. Dr. Burns.

Dr. Lawton R. Burns is the James Joo-Jin Kim Professor at the Wharton School of the University of Pennsylvania, where he serves as a professor in the Departments of Management and Health Care Management. Payton Decl., Ex. B ("Burns Report") at ¶ 1. Dr. Burns has a Ph.D. in organizational sociology, a Masters in Business Administration in hospital administration, and his research focuses on healthcare distribution issues. *Id.* ¶¶ 5-6.

Dr. Burns rebuts Plaintiffs' assertion that the only explanation for transgender exclusions in employer-sponsored health plans is animus. Dr. Burns shows that (1) plan designs that contain various iterations of exclusions for transgender-related services are common; (2) those plan designs "allow greater economic flexibility for employers and further their ability to make health coverage available at customized price-points"; (3) eliminating the ability to purchase health plans with exclusions for transgender-related services would be harmful to consumers; and (4) individuals would ultimately bear the burden of price increases. *Id.*, § III(i)-(iv).

C. Dr. Carr.

Dr. Carr is a Senior Managing Director and leader of the Competition Class Actions Practice at Ankura Consulting Group. Payton Decl., Ex. C ("Carr Rebuttal Report") at 1. Dr. Carr has a Ph.D. in Business Administration and a Ph.D. in Industrial and Operations Engineering; an M.S.E. in Industrial and Operations Engineering; an M.S.E. in Construction Management and Engineering; and a B.S.E. in Mechanical Engineering. *Id.*

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

Dr. Carr rebuts the amended report offered by Plaintiffs' expert Dr. Frank G. Fox. He shows that Dr. Fox's estimate of the number of transgender people enrolled in BCBSIL ERISA self-funded plans is misleading and unreliable because Dr. Fox (1) "fails to account for the marked uncertainty in the published data upon which he relies"; (2) "assumes that the prevalence of transgender people in the relevant Group Plans is identical to the prevalence of transgender people in the general population"; (3) "assumes that all Group Members in these plans reside in Illinois"; and (4) "failed to exclude duplicate data entries in the data on which he relies." *Id.* at 5. Dr. Carr further opines that Dr. Fox's estimates are methodologically incorrect, misleading, and unreliable because Dr. Fox "misinterprets, misuses, and overstates the published data upon which he relies." *Id.* BCBSIL disclosed Dr. Carr's rebuttal report twenty-two days after Plaintiffs disclosed Dr. Fox's Amended Report. *See* Ex. C.

III. ARGUMENT

A. Dr. Laidlaw's Rebuttal Opinion Is Both Relevant and Reliable.

Dr. Laidlaw rebuts the opinions of Dr. Ettner, Dr. Karasic, and Dr. Schechter. Rebuttal disclosures of expert testimony are intended "'to contradict or rebut evidence on the same subject matter identified by another party' in its expert disclosures." *In re High-Tech Emp. Antitrust Litig.*, No. 11-CV-2509-LHK, 2014 WL 1351040, at *3 (N.D. Cal. Apr. 4, 2014) (quoting Fed. R. Civ. P. 26(a)(2)(D)(ii)). Rebuttal testimony is proper "as long as it addresses the same subject matter that the initial experts address." *Perez v. State Farm Mut. Auto. Ins. Co.*, No. C 06-01962-JW, 2011 WL 8601203, at *8 (N.D. Cal. Dec. 7, 2011).

Dr. Laidlaw's opinion is both relevant and reliable.

1. Dr. Laidlaw's opinion is relevant to rebut Plaintiffs' expert opinions.

a. BCBSIL is entitled to rebut Plaintiffs' expert opinions on the medical consensus concerning gender-affirming treatment.

Plaintiffs recognize that, in order to establish that the exclusion in the CHI Plan discriminates on the basis of sex, they must prove that the transgender-related surgery for which they seek coverage is "well-established, widely accepted, and evidence-based." Cross-Motion for

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

Summary Judgment, Dkt. 96, at 22. Plaintiffs' three medical experts all claim there is no legitimate debate about what the proper standard of care is for people with gender dysphoria. This is incorrect.

Dr. Laidlaw testifies that reasonable medical experts disagree regarding transgender-related services (1) in general and (2) specifically with respect to named plaintiff C.P. This lack of medical consensus regarding gender-related services defeats Plaintiffs' discrimination claim. In *Whitman-Walker Clinic, Inc. v. United States Department of Health & Human Services*, 485 F. Supp. 3d 1 (D.D.C. 2020), *appeal dismissed*, No. 20-5331, 2021 WL 5537747 (D.C. Cir. Nov. 19, 2021), the court upheld the Department of Health and Human Services ("HHS")'s 2020 Rule,[1] which concluded that categorical exclusions for transgender-related services did not discriminate on the basis of sex, because "HHS thoroughly considered the evidence Plaintiffs raise, but nevertheless concluded that 'there is no medical consensus to support one or another form of treatment for gender dysphoria.'" 485 F. Supp. 3d at 48-49 (citation omitted). Likewise, here the Court cannot find that the exclusion discriminates on the basis of sex because there is no medical consensus regarding transgender-related services.

In response to Plaintiffs' experts, Dr. Laidlaw shows that "[t]here is ongoing debate and study in the medical community regarding gender affirmative treatment." Laidlaw Report ¶ 14. Dr. Laidlaw explains that "[t]he medical community is divided on many issues related to the appropriate medical care for gender identity, and the necessity or value of gender affirmative care. This is especially true for minors." *Id.*

Dr. Laidlaw's testimony analyzes the reports of Drs. Ettner, Schechter, and Karasic in detail and rebuts their categorical assertions that transgender-related services are always medically necessary by demonstrating that there is ongoing debate and study in the medical community regarding to the appropriate medical care for gender dysphoria and the necessity or value of certain transgender-related services. Laidlaw Report ¶ 14. In particular, Dr. Laidlaw demonstrates the

[1] Nondiscrimination in Health and Health Education Programs or Activities, 85 Fed. Reg. 37,160 (June 19, 2020) (the "2020 Rule").

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

considerable division in the medical community about appropriate treatment for minors such as C.P., as most medical professionals agree that treatment altering biological development in children should be used with extreme caution and regarded as a last resort. *Id.* ¶ 11. He explains that many medical professionals remain concerned about the quality of medical care received by minors who undergo irreversible transgender-related services. *Id.* ¶ 16.

Drs. Ettner and Karasic also opine that there is no legitimate dispute that transgender-related services were medically necessary for the named plaintiff, C.P. Dkt. 104-1, Ex. B, ¶¶ 82-83; Ex. E ¶¶ 76-77. Dr. Laidlaw rebuts this and explains the consensus medical opinion is that C.P. should not have received a double mastectomy as a minor because (1) there is insufficient evidence available supporting such treatments; and (2) there is no evidence C.P. saw a qualified mental health professional to assess "sufficient mental capacity to give informed consent." Laidlaw Report ¶¶ 181, 221-23. While Plaintiffs critique Dr. Laidlaw's reliance on C.P.'s medical records rather than on an evaluation of C.P., none of Plaintiffs' own experts conducted any psychiatric evaluation of C.P. either.

The Ninth Circuit has already found Dr. Laidlaw's opinions on this subject credible in a similar case. In *Doe v. Snyder*, the Ninth Circuit relied on Dr. Laidlaw's testimony when it found there were disagreements in the medical community regarding the value of transgender-related services. 28 F.4th 103, 110-13 (9th Cir. 2022). The lower court had held that (1) the exclusion was not discriminatory and did not violate Section 1557, and (2) the plaintiffs failed to prove irreparable harm if the plaintiff, a minor, did not receive the surgery for which benefits were sought. *Id.* at 110. The Ninth Circuit affirmed. *Id.* at 112-13. The Ninth Circuit acknowledged the disagreements in the medical community regarding the value of gender-affirming care:

> Defendant proffered competing expert testimony that WPATH's Standards of Care are not universally endorsed and questioning whether there have been any high-quality studies showing that male chest reconstruction surgery is safe, effective, or optimal for treating gender dysphoria. For example, Defendant's expert noted that, as of 2016, the Centers for Medicare & Medicaid Services declined to issue a National Coverage Determination for gender reassignment surgery for Medicare patients with gender dysphoria "because the clinical evidence is inconclusive for the Medicare population." In its order, the district court explicitly noted that

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

> testimony in describing the evidence from Defendant's expert.
>
> . . . . [G]ender dysphoria often resolves itself by adulthood and, specifically citing the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, that "[i]n natal females, persistence has ranged from 12% to 50%." The district court explicitly noted that testimony as well in describing the evidence from Defendant's expert. Also, given the evidence presented that the human brain continues to mature well into a person's twenties, it was reasonable for a district court to question whether Doe appreciated the impact of irreversible surgery and to require further counseling before "authorizing" surgery.

Id. at 112.

After considering the testimony of Dr. Laidlaw and others, the Ninth Circuit concluded that the plaintiffs had failed to prove medical necessity because "Doe failed to provide a declaration from any psychiatrist or medical doctor who is treating him that attested to the necessity and suitability of the surgery in his particular case" and because "Doe's expert psychiatrist had not opined as to whether Doe himself is a suitable candidate for surgery and had not met or examined Doe." *Id*. at 112-13.

Here, Plaintiffs likewise fail to present any testimony from a treating psychiatrist, instead relying on testimony from Plaintiffs' non-treating experts who opine regarding the medical necessity of C.P.'s double mastectomy after meeting via Zoom for no more than two hours. Dkt. 104-1, Ex. B, ¶¶ 82-83; Ex. E ¶¶ 76-77. This is particularly troubling because Plaintiffs' own experts agree with the Endocrine Society's Guidelines recommending that a minor should be diagnosed by a qualified mental health professional, with training and expertise in (1) child and adolescent gender development, and (2) child and adolescent psychopathology. Dkt. 104-1, Ex. C at 63:2-17; Ex. F at 51:23-53:2; Ex. K at 46:6-47:6.

b. Dr. Laidlaw's criticisms of the WPATH standards of care are relevant and have been cited with approval by the Ninth Circuit.

Dr. Laidlaw responds to the testimony of each of Plaintiffs' experts that for patients with gender dysphoria, the *only* acceptable standard of care is the approach endorsed by WPATH. Laidlaw Decl. ¶ 12. Plaintiffs' experts are all closely affiliated with WPATH and rely almost exclusively on the WPATH standards for their opinions. WPATH claims hormone blockers,

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

followed by hormone therapy, followed by irreversible surgery is the "only effective treatment" for gender dysphoria. *Whitman-Walker*, 485 F. Supp. 3d at 48-49.

The concerns Dr. Laidlaw expresses regarding Plaintiffs' experts' rote reliance on WPATH echo concerns voiced by the Ninth Circuit and other courts.[2] In *Doe v. Snyder*, in which Dr. Laidlaw testified as an expert, the district court concluded that the medical consensus did not support the value of certain transgender-related services, and the Ninth Circuit affirmed, emphasizing that the evidence offered by the defendants contradicted testimony from the plaintiffs' WPATH-affiliated experts. 28 F.4th 103 at 112; *see id.* ("Defendant proffered competing expert testimony that WPATH's Standards of Care are not universally endorsed and questioning whether there have been any high-quality studies showing that male chest reconstruction surgery is safe, effective, or optimal for treating gender dysphoria."). Other courts agree that WPATH's position does not reflect the medical consensus. *See Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019) ("[T]he WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery.").

Likewise, in *Whitman-Walker,* the court rejected the plaintiffs' reliance on WPATH, noting that HHS "explicitly considered" the WPATH standards in promulgating the 2020 Rule and finding that HHS's reasoned consideration of and rejection of WPATH's advocacy was not arbitrary and capricious. *See* 485 F. Supp. 3d at 48 ("HHS also indicated its agreement with certain commenters 'that the 2016 Rule relied excessively on . . . . WPATH,'" and that WPATH is "an advocacy group.").

c. Dr. Laidlaw's disagreement with Dr. Reed demonstrates the lack of consensus in the medical community on transgender-related services.

Plaintiffs claim that any difference between Dr. Laidlaw's opinion and that of BCBSIL's 30(b)(6) witness, Dr. Kim Reed, renders Dr. Laidlaw's opinion irrelevant. Motion at 11. This is

[2] Recently, WPATH further separated itself from the mainstream medical science, issuing new standards that eliminated age minimums. WPATH's new standards originally included a minimum age for treatments – 14 years old for cross-sex hormones and 15 years old for mastectomies. C.P. received hormone treatments at age 11 and a mastectomy at age 14, well below the minimum age for both treatments. WPATH later issued a "correction" that eliminated the age minimums for such treatments. *See* Dkt. 94-1, Ex. F.

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

incorrect.

The fact that Dr. Reed and Dr. Laidlaw disagree demonstrates the difference of opinion in the medical community regarding transgender-related services. While BCBSIL refers to a medical policy that references WPATH's guidelines when administering claims where there is no exclusion in the plan, that does not change the fact that "the medical community is divided on many issues related to gender identity, including the value of various 'gender-affirming' treatments for gender dysphoria." *Whitman-Walker*, 485 F. Supp. 3d at 48-49 (citation omitted). As the Ninth Circuit concluded when relying on Dr. Laidlaw's testimony, "WPATH's Standards of Care are not universally endorsed." *Doe v. Snyder*, 28 F. 4th at 112; *see also Gibson*, 920 F.3d at 221 ("[T]he WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery.").

2. Dr. Laidlaw's is qualified to opine in this case, and his opinions are reliable.

a. Dr. Laidlaw is qualified to offer his opinion, which is based on reputable scientific and medical literature and specialty society organizations.

Plaintiffs claim Dr. Laidlaw's opinion is solely based on his own opinions, not scientific literature. Motion at 14. This is false. As his bibliography demonstrates, Dr. Laidlaw relied on extensive scientific and medical literature in forming his opinion. Payton Decl., Ex. D. Dr. Laidlaw has also written numerous articles on gender identity and gender dysphoria. *Id.*

Dr. Laidlaw relies on the opinions of credible specialty society organizations, including the Endocrine Society, of which Dr. Laidlaw is a member. Payton Decl., Ex. E; Laidlaw Report ¶¶ 26-30. The Endocrine Society issues guidelines titled "Endocrine Treatment of Gender-Dysphoric / Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guidelines" (the "Endocrine Society Guidelines"). Laidlaw Report ¶ 26. Those Guidelines include a grading system indicating the strength of the society's recommendations and the quality of the evidence presented to support its recommendations. *Id.* ¶¶ 22, 24. For example, the Endocrine Society concludes that the quality of scientific evidence for the treatment of adolescents with gender

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

dysphoria is rated "very low-quality evidence" and "low quality evidence."[3] *Id.* ¶ 27.

Plaintiffs' own experts Drs. Ettner, Karasic, and Schechter cite to the Endocrine Society's Guidelines in their expert disclosures. *See* Dkt. 104-1, Ex. B ¶ 54; Ex. E ¶¶ 35-36; Ex. D ¶ 26. Dr. Schechter refers to the Endocrine Society as "the leading professional organization devoted to research on hormones and the clinical practice of endocrinology." *Id.*, Ex. D. ¶ 26. During their depositions, all three experts agreed that the Endocrine Society's guidelines are authoritative on mental health care; education for minors regarding the impacts of transgender-related services on fertility; and informed consent for minors. *Id.*, Ex. C at 63:2-17, 75:10-76:9; Ex. F at 51:23-53:2, 76:18-77:25, 85:21-86:13; Ex. K. at 46:6-47:6, 50:15-51:18.

Plaintiffs attempt to paint Dr. Laidlaw's opinions as extremist and outlier, but this attack lacks merit. Dr. Laidlaw rebuts specific statements made by Plaintiffs' experts by relying on scientific and medical literature and information from the American Psychiatric Association. *See, e.g.*, Laidlaw Report at ¶ 7 (rebutting Dr. Ettner's unsupported statement that gender identity is immutable and biologically based); *id.* ¶¶ 8-9 (rebutting Dr. Karasic's opinions regarding regret and desistance). Dr. Laidlaw's opinion rebuts Plaintiffs' expert opinions and is therefore relevant. It is also reliable and aligns with the opinions of the leading specialty society organization for hormones and endocrinology.

b. Dr. Laidlaw is qualified to opine regarding the intersection of gender dysphoria and endocrinology.

Plaintiffs claim that Dr. Laidlaw is not qualified to opine regarding gender dysphoria because he is an endocrinologist, rather than a mental health professional. But as Dr. Laidlaw explains in his report, endocrinologists are widely-considered the appropriate experts related to gender dysphoria because hormonal and gland disorders "can cause or be associated with psychiatric symptoms, such as depression, anxiety, and other psychiatric symptoms." Laidlaw

[3] WPATH's standards of care, in contrast, do not provide any grading system indicating the strength of the evidence relied upon and thus "do not follow recognized procedures for establishing the guidelines as the fruit of genuine scientific method." *Id.* ¶ 24.

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Report ¶ 5. Dr. Laidlaw "frequently assess[es] and treat[s] patients demonstrating psychiatric symptoms and determine whether their psychiatric symptoms are being caused by a hormonal issue, gland issue, or a different cause." *Id.* In fact, as Dr. Laidlaw explains, the "reason that endocrinologists become involved in treatment of gender dysphoria is that gender dysphoria, a psychiatric issue, may be interrelated with hormone and gland disorders." *Id.*

Indeed, Plaintiffs' own experts acknowledge that gender dysphoria is often treated through hormone treatments. *See, e.g.*, Dkt. 104-1, Ex. B at ¶¶ 42-44; Ex. E at ¶¶ 36-39. Likewise, the Endocrine Society – the leading specialty organization on hormones – issues the authoritative guidelines for the diagnosis and treatment of gender dysphoria, and Plaintiffs' own experts consider those guidelines authoritative. Dkt. 104-1, Ex. B ¶ 54; Ex. E ¶¶ 35-36; Ex. D ¶ 26.

Plaintiffs rely on the district court's exclusion of a different endocrinologist in *Kadel v. Folwell*, No. 1:19-CV-272, 2022 WL 3226731, at *8-10 (M.D.N.C. Aug. 10, 2022). The endocrinologist in that case espoused an opinion on the "'Gender Transition Industry,' 'Cancel Culture,'" and conspiracies surrounding "political activists working to 'silence open public debate,'" and he referred to gender dysphoria as a "social contagion." *Id.* at *10. The district court found that endocrinologist proffered an opinion based on moral, faith-based, and political objections.[4]

Here, Dr. Laidlaw offers no such faith-based or politically-motivated testimony. Dr. Laidlaw offers science-based opinions concerning the "ongoing debate and study in the medical community regarding gender affirmative treatment," and explains the "medical community is divided on many issues related to the appropriate medical care for gender identity and the necessity or value of gender affirmative care," particularly for minors. Laidlaw Report ¶ 14. Dr. Laidlaw is qualified to offer these opinions, and his opinion regarding the intersection of endocrinology and gender dysphoria is reliable.

[4] Plaintiffs also rely repeatedly upon a short excerpt of a non-public hearing transcript from *Dekker v. Marstiller*, No. 4:22-CV-00325-RH-MAF (N.D. Fla. Oct. 12, 2022), in which Dr. Laidlaw recently testified. Plaintiffs do not disclose that after hearing testimony from Dr. Laidlaw, the court agreed, denied the motion for preliminary injunction, and declined to enjoin the State of Florida's rule barring Medicaid payments for transgender-related services. *Id.* at [Dkt. 64].

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

c. Plaintiffs mischaracterize the scope of Dr. Laidlaw's opinions.

Plaintiffs claim Dr. Laidlaw's testimony is limited to minors. Motion at 12. But Dr. Laidlaw's testimony on this issue is more nuanced – he focuses on whether the individual seeking transgender-related services has the capacity to consent. Payton Decl., Ex. F. Dr. Laidlaw, the Endocrine Society, others in the medical community, and the Ninth Circuit all express concern about the ability for minors to provide informed consent for irreversible transgender-related services. Laidlaw Report ¶¶ 170-75; *see also* Dkt. 104-1, Ex. L ("Endocrine Society Guidelines") at 3. The Ninth Circuit expressed this concern in *Doe v. Snyder*, which affirmed the district court's refusal to issue an injunction because the minor plaintiffs in that case "had not demonstrated that they are capable of providing informed consent." 28 F.4th at 110.

Plaintiffs ask the Court to exclude Dr. Laidlaw for opining on "reparative therapy," Motion at 13, but Dr. Laidlaw does not have any such opinion or use that term anywhere in his report. When asked about how "other people" use the term "reparative therapy" during his deposition, Dr. Laidlaw responded that he did not know. Payton Decl., Ex. G.

Plaintiffs also seek to exclude Dr. Laidlaw based on his opinion on "desistance," which Dr. Laidlaw describes 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." *Id.*, Ex. H. Dr. Laidlaw opines that desistance is medically recommended until a person reaches the age of majority for puberty blockers, cross-sex hormones, and reconstructive surgery based on issues of informed consent for minors and the lack of sufficient, long term evidence on the side effects of these treatments on fertility, sterilization, ability to breastfeed, and bone density. *Id.*; Laidlaw Report ¶¶ 123-28, 178. Dr. Laidlaw's opinion on desistance is reliable and rebuts Plaintiffs' experts, who opine that there is uniform consensus in medical community supporting the treatment of people of all ages with gender dysphoria and who fail to adequately address the potential side effects of such treatments.

B. Dr. Burns' Opinion Is Both Relevant and Reliable.

The opinions offered by Dr. Burns are both relevant and reliable and would assist the trier of fact. Plaintiffs argue that the only explanation for the exclusions is animus towards transgender

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

individuals. Dr. Burns explains how the healthcare market for ERISA self-funded works, and that employers decide the design of their plans and then hire a third-party administrator to handle claims. Burns Report ¶¶ 17-18. He shows that (1) plan designs that contain various iterations of exclusions for transgender-related services are common; (2) those plan designs "allow greater economic flexibility for employers and further their ability to make health coverage available at customized price-points"; (3) eliminating the ability to purchase health plans with exclusions for transgender-related services would be harmful to consumers; and (4) individuals would ultimately bear the burden of price increases. *Id.*, § III(i)-(iv).

1. Dr. Burns' opinion is relevant.

Plaintiffs' only argument as to the relevancy of Dr. Burns' opinion is that anti-discrimination law does not permit courts to consider "cost" to justify discrimination. Motion at 19. But that is not the issue – the questions is whether there was discrimination in the first place. Dr. Burns' testimony is directly relevant to why the exclusions are not discriminatory in the first instance, and why some employers chose to offer plans with exclusions.

The cases Plaintiffs cite do not support their position. In *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), the Supreme Court held that the Court **should** take into account the resources available when evaluating a state's defense to an ADA discrimination claim. *See id.* at 597 ("In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.").

Sch. Bd. Of Nassau Cnty., Fla. v. Arline, 480 U.S. 273 (1987), is off-point. It involved a claim under the Rehabilitation Act brought by a teacher who was fired due to her susceptibility to tuberculosis and does not address whether cost or financial impact could be considered. *E.E.O.C. v. Puget Sound Log Scaling & Grading Bureau*, 752 F.2d 1389, 1390-91 (9th Cir. 1985), is likewise inapplicable because it involved whether a Supreme Court decision applied retroactively to require an employer to cover prior claims for pregnant spouses of employees. Moreover, *Puget*

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1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

Sound recognized, as Dr. Burns does, that "[a]ny increase in expense to the insurer will doubtless be the subject of bargaining between employees and employers with regard to the desirable extent of insurance coverage and costs." *Id.* at 1394.

Plaintiffs categorically state that there is no possible justification for BCBSIL to administer any transgender-related services exclusion. Plaintiffs are wrong – there are statutory, economic, religious, and scientific rationales for these exclusions. By arguing that there is no justifiable rationale, Plaintiffs open the door to Dr. Burns' testimony supporting those justifiable economic rationales.

2. Dr. Burns' opinion is reliable.

Plaintiffs move to exclude Dr. Burns as unreliable because (1) they claim his testimony about plan choice is not based on data; (2) they claim he has no expertise related to transgender-related services and ignored evidence that the costs of transgender-related services are *de minimis*; and (3) they claim Dr. Burns did not follow any "methodology" in drafting his report. Plaintiffs misstate Dr. Burns' testimony in each respect.

a. Dr. Burns' opinion on plan choice is reliable and properly based on data provided by BCBSIL.

Dr. Burns' opinions on plan choice are limited in scope, grounded in his expertise in the managed healthcare industry, and properly based on information provided by BCBSIL. Based on his expertise in the industry, Dr. Burns explains how the ERISA self-funded market works and opines that employers and employee bear the burden of higher health care costs in several ways: (1) higher health care costs can translate into higher premiums; (2) members' cost-share payments may increase; (3) as health care prices rise, some employers may cease offering insurance to their employees altogether; and (4) some employers may choose to offer increased health care costs through lower wages. Burns Report ¶ 27. Offering employees choices in plan design helps employers mitigate the impacts of higher health care costs.

In reaching his conclusions, Dr. Burns properly relied on BCBSIL data demonstrating that many of the employers for whom BCBSIL administers self-funded plans with exclusions also offer

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SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

plan designs to employees with coverage for transgender-related services, so that employees can choose a plan best suited for their circumstances. *See* Payton Decl., Ex. I. Dr. Burns' opinions regarding the impact of plan design choice on higher healthcare costs are both relevant to the claims at issue in this case and are reliable.

b. Plaintiffs misconstrue the scope of Dr. Burns' testimony in this case.

Plaintiffs claim that Dr. Burns' opinion should be excluded because he "has no background experience regarding gender-affirming care." Motion at 21. This argument is a red herring. Dr. Burns does not profess to have medical expertise in the treatment of gender dysphoria or the medical necessity of transgender-related services. None of Dr. Burns' conclusions require him to have medical expertise in the diagnosis or treatment of gender dysphoria. Rather, based on his over forty years of experience conducting academic research on health care delivery networks and his review of reputable literature on medical groups and professional service agreements, Dr. Burns reaches the following conclusions: (1) plan designs containing varied exclusions for transgender-related services are common; (2) plan designs with such exclusions provide employers with flexibility to offer health care at accessible and customized price points; and (3) eliminating the ability to purchase plans with certain exclusions can harm consumers who will ultimately bear the burden of price increases. Burns Report ¶¶ 14-15.

Plaintiffs also make a number of arguments that that evince disagreement but do not support exclusion of Dr. Burns' testimony. Plaintiffs claim that Dr. Burns should have considered the cost impact of the removal of exclusions for transgender-related services. Motion at 23. However, the data that Plaintiffs cite addresses largely addresses fully-insured plans over large population sets. *Id.* As Dr. Burns opines, self-funded and fully insured plans is an apples-to-oranges comparison. In fully-insured plans, the insurance risk rests with the insurer and is aggregated over the entire population. Burns Report ¶ 17. By comparison, for self-insured plans such as the CHI Plan, the employer "directly assume[s] financial responsibility for employees' medical claims and administrative costs and use their own money to pay health care costs" and must pay claims out of its own pocket. *Id.*

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

Finally, Plaintiffs critique Dr. Burns for not utilizing some form of "cost-benefit analysis" as part of his opinion. Motion at 24. Although Plaintiffs are vague about what type of "cost-benefit analysis" they believe would be useful (and they have offered none themselves), Dr. Burns conducted an analysis of the health care value chain, based in part on his analysis of the Kaiser Family Foundation and the Health Research & Educational Trust's Annual Survey of Employer Health Benefits and other reputable scientific literature on the impact of rising health care costs on employees. Burns Report ¶¶ 23-26. Dr. Burns is eminently qualified to opine on these issues, and his analysis is reliable.

C. Dr. Carr's Rebuttal Opinion Was Timely Disclosed and is Relevant.

Plaintiffs move to exclude the rebuttal expert opinion of BCBSIL expert Scott Carr, Ph.D. as untimely and irrelevant. Dr. Carr's rebuttal opinion was timely disclosed and is relevant to rebutting the opinions offered by Plaintiffs' expert Dr. Frank G. Fox. For the reasons stated herein and in BCBSIL's surreply in response to Plaintiffs' Subjoined Motion to Strike the Expert Report of Scott Carr [Dkt. 99], Plaintiffs' attempts to exclude Dr. Carr should be denied.

1. Dr. Carr's rebuttal opinion was disclosed in a timely manner.

a. BCBSIL timely disclosed the rebuttal report of Dr. Scott Carr within 30 days of the amended report of Dr. Frank Fox.

The deadline to serve expert witness disclosures in this action was June 17, 2022. *See* Dkt. 48. While Plaintiffs identified Dr. Frank Fox as an expert by name on that date, Plaintiffs did not serve Dr. Fox's initial report until August 19, 2022 and did not serve his Amended Report until September 29, 2022. *See* Dkt. 104-1, Exs. G-H.

The parties were required to disclose their rebuttal witnesses within 30 days after the other party's disclosure. *See* Fed. R. Civ. P. 26(a)(2)(D)(ii). This Court has recognized that Fed. R. Civ. P. 26(a)(2)(D)(ii) requires that rebuttal reports may be submitted within 30 days of any expert report unless the Court has ordered a different deadline. *Romero v. Washington*, No. C20-1027-TL-MLP, 2022 WL 952242, at *2 (W.D. Wash. Mar. 30, 2022).

It is undisputed that Dr. Carr's rebuttal report was disclosed well within the 30-day window

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

contemplated by Rule 26(a)(2)(D)(ii). On October 21, 2022, twenty-two days after the disclosure of Dr. Fox's Amended Report, BCBSIL disclosed the Carr Rebuttal Report in response. *See* Dkt. 104-3, Ex. S.

Plaintiffs claim that Dr. Fox's Amended Report "applie[d] the same methodology employed in his original report to new figures." Motion at 27. This is incorrect: Dr. Fox materially revised his report to incorporate new statistics from the Williams Institute into his analysis. Regardless of whether Dr. Fox's material revisions to his initial report impacted his ultimate conclusions, BCBSIL has the right to respond to that Amended Report within 30 days.

Plaintiffs also claim that the Carr Rebuttal Report is untimely merely because it references Dr. Fox's initial report as well as his Amended Report. The mere fact that the Carr Rebuttal Report references Dr. Fox's initial report does not render his rebuttal untimely. It makes practical sense that the Carr Rebuttal Report would respond to Dr. Fox's revised conclusions by referencing both versions of Dr. Fox's reports. Plaintiffs do not dispute that Dr. Carr's rebuttal report analyzes the data from Dr. Fox's Amended Report in detail. *See* Carr Rebuttal Report at 1, 6-8, 13, 15-20 (analyzing the updated data in the revised tables of Dr. Fox's Amended Report).

b. Plaintiffs' disclosure of Dr. Fox's Amended Report was itself untimely.

Plaintiffs' timeliness argument is contradictory. Plaintiffs' disclosure of Dr. Fox's Amended Report in late September 2022 was itself untimely. The deadline to serve opening expert reports was June 17, 2022, but Plaintiffs did not serve Dr. Fox's Amended Report until over two months later, on September 29, 2022, 104 days after the expert disclosure cutoff. *See* Dkt. 104-1, Ex. H. Plaintiffs cannot have it both ways. If Dr. Carr's rebuttal report is untimely, so too is Dr. Fox's Amended Report. Thus, if the Court grants Plaintiffs' Motion to Strike the Carr Rebuttal Report, it should also exclude Dr. Fox's untimely Amended Report.

c. Plaintiffs Have Not Alleged Any Prejudice.

Plaintiffs do not, and cannot, argue they were prejudiced by BCBSIL's timely disclosure of the Carr Rebuttal Report. If Plaintiffs truly had concerns regarding their ability to respond to the rebuttal report, they could have taken Dr. Carr's deposition or requested more time to respond, but

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

they have not sought to do so.

2. Dr. Carr's rebuttal opinion is relevant to rebut Dr. Fox's unreliable methodology and conclusions regarding numerosity.

BCBSIL was entitled to rebut Plaintiffs' numerosity expert, whose methodology and conclusions are unreliable. *See Perez*, 2011 WL 8601203, at *8 (finding rebuttal testimony proper "as long as it addresses the same subject matter that the initial experts address"); *Baker*, F. Supp. 3d at 896 (overruling objection to expert's rebuttal report because rebuttal expert properly responded to same subject matter as affirmative expert); *In re High-Tech Emp. Antitrust Litig.*, 2014 WL 1351040, at *3 (rebuttal testimony is intended "to contradict or rebut evidence on the same subject matter identified by another party in its expert disclosures").

As explained in BCBSIL's *Daubert* Motion to exclude Dr. Fox, Dkt. 103, Dr. Carr establishes that Dr. Fox's methodology is fatally flawed because (1) his estimate of individuals who would have been expected to seek gender-related care does not include C.P., the named plaintiff; (2) his calculation of the estimated number of transgender enrollees fails to take into account wide-ranging credible intervals in the data on which he relies; (3) he assumes that the prevalence of transgender persons in the relevant BCBSIL plans is identical to the prevalence of transgender persons in the general population; (4) he includes duplicate enrollees in his enrollment counts, which improperly inflates his enrollee estimates; (5) he includes meaningless variables in his calculations; (6) his assumption that 0.075 percent of enrollees in relevant BCBSIL plans seek gender-related care annually is misleading; (7) his estimates are biased upwards; and (8) he improperly cherry-picked transgender population percentages from the data on which he relies. *See* Dkt. 103 at 16-19.

Plaintiffs claim that Dr. Carr "offers no opinions of his own on numerosity." Motion at 29. That should come as no surprise to Plaintiffs given that BCBSIL is not contesting numerosity, and the purpose of Dr. Carr's opinion is to rebut the methodological flaws in Dr. Fox's Amended Report.

Plaintiffs claim that BCBSIL "conced[es] that Dr. Fox's numerosity conclusion is correct."

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

Id. at 29. This is false. BCBSIL has shown that Dr. Fox's methodology *and* conclusions are irrelevant, unsound, and unsupported. *See* Dkt. 103 at 16-19.

IV. CONCLUSION

BCBSIL requests that this Court deny Plaintiffs' Consolidated Motion to exclude the testimony of Dr. Laidlaw, Dr. Burns, and Dr. Carr in its entirety.

Dated this 10th day of November, 2022.

KILPATRICK TOWNSEND & STOCKTON LLP

By */s/ Gwendolyn C. Payton*

Gwendolyn C. Payton, WSBA No. 26752
gpayton@kilpatricktownsend.com
John R. Neeleman, WSBA No. 19752
jneeleman@kilpatricktownsend.com
1420 Fifth Ave., Suite 3700
Seattle, WA 98101
Telephone: (206) 626-7714
Facsimile: (206) 623-6793

Counsel for Blue Cross Blue Shield of Illinois

CERTIFICATE OF SERVICE

I certify that on the date indicated below I caused a copy of the foregoing document, BLUE CROSS BLUE SHIELD OF ILLINOIS'S RESPONSE TO PLAINTIFFS' CONSOLIDATED MOTION TO EXCLUDE EXPERT TESTIMONY OF MICHAEL LAIDLAW, M.D., LAWTON R. BURNS, Ph.D., and SCOTT CARR, Ph.D. to be filed with the Clerk of the Court via the CM/ECF system. In accordance with their ECF registration agreement and the Court's rules, the Clerk of the Court will send e-mail notification of such filing to the following attorneys of record:

Eleanor Hamburger SIRIANNI YOUTZ SPOONEMORE HAMBURGER 3101 WESTERN AVENUE STE 350 SEATTLE, WA 98121 206-223-0303 Fax: 206-223-0246 Email: ehamburger@sylaw.com	☑ by CM/ECF ☐ by Electronic Mail ☐ by Facsimile Transmission ☐ by First Class Mail ☐ by Hand Delivery ☐ by Overnight Delivery
Jennifer C Pizer LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC 4221 WILSHIRE BLVD., STE 280 LOS ANGELES, CA 90010 213-382-7600 Email: jpizer@lambdalegal.org	☑ by CM/ECF ☐ by Electronic Mail ☐ by Facsimile Transmission ☐ by First Class Mail ☐ by Hand Delivery ☐ by Overnight Delivery
Omar Gonzalez-Pagan LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC. (NY) 120 WALL STREET 19TH FLOOR NEW YORK, NY 10005 212-809-8585 Email: ogonzalez-pagan@lambdalegal.org	☑ by CM/ECF ☐ by Electronic Mail ☐ by Facsimile Transmission ☐ by First Class Mail ☐ by Hand Delivery ☐ by Overnight Delivery

DATED this 10th day of November, 2022.

KILPATRICK TOWNSEND & STOCKTON LLP

By: */s/ Gwendolyn C. Payton*
Gwendolyn C. Payton, WSBA #26752

Counsel for Blue Cross Blue Shield of Illinois

KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946