The Honorable Robert J. Bryan

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard, individually and on behalf of others similarly situated; and PATRICIA PRITCHARD,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

No. 3:20-cv-06145-RJB

PLAINTIFFS' REPLY IN SUPPORT OF THEIR CONSOLIDATED MOTION TO EXCLUDE EXPERT TESTIMONY OF MICHAEL LAIDLAW, M.D., LAWTON R. BURNS, PH.D., AND SCOTT CARR, PH.D.

Note on Motion Calendar:
November 18, 2022

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I. LAW AND ARGUMENT[1]

A. Dr. Laidlaw's Testimony Should Be Excluded.

BCBSIL asks that the Court deny Plaintiffs' motion to exclude Dr. Laidlaw's testimony but fails to meet its burden to prove that Dr. Laidlaw is qualified to proffer his testimony, and that his testimony is reliable and relevant to the case at hand. *See Chawla v. W. Washington Univ.*, No. 2:20-CV-1129-BJR, 2021 U.S. Dist. LEXIS 248202, at *4 (W.D. Wash. Dec. 30, 2021).

1. Dr. Laidlaw is Unqualified.

BCBSIL argues that Dr. Laidlaw "has expertise regarding the appropriate treatment of people with gender dysphoria" (Dkt. No. 115 at 1) but offers no record citation in support of such statement. Dr. Laidlaw is not qualified to render any of the opinions in his declaration. *See* Dkt. No. 107 at 6–10.

Specifically, Dr. Laidlaw (1) has never conducted any original, peer-reviewed research about gender identity, transgender people, or gender dysphoria; (2) has not published any scientific, peer-reviewed literature on gender dysphoria or transgender people; (3) has never diagnosed a patient with gender dysphoria; (4) has only treated one patient with gender dysphoria (nearly two decades ago, prior to the existence of the DSM-5's gender dysphoria diagnosis); and (5) is not a psychiatrist, psychologist, or mental health care provider of any kind qualified to ***diagnose*** gender dysphoria or to opine on the reliability of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5"). *See* Dkt. No. 107 at 8–9. Dr. Laidlaw "is not a surgeon and has no experience with surgery for gender dysphoria and, therefore, is not qualified to testify to the risks associated with surgery or the standard of care used by surgeons for obtaining informed consent for surgery." *Kadel v. Folwell*, 2022 U.S. Dist. LEXIS 103780, at *33 (M.D.N.C. June 10, 2022). These facts are not disputed by BCBSIL.

[1] Consistent with Plaintiffs' opening brief, this consolidated reply is less than the combined total page limit of 18 pages had three separate briefs been filed. *See* LCR 7(e)(3).

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Nonetheless, BCBSIL argues that Dr. Laidlaw is qualified to testify regarding the intersection of gender dysphoria and endocrinology because, according to Dr. Laidlaw's ipse dixit, "hormonal and gland disorders" "can cause or be associated with psychiatric symptoms, such as depression, anxiety, and other psychiatric symptoms." Dkt. 115 at 9–10 (citing to Laidlaw Report at ¶5). Standing alone, Dr. Laidlaw's ipse dixit is insufficiently supported to merit admission. *Bell v. Boeing Co.*, No. 20-CV-01716-LK, 2022 U.S. Dist. 73964, at *24 (W.D. Wash. Apr. 22, 2022) ("An expert must bridge the analytic gap with more than bald assertions or his own ipse dixit."). Moreover, this new argument is inconsistent with BCBSIL's own position throughout this case and Dr. Laidlaw's own testimony. Throughout this case, BCBSIL has repeatedly asserted that the diagnosis and assessment of gender dysphoria can only be done by a "psychiatrist or other 'qualified mental health professional.'" Dkt. No. 118 at 3; *see also*, *e.g.*, Dkt. No. 87 at 22; Dkt. No. 103 at 12 (BCBSIL arguing that surgeon who has actual expertise providing gender-affirming surgery and has studied and written on the subject is not "qualified to opine on the efficacy of those surgeries as treatment for the underlying mental health disorder of gender dysphoria"). Dr. Laidlaw himself opines (wrongly) that a patient should only "be provided an assessment by a qualified psychologist or psychiatrist who does not follow the WPATH GAT model." Laidlaw Report at ¶177.

To be clear, the Endocrine Society Guidelines, consistent with the WPATH Standards of Care, recommend that "a mental health provider for adolescents" diagnose gender dysphoria in adolescents. Dkt. No. 104-1, *Exh. L* (hereinafter "ES Guidelines"), at 3869, 3870 (Recommendation 1.2). The WPATH Standards of Care have a similar requirement. Dkt. No. 116-5 at 13. Specifically, WPATH recommends that those "who assess, refer, and offer therapy to … adolescents presenting with gender dysphoria," among other things, "[m]eet the competency requirements for mental health professionals working with adults." Those competency requirements establish that:

> [t]he training of mental health professionals competent to work with gender dysphoric adults … may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work,

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> mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling."

Id. at 22. Dr. Laidlaw admits that he is not a psychiatrist, psychologist, or other mental health care provider. Dkt. No. 108-2 ("Laidlaw Dep.") at 47:16–47:17; Dkt. No. 108-5 ("*Dekker* Hrg. Tr.") at 7:20–8:2. He admits he has never diagnosed any patients with gender dysphoria and only treated one patient with gender dysphoria nearly two decades ago by reissuing a prescription. Laidlaw Dep. at 43:11–43:17, 45:21–46:3; *Dekker* Hrg. Tr. at 11:19–11:21, 12:13–12:16. According to BCBSIL's own arguments, Dr. Laidlaw is not qualified to testify about the diagnosis and assessment of gender dysphoria. BCBSIL cannot have it both ways.

BCBSIL does not address and therefore concedes to Plaintiffs' argument that Dr. Laidlaw is not qualified to testify as to C.P.'s mental health. *See* Dkt. 107 at 9, n.8.

BCBSIL argues that Dr. Laidlaw "relied on extensive scientific evidence and medical literature in forming his opinion," "[a]s his bibliography demonstrates." Dkt. No. 115 at 8.[2] But BCBSIL and Dr. Laidlaw fail to explain how the listed literature supports Dr. Laidlaw's opinions, without which the bibliography is meaningless. Moreover, "[m]erely reading literature in a scientific field does not qualify a witness—even an educated witness—as an expert." *Kadel*, 2022 U.S. Dist. LEXIS 103780, at *31; *see also Lebron v. Sec'y of the Fla. Dep't of Children & Families*, 772 F.3d 1352, 1368 (11th Cir. 2014). And Dr. Laidlaw has only familiarized himself with this literature just recently. *See Dekker* Hrg. Tr. at 15:24–16:2.[3]

In sum, Dr. Laidlaw is "not qualified by background, training, or expertise to opine" on any of the factual issues in this case. *Lebron*, 772 F.3d at 1369. Like the defendants' endocrinologist in *Kadel*, Dr. Laidlaw is "not qualified to offer expert opinions on the diagnosis

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[2] BCBSIL omits that Dr. Laidlaw's bibliography was produced ***after*** Dr. Laidlaw's deposition and ***long after*** the deadline for expert disclosures in this case. Hamburger Decl., *Exh. 1*; *Exh.* 2 at 63:16–64:21.

[3] BCBSIL misleads the Court when it states that "Dr. Laidlaw has also written numerous articles on gender identity and gender dysphoria." Dkt. No. 115 at 8. Dr. Laidlaw has not published any scientific, peer-reviewed literature on gender dysphoria or transgender people. Laidlaw Dep. at 42:10–42:22. His only publications relating to gender dysphoria in a peer-reviewed journal are letters to the editor, which are not based on any original research or scientific study, and which he cannot confirm are subjected to peer-review. Laidlaw Dep. at 31:14–39:23; *Dekker* Hrg. Tr. at 9:21–11:18.

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of gender dysphoria, the DSM, gender dysphoria's potential causes, the likelihood that a patient will 'desist,' or the efficacy of mental health treatments." *Kadel,* 2022 U.S. Dist. LEXIS 103780, at *31. Dr. Laidlaw is also not qualified to opine on the efficacy of the medicinal or surgical treatment of gender dysphoria, or to provide any opinions specific to C.P., let alone C.P.'s mental health. Put simply, BCBSIL has not come close to meeting its burden that Dr. Laidlaw is qualified.

2. Dr. Laidlaw's Opinions are Not Relevant.

To be relevant, Dr. Laidlaw's opinions need to help the "the trier of fact in understanding evidence or in determining a fact in issue." *Easton v. Asplundh Tree Experts, Co.*, No. C16-1694RSM, 2017 U.S. Dist. LEXIS 147508, at *12 (W.D. Wash. Sept. 12, 2017). They do not.

BCBSIL argues that Dr. Laidlaw's opinions are relevant because they show "that '[t]here is ongoing debate and study in the medical community regarding gender affirmative treatment.'" Dkt. No. 115 at 4 (quoting to Laidlaw Report, ¶14). Not only is that wrong, it is also beside the point. The issue before this Court is not whether gender-affirming care, including surgery, can be medically necessary. Plaintiffs and BCBSIL agree that it can be. *See* Dkt. No. 84-4 at 7; Dkt. No. 108-15 at 40:12–41:20. Rather, the issue is whether BCBSIL's administration of categorical exclusions of gender-affirming care is unlawful sex discrimination under Section 1557 of the ACA. BCBSIL fails to explain how Dr. Laidlaw's testimony is relevant in any way.

Dr. Laidlaw cites to no peer-reviewed literature or medical organization in the United States that concludes that medical treatment for gender dysphoria is never medically necessary, because there is none. Ultimately, Dr. Laidlaw's opposition to gender-affirming care is not scientific but rather ideological. Indeed, ***Dr. Laidlaw opposes affirmation of a transgender person's identity in any circumstances***. *See, e.g.*, *Dekker* Hrg. Tr. at 87:15–87:21; *id.* at 39:22–40:19. The fact that Dr. Laidlaw is an endocrinologist does not alter the unscientific nature of his opinions. Dr. Laidlaw's personal and ideological opinions regarding the treatment of gender dysphoria are wholly irrelevant here.

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That a doctor (who does not diagnose or treat gender dysphoria) vehemently opposes gender-affirming care does not "demonstrate[] [a] lack of consensus in the medical community on transgender-related services," as BCBSIL argues. Dkt. No. 115 at 7–8. Consensus does not require unanimity of every medical professional. Rather, it means broad general agreement. *Cf. Pitsilides v. Barr*, No. CV 3:19-01736, 2021 U.S. Dist. LEXIS 224331, at *18 (M.D. Pa. Nov. 19, 2021) ("[A] successful showing of … consensus does not require demonstrating unanimity, but rather an acknowledged existence of a general agreement is enough.") (cleaned up). Even Dr. Laidlaw admits that his "opposition to gender-affirming care for the treatment of gender dysphoria in youth and adults is contrary to the vast majority of medical associations' recommendations." *Dekker* Hrg. Tr. at 25:22–26:1; *see also* Dkt. No. 107 at 17–19.

What is more, BCBSIL cannot rely on Dr. Laidlaw's testimony to implicitly undermine the testimony of its Rule 30(b)(6) witness, Dr. Kim Reed. BCBSIL neither disclaims Dr. Reed's testimony nor presents any authority as to why it is not bound by it. *See* 7 James Wm. Moore, et al., *Moore's Federal Practice*, §30.25[3] (3d ed. 2016); *see also* Dkt. No. 107 at 11–12.

Dr. Laidlaw's testimony about medical consensus is irrelevant because the motivations for the exclusions do not matter under anti-discrimination law. "[I]t's irrelevant what [BCBSIL] might call its discriminatory practice, how others might label it, or what else might motivate it." *Bostock v. Clayton Cnty., Georgia*, 140 S. Ct. 1731, 1744 (2020); *see also Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am., UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 199–200 (1991) ("Whether an employment practice involves disparate treatment through explicit facial discrimination does not depend on why the employer discriminates but rather on the explicit terms of the discrimination. … The beneficence of an employer's purpose does not undermine the conclusion that an explicit gender-based policy is sex discrimination[.]"); *Frank v. United Airlines, Inc.*, 216 F.3d 845, 854 (9th Cir. 2000).

BCBSIL spills much ink making misleading characterizations about *Whitman-Walker Clinic, Inc. v. United States Department of Health & Human Services*, 485 F.Supp.3d 1 (D.D.C. 2020), and *Doe v. Snyder*, 28 F.4th 103 (9th Cir. 2022), asserting that those cases rejected the

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WPATH Standards of Care, agreed that there was a lack of medical consensus on the treatment of gender dysphoria, and that the Ninth Circuit relied on Dr. Laidlaw. None of this is true.

Whitman-Walker involved a preliminary injunction in an APA challenge to the 2020 Rule implementing Section 1557 of the ACA. "Mindful of the 'narrow' scope of arbitrary-and-capricious review" and "[w]ithout entering the merits of the debate," the court concluded that, at that juncture, the plaintiffs had not demonstrated the determination to eliminate the 2016 Rule's explicit prohibition on categorical coverage exclusions "to be arbitrary and capricious simply by pointing to evidence that the agency plainly took into account." *Id.*, 485 F.Supp.3d at 46, 48–49. When speaking of WPATH and the medical consensus, the court simply *described the Trump administration's views as articulated in the preamble to the 2020 Rule*. BCBSIL misleads the Court when it claims that the *Whitman-Walker* court came to any conclusions about the WPATH Standards of Care or the medical consensus since it explicitly stated it was not doing so.

Similarly, BCBSIL mischaracterizes *Doe v. Snyder*, in which the Ninth Circuit considered the appeal of the denial of a mandatory preliminary injunction, noting that, "The standard for issuing a mandatory preliminary injunction is high." *Doe*, 28 F.4th at 111. As such, the Ninth Circuit's review was limited to reviewing "the district court's evaluation of Plaintiffs' alleged harm [as] a factual determination … for clear error, which exists if the finding is illogical, implausible, or without support in inferences that may be drawn from the facts in the record." *Id.* at 111–12. The Ninth Circuit thus "h[e]ld only that even accepting the merits of Doe's underlying claim of discrimination, he ha[d] not shown that the district court's denial of a mandatory preliminary injunction was unreasonable or unsupported by the record" "that was before the court at that time"—"a ***preliminary*** record." *Id.* at 113 (emphasis added).[4] The Ninth Circuit ***did not*** (1) rely on Dr. Laidlaw, (2) disavow the WPATH Standards of Care, or (3) find that there was a lack of medical consensus regarding the treatment of gender dysphoria. Nor did it reach any independent

[4] Unlike here, in *Doe v. Snyder*, the admissibility of Dr. Laidlaw's opinions was not challenged by the plaintiffs, and the district court based its decision solely on the declarations filed by the parties, without the benefit of cross-examination.

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conclusions, as BCBSIL misleadingly claims. This is unlike *Edmo v. Corizon, Inc.*, where the Ninth Circuit ***explicitly agreed*** with the district court's finding that "[t]here are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups" to the WPATH Standards of Care. *Edmo v. Corizon, Inc.*, 935 F.3d 757, 791 (9th Cir. 2019).

Finally, BCBSIL bears the burden of demonstrating that Dr. Laidlaw's testimony is admissible, but BCBSIL provides no response to Plaintiffs' arguments that Dr. Laidlaw's opinions about the following topics are irrelevant: (1) Dr. Laidlaw's opinions about "controversies" in other countries, Dkt. No. 107 at 12, n.12; (2) Dr. Laidlaw's opinions about desistance, *id.* at 15, n.14; and (3) Dr. Laidlaw's opinions about the causes of gender dysphoria, *id.* at 16. "The Court may consider [BCBSIL's] failure to respond to [Plaintiffs'] argument on these … issues as an admission that [Plaintiffs'] argument has merit." *Lexington Ins. Co. v. Swanson*, 2007 U.S. Dist. LEXIS 37620, n.9 (W.D. Wash. May 23, 2007).

3. Dr. Laidlaw's Opinions are Not Reliable.

BCBSIL appears to concede that much of Dr. Laidlaw's opinions are unreliable. Specifically, BCBSIL offers no real response to any of the following arguments, which amounts to an admission that the arguments have merit. *See Lexington Ins. Co.*, 2007 U.S. Dist. LEXIS 37620, n.9.

One. Plaintiffs challenged the reliability of Dr. Laidlaw's opinion that "no person under the age of majority [should] be prescribed puberty blockers, hormones or surgery as treatment for gender dysphoria," which Dr. Laidlaw admitted "was simply his opinion." Dkt. No. 107 at 12–13 (quoting Laidlaw Dep. at 136:1–137:9). BCBSIL offers no response on why this ipse dixit should be considered reliable and "an expert's self-serving assertion that his conclusions were derived by the scientific method [cannot] be deemed conclusive." *Whisnant v. United States*, No. C03-5121-FDB, 2006 U.S. Dist. LEXIS 76321, at *7 (W.D. Wash. Oct. 11, 2006).

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Two. Plaintiffs challenged the reliability of Dr. Laidlaw's opinions about desistance. *See* Dkt. 107 at 15–16. Specifically, Plaintiffs noted, among other things, that no gender-affirming medical or surgical care is provided to prepubertal children; that Dr. Laidlaw admits that the "desistance" studies on which he relies speak only to preadolescent youth who were diagnosed with gender identity disorder under the DSM-III or the DSM-IV, and do not pertain to "desistance" of youth diagnosed with gender dysphoria under the DSM-5; and that Dr. Laidlaw does not know of any studies documenting "desistance" among adolescents (people over the age of 12) or adults. *Id.* BCBSIL's conclusory response that "Dr. Laidlaw's opinion on desistance is reliable" (Dkt. No. 115 at 11) is not enough. Like one of the defendants' experts in *Kadel*, Dr. Laidlaw "is not qualified … to offer expert opinions on the rates of desistance and 'de-transitioning' among gender dysphoric patients." *Kadel*, 2022 U.S. Dist. LEXIS 103780, at *46.

BCBSIL argues that "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." Dkt. No. 115 at 11. But Dr. Laidlaw cites no support for this opinion. Instead, when asked for the basis of his opinion that a young person's gender identity might change, Dr. Laidlaw cavalierly compared transgender youth's gender identities to "think[ing] they're a butterfly for a while" or "the $6 million man for a little while." Laidlaw Dep. at 145:7–145:12. Dr. Laidlaw could not offer any peer-reviewed literature in support of his opinion and only provided as its basis that "[i]t's just an observation that anyone would see, I think, with children." *Id.* at 145:14–145:17. Dr. Laidlaw's personal opinion, without any scientific grounding, is unreliable. *See Bell*, 2022 U.S. Dist. 73964, at *24. And "[g]eneralized common sense does not rise to the level of expert opinion solely because it is offered by someone with an academic pedigree." *Fedor v. Freightliner, Inc.*, 193 F.Supp.2d 820, 832 (E.D. Pa. 2002).

BCBSIL also contends that Dr. Laidlaw does not have an opinion on "reparative therapy" (Dkt. No. 107 at 11), but that is not true. Dr. Laidlaw opines that an acceptable mode of treatment for gender dysphoria includes "psychosocial treatment that ***helps the young person align their***

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internal sense of gender with their physical sex." Laidlaw Decl. at ¶65 (emphasis added); Laidlaw Dep. at 138:24–139:10. But Washington State has outlawed such efforts under the rubric of "conversion therapy." *See* RCW 18.130.180(27). "Conversion therapy" is defined as "a regime that seeks to change an individual's … gender identity" and that "includes … practices commonly referred to as 'reparative therapy.'" RCW § 18.130.020(4)(a). Also, the American Psychological Association defines "Gender identity change efforts (GICE)" as "a range of techniques used by mental health professionals and non-professionals with the goal of changing gender identity, gender expression, or associated components of these to be in alignment with gender role behaviors that are stereotypically associated with sex assigned at birth" and "opposes GICE because such efforts put individuals at significant risk of harm and encourages individuals, families, health professionals, and organizations to avoid GICE." Declaration of Eleanor Hamburger in Support of Plaintiffs' Reply on Consolidated Motion to Exclude Expert Testimony ("Hamburger Decl."), *Exh. 3*. Because such fringe opinions are so outside the mainstream and have no evidentiary support, and because the treatment they recommend is harmful and outlawed, the Court should find Dr. Laidlaw's opinions about reparative therapy, the mode of treatment for gender dysphoria, and desistance to be unreliable.

Three. Plaintiffs challenged Dr. Laidlaw's opinion that gender dysphoria may be caused by social pressures. *See* Dkt. No. 107 at 16 (citing to Laidlaw Rep., ¶¶ 16, 23–24). BCBSIL makes no attempt to defend this opinion by Dr. Laidlaw and therefore concedes it.

Four. Plaintiffs have argued that Dr. Laidlaw does not have "any experience with … WPATH … upon which to base his criticisms," and that he is therefore not qualified to testify about the credibility of WPATH. *See* Dkt. No. 107 at 16–17 (quoting *Kadel*, 2022 U.S. Dist. LEXIS 103780, at *33). BCBSIL offers no response to this argument, nor to the fact that Dr. Laidlaw bases his opinions on this subject solely on a single conversation with one psychologist and the fact that WPATH published the Standards of Care. Laidlaw Dep. at 92:2–92:12. His opinions are therefore unreliable and must be excluded. *See Sudre v. The Port of Seattle*, No. C15-0928JLR, 2016 U.S. Dist. LEXIS 166882, at *61 (W.D. Wash. Dec. 2, 2016) (excluding

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expert's "testimony as to the standard of care," in part, because the proffered expert did not have "knowledge of or experience with the relevant standard of care for policies and practices").

Five. Dr. Laidlaw's opinions about the medical consensus surrounding gender-affirming care are unreliable. *See* Dkt. No. 107 at 17–19. He points to no peer-reviewed literature or medical organization in the United States that disagrees with the provision of this care. Indeed, Dr. Laidlaw admits that his "opposition to gender-affirming care for the treatment of gender dysphoria in youth and adults is contrary to the vast majority of medical associations' recommendations." *Dekker* Hrg. Tr. at 25:22–26:1. He rejects the standard of care adopted or supported by the American Medical Association, American Psychological Association, American Psychiatric Association, Endocrine Society, Pediatric Endocrine Society, American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, and American College of Physicians. *See Dekker* Hrg. Tr. at 29:16–36:18.

BCBSIL claims that Dr. Laidlaw's opinions rely on the Endocrine Society's Guidelines and information from the American Psychiatric Association. Dkt. No. 115 at 8, 9. The exact opposite is true. Dr. Laidlaw ***disagrees*** with the substantive positions of the Endocrine Society and the American Psychiatric Association on these issues. Both the Endocrine Society and American Psychiatric Association support the provision of medicinal and surgical gender-affirming care as medically necessary for the treatment of gender dysphoria. The official position of the Endocrine Society is that:

> Medical intervention for transgender youth and adults (including puberty suppression, hormone therapy and medically indicated surgery) is effective, relatively safe (when appropriately monitored), and has been established as the standard of care. Federal and ***private insurers should cover such interventions as prescribed by a physician*** as well as the appropriate medical screenings that are recommended for all body tissues that a person may have.

Hamburger Decl., *Exh. 4* (emphasis added). And the American Psychiatric Association:

> 1. Recognizes that appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments.

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2. Advocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment.

3. ***Opposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician***.

Hamburger Decl., *Exh. 5* (emphasis added). BCBSIL cannot cloak Dr. Laidlaw's opinions with reliability by saying he relies on the Endocrine Society's Guidelines and information from the American Psychiatric Association, when he actually does the opposite.

* * *

In sum, Dr. Laidlaw is not qualified to offer expert testimony in this case, and his opinions are not relevant or reliable. BCBSIL failed to meet its burden to prove Dr. Laidlaw's opinions to be admissible, and by failing to respond to many of Plaintiffs' arguments, has admitted the merits of such arguments. Dr. Laidlaw's opinions and testimony should be excluded in their entirety.

B. Dr. Burns' Testimony is Neither Relevant Nor Reliable.

BCBSIL argues, without citation, that Plaintiffs assert that "the only explanation for transgender exclusions in employer-sponsored health plans is animus" such that Dr. Burns' testimony is relevant to rebut that claim. Dkt. No. 115 at 3, 14. This is simply untrue. Plaintiffs make no assertion about the intent of BCBSIL's employer clients. There is no evidence about employers' intent because BCBSIL never asks the employers for any justification for the Exclusion before it agrees to administer it. Dkt. No. 84-6 at 72:21–73:7. BCBSIL will administer the Exclusions regardless of any justification offered by employers. Dkt. No. 84-9 at 28:14–17.

In any event, the motivations of the employers that directed BCBSIL to administer the Exclusions do not matter in this case (nor would their motivations matter if a claim of sex discrimination under Section 1557 were applied directly to them). *See Bostock*, 140 S. Ct. at 1744; *Johnson Controls, Inc.*, 499 U.S. at 199–200. This issue was recently addressed in *Lange v. Houston Cnty.*, 2022 U.S. Dist. LEXIS 98874 (M.D. Ga. June 2, 2022). In that case, a plaintiff employee challenged an exclusion of coverage of gender-affirming care by a governmental employer under Equal Protection grounds, as well as Title VII. The trial court concluded that the

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Exclusion was a form of ***facial*** sex discrimination in violation of Title VII, such that the intent of the employer was irrelevant:

> [A]s *Bostock* makes clear … [d]enying healthcare coverage "because of" sex unquestionably violates Title VII because those benefits are "compensation, terms, conditions, or privileges of employment" under the Act.
>
> A facially discriminatory employer action against a member of a protected class violates Title VII. And if an adverse employment action is facially discriminatory, the employer's intent is immaterial—"the absence of a malevolent motive does not convert a facially discriminatory policy into a neutral policy with a discriminatory effect." Here, it is undisputed that the Exclusion is facially discriminatory.

Id. at *26 (internal quotations omitted). Similarly here, the Exclusions at issue are facially discriminatory. *See* Dkt. No. 96 at 17–26. Employers' intent simply does not matter.

Cost concerns also have no place in gender discrimination cases. "[N]either Congress nor the courts have recognized [a cost justification] defense under Title VII [sex discrimination]." *City of L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 716 (1978); *see also Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 685 n.26 (1983) ("[N]o such [cost] justification is recognized under Title VII once discrimination has been shown"); 29 C.F.R. § 1604.9 (e) ("It shall not be a defense … to a charge of sex discrimination in benefits that the cost of such benefits is greater with respect to one sex than the other"); *Lange*, 2022 U.S. Dist. LEXIS 98874, at *35 n.15 (whether an employer had "discriminatory intent" "has no place" in a sex discrimination claim regarding coverage of benefits). Dr. Burns' opinions are therefore irrelevant and should be rejected on this basis alone.

Dr. Burns' report is also wholly unreliable. BCBSIL claims that Dr. Burns "properly ***relied*** on BCBSIL data" for his conclusion that some class members had a choice of plans by citing to an email between counsel that merely states that certain data were "provided" to Dr. Burns. Dkt. No. 115 at 13:25–14:2 (emphasis added); *see* Dkt. No. 117-1, *Exh. I.* That statement is demonstrably false. (1) There is no evidence that the BCBSIL data referenced in its brief contains the information BCBSIL claims it does; and (2) the data is not mentioned in Dr. Burns' report as being something he considered. *See* Burns Decl., ¶27 (Dr. Burns did not identify any data, only

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that he "understood from BCBSIL that many of these employers also offer a plan design to employees that includes coverage for these services"). (3) Dr. Burns was unaware of it when he was deposed. Burns Dep., pp. 84:16–86:10 (Dr. Burns did not know whether any employer that asked BCBSIL to administer an Exclusion offered an alternative to cover gender-affirming care). And (4) the data BCBSIL now references was not produced to Plaintiffs until August 1, 2022, as a result of a Court Order (Dkt. No. 70), long after Dr. Burns' report was written. Dkt. No. 108-4. This is yet another example of BCBSIL bending the truth to fit its preferred story.

BCBSIL tries to distinguish the research cited by Plaintiffs that shows there is no material cost impact when adding gender-affirming care by asserting that the studies apply "largely" to fully insured plans (they do not; *compare* Dkt. No. 115, p. 14 to Dkt. No. 107, pp. 22–23),[5] but BCBSIL ignores the crucial undisputed fact that ***there is extensive research on the ultimate conclusion on which Dr. Burns opines that he wholly failed to consider***. Neither BCBSIL nor Dr. Burns identifies any evidence-based analysis demonstrating that adding gender-affirming care results in a genuine cost concern.

When defense experts conduct a good faith analysis of the costs involved with adding gender-affirming care, even they admit that the costs are so minimal as to be irrelevant. For example, in *Boyden v. Conlin*, plaintiffs challenged a similar exclusion of coverage for gender-affirming care in Wisconsin's self-funded state employee health benefit plan. 341 F. Supp. 3d 979, 990 (W.D. Wis. 2018). The state's own actuarial expert concluded that the cost of removing the exclusion was less than 0.1% of the total cost of medical care. *Id.* Even the defendant state actuary was forced to admit that the impact of such additional costs "would be negligible." *Id.*; *Flack v. Wis. Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1021–22 (W.D. Wis. 2019) (same).

[5] The Williams Institute study considered the impact of adding gender-affirming care to employer sponsored health benefit plans (not fully insured plans). *See* https://williamsinstitute.law.ucla.edu/publications/trans-employee-transition-coverage/ (last visited 11/11/2022). As described in the Rand study, it considered extensive data from public employers (which typically self-fund) on the actuarial cost of covering gender-affirming care. *See* Dkt. No. 108-13, pp. 33–34.

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C. Dr. Carr's Testimony Must Be Excluded.

1. Dr. Carr's Testimony was Untimely Disclosed and Should Be Excluded.

When BCBSIL submitted the Carr report on October 21, 2022, they missed Fed. R. Civ. P. 26(a)(2)(D)(ii)'s 30-day deadline (by 33 days) to rebut Dr. Fox's report. Dkt. 107 at 27:7–9, 27:13–18. To try to avoid this conclusion, BCBSIL makes two mistakes. First, BCBSIL misconstrues what constitutes a methodology, when baldly asserting that Dr. Fox changed his methodology in the Addendum because he "materially revised his report to incorporate new statistics from the Williams Institute into his analysis." Dkt. No. 115 at 16:5–6. But that conflates a ***methodology*** with ***data*** (in this case, the Williams Institute statistics) to which it is applied. "A methodology is 'a particular procedure or set of procedures' typically used in a certain discipline." *Woniewala v. Merck & Co.*, 2017 U.S. Dist. LEXIS 148338, *13 (E.D. Pa. Sept. 13, 2017), *quoting* Methodology, Merriam-Webster's Collegiate Dictionary (11th ed. 2004).[6] *See also* Fed. R. Evid. 702(b)-(d) (distinguishing between an expert witness' principles and methods on the one hand and the facts or data to which those methods and principles are applied).

BCBSIL does not contest that Dr. Fox used the same "particular procedure or set of procedures" to generate the numerosity estimates found in both his report and its Addendum. That procedure included plugging the statistics for "transgender prevalence" released by the Williams Institute into rows 7–11 of Dr. Fox's numerosity estimation calculations. Dkt. No. 104-1, *Exh. G.*, ¶7, ¶15, Table 4; *Exh. H*, p. 242:2, Updated Table 1, n.1. The only difference between the calculations in the Fox report and its Addendum is that the former inputted the Williams Institute's 2017 transgender prevalence statistics into the methodology described in that report, and the latter

[6] *See also J.B. by & through Belt v. D.C.*, 2018 U.S. Dist. LEXIS 151992, *49 (D.D.C. May 8, 2018) ("A 'methodology' is 'a body of methods, procedures, working concepts, rules, and postulates employed by a science, art, or discipline' or 'the processes, techniques, or approaches employed in the solution of a problem or in doing something.'" (quoting Methodology, Merriam-Webster Unabridged, http://unabridged.merriam-webster.com/unabridged/methodology)), *report and recommendation adopted*, 325 F. Supp. 3d 1 (D.D.C. 2018); *Oceana, Inc. v. Ross*, 275 F.Supp.3d 270, 284–85 (D.D.C. 2017) ("A 'methodology' is 'a body of methods, rules, and postulates employed by a discipline.'" (quoting Methodology Definition, Merriam–Webster's Dictionary, https://www.merriam-webster.com/dictionary/methodology)).

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inputted the Williams Institute's 2022 transgender prevalence statistics into the same methodology. *Id*.; *see also* Dkt. No. 94-3, *Exh. T*, p. 73; Dkt. No. 108-14 (Fox Dep.) at 44:21–45:17. Changing the Williams transgender prevalence statistics inputted into Dr. Fox's numerosity estimation methodology yielded a change in Dr. Fox's numerosity estimation results. *Compare* Dkt. No. 104-1, *Exh. G*, Table 5, Row 16, *with Exh. H*, Updated Table 5, Row 16. But that happened as a result of changing the "facts or data" to which the principles and methods described in the Fox report were applied, not because of a change in those methods or principles. Moreover, BCBSIL's quarrel with the modest change in Dr. Fox's results goes to the weight of his opinions and merits cross-examination, not exclusion. *Primiano v. Cook*, 598 F.3d 558, 564 (9th Cir. 9010).

Significantly, Dr. Carr makes no attempt to rebut the only change between the Fox report and its Addendum—Dr. Fox's decision to substitute the new Williams data into his previously described methodology. Nor does Dr. Carr or BCBSIL claim that Dr. Fox miscalculated the final estimates listed in the Addendum when he substituted the new Williams data into this methodology. To the contrary, when explaining the asserted relevance of Dr. Carr's testimony, BCBSIL refers to Dr. Carr's attack on Dr. Fox's methodology and makes no mention of the actual changes that were made between the Fox report and its Addendum. Dkt. No. 115, p. 17:11–12.

Faced with the presumptive exclusion of Dr. Carr's untimely testimony under Fed. R. Civ. P. 37(c) (*see Luke v. Family Care & Urgent Med. Clinics*, 323 Fed. App'x 496, 499 (9th Cir. 2009)), BCBSIL simply ignores the harm Plaintiffs described in their motion (Dkt. No. 107 at 28:6–11), suggesting that any prejudice could have been alleviated by Plaintiffs deposing Dr. Carr within days of his disclosure, ***months after the discovery cutoff and in the middle of dispositive briefing***. Dkt. No. 115 at 16. But even if no substantive harm flowed from Dr. Carr's late disclosure, asking for the Court's authorization to modify the case schedule for discovery constitutes harm under Rule 37. *See Wong v. Regents of the Univ. of Cal.*, 410 F.3d 1052, 1062 (9th Cir. 2005) (excluding untimely disclosed witness "even though the ultimate trial date was still some months away," noting that "[d]isruption to the schedule of the court and the other parties … is not harmless").

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2. Dr. Carr's Testimony is Irrelevant.

As Dr. Carr neither disputes numerosity nor offers any opinion of his own on the subject, his testimony is irrelevant and should on that ground be excluded as well.

D. The Opinions of Dr. Laidlaw, Dr. Burns, and Dr. Carr Lack Probative Value Under Federal Rule of Evidence 403.

BCBSIL ignores Plaintiffs' arguments that defense experts' opinion testimony is excludable under Fed. R. Evid. 403. It is therefore undisputed that the proposed expert testimony seeks to sow confusion about the propriety and cost effectiveness of gender-affirming care based on speculation, irrelevant, misleading, and, in Dr. Laidlaw's case, biased opinions, justifying its exclusion under Rule 403 as well.

II. CONCLUSION

For the foregoing reasons, the Court should exclude the reports, opinions, and testimony of Dr. Laidlaw, Dr. Burns, and Dr. Carr.

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