# EXHIBIT A

HONORABLE JUDGE 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,

Plaintiff,

vs.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendants.

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

**DECLARATION OF LAWTON R. BURNS**

## I. Expert Witness Background & Qualifications

1. My name is Lawton R. Burns. I am the James Joo-Jin Kim Professor at the Wharton School of the University of Pennsylvania, where I am a Professor in the Departments of Health Care Management and Management. For seven years (2007–2014), I also served as the Chair of the Health Care Management Department. Currently, I am the Co-Director of the Roy and Diana Vagelos Program in Life Sciences and Management at the University of Pennsylvania. I have taught at Wharton since 1994. Prior to Wharton, I taught in the health administration programs of two other business schools: the Graduate School of Business at the University of Chicago and the College of Business and Public Administration at the University



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

of Arizona. I have also taught in the healthcare management programs at the Indian School of Business in Hyderabad and the Guanghua School of Management at Peking University.

2. At Wharton, I teach the first-year course, "Introduction to the U.S. Health Care System" to graduate students. The course covers the entire value chain of health care, including hospital/physician providers, managed care organizations and insurers who contract with and reimburse providers for their services, and employers, individuals, and governmental bodies who ultimately pay for those services. I have taught this course at Wharton in the daytime MBA program for over twenty years. I have also taught the same course to the weekend MBA program on both the East and West coast campuses for over a decade. I have taught various versions of this course at each of the Universities I have worked at since 1981.

3. Between 1998 and 2013, I also taught a graduate business elective course on "Managed Care and the Industrial Organization of Healthcare." I resumed teaching this course in 2017. The course covers (a) the horizontal integration of physicians, hospitals, and insurers; and (b) the vertical integration between physicians, hospitals, and insurers. The course also covers the contractual and bargaining relationships between physicians, hospitals, and insurers—and the strategies those three parties have undertaken to align with and/or negotiate with one another. I taught an earlier, but parallel version of this course between 1998–2002 to physicians pursuing a masters' degree in the Administrative Medicine Program at the University of Wisconsin School of Medicine.

4. I have testified on these and related topics (*e.g.*, economic and clinical integration) to the Federal Trade Commission (FTC) on several occasions and have served as an expert witness for both the FTC and the Department of Justice (DOJ) on issues concerning horizontal integration, vertical integration, and payer-provider contracting. Most of these cases involved horizontal mergers of physician practices and vertical integration of physicians with hospital systems. In all of these cases, I opined on whether there was sufficient economic and/or clinical integration benefits to potentially offset the consumer welfare loss from consolidation and



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

reduced competition. A list of cases in which I have testified at trial or deposition during the past four years is attached as Appendix 1.

5. I received my Ph.D. in organizational sociology (in 1981) and my Masters in Business Administration in hospital administration (in 1984), both from the University of Chicago. During my MBA training, I interned with the Hospital Corporation of America ("HCA"), the largest for-profit chain of hospitals in the US. I also completed a one-year residency with Jackson Park Hospital in Chicago. For both institutions, I served as the Assistant to the Administrator. I have spent my career since that time seeking to use (a) the theory and research of management, corporate strategy, and industrial organization to (b) analyze healthcare delivery and (c) improve observed patterns of physician and hospital behavior that serve to decrease costs while maintaining or improving quality.

6. Throughout my career, I have focused much of my research on the hospital industry and the medical profession. Earlier research examined:

- hospital-sponsored primary care
- physicians' use of hospitals (*e.g.,* admitting patterns and loyalty)
- historical transformation of the hospital from a philanthropic to a business base
- hospital adoption of reengineering
- medical group practices
- medical staff organization
- physician-hospital relationships and conflicts
- physician-hospital alignment
- physician-hospital alliances (*e.g.*, PHOs, MSOs, IPAs, etc.)
- integrated delivery networks (IDNs)
- hospital supply of community benefits
- hospital performance (*e.g.,* operating costs, profitability)
- formation of hospital systems
- hospital mergers
- hospital bankruptcies
- hospital competition
- hospital-managed care bargaining
- capitated contracting between hospitals and health plans
- hospital ownership conversions, and
- alternative delivery systems (non-hospital based).



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

In recognition of this research, the American Hospital Association awarded me the Edwin Crosby Memorial Fellowship to study physician-hospital relationships in 1992–1993. In 2015, the Academy of Management and its Health Care Administration Division awarded me the Distinguished Scholar Award.

7. In terms of management topics, I have focused much of my attention on organization structures, organization processes (*e.g.*, participation in decision-making), and employee behavior (*e.g.*, collaboration, conflict, satisfaction, loyalty and commitment to the organization, citizenship behaviors, etc.). In terms of corporate strategy and industrial organization topics, I have focused on "governance decisions" (*e.g.*, make-in-house versus buy from the market), horizontal and vertical integration, diversification, strategic alliances and networks, and value-chain alliances.

8. In terms of healthcare topics, I have focused much of my attention on organized delivery systems. These include physician group practices; physician practice management companies ("PPMCs"); ambulatory surgery centers ("ASCs"); and a variety of integrated delivery networks ("IDNs"), such as physician-hospital organizations ("PHOs"), management services organizations ("MSOs"), clinically integrated networks ("CINs"), accountable care organizations ("ACOs"); and economic and clinical integration. Many of these centered on the integration within physician organizations and the integration between physician organizations and hospitals. During this period, I have conducted mail surveys of thousands of physicians, personally interviewed hundreds of physicians and executives in IDNs, received numerous grants and research contracts to study physicians and IDNs, written or co-written five case studies of IDNs, and published multiple articles and book chapters relating to the topic of physician-hospital integration.

9. I have written extensively on healthcare related topics.[1] I have written about both professional service agreements and the different contractual arrangements among physicians

[1] Lawton R. Burns and Douglas R. Wholey. "Responding to a Consolidating Healthcare System: Options for Physician Organizations." In *Advances in Health Care Management* Volume 1 (New York: Elsevier): 273-335. 2000. Lawton R. Burns and Ralph Muller. "Hospital-Physician Collaboration: Landscape of Economic Integration



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

and between physicians and other parties, such as hospitals and practice management companies.[2]

10. I have two new books. The first is an introductory textbook to the entire U.S. healthcare ecosystem. The second is an analysis of the harmful effects of consolidation among healthcare providers and the historical chronicle of consolidation efforts stretching back from the 1990s into the present. The latter covers both horizontal and vertical integration involving hospitals and physicians.[3]

11. I have published over one hundred and fifty articles and book chapters on these topics. I have also published several books in the same areas. Exhibit 1 contains my curriculum vitae.

## II. Summary of Work Performed

12. I have been asked to analyze the effect of Blue Cross of Illinois ("BCBSIL")'s practice of administering self-funded health plans that contain exclusions from gender affirming care.

---

and Impact on Clinical Integration." *Milbank Quarterly* 86(3):375-434. 2008. Lawton R. Burns, Jeff C. Goldsmith, and Ralph Muller. "History of Hospital/Physician Relationships: Obstacles, Opportunities, and Issues." In Jay Crosson and Laura Tollen (Eds.), *Partners in Health* (Kaiser Permanente Institute for Health Policy, Oakland, CA). 2010. Lawton R Burns and Mark V Pauly. "Accountable Care Organizations May Have Difficulty Avoiding The Failures of Integrated Delivery Networks of The 1990s." *Health Affairs* 31(11): 2407-2416. 2012. Lawton R. Burns, Jeff Goldsmith, and Aditi Sen. "Horizontal and Vertical Integration of Physicians: A Tale of Two Tails." In *Annual Review of Health Care Management: Revisiting the Evolution of Health Systems Organization. Advances in Health Care Management*, Volume 15: 39-117. (Emerald Group Publishing). 2013. Lawton R. Burns and Mark V. Pauly. "Transformation of the Healthcare Industry: Curb Your Enthusiasm?" *Milbank Quarterly*. (March 2018) 96(1): 57-109.

[2] Burns and Muller. 2008. Lawton R. Burns and Darrell P. Thorpe. "Trends and Models in Physician-Hospital Organization." *Health Care Management Review* 18(4): 7-20. 1993. Jeffrey Alexander, Thomas Vaughn, Lawton R. Burns et al. "Organizational Approaches to Integrated Healthcare Delivery: A Taxonomic Analysis of Physician Organization Arrangements." *Medical Care Research and Review* 53(1): 71-93. 1996. Lawton R. Burns. "Physician Practice Management Companies." *Health Care Management Review* 22(4):32-46. 1997. Lawton R. Burns, Jeffrey Alexander, and Ronald Andersen. "How Different Governance Models May Impact Physician-Hospital Alignment." *Health Care Management Review*. Forthcoming.

[3] Lawton R. Burns. *The U.S. Healthcare Ecosystem: Payers, Providers, Producers* (McGraw-Hill, 2021). David Dranove and Lawton R. Burns. *Big Med: Megaproviders and the High Cost of Health Care in America* (Chicago, IL: University of Chicago Press, 2021).



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

13. I have also been asked to determine whether the elimination of BCBSIL's to administer plans with varying designs, including designs that exclude gender affirming care, will harm employers and consumers.

14. I have reached opinions on these matters in my report based on a combination of (a) knowledge developed over nearly forty years of conducting academic research on health care delivery networks; (b) knowledge developed over the past thirty years of conducting extramurally-funded research; (c) knowledge acquired over the past twenty years in expert witness work on related cases; (d) evidence gleaned from depositions and documents produced in this litigation; and (e) the broader literature on medical groups, professional service agreements, including prior research and rulings and advisories by the FTC. My work on this matter is continuing, and I reserve the right to amend my opinions and testimony, including in response to any of plaintiffs' experts.

15. I am compensated at the rate of $900 per hour for performing my work on this matter. I am paid this rate regardless of the opinions I reach in connection with my work.

## III. Summary of Opinions

i. Plan designs that contain various iterations of exclusion for gender affirming care are common;

ii. These Plan designs allow greater economic flexibility for employers and further their ability to make health care coverage available at customized price-points;

iii. Eliminating the ability to purchase health plans with gender-affirming care exclusions would be harmful to consumers.

iv. Individuals will ultimately bear the burden of price increases.

## IV. Background Regarding the Healthcare Industry.

16. Individuals not eligible for public insurance, such as Medicare or Medicaid, can obtain health insurance coverage in two ways. First, they can buy insurance on their own on the individual market (the self-employed, those working for firms that do not offer coverage, early



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

retirees). Second, like the majority of the population, they can obtain coverage on the group market through their, or a family member's, employer. Group coverage can include both small group (defined as firms with less than 50–100 workers, depending on the state) as well as large group (firms with 100+ workers).

17. Employers are often referred to as ERISA plan sponsors. Employers sponsor insurance for their workers in one of two ways. Some employers purchase it. In this situation, the employer purchases insurance from a company such as BCBSIL. These employers are referred to as "fully insured" because the insurance risk rests with the insurer. Other employers, especially the majority of large employers, directly assume financial responsibility for employees' medical claims and administrative costs and use their own money to pay health care costs. These employers are known as "self-insured." Most self-insured employers hire companies such as BCBSIL to assemble a network of providers, process claims, and handle provider billing.

18. Generally, self-insured ERISA plans design their own coverages. In other words, the employer choses what it will cover for employees and then hires an administer to provide employees with a network of providers and process the claims. In order to price these products, parties need to employ actuaries and underwriters. These staff estimate the likely cost of a given plan based on the utilization of its enrollees over a future period and then derive an annual premium to cover the plan's cost, including medical and administrative costs.

**A. When Health Care Costs Rise, Consumers Are Adversely Affected.**

19. When the amount that employers pay for health care goes up, the end consumer ultimately feels the impact. As in other segments of the health care value chain (*e.g.*, rising drug prices), rising fees upstream (*e.g.*, the prices charged by providers) are passed along to the health plans, the employers who sponsor those plans, and ultimately to the workers who enroll in these plans.

20. Consumers generally have what are called cost-sharing obligations for their health care. These obligations span deductibles, co-pays, and co-insurance. Monies to cover these



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

obligations come directly from the consumer's own pocket. Individuals who obtain insurance through their employer also pay higher premiums directly, if their employer requires them to contribute to premiums or plan costs through a payroll deduction. But even when an employer nominally pays for health coverage, the employee ultimately bears the burden of overall higher prices for health services.[4]

21. To attract more and better-qualified labor, employers offer prospective employees a combination of salary and benefits. Together, salary and benefits are considered the employee's total compensation and the employee's money. Employer payments for health insurance premiums ultimately come out of what would otherwise have been paid to workers as money wages. As of the mid-1990s, consultants estimated that 88% of premiums were offset by money wage reductions. Thus, it is the employee, and not the employer, who pays for the increased health insurance premium.[5]

22. Employees may bear the burden of higher prices in two ways. First, some employers will stop offering insurance to their employees entirely.[6] This leaves the employee either uninsured, and thus fully exposed to the financial risk of medical costs, or in the position where they need to purchase coverage on their own in the individual market at a much higher price. Second, those employers who do continue to offer insurance will offset the increased cost through higher premiums, higher cost-sharing, and lower wages.

23. The 2017 Annual Survey of Employer Health Benefits published by the Kaiser Family Foundation ("KFF") and the Health Research & Educational Trust ("HRET") highlights the ways in which rising healthcare costs are passed on to end-consumers:

---

4 Carlin CS, Feldman R, Dowd B, *The Impact of Provider Consolidation on Physician Prices*, 26 HEALTH ECONOMICS 1789 (2017)

[5] Mark V. Pauly. *Health Benefits at Work* (Ann Arbor: University of Michigan Press, 1997). Lewin-VHI. *The Financial Impact of the Health Security Act* (Fairfax, VA: Lewin-VHI, 1993).

6 Fronstin P, Sources of Health Insurance Coverage: *A Look at Changes Between 2013 and 2014 from the March 2014 and 2015 Current Population Survey, 2015*, EMPLOYEE BENEFIT RESEARCH INSTITUTE ISSUE BRIEF 419, available at https://www.ebri.org/pdf/briefspdf/EBRI IB 419.0ct15.Sources.pdf, accessed October 23, 2018.



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

- Increased premiums. Average annual premiums for employer-sponsored family coverage reached $18,764 in 2017, up 55% from $12,106 in 2007.[7] This is an average growth rate of 4.4% per year. The worker contribution increased 74%, from $3,281 in 2007 to $5,714 in 2017.[8]
- Increased deductibles. The percentage of covered workers enrolled in a plan with an annual deductible of $1,000 or more increased from 34% in 2012 to 51% in 2017 (for single coverage plans).[9]
- Increased percentage of premium paid by workers. For single coverage, employees in 2017 paid 18% of the total premium, up from 16% in 2007; for family coverage, the employee share of the total premium increased from 28% to 31% over the same period.[10]

24. Among firms with between 3 and 199 employees that do not offer insurance coverage, the high cost of health insurance was the most commonly cited reason for not offering coverage.[11] Professors Katherine Baicker of UCLA and Amitabh Chandra of Harvard University have studied the effects of increased health insurance premiums and have concluded that workers, as opposed to employers, bear the brunt of such increases.[12] Specifically, they estimate that, on average, the effects of a 10% economy-wide increase in insurance premiums include the following:

- A 1.2 percentage point reduction in the aggregate probability of employment;
- Among the employed population, a 1.9 percentage point reduction in the probability of working full time instead of part time;
- A 2.4% reduction in hours worked; and

[7] *Kaiser/HRET 2017 Survey*, Figure B. Overall, this is attributable primarily to rising payments for healthcare services rather than to higher administrative costs or health plan profits. From 2007 to 2016, between 86% and 89% of all premiums collected were paid out in the form of health benefits. US Centers for Medicare & Medicaid Services, "Table 20 Private Health Insurance Premiums, Benefits and Net Cost; Levels, Annual Percent Change and Percent Distribution, Selected Calendar Years 1960–2016," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip.

[8] *Id.* Figure B.

[9] *Id*. Figure E.

[10] *Id*. Figure 6.1.

[11] *Id*. Figure 2.22.

[12] Katherine Baicker and Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 JOURNAL OF LABOR ECONOMICS 609, 629–31 (2006).



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

- Among workers who have employer provided insurance coverage, a 2.3% decrease in wages.[13]

25. In self-insured plans, employers pay for claims directly, and higher prices from health care providers translate dollar-for-dollar into higher expenditures by employers. In fully-insured plans, higher prices lead to higher premiums for individuals and employers. If group expenditures are uncertain, including as a result of uncertain medical reimbursement, employers may face the cost of supplemental stop-loss insurance or may decide not to self-insure. Both fully-insured and self-insured plans would have a limited ability to make changes mid-year in response to changes to reimbursement rates demanded by physician groups. For example, fully-insured plans have regulatory limits on premium increases and medical loss ratios. Fully-insured and self-insured plans would also face limits to their ability to change plan benefits, provider networks and individual premium contributions.

26. When self-insured plans are unable to change premiums in response to unanticipated increases in medical expenditures, due either to utilization or price increases, on-going plan losses are not sustainable and can lead either to eventual increases in plan premiums or to plan exit.

**F. Loss of Choice in Plan Design Harms Employers and Consumers.**

27. I understand from BCBSIL that many of their self-funded ERISA groups offer plans with exclusions for some or all gender-affirming care. I also understand from BCBSIL that many of these employers also offer a plan design to employees that includes coverage for these services, so that employees can chose what plan design is right for their circumstances.

27. Employers and consumers bear the burden of higher prices several ways. First, higher health care costs translate into higher premiums. Second, members' cost share payments immediately increase. Third, as health care prices rise, some employers will stop offering

[13] *Id*. at 609. This means that increases in health insurance premiums come out of wages close to dollar for dollar. For example, if premiums for a family of four are $14,000, then a 10% increase would be $1,400. If that family has wage income of $60,000, then a 2.3% offsetting wage reduction would be $1,380.



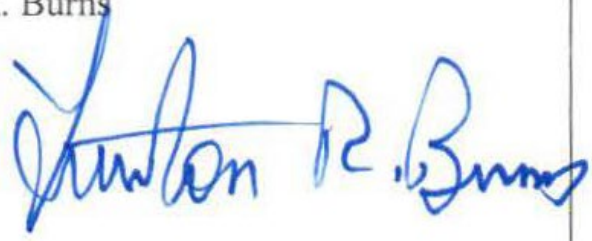
KILPATRICK TOWNSEND & STOCKTON LLP
1420 FIFTH AVENUE, SUITE 3700
SEATTLE, WA 98101
(206) 626-7713 FAX: (206) 260-8946

insurance to their employees entirely. Fourth, those employers who do continue to offer insurance will offset the increased cost through lower wages.

**G.** I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge and belief.

at BRYN MAWR, Pennsylvania.

By
Lawton R. Burns





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

# APPENDIX 1

# Lawton Robert Burns, PhD, MBA

**The James Joo-Jin Kim Professor**
**Professor - Health Care Management**
**Professor – Management**
**Co-Director - Roy & Diana Vagelos Program in Life Sciences and Management**
**The Wharton School**

## CURRICULUM VITAE (February 2022)

**Office Address:**

Health Care Management Department
The Wharton School
203 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104

Phone: 215-898-3711
Fax: 215-573-2157
Cell: 610-247-0902
Email: burnsL@wharton.upenn.edu
http://hcmg.wharton.upenn.edu/burnsL

### HONORS AND FELLOWSHIPS

Teaching Excellence Award. The Wharton School. 2020.

Midland Lecture, Ohio State University, March 2017

Teaching Excellence Award, Wharton Weekend MBA Program, Class of 2017.

Distinguished Scholar Award, Academy of Management – Health Care Administration Division, August 2015.

Outstanding Author Contribution Award. Emerald Literati Network. 2012.

Institute of Medicine Committee on Evaluation of the Lovell Federal Health Center Merger (2011-2012)

Outstanding Author Contribution Award. Emerald Literati Network. 2010.

Wharton Faculty Seminar: Beijing and Shanghai, August 2009

Board of Institute of Medicine (IOM) – Health Services Section. 2003-2006.

Paul A. Gross Distinguished Leadership Lecture, Virginia Commonwealth University. 2002.

Election to Life Fellow, Clare Hall, University of Cambridge. 2001.

Arthur Andersen Distinguished Visiting Professor, Judge Institute of Management Studies, University of Cambridge. 2001.

Invited Lecture Series, National University of Singapore (NUS). 2000.

James Joo-Jin Kim Professorship (Endowed Chair). 1999.

Teacher of the Year, Administrative Medicine Program, University of Wisconsin School of Medicine. 1999.

Invited Lecture Series. Catholic University of Rome, LUISS, & National Agency Health Care Services (Italy). 1997.
Edwin L. Crosby Memorial Fellowship, Hospital Research and Educational Trust, Chicago IL. 1992-1993.

Udall Fellowship in Public Policy, Udall Center for Studies in Public Policy, University of Arizona. 1990-1991.
Graduate Training Fellowship, Kaiser Family Foundation and the Graduate School of Business, University of Chicago. 1982-1984.

Post-Doctoral Research Fellowship, Graduate School of Business, University of Chicago. 1981-1982.

Doctoral Research Fellowship, Kaiser Family Foundation and the Graduate School of Business, University of Chicago. 1979-1980.

Doctoral Research Fellowship, National Health Care Management Center, University of Pennsylvania.1979-1980.

Ernest W. Burgess Fellowship, Department of Sociology, University of Chicago. 1975-1976.

**EDUCATION**

MBA, Graduate School of Business, University of Chicago, Chicago, Illinois, 1984
Specialization in Hospital Administration & Marketing.

Ph.D. Sociology, University of Chicago, Chicago, Illinois, 1981
- Dissertation: "The Adoption and Diffusion of Decentralized Management in Hospitals."
- Committee: James Coleman, Edward Laumann, Charles Bidwell

M.A. Sociology, University of Chicago, Chicago, Illinois, 1976

B.A. Sociology and Anthropology, cum laude, Haverford College, Haverford, Pennsylvania, 1973

**MAJOR FIELDS OF INTEREST**

- Health Care Management
- Integrated Health Care
- Strategic Alliances
- Organizational Change
- Health Care Systems of India & China
- Strategic Management
- Formal Organizations
- Evaluation Research
- Strategic Implementation
- Health Systems Science (School of Medicine)

**ACADEMIC POSITIONS**

Co-Director, Vagelos Life Sciences & Management Program (LSMP). 2013 – Present

Area Leader, Health Care Management Program, India School of Business. 2010 – 2017.

Chair, Department of Health Care Management. 2007 – 2014.

Arthur Andersen Distinguished Visiting Professor, Judge Institute of Management Studies, University of

Cambridge, 2001

James Joo-Jin Kim Professor, University of Pennsylvania, 1999-Present

Director, Wharton Center for Health Management and Economics, 1999-2020

Professor of Health Care Systems, The Wharton School, 1998-Present

Visiting Professor, Department of Preventive Medicine, University of Wisconsin Medical School, 1997-Present

Director of Research, Leonard Davis Institute of Health Economics, University of Pennsylvania, 1996-2000

Associate Professor of Health Care Systems, The Wharton School, University of Pennsylvania, Philadelphia PA (Tenured), 1994-1998

Associate Professor, College of Business and Public Administration, University of Arizona, Tucson, Arizona. Joint Appointments in Management & Policy, Public Administration & Policy, Psychology, 1992-1994

Assistant Professor, College of Business, Univ. of Arizona, 1985-1991

Administrative Practicum, Jackson Park Hospital, Chicago, Illinois, 1983-1984

Assistant to the Administrator, Medical Plaza Hospital, Ft Worth, 1983

Lecturer in Health Administration, Graduate School of Business, University of Chicago, 1981-1984

Post-Doctoral Fellow, Graduate School of Business, Univ. of Chicago, 1981-1982

**GRANTS AWARDED**

| | |
|---|---|
| 2017-2018 | "Physician Consolidation and its Effect on Specialist Care: A Causal Analysis with Machine Learning." Robert Wood Johnson Foundation. Co-Investigator. |
| 2014 | American Hospital Association. "Purchasing Executives' Perspective on Group Purchasing Organizations," $138,000. |
| 2011-2012 | University of Pennsylvania Health System, "Accountable Care Organizations (ACOs): Stakeholder Analysis in the Philadelphia Market," $45,000. |
| 2009-2011 | Understanding the Role of Clinician Collaborators in Medical Device Innovation. InHealth. Award: $380,000. |
| 2007-2008 | Retail Medical Clinics and Their Impact on Physician-Hospital Relationships. Center For Health Management Research. Award: $97,000 |
| 2006-2007 | Guanghua - Wharton Joint Research Initiative. "Informal Payments in China's Health Care Sector." |
| 2004-2006 | National Science Foundation. "Inventory and Distribution in Integrated Delivery Networks." Co-Principal Investigator. Award: $200,000 |
| 2004-2006 | Robert Wood Johnson Foundation, HCFO Initiative. "Co-Evolution in HMO and Hospital Markets." (With Robert Town) |
| 2003-2004 | IBM Global Services. "Trends in the Pharmaceutical Outsourcing Market." Award: $50,000. |

| | |
|---|---|
| 2000-2001 | Robert Wood Johnson Investigator Award in Health Policy Research. "Implementing and Sustaining Fundamental Change in Health Care Organizations." (With Gloria Bazzoli). Award: $250,000. |
| 1999-2001 | Wharton Program on Pharmaceutical Policy, Economics, and Management." Research Grant from Merck Award: $200,000. |
| 1998-2000 | "Hospital Ownership Conversions." Robert Wood Johnson Foundation. Award: $349,000. (Co-Investigator; PI: Frank Sloan). |
| 1998-1999 | "Provision of Community Benefits among FAHS Member Hospitals." Federation of American Health Systems. Award: $120,000. (Co-Investigator; PI: Mark Pauly). |
| 1998-2000 | "Impact of Hospital Consolidation on Supplier-Provider Contracting: Value Chain Analysis." Center for Health Management Research. Award: $183,000. (Principal Investigator). |
| 1996-1999 | "Aligning Physician Groups and Health Systems." National Science Foundation and Center for Organized Delivery Systems. Award: $840,000. (Co-Investigator; PI: Steve Shortell). Analyze success factors in strategic alliances between integrated delivery systems and physician group practices. |
| 1996-1999 | "Referrals to Specialists in HMOs". Agency for Health Care Policy & Research (AHCPR). Award: $250,000. (Co-Investigator). Measure rates and types of referrals in midwestern HMO. |
| 1996-1997 | "Physician-Organization Arrangements: Impact on Integration and Managed Care." Robert Wood Johnson Foundation. Award: $232,394. (Co-Principal Investigator). Assess impact of integrated delivery systems on primary care and managed care infrastructure in hospitals. |
| 1995-1997 | "HMO Impact on Integrated Networks and Services." Grant from Agency for Health Care Policy & Research. Award: $288,157 (Principal Investigator). Assess impact of HMO prevalence and penetration on development of integrated systems in local markets. |
| 1995-1997 | "Managed Care and Hospital-Physician Integration." Grant from Agency for Health Care Policy & Research. Award: $313,482 (Co- Investigator). Assess impact of managed care on specific mechanisms used by hospitals to integrate their medical staffs. |
| 1994-1997 | "Managing Uncertainty to Promote Self-Help in Breast Cancer." Grant from National Cancer Institute. Award: $990,000. (Co-Investigator). Evaluation of efficacy of nursing intervention to promote self-care and self-help in treatment for breast cancer. |
| 1993-1995 | "A Comprehensive Evaluation of Physician-Hospital Arrangements." Grant from the Industry/University Cooperative Research Center for Health Management. Award: $200,000. (Co-Investigator). Evaluation of physician-hospital networks forming in response to managed competition and managed care contracting. |
| 1991-1992 | "Impact of State Subsidies for Liability Insurance on the Delivery of Obstetrical Care by Rural Physicians." Grant from Office for Rural Health Policy, Health Resources & Services Administration (USPHS). Award: $ 6,000. (Principal Investigator). Evaluation of impact of stipend award and stipend amount on decisions by rural physicians to continue obstetrical practice. |
| 1990-1993 | "Interdisciplinary Training for Rural Health Action." Grant from Bureau of Health Professions. Award: $891,000. Department of Family and Community Medicine, College of Medicine, University of Arizona. (Faculty Trainer). |

| | |
|---|---|
| 1990-1991 | "Structure and Outcomes of Joint-Venture Relationships Between Physicians and Hospitals." Grant from Health Care Management and Technology Assessment Center, University of Arizona. Award: $ 6,700. (Principal Investigator). Survey of joint ventures between Arizona physicians & hospitals and their impact on utilization of hospitals. |
| 1989-1991 | "Nursing Interventions Promoting Self-Help to Cancer." Grant from the National Cancer Institute. Award: $1.2 million. College of Nursing, University of Arizona. (Co-Investigator). Experimental Design to study the clinical- and cost-effectiveness of three nursing interventions to improve self-care knowledge and behaviors among 360 women with breast cancer. |

**RESEARCH CONTRACTS**

| | |
|---|---|
| 2020-2021 | Private Equity and Nurse Practitioners. Funded by the American Medical Association. |
| 2006 | “Determinants of Small Device Firm Survival and Growth.” Funded by C.R. Bard. |
| 2005- 2006 | "Assessment and Restructuring of the University of Pennsylvania Health System Supply Chain." Funded by UPHS. |
| 2005 | "Physician Preference Among Surgical Products." Funded by Broadlane. |
| 2004 | "Buyer-Supplier Contracting." Funded by Johnson & Johnson Health Care Systems. |
| 2000 | "Using Network Analysis to Understand Change in Local Healthcare Markets." Funded by Center for Studying Health System Change. (With Douglas Wholey) |
| 1998-1999 | "The Rise and Fall of AHERF: Lessons for Academic Medical Centers." Funded by Association of Professors of Medicine. |
| 1995-1997 | "Development of Integrated Delivery Systems in Illinois." Funded by Illinois Hospital and Health Systems Association. Statewide study of integrated system development in community and academic medical centers. With Institute of Medicine. |
| 1997 | "Impact of Physician Practice Management Companies on Hospital-Based Integrated Delivery Systems." Center for Health Management Research. With James C. Robinson. |
| 1992-1993 | "Physicians' Decisions Concerning Resource Allocation by Hospitals." Funded by Tucson Medical Center, Tucson AZ. County-wide study of physician estimates regarding the areas to which hospitals should allocate their scarce resources. |
| 1992 | "Patient Care Restructuring Project." Funded by University Medical Center, Tucson AZ. Evaluation of new personnel roles on inpatient units to relieve nurses of nonprofessional tasks and improve patient management. |
| 1992 | "Decentralization of the Veterans Administration Hospital System." Funded by the VA Medical Center, Boston, MA. Study to develop models for the decentralized operation of the VA hospital system. Reviewer. |
| 1991-1992 | "Clinical and Cost Outcomes of Nurse Case Management in a Medicare HMO Setting." Funded by Carondelet-St. Mary's Hospital/Health System, Tucson AZ. |
| 1989-1990 | "Access and Quality of Care Outcomes in Medicaid HMOs." Funded by Joint Commission on Accreditation of Healthcare Organizations. Analysis of the adherence of Medicaid HMOs to JCAHO accreditation criteria. |

**PUBLICATIONS**

**Books:**

Mark Pauly, David Asch, Lawton R. Burns, et al. *Seemed Like a Good Idea: Alchemy versus Evidence-Based Approaches to Healthcare Management Innovation*. (Cambridge, UK: Cambridge University Press, 2022).

Lawton R. Burns. *The U.S. Healthcare Ecosystem: Payers, Providers, Producers* (New York: McGraw-Hill, 2021).

David Dranove and Lawton R. Burns. *Big Med: Megaproviders and the High Cost of Healthcare in America*. (Chicago, IL: University of Chicago Press, Forthcoming 2021).

Lawton Burns. *The Business of Healthcare Innovation* – 3rd Edition. (Cambridge, UK: Cambridge University Press). 2020. Prior editions in 2005 and 2012.

Lawton R. Burns, Elizabeth Bradley, and Bryan Weiner (Eds.), Shortell & Kaluzny's *Health Care Management: Organization Design and Behavior* - Seventh Edition. (Delmar). 2019. Prior edition in 2011.

Philip Rea, Mark V. Pauly, and Lawton R. Burns (Eds.). *Managing Discovery: Harnessing Creativity to Drive Biomedical Innovation* (Cambridge, UK: Cambridge University Press, 2018).

Lawton R. Burns and Gordon Liu. *China's Healthcare System and Reform* (Cambridge, UK: Cambridge University Press, 2017).

Lawton R. Burns. *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing* (Cambridge, UK: Cambridge University Press, 2014).

Rosemary Stevens, Charles Rosenberg, and Lawton R. Burns (Eds.), *Health Care History and Policy in the United States* (New Brunswick, NJ: Rutgers University Press). 2006.

Lawton R. Burns & Wharton School Colleagues. *The Health Care Value Chain: Producers, Purchasers, and Providers* (San Francisco: Jossey-Bass). 2002.

**Articles/Book Chapters:**

Lawton R. Burns, Ingrid M. Nembhard, and Stephen Shortell. "Integrating Network Theory into the Study of Integrated Healthcare." *Social Science and Medicine* (2022). https://doi.org/10.1016/j.socscimed.2021.114664

Lawton R. Burns, David Asch, and Ralph Muller. "Vertical Integration of Physicians and Hospitals: Three Decades of Futility?" in Mark V. Pauly (Ed.), *Seemed Like a Good Idea: Alchemy versus Evidence-Based Approaches to Healthcare Management Innovation* (Cambridge, UK: Cambridge University Press, 2022).

Lawton R. Burns and Rachel M. Werner. "Care Coordination," in Mark V. Pauly (Ed.), *Seemed Like a Good Idea: Alchemy versus Evidence-Based Approaches to Healthcare Management Innovation* (Cambridge, UK: Cambridge University Press, 2022).

Lawton R. Burns, Howard Forman, and Carolyn Watts. "Teaching the Introductory Course on the U.S. Healthcare System: Issues, Challenges, and Lessons." *Journal of Health Administration Education* (forthcoming 2022).

Akshat Kumar, Rohit Gupta, and Lawton R. Burns. "Strategic Analysis of India's Private Hospital Sector," in Ali Mehdi and Irudaya Rajan (Eds.), *Health of the Nation: Perspectives for a New India*. (Oxford University Press 2020): 223-239.

Gregory Kruse, Lawton R. Burns, and Ralph Muller. "Health Care Inc." in James Schaefer, Richard M. Mizelle, Jr., & Helen K. Valier (Eds.), *Oxford Handbook of American Medical History*. Chapter 16. Forthcoming 2020.

Mark V. Pauly and Lawton R. Burns. "When is Medical Care Price Transparency a Good Thing (And When Isn't It)?" in Jennifer Hefner and Mona Al-Amin (Eds.), *Advances in Health Care Management – Transforming Health: A Focus on Consumerism and Profitability*. Volume 19 (Emerald Press, 2020): 75-97.

Ann Kutney-Lee, Douglas Sloane, Kathryn Bowles, Lawton R. Burns, & Linda Aiken. (2019). "Electronic Health Record Adoption and Nurse Reports of Usability and Quality of Care: The Role of Work Environment. *Applied Clinical Informatics*. https://doi.org/10.1055/s-0039-1678551. 10(1) (2019): 129-139.

Lawton R. Burns and Allison Briggs. "Hospital Purchasing Alliances: Ten Years After." *Health Care Management Review*. Forthcoming.

Lawton R. Burns, Jeffrey Alexander, and Ronald Andersen. "How Different Governance Models May Impact Physician-Hospital Alignment." *Health Care Management Review*. Forthcoming.

Lawton R. Burns and Mark V. Pauly. "Transformation of the Healthcare Industry: Curb Your Enthusiasm?" *Milbank Quarterly*. (March 2018) 96(1): 57-109.

Edward Zajac, Thomas D'Aunno, and Lawton R. Burns. "Managing Strategic Alliances: Neither Make nor Buy but Ally," in L.R. Burns, E. Bradley, & B. Weiner (Eds.), *Health Care Management: Organization Design & Behavior*. 7th Edition. (Delmar Cengage Learning, forthcoming).

Lawton R. Burns, Elizabeth Bradley, & Bryan Weiner. "The Management Challenge of Delivering Value in Health Care: Global and U.S. Perspectives," in L.R. Burns, E. Bradley, & B. Weiner (Eds.), *Health Care Management: Organization Design & Behavior*. 7th Edition. (Delmar Cengage Learning, forthcoming).

Lawton R. Burns and Gordon G. Liu. "Health, Disease, and Medical Care," in Weiping Wu and Mark Frazier (Eds.), *The SAGE Handbook of Contemporary China* (Sage, 2018).

Lawton R. Burns, Alex Rosen, Philip Rea et al. "Regeneron: Agility, Resilience, and Balance." Forthcoming in Philip Rea, Mark V. Pauly, and Lawton R. Burns (Eds.), *Managing Discovery in the Life Sciences*. (Cambridge, UK: Cambridge University Press, 2018).

Lawton R. Burns and Philip Rea. "Organization of the Discovery Process." Forthcoming in Philip Rea, Mark V. Pauly, and Lawton R. Burns (Eds.), *Managing Discovery in the Life Sciences*. (Cambridge, UK: Cambridge University Press, 2018).

Simon Basseyn, Sourav Bose, Lawton R. Burns, and Chris Groskaufmanis. "The Development of Percutaneous Transluminal Coronary Angioplasty." Forthcoming in Philip Rea, Mark V. Pauly, and Lawton R. Burns (Eds.), *Managing Discovery in the Life Sciences*. (Cambridge, UK: Cambridge University Press, 2018).

Lawton R. Burns, Michael Housman, Robert Booth, and Aaron Koenig. "Physician Preference Items: What Factors Matter to Surgeons? Does the Vendor Matter?" *Medical Devices: Evidence and Research* 11 (2018): 39-49.

Karen B Lasater, Michael R Richards, Nikila Dandapani, Lawton R Burns, and Matthew D McHugh. "Magnet Hospital Recognition in Hospital Systems Over Time," *Health Care Management Review*. 42 (2017):

Mirko Noordegraff and Lawton R. Burns. "Paradoxes of Leading and Managing Healthcare Professionals to Integrate Healthcare Services," in Gary Young, Kathleen Sutcliffe, and Tim Hoff (Eds.), *The Healthcare Professional Work Force: New Directions in Theory and Practice* (Oxford, UK: Oxford University Press, 2016).

Lawton R. Burns, Jeffrey McCullough, Douglas Wholey, Peter Kralovec, Gregory Kruse, and Ralph Muller. "Is the System Really the Solution? Operating Costs in Hospital Systems," *Medical Care Research and Review* 72(3) (2015): 247-272.

Michael McHugh, Linda Aiken, Myra Eckenhoff, and Lawton R Burns. “Achieving Kaiser Quality,” *Health Care Management Review* (2015).

Jeff Goldsmith, Lawton R. Burns, Aditi Sen, and Trevor Goldsmith. *Integrated Delivery Networks: In Search of Benefits and Market Effects*. (Washington, D.C.: National Academy of Social Insurance, 2015).

Lawton R Burns. “Medical Tourism Opportunities and Challenges: Illustration from US-India Trade.” *International Journal of Healthcare Management* 8(1) (2015): 15-26.

Guy David, Richard Lindrooth, Lorens Helmchen. and Lawton R Burns. “Do Hospitals Cross-subsidize?” *Journal of Health Economics* 37 (September 2014): 198-218. 2014.

Lawton R. Burns. *The Performance of Group Purchasing Organizations (GPOs) in the Health Care Value Chain: A Literature Review*. (Philadelphia, PA: Wharton Center for Health Management & Economics, 2014).

Lawton R. Burns and Rada Yovovich. *Hospital Supply Chain Executives Perspectives on Group Purchasing: Results from a 2014 Survey*. (Philadelphia, PA: Wharton Center for Health Management & Economics, 2014).

R. Carter Clement, Arunavo Roy, Ravi Shah, James Calderwood, and Lawton R. Burns. "The Aravind Eye Care System," in Lawton Burns (Ed.), *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing*. 2014.

Jessica Pickett, Aditi Sen, and Lawton R Burns. "The Health Insurance Sector in India: History and Opportunities." In Lawton Burns (Ed.), *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing*. 2014.

Ajay Bakshi and Lawton Burns. “The Medical Profession in India.” In Lawton Burns (Ed.), *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing*. 2014.

Lawton R Burns, Prashanth Jayaram, and Richa Bansal. "Medical Tourism: Opportunities and Challenges." In Lawton Burns (Ed.), *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing*. 2014.

Lawton R. Burns, Bhuvan Srinivasan, and Mandar Vayda. "India’s Hospital Sector: The Journey from Public to Private Healthcare Delivery." In Lawton Burns (Ed.), *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing*. 2014.

Lawton R Burns. "India’s Healthcare Industry: A System Perspective." In Lawton Burns (Ed.), *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing*. 2014.

Lawton R Burns. "India’s Healthcare Industry: An Overview of the Value Chain." In Lawton Burns (Ed.), *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing*. 2014.

Lawton Burns, Tanmay Mishra, Kalyan Pamarthy, and Arunavo Roy. “The Medical Device Sector in India” In Lawton Burns (Ed.), *India's Healthcare Industry: Innovation in Delivery, Financing, and Manufacturing*. 2014.

Lawton R. Burns, Jeff Goldsmith, and Aditi Sen. “Horizontal and Vertical Integration of Physicians: A Tale of Two Tails.” In *Annual Review of Health Care Management: Revisiting the Evolution of Health Systems Organization Advances in Health Care Management*, Volume 15: 39-117. (Emerald Group Publishing). 2013.

Lawton R Burns. "Matrix Structure." *Encyclopedia of Management Theory*. 2013.

Corinna Sorenson, Michael Drummond, and Lawton Burns. “Evolving Reimbursement and Pricing Policies for Devices in Europe and the United States Should Encourage Greater Value.” *Health Affairs* 32(4): 788-796: 2013.

Lawton R Burns, Douglas Wholey, Jeffrey McCullough, Ralph Muller, and Peter Kralovec. "The Changing Configuration of Hospital Systems: Centralization, Federalization, or Fragmentation?" In L. Friedman, G. Savage, and J. Goes (Eds.), *Annual Review of Health Care Management: Strategy and Policy Perspectives on Reforming Health Systems*. Volume 13. (Emerald Group Publishing): 189-232. 2012.

Lawton R Burns and Mark V Pauly. "Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s." *Health Affairs* 31(11): 2407-2416. 2012.

Michael Johns, Stephen Shortell, Nancy Adams, George Anderson, Peter Angood, Lawton Burns, et al. *Evaluation of the Lovell Federal Health Care Center Merger: Findings, Conclusions, and Recommendations* (Washington, D.C.: Institute of Medicine). 2012.

Lawton R Burns, Stephen Sammut, and David Lawrence. "Healthcare Innovation across Sectors: Convergences and Divergences." Chapter 8. In LR Burns (Ed.), *The Business of Healthcare Innovation* (Cambridge, UK: Cambridge University Press). 2012.

Lawton R Burns, Sean Nicholson, and Joanna Wolkowski. "Pharmaceutical Strategy and the Evolving Role of Mergers and Acquisitions (M&A)." Chapter 3. In LR Burns (Ed.), *The Business of Healthcare Innovation* (Cambridge, UK: Cambridge University Press). 2012.

Lawton R. Burns, Eduardo Cisneros, William Ferniany, and Harbir Singh. "Strategic Alliances Between Buyers and Suppliers: Lessons From the Medical Imaging Industry," in C. Harland, G. Nassimbeni, and E. Schneller (Eds.), *The SAGE Handbook of Strategic Supply Management* (Sage Publications). 2012.

Stefanos Zenios, Lawton Burns, and Lyn Denend. *The Role of Physicians in Device Innovation: Critical Success Factor or Conflict of Interest?* (Stanford University, Graduate School of Business). 2012.

Lawton R Burns. "Comparative Effectiveness Research: What it Means, What it Means for Hospitals." *Economic Outlook* (September): 14-18. 2011.

Lawton R Burns and Stephen Sammut. "Doing More with Less: Lessons From a Doctor." *Insight* 9(2): 16-19. 2011.

Stephen Sammut and Lawton R Burns. "Meeting the Challenges of Healthcare Needs in India: Paths to Innovation." *Insight* 9(2): 5-9. 2011.

Lawton R. Burns, Elizabeth Bradley, and Bryan Weiner. "The Management Challenge of Delivering Value in Health Care: Global and U.S. Perspectives." In Burns, Bradley, and Weiner (Eds.), *Health Care Management: Organization Design and Behavior*, Sixth Edition. (Delmar). 2011.

Lawton R. Burns, Guy David, and Lorens Helmchen. "Strategic Responses by Providers to Specialty Hospitals, Ambulatory Surgery Centers, and Retail Clinics." *Population Health Management* 14(2): 69-77. 2011.

Edward Zajac, Thomas D'Aunno, and Lawton R. Burns. "Managing Strategic Alliances." in *Health Care Management: Organization Design and Behavior* 6th Edition. (Albany, NY: Delmar). 2011.

Lawton R. Burns, Jeff C. Goldsmith, and Ralph Muller. "History of Hospital/Physician Relationships: Obstacles, Opportunities, and Issues." In Jay Crosson and Laura Tollen (Eds.), *Partners in Health* (Kaiser Permanente Institute for Health Policy, Oakland, CA). 2010.

Lawton R. Burns, Michael Housman, Robert Booth, and Aaron Koenig. "Implant Vendors and Hospitals: Competing Influences over Product Choice by Orthopedic Surgeons." *Health Care Management Review* 34(1): 2-18. 2009.

Archstone Consulting and Lawton R. Burns. *The Biopharmaceutical Sector's Impact on the U.S. Economy: Analysis at the National, State, and Local Levels*. Report issued by PhRMA. 2009.

Lawton R. Burns, Rajiv Shah, Frank Sloan, and Adam Powell. “The Impact of Hospital Ownership Conversions: Results From a Comparative Field Study." *Biennial Review of Health Care Management: Meso Perspectives*. Volume 8: 171-229. 2009.

Lawton R. Burns and Mark V. Pauly. "Price Transparency for Medical Devices." *Health Affairs* 27(6): 1544-1553. 2008.

Lawton R. Burns, Michael Housman, and Charles Robinson. "Market Entry and Exit by Medical Device and Biotechnology Companies Funded by Venture Capital." *Health Affairs.* Web Exclusive. December 2, 2008. W76-86.

Lawton R. Burns and Ralph Muller. "Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration." *Milbank Quarterly* 86(3):375-434. 2008.

Lawton R. Burns and J. Andrew Lee. "Group Purchasing Organizations (GPOs): Issues and Evidence." *Health Care Management Review* 33(3): 203-215. 2008.

Lawton R. Burns, J. Andrew Lee, Eric T. Bradlow, and Anthony C. Antonacci. "Assessment of Medical Devices: How to Conduct Comparative Technology Evaluations of Product Performance." *International Journal of Technology Assessment in Health Care* 23(4): 455-463. 2007.

Lawton R. Burns, David Nash, and Douglas Wholey. "The Evolving Role of Third Parties in the Hospital-Physician Relationship." *American Journal of Medical Quality* 22(6): 402-409. 2007.

Lawton R. Burns, J. Andrew Lee, Eric T. Bradlow, and Anthony C. Antonacci. "Surgeon Evaluation of Suture and Endo-Mechanical Products." *Journal of Surgical Research* 141: 220-233. 2007.

Robert Town, Douglas Wholey, Roger Feldman, and Lawton R. Burns. "Hospital Consolidation and Racial/Income Disparities in Health Insurance Coverage." *Health Affairs* 26 (4): 1170-1180. 2007.

Kwang Jum Kim and Lawton R. Burns. "Factors Affecting the Performance of Hospital Alliances: Evidence from Korea." *Health Services Management Research* 20: 141-152. 2007.

Lawton R. Burns. "Growth and Innovation in Medical Devices: A Conversation with Stryker Chairman John Brown." *Health Affairs*. May 1, 2007. Web Exclusive.

James Zazzali, Stephen Shortell, Jeffrey Alexander, and Lawton R. Burns. "Organizational Culture and Physician Satisfaction with Group Practice: A Multilevel Model of Cultural Perception and Context." *Health Services Research* 42 (3): 1150-1176. 2007.

Robert Town, Roger Feldman, Douglas Wholey, and Lawton R. Burns "Revisiting the Relationship Between Managed Care and Hospital Consolidation.” *Health Services Research* 42 (1): 219-238. 2007.

Lawton R. Burns. "Clinical Technology: Confronting the Technological Imperative." *Future Scan: Healthcare Trends and Implications, 2007 – 2012*: 29-33. 2007.

Lawton R. Burns. “Dealing with Innovation and Costs in Orthopedics: A Conversation with Dane Miller.” *Health Affairs* 25 (2006): W241-251. Published online May 18, 2006.

Lawton R. Burns and Alexandra Burns. “Policy Implications of Hospital System Failures: The Allegheny Bankruptcy." In Stevens, Rosenberg, and Burns (Eds.), *History and Health Policy in the United States*. Rutgers University Press. 2006.

Lawton R. Burns, Gilbert Gimm, and Sean Nicholson. “The Financial Performance of Integrated Health Organizations (IHOs).” *Journal of Healthcare Management* 50(3): 191-213. 2005.

Gloria Bazzoli, Linda Dynan, Lawton R. Burns, Clarence Yap. "Two Decades of Organizational Change in Health Care: What Have We Learned?" *Medical Care Research & Review* 61(3): 247-331. 2004.

Douglas R. Wholey, Jon B. Christianson, Debra Draper, Cara Lesser, and Lawton R. Burns. "Embedded Responses of Communities to National Healthcare Firms." *Journal of Health and Social Behavior* 45(Extra Issue): 118-135. 2004.

Lawton R. Burns, Thomas D'Aunno, and John Kimberly. "Globalization in Healthcare." In H. Gatignon and J. Kimberly (Eds.), *The INSEAD-Wharton Alliance on Globalizing: Strategies for Building Successful Global Businesses*. (Cambridge, UK: Cambridge University Press): 395-421. 2003.

Lawton R. Burns. "Physician-Hospital Organizations." *Encyclopedia of Health Care Management*. 2003.

Lawton R. Burns. "Networks." *Encyclopedia of Health Care Management*. 2003.

Lawton R. Burns and Mark V. Pauly. "Integrated Delivery Networks (IDNs): A Detour on the Road to Integrated Healthcare?" *Health Affairs*, 21(4): 128-143. 2002.

Lawton R. Burns. "Competitive Strategy." In Daniel Albert (Ed.), *A Physician's Guide to Healthcare Management*. (Malden, MA: Blackwell Science): 46-56. 2002.

Grace Kreulen, Manfred Stommel, Barbara Gutek, Lawton R. Burns, Carrie Braden. "Utility of Retrospective Pretest Ratings of Patient Satisfaction with Health Status." *Research in Nursing and Health* 25: 233-241. 2002.

Peter Budetti, Stephen M. Shortell, Teresa Waters, Jeffrey Alexander, Lawton R. Burns, et al. "Physicians and Health System Integration." *Health Affairs* 21(1): 203-210. 2002.

Douglas R. Wholey and Lawton R. Burns. "Understanding Health Care Markets: Actors, Products, and Relations." Paper prepared for Center for Studying Health System Change. In Stephen Mick (Ed.), *Innovation in Health Care Delivery*. 2nd Edition. 2002.

Lawton R. Burns, Jeffrey Alexander, Stephen M. Shortell et al. "Physician Commitment to Organized Delivery Systems." *Medical Care* 39(7): I 9-29. July Supplement. 2001.

Jeffrey Alexander, Teresa Waters, Lawton R. Burns et al. "The Ties that Bind: Organizational Linkages and Physician-System Alignment." *Medical Care* 39(7): I 30-45. July Supplement. 2001.

Stephen M. Shortell, James Zazzali, Lawton R. Burns et al. "Implementing Evidence-Based Medicine: The Role of Market Pressures, Compensation Incentives and Culture in Physician Organizations." *Medical Care* 39(7): I 62-78. July Supplement. 2001.

Stephen M. Shortell, Jeffrey Alexander, Lawton R. Burns et al. "Physician-System Alignment: Introductory Overview." *Medical Care* 39(7): I 1-18. July Supplement. 2001.

Robin Gillies, Howard Zuckerman, Lawton R. Burns, Stephen M. Shortell, et al. "Physician-System Relationships: Stumbling Blocks and Promising Practices." *Medical Care* 39(7): I 92-106. July Supplement. 2001.

Jeffrey Alexander, Teresa Waters, Shawn Boykin, Lawton R. Burns et al. "Risk Assumption and Physician Alignment with Health Care Organizations" *Medical Care* 39(7): I 46-61. July Supplement. 2001.

Teresa Waters, Peter Budetti, Katherine Reynolds, Robin Gillies, Howard Zuckerman, Jeffrey Alexander, Lawton R. Burns, and Stephen Shortell. "Factors Associated with Physician Involvement in Care Management." *Medical Care* 39(7): I 79-91. July Supplement. 2001.

Lawton R. Burns, Stephen Walston, Jeffrey Alexander, Howard Zuckerman, Ronald Andersen, and Paul Torrens. "Just How Integrated Are Integrated Delivery Systems? Results from a National Survey." *Health Care Management Review* 26(1): 22-41. 2001.

Stephen Walston, John R. Kimberly, and Lawton R. Burns. "Institutional and Economic Influences on the Adoption and Extensiveness of Managerial Innovation in Hospitals: The Case of Reengineering." *Medical Care Research & Review* 58(2): 194-228. 2001.

Jeffrey Alexander, Lawton R. Burns, Michael Morrisey, and Victoria Johnson. "CEO Perceptions of Competition and Strategic Response in Hospital Markets." *Medical Care Research & Review* 58(2): 162-193. 2001.

Lawton R. Burns and Darrell P. Thorpe. "Why Provider-Sponsored Health Plans Don't Work." *Healthcare Financial Management: 2001 Resource Guide*: 12-16. 2001.

Sean Nicholson, Mark V. Pauly, Lawton R. Burns, Agnieshka Baumritter, and David Asch. "Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals." *Health Affairs* 19(6): 168-177. 2000.

Lawton R. Burns. "A Research Agenda for Health Services Management." *Health Care Management Review* 25(4): 85-87. 2000.

Craig Holm and Lawton R. Burns. "The Future of Health System - Physician Integration." *Journal of Healthcare Management* 45(6): 356-358. 2000.

Lawton R. Burns, Gloria Bazzoli, Linda Dynan, and Douglas Wholey. "Impact of HMO Market Structure on Physician-Hospital Strategic Alliances." *Health Services Research* 35(1): 101-132. 2000.

Lawton R. Burns, John Cacciamani, James Clement, and Welman Aquino. "The Fall of the House of AHERF: The Allegheny Bankruptcy." Paper presented to Association of Professors of Medicine (Pasadena, February). *Health Affairs* 19(1): 7-41. 2000.

Edward Zajac, Thomas D'Aunno, and Lawton R. Burns. "Managing Strategic Alliances." In *Health Care Management: Organization Design and Behavior* 4th Edition. (Albany, NY: Delmar): 307-329. 2000.

Douglas R. Wholey and Lawton R. Burns. "Tides of Change: The Evolution of Managed Care in the United States." In *Handbook of Medical Sociology* 5th Edition, Ed. By Chloe Bird, Peter Conrad, and Allen Fremont. (Upper Saddle River, NJ: Prentice Hall): 217-237. 2000.

Lawton R. Burns and Douglas R. Wholey. "Responding to a Consolidating Healthcare System: Options for Physician Organizations." In *Advances in Health Care Management* Volume 1 (New York: Elsevier): 273-335. 2000.

Gloria Bazzoli, Linda Dynan, Lawton R. Burns, and Richard Lindrooth. "Is Provider Capitation Working? Effects on Physician-Hospital Integration and Costs of Care." *Medical Care* 38(3): 311-324. 2000.

Jeffrey Alexander, Thomas Vaughn, and Lawton R. Burns. "The Effects of Structure, Strategy, and Market Conditions on the Operating Practices of Physician-Organization Arrangements." *Health Services Management Research* 13:1-15. 2000.

Gloria Bazzoli, Linda Dynan, and Lawton R. Burns. "Capitated Contracting of Integrated Health Provider Organizations." *Inquiry* 36(4): 426-444. 2000.

Gloria Bazzoli, Linda Dynan, and Lawton R. Burns. "Capitated Contracting Roles and Relationships in Health Care." *Journal of Healthcare Management* 45(3): 170-187. 2000.

Stephen Walston, Lawton R. Burns, and John Kimberly. "Does Reengineering Really Work? An Examination of the Context and Outcomes of Hospital Reengineering Programs." *Health Services Research* 34(6): 1363-1388. 2000.

Lawton R. Burns, Kevin Anbari, and Jasmin Patel. "The Physician Practice Management Industry: A Partner for Pharmaceutical Companies in Clinical Trials?" *Spectrum: Health Care Delivery and Economics*. 2000.

Lawton R. Burns, Robert DeGraaff, and Harbir Singh. "Acquisition of Physician Group Practices by For-Profit and Not-for-Profit Organizations." *Quarterly Review of Economics and Finance* 39(4): 465-490. 1999.

Michael Morrisey, Jeffrey Alexander, Lawton R. Burns, and Victoria Johnson. "The Effects of Managed Care on Physician and Clinical Integration in Hospitals." *Medical Care* 37(4): 350-361. 1999.

Lawton R. Burns. "Polarity Management: The Key Challenge for Integrated Health Systems." *Journal of Healthcare Management* 44(1): 14-33. 1999.

Lawton R. Burns, Terry Connolly, and Robert DeGraaff. "The Impact of Physicians' Perceptions of Malpractice and Adaptive Changes on Intention to Cease Obstetrical Practice." *Journal of Rural Health* 15(2): 134-146. 1999.

Douglas R. Wholey, Lawton R. Burns, and Risa Lavizzo-Mourey. "Managed Care and the Delivery of Primary Care to the Elderly." *Health Services Research* Part II 33(2): 322-353. 1998.

Lawton R. Burns, Michael Morrisey, Jeffrey Alexander, and Victoria Johnson. "Managed Care and Processes to Integrate Physicians/Hospitals." *Health Care Management Review* 23(4): 70-80. 1998.

Linda Dynan, Gloria Bazzoli, and Lawton R. Burns. "Assessing the Extent of Operational and Financial Integration Achieved Through Physician-Hospital Arrangements." *Journal of Healthcare Management* 43(3): 242-262. 1998.

Howard Zuckerman, Diana Hilberman, Ronald Andersen, Jeffrey Alexander, Lawton R. Burns, and Paul Torrens. "Physicians and Organizations: Strange Bedfellows or a Marriage Made in Heaven?" *Frontiers of Health Services Management* 14(3): 3-34. 1998.

Jeffrey Alexander, Michael Morrisey, Lawton R. Burns, and Victoria Johnson. "Physician and Clinical Integration in Rural Hospitals." *Journal of Rural Health* 14(4): 312-326. 1998.

Lawton R. Burns, Stephen M. Shortell, and Ronald M. Andersen. "Does Familiarity Breed Contentment? The Effects of Physician-Hospital Integration." *Research in the Sociology of Health Care*, (Greenwich, CT: JAI Press): 85-110. 1998.

Lawton R. Burns and James C. Robinson. "Physician Practice Management Companies: Implications for Hospital-Based Integrated Delivery Systems." *Frontiers of Health Services Management* 14(2): 3-35. 1997.

Lawton R. Burns, Gloria Bazzoli, Linda Dynan, and Douglas Wholey. "Managed Care, Market Stages, and Integrated Delivery Systems: Is There a Relationship?" *Health Affairs* 16(6): 204-218. 1997.

Lawton R. Burns. "Physician Practice Management Companies." *Health Care Management Review* 22(4):32-46. 1997.

Lawrence Van Horn, Lawton R. Burns, and Douglas R. Wholey. "The Impact of Physician Involvement in Managed Care on Efficient Use of Hospital Resources." *Medical Care* 35(9): 873-889. 1997.

Lawton R. Burns, Jill Egan, and Susan Van Duyne. *The Process of Physician-System Integration in Illinois*. (Naperville, IL: Illinois Hospital & Health System Association). 1997.

Lawton R. Burns and Darrell P. Thorpe. "Physician-Hospital Organizations: Strategy, Structure, and Conduct." In R. Conners (Ed.), *Integrating the Practice of Medicine*. (Chicago, IL: American Hospital Association Publishing Co:): 351-371. 1997.

Michael A. Morrisey, Jeffrey A. Alexander, Lawton R. Burns, and Victoria A. Johnson. "Managed Care and Physician-Hospital Integration." *Health Affairs* 15(4): 62-73. 1996.

Jeffrey Alexander, Thomas Vaughn, Lawton R. Burns et al. "Organizational Approaches to Integrated Healthcare Delivery: A Taxonomic Analysis of Physician- Organization Arrangements." *Medical Care Research and Review* 53(1): 71-93. 1996.

Jeffrey Alexander, Lawton R. Burns, Howard Zuckerman et al. "An Exploratory Analysis of Market-based Physician-Organization Arrangements." *Hospital and Health Services Administration* 41(3): 311-329. 1996.

Stacie Geller, Lawton R. Burns, and David Brailer. "The Impact of Non-Clinical Factors on Practice Variations: The Case of Hysterectomies." *Health Services Research* 30(6): 729-750. 1996.

Lawton R. Burns, Gerri S. Lamb, and Douglas R. Wholey. "Impact of Integrated Community Nursing Services on Hospital Utilization and Costs in a Medicare Risk Plan." *Inquiry* 33(1): 30-41. 1996.

Stephen Walston, John Kimberly, and Lawton Burns. "Owned Vertical Integration and Health Care: Promise and Performance." *Health Care Management Review* 21(1): 83-92. 1996.

Lawton R. Burns. "Medical Organization Structures that Promote Quality and Efficiency: Past Research and Future Considerations." *Quality Management in Health Care* 3(4): 10-18. 1995.

Lawton R. Burns and Darrell P. Thorpe. "Managed Care and Integrated Healthcare." In *Health Care Management: Managed Care*. Harvey Jolt (Ed.). (Philadelphia, PA: Hanley & Belfus): 101-108. 1995.

Lee R. Beach and Lawton R. Burns. "The Service Quality Improvement Strategy (QIS): Identifying Priorities for Change." *International Journal of Service Industry Management* 6(5): 5-15. 1995.

Lawton R. Burns, Stacie Geller, and Douglas Wholey. "The Effect of Physician Factors on the Cesarean Section Decision." *Medical Care* 33(4): 365-382. 1995.

Lawton R. Burns, Jon Chilingerian, and Douglas Wholey. "The Effect of Physician Practice Organization on Efficient Utilization of Hospital Resources." *Health Services Research* 29(5): 583-603. 1994.

Lawton R. Burns and Lee Sechrest. "Key Challenges Posed by the Clinton Healthcare Reform Proposal." In *Health Care Management: U.S. Healthcare in Transition*. Harvey Jolt (Ed.) (Philadelphia, PA: Hanley & Belfus): 81-90. 1994.

Lawton R. Burns and Lee R. Beach. "The Quality Improvement Strategy (QIS): A Method for Tying Quality Improvement to Physician Satisfaction with Hospital Services." *Health Care Management Review* 19(2): 21-31. 1994.

Lawton R. Burns. "Network Models of the Dissemination of Innovations and Information." In *Effective Dissemination of Clinical and Health Information*. Lee Sechrest, Everett Rogers, et al. (Eds.) (Rockville, MD: Agency for Health Care Policy & Research): 153-158. 1994.

Lawton R. Burns and Douglas R. Wholey. "Adoption and Abandonment of Matrix Management Programs: Effects of Organizational Characteristics and Interorganizational Networks." *Academy of Management Journal* 36(1): 106-138. 1993.

Lawton R. Burns, Douglas R. Wholey, and Marty O. Abeln. "Using Managed Care to Mainstream the Poor: Hospital Utilization and Mortality Levels for Patients in the Arizona Health Care Cost Containment System." *Inquiry* 30(2): 142-156. 1993.

Lawton R. Burns, Ronald M. Andersen, and Stephen M. Shortell. "Trends in Hospital/Physician Relationships." *Health Affairs* 12(3), 213-223. 1993.

Douglas R. Wholey and Lawton R. Burns. "Organizational Transitions: Form Changes by Health Maintenance Organizations." In *Research in the Sociology of Organizations*, Samuel Bacharach (Ed.) (Greenwich, CN: JAI Press): 257-293. 1993.

Lawton R. Burns. *1991 Medical Staff Survey Report*. Division of Medical Affairs. (Chicago, IL: American Hospital Association). 1993.

Lawton R. Burns and Darrell P. Thorpe." Trends and Models in Physician- Hospital Organization." *Health Care Management Review* 18(4): 7-20. 1993.

Lawton R. Burns. *Physician-Hospital Relations: Bibliography Drawn from the Academic and Trade Literatures*. Chicago, IL: Hospital Research & Educational Trust. 1993.

Lawton R. Burns, Jon Chilingerian, and Douglas R. Wholey. "Factors Affecting Physician Efficiency in Managing Hospitalized Patients." In M. Malek (Ed.), *Strategic Issues in Health Care Management*. (Chichester: John Wiley): 211-228. 1993.

Linda D. MacKeagan, Lon N. Larson, JoLaine R. Drugalis, J. Lyle Bootman, and Lawton R. Burns. "Time Preference for Health Gains Versus Health Losses." *PharmacoEconomics* 3(5): 374-386. 1993.

Lawton R. Burns et al. "The Use of Continuous Quality Improvement Methods in the Dissemination of Medical Practice Guidelines." *Quality Review Bulletin* 18(12): 434-439. 1992.

Lawton R. Burns and Douglas R. Wholey. "The Impact of Physician Characteristics in Conditional Choice Models for Hospital Care." *Journal of Health Economics* 11: 43-62. 1992.

Lawton R. Burns and Douglas R. Wholey. "Factors Affecting Physician Loyalty and Exit: A Longitudinal Analysis of Physician-Hospital Relationships." *Health Services Research* 27(1): 1-24. 1992.

Lawton R. Burns, Denise Hurtado, and Leila Shehab. "Hospitals' Investment and Return from Volunteer Departments and Auxiliaries: Evidence from One Community." *Health Care Management Review* 16(4): 79-89. 1991.

Douglas R. Wholey and Lawton R. Burns. "Convenience and Independence: Do Physicians Strike a Balance in Admitting Decisions?" *Journal of Health and Social Behavior* Vol. 32(3): 254-272. 1991.

Lawton R. Burns and Douglas R. Wholey. "Differences in Access and Quality of Care Across HMO Types." *Health Services Management Research*. 4 (1): 32-45. 1991.

Lawton R. Burns and Douglas R. Wholey. "The Effects of Patient, Physician, and Hospital Characteristics on Length of Stay and Mortality." *Medical Care* 29 (3): 251-271. 1991.

Lawton R. Burns, Ronald M. Andersen, and Stephen M. Shortell. "The Effect of Hospital Control Strategies on Physician Satisfaction and Hospital-Physician Conflict." *Health Services Research* 25 (3): 527-560. 1990.

Lawton R. Burns. "The Transformation of the American Hospital: From Community Institution Towards Business Enterprise." In Craig Calhoun (Ed.) *Comparative Social Research, Vol. 12: Business Institutions.* (JAI Press): 77-112. 1990.

Lawton R. Burns. "Matrix Management in Hospitals: Testing Theories of Matrix Structure and Development." *Administrative Science Quarterly* 34 (3): 349-368. 1989.

Lawton R. Burns, Ronald M. Andersen, and Stephen M. Shortell. "The Impact of Corporate Structures on Physician Inclusion and Participation." *Medical Care* 27 (11): 967-982. 1989.

Lawton R. Burns, Douglas R. Wholey, and John Huonker. "Physician Use of Hospitals: Effects of Physician, Patient, and Hospital Characteristics." *Health Services Management Research* 2 (3): 191-203. 1989.

Lawton R. Burns and Selwyn Becker. "Leadership and Managership." In Stephen Shortell and Arnold Kaluzny (Eds.), *Health Care Management: A Text in Organizational Theory and Behavior*, 2nd Edition (John Wiley & Sons): 147-186. 1987.

Lawton R. Burns. "Hospital-Medical Staff Tensions: An Historical Overview and Analysis." *Medical Practice Management*. 1 (3): 191-198. 1986.

Lawton R. Burns, Ronald M. Anderson, and Stephen M. Shortell. "Evidence on Changing Hospital-Physician Relationships." In *Cost Containment and Physician Autonomy: Implications for Quality Care*, George Bugbee Symposium on Hospital Affairs, Graduate School of Business, University of Chicago: 122-142. 1986.

Lawton R. Burns. "A Framework to Measure the Impact of Hospital-Sponsored Primary Care on Patient Access." In *Hospital-Physician Sponsored Primary Care: Marketing and Impact*, by Lu Ann Aday, Ronald M. Anderson, et al. (Ann Arbor, Michigan: Health Administration Press): 20-34. 1985.

Lawton R. Burns and Selwyn Becker. "Leadership and Decision Making." In Stephen Shortell and Arnold Kaluzny, (Eds.), *Health Care Management: A Text in Organizational Theory and Behavior* (John Wiley & Sons): 128-166. 1983.

Lawton R. Burns. "Diffusion of Unit Management Among United States Hospitals" *Hospital and Health Services Administration*, Vol. 27 (2): 43-57. 1982.

Lawton R. Burns. "The Chicago School and the Study of Organization-Environment Relations." *Journal of the History of the Behavioral Sciences* 16: 342-358. 1980.

Kenneth E. Friend and Lawton R. Burns. "Sources of Variation in Job Satisfaction: Job Size Effects in a Sample of the U.S. Labor Force." *Personnel Psychology* 30 (Winter): 589-605. 1977.

***Web Affairs* / LDI / Other Blogs:**

David Dranove and Lawton R. Burns. "Where Did All Our Provider Systems Come From? Part I: Large Provider Systems Dominate American Healthcare." *Psychology Today* (June 3, 2021). https://www.psychologytoday.com/us/blog/the-health-healthcare/202106/where-did-all-our-provider-systems-come

Ingrid Nembhard, Lawton R. Burns, and Stephen Shortell. "Responding to Covid-19: Lessons from Management Research," *NEJM Catalyst* (April 17, 2020). https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0111

Lawton R. Burns and Mark V. Pauly. "Detecting BS in Health Care," https://ldi.upenn.edu/brief/detecting-bs-health-care

Lawton R. Burns and Mark V. Pauly. "Detecting BS in Health Care 2.0," https://ldi.upenn.edu/brief/detecting-bs-health-care-20

Jeff Goldsmith and Lawton R. Burns, "Fail To Scale: Why Great Ideas In Health Care Don't Thrive Everywhere," September 29, 2016. http://healthaffairs.org/blog/2016/09/29/fail-to-scale-why-great-ideas-in-health-care-dont-thrive-everywhere/.

Jeff Goldsmith, Nathan Kaufman, and Lawton R. Burns. "The Tangled Hospital-Physician Relationship," May 9, 2016. http://healthaffairs.org/blog/2016/05/09/the-tangled-hospital-physician-relationship/.

Francois de Brantes and Lawton R. Burns, "Payment Reform Should Drive Delivery System Reform," April 16, 2009. http://healthaffairs.org/blog/2009/04/16/payment-reform-should-drive-delivery-system-reform/.

**Book Reviews:**

*Mergers of Teaching Hospitals in Boston, New York, and Northern Californi*a by John Kastor. Health Affairs 21(1): 266. 2002.

*Medicare's New Hospital Payment System: Is It Working?* by Louise Russell, American Political Science Review. 1992.

*Purchasing Power in Health: Business, The State, and Health Care Politics* by Linda Bergthold, American Political Science Review. 86(2): 524-525. 1992.

*All Organizations are Public* by Barry Bozeman, Contemporary Sociology (September).1988.

*Consumerism in Medicine* by Marie Haug and Bebe Lavin, American Journal of Sociology (January: 1004-1007. 1986.

**Wall Street Reports:**

Salomon Brothers PPM Perspectives Series - Wharton Professor Interview. New York: Salomon Brothers. 1997.

**Case Studies:**

Multispecialty Practice Plan at Academic Medical Center. 1997.

**RESEARCH UNDER REVIEW & CURRENT MANUSCRIPTS**

**Articles/Book Chapters:**

Lawton R. Burns, Mark V. Pauly, and Judd Hollander. "Can Retail Clinics Serve as a Healthcare Hub? Assessing the Rationales for Pharmacy-Insurer Mergers."

Allison Briggs and Lawton R. Burns. "Do Group Purchasing Organizations Help Hospitals to Reduce Supply Costs?"

Lawton R. Burns, Michael Housman, Allison Briggs, Robert Booth, and Aaron Koenig. "What Factors Shape Physician Preferences for Physician Preference Items?"

Jeffrey McCullough, Ira Moscovice, and Lawton R. Burns. "Integration and Competition in Physician Markets: Urban versus Rural Effects."

Lawton R. Burns, Mark V. Pauly, and Philip Rea. "How to Manage Scientific Innovation: Penn's Program in Life Sciences & Management (LSM)."

Lawton R Burns, Riitta Katila, Sruthi Thatchenkery, and Stefanos Zenios. "Innovation in Medical Device Startups: A Multi-Level Analysis".

**INDUSTRY PRESENTATIONS**

Palo Alto Medical Foundation (Palo Alto), July 1994
Western Network for Healthcare Education (Berkeley, CA), August 1994
Berlex Laboratories (NJ), January 1995
Main Line Health (Radnor, PA), January 1995

Medical Group Management Association, January 1995
St. Luke's Medical Center (K.C.), January 1995
Center for Physician Development, Beth Israel Hospital (Boston), May 1995
Johnson & Johnson Wharton Fellows Program, June 1995
American Healthcare Radiology Administrators (Nashville, TN), August 1995
Orthopedics in a Managed Care Environment (Scottsdale, AZ), October 1995
Massachusetts Health Data Consortium (Boston), September 1995
Berlex Laboratories (NJ), January 1996
Geisinger Medical Center (Danville, PA), January 1996
American Society of Ophthalmic Administrators, February 1996
Main Line Health (Radnor, PA), February 1996
Geisinger Medical Center (Danville, PA), May 1996
Johnson & Johnson Wharton Fellows Program, June 1996
American Society of Cataract and Refractive Surgery (Nashville), July 1996
VA/VISN 11 Task Force (An Arbor), November 1996
Health Strategy Network (Philadelphia), December 1996
American Society of Ophthalmic Administrators, January 1997
Main Line Health (Radnor, PA), February 1997
UNUM Insurance, March 1997
AHA Center for Health Care Leadership (Chicago), June 1997
Johnson & Johnson Wharton Fellows Program, June 1997
Prime Care/Merck (Staten Island), June 1997
Association of Professors of Medicine (Philadelphia), July 1997
University of Alabama Alumni of Health Administration (Fort Walton Beach), August 1997
HRET Future Focus Forum (Boston), September 1997
Illinois Hospital & Health Systems Association (Chicago), October 1997
Brazilian Social Security Cultural Institute, November 1997
Catholic University of Rome (Rome), November 1997
Italian National Agency for Health Care Services (Rome), November 1997
Memorial Health System (Springfield, IL), November 1997
Main Line Health (Radnor, PA), December 1997
American Society of Ophthalmic Administrators, January 1998
Association of Professors of Medicine (Scottsdale), February 1998
American Organization of Nurse Executives, March 1998 (San Diego)
American Society of Cataract and Refractive Surgery (Phoenix), March 1998
University of Alabama Executive Education Program for Physicians, March 1998
UNUM Insurance, March 1998
Johnson & Johnson Wharton Fellows Program, June 1998
Riverview Medical Center (Red Bank, NJ), June 1998
Smithkline Beecham, June 1998
Small & Rural Hospitals Constituency Section, IHHA (Springfield, IL), September 1998
National Association of Children's Hospitals (Houston), October 1998
Meridian Health System (NJ), October 1998
University of Alabama Executive Education Program for Physicians, October 1998
Premier Health Alliance (Chicago), November 1998
Martins Point Health Care (Portland, ME), January 1999
Association of Professors of Medicine (Scottsdale), February 1999
Children's Hospital (Columbus, OH), February 1999
Children's Memorial Hospital (Chicago, IL), February 1999
Christiana Care Physicians Organization (Wilmington, DE), February 1999
Johnson & Johnson (New Brunswick, NJ), February 1999
Martins Point Health Care (Portland, ME), February 1999
Integrated Healthcare 2000 (Vail, CO), March 1999
IBM Global Services (Palm Beach), April 1999
Interurban Clinical Club (Philadelphia), April 1999
East Coast Health Care Executive Summit (Boston), June 1999

Johnson & Johnson Wharton Fellows Program, June 1999
Premier Practice Management (Charlotte), June 1999
Annual Symposium on Governing Integrated Healthcare Systems (Aspen, CO), August 1999
University of Alabama Alumni of Health Administration (Fort Walton Beach), August 1999
Wisconsin Health & Hospital Association Convention (Lake Geneva), September 1999
Austral University (Argentina), October 1999
IBM Global Services (Palm Beach), October 1999
The Global Rx Supply Chain Conference (Philadelphia), October 1999
University of Alabama Executive Education Program for Physicians, October 1999
Symposium for Governing Healthcare Systems (Palm Springs), November 1999
Symposium on Governing/Managing Integrated Health Systems (Naples), January 2000
Annual Winter Symposium on Integrated Healthcare (Aspen), March 2000
Centocor/Johnson & Johnson (Cincinnati), April 2000
INSEAD, Seminar on Healthcare Management (Fontainebleau), May 2000
Merck Advisory Board (Chicago), May 2000
National Association of Children's Hospitals (Philadelphia), September 2000
SmithKline Beecham (Philadelphia), September 2000
University of Alabama Physician Leadership Institute (Birmingham), October 2000
Johnson & Johnson Hospital Program/National University of Singapore, November 2000
Sparrow Hospital and Health System (Lansing, MI), November 2000
Glaxo SmithKline Industry Conference, (Raleigh, NC), May 2001
J&J Wharton CEO Program in Health Care Leadership (Philadelphia), October 2001
Johnson & Johnson Hospital Program/National University of Singapore, November 2001
Johnson & Johnson Health System CEO Forum (Philadelphia, PA), December 2001
Ochsner Clinic Foundation (New Orleans, LA), December 2001
Chestnut Hill Health Care - Board Retreat (Philadelphia), February 2002
Glaxo SmithKline Pharmacy Leaders (Philadelphia), February 2002
Health Industry Distributors Association (Tucson, AZ), March 2002
College of Surgeons (Philadelphia), "Lessons from the Allegheny Bankruptcy," April 2002
Center for Health Management Research CHMR Value Chain," May 2002
Goldman Sachs Institutional Investors (NYC), "Improving the Health Care Value Chain," May 2002
Health Industry Group Purchasing Association Global Summit (Amsterdam), May 2002
Putnam Institutional Investors (Boston), "Improving the Health Care Value Chain," May 2002
Accenture Conference on Supply Chain Excellence (London, UK), June 2002
Association for Health Services Research and Policy (Washington D.C.), June 2002
Johnson & Johnson Nurse Fellows Program, "Integrated Delivery Networks," June 2002
American Society of Ophthalmic Administrators and American Society of Corrective and Refractive Surgeons (ASOA/ASCRS), August 2002
Association for Health Resource and Materials Management (San Antonio), August 2002
IDN Summit (Atlanta), "Improving the Health Care Value Chain," September 2002
UniMED (Sao Paolo), September 2002
VHA West Materials Managers Meeting, September 2002
Workshop on Antitrust in Health Care. Federal Trade Commission (Washington D.C.), "Group Purchasing Organizations and Antitrust Implications," September 2002
Health Industry Group Purchasing Association (Orlando), October 2002
Healthcare Marketing and Manufacturers Council (Chicago), November 2002
Johnson & Johnson Hospital Management Program (Singapore), November 2002
Premier 2002 Partnerships Meeting (Chicago), November 2002
Dade Behring (Fort Lauderdale), January 2003
Premier Governance Education Conference (Naples), January 2003
NCI Conference on Hospital Systems (Orlando), January 2003
International Pharmaceutical Wholesalers Conference (New York), February 2003
Aventis Pharmaceuticals (Philadelphia), April 2003
Inova Health Systems (Virginia), April 2003
VHA Leadership Conference (Boston), April 2003
Premier Leadership Conference (Las Vegas), May 2003

Humana (Philadelphia), June 2003
Association of Biotechnology Financial Officers (Scottsdale), June 2003
UniMED (Sao Paolo), July 2003
Dade Behring Executive Team (Philadelphia), July 2003
Association of Healthcare Resource and Materials Managers (San Diego), August 2003
McKesson Corporation (Atlanta), August 2003
W.L. Gore & Associates (Maryland), August 2003
UNIMED (Philadelphia), September 2003
Kettering Medical Center Network (Dayton), October 2003
DePuy, November 2003
Johnson & Johnson Hospital Management Program (Singapore), November 2003
Ethicon (Somerville, NJ), January 2004
Health Industry Distributors Association (Amelia Island Plantation), March 2004
Lehigh Valley Health System (Allentown), March 2004
Heritage Valley Health System (Beaver, PA), April 2004
New England Health Care Assembly (Worcester, MA), April 2004
Ohio State Medical Society (Cincinnati), May 2004
Inova Health System (Virginia), May 2004
American Medical Association - HMSS Section (Chicago), June 2004
Johnson & Johnson Contract Excellence (Princeton), September 2004
Chesapeake General Hospital (Williamsburg), September 2004
Biosciences Forum (Philadelphia), October 2004
Cooper Heart Institute (Voorhees, NJ), October 2004
Adventist Health Care (Nemacolin, PA), October 2004
Christiana Care (Wilmington, DE), November 2004
Christiana Care (Wilmington, DE), January 2005
Cooper University Hospital (Camden, NJ), May 2005
Cerner Corporation May 2005
HDMA (Orlando, FL), June 2005
Johnson & Johnson Wharton Nurse Fellows Program, June 2005
Maine Health (Bar Harbor, ME), October 2005
Greater New York Hospital Association (NYC), October 2005
DePuy (Puerto Rico), January 2006
Broadlane Annual Client Summit (Dallas), March 2006
Owens & Minor Board Retreat (Richmond), March 2006
Johnson & Johnson/ Wharton Executive Management Academy, April 2006
Cooper University Hospital - Heart Institute Advisory Board, May 2006
Medtronic Marketing Leader Program (Minneapolis), May 2006
Johnson & Johnson/Wharton Nurse Fellows Program, June 2006
Medtronic Directors Program, July 2006
Sisters of Charity of Leavenworth Health System (San Diego), October 2006
Health Industry Group Purchasing Association (HIGPA), 2006 Expo, October 2006
National Federation of Municipal Analysts. (Washington, D.C.), November 2006
ECRI Conference on "Confronting Dilemmas of Risk in Healthcare" (Plymouth Meeting, PA), November 2006
Greater New York Hospital Association (NYC), November 2006
Johnson and Johnson/ Wharton Hospital CEO Program, November 2006
South Jersey Healthcare, December 2006
Medtronic Director Development Program, January 2007
World Congress Summit on Healthcare Supply Chain Management, January 2007
Johnson & Johnson Health Care Systems National Meeting, February 2007
Lancaster General Hospital Leadership Conference, April 2007
Medtronic Directors Program, May 2007
United Healthcare (Minneapolis), May 2007
Cooper Health System, June 2007
Healthcare Distribution Management Association, June 2007
Johnson & Johnson/ Wharton Nurse Fellows Program, June 2007

Teva Pharmaceuticals, June 2007
Eisai Pharmaceuticals, July 2007, August 2007
Hospital & Healthcare Association of Pennsylvania, July 2007
Novartis, July 2007
United HealthCare, July 2007
Medtronic Directors Program, August 2007
University of Miami / Humana Health Services Research Center, January 2008
United Healthcare, January 2008
Kaiser Permanente Institute for Health Policy, February 2008
United HealthCare, April 2008
Cooper University Hospital, May 2008
Trinity College - Dublin, June 2008
Health Services Executive, Republic of Ireland, June 2008
Johnson & Johnson / Wharton Nurse Fellows Program, June 2008
Medtronic Directors Program, June 2008
Lehigh Valley Health System, June 2008
Health Industry Group Purchasing Association (HIGPA), October 2008
Ephrata Community Hospital. September 2008
American Health & Drug Benefits Conference, October 2008
World Health Care Information Technology Congress, December 2008
Novartis, February 2009
Astra-Zeneca, March 2009.
LeHigh Valley Health System, April 2009
West Penn Allegheny Health System, April 2009
McKesson, April 2009
West Penn Allegheny Health System, June 2009
Boston Scientific, June 2009
Cooper Heart Institute, June 2009
Johnson & Johnson / Wharton Nurse Fellows Program, July 2009
Beijing University, August 2009
Anesthesia Business Group, September 2009
American Health & Drug Benefits Conference, October 2009
Indian School of Business, Hyderabad, January 2010
World Economic Forum, Davos (Switzerland), January 2010
West Penn Allegheny Health System, March 2010
Medtronic, March 2010
Universal Health Services, March 2010
Wheaton Franciscan Health System, April 2010
Johnson & Johnson/Wharton Nurse Fellows, June 2010
Anesthesia Business Group, September 2010
Sanofi/Aventis, September 2010
Cooper Heart Institute, September 2010
Academy Health and Research Insights, December 2010 and February 2011
Methodist Health System, February 2011
Lockheed Martin, March 2011
Becton Dickinson, April 2011
Association of Health Journalists, April 2011
VHA Leadership Conference, May 2011
MacEachern Symposium/Kellogg Graduate School of Management, May 2011
West Penn Allegheny Health System, June 2011
Johnson & Johnson, June 2011
Harkness Fellows Program, September 2011
APAX Partners, October 2011
Anesthesia Business Group, January 2012
PricewaterhouseCoopers, March 2012
Morgan Stanley, May 2012

US-China Biopharma Congress 2012 & SAPA-GP 10th Annual Conference, June 2012
HealthTrust, July 2012
Rite-Aid, August 2012
Edwards Life Sciences, December 2012
Anesthesia Business Group, January 2013
Astra-Zeneca, January 2013
US Congressional Staffers & Health Industry Group Purchasing Association, January 2013
Edwards Life Sciences, April/May 2013
Rite-Aid, August 2013
Edwards Life Sciences, August 2013
Novo Nordisk, December 2013
Anesthesia Business Group, January 2014
Novo Nordisk, January 2014
Securities Industry Institute, March 2014
Novo Nordisk, April 2014
World Bank, April 2014
Wharton Global Forum – Beijing , June 2014
Novo Nordisk, October 2014
Novartis, October 2014
Edwards Life Sciences, October 2014
Vertex Pharmaceuticals, November 2014
Edwards Life Sciences, November 2014
Webinar on India's Healthcare System, November 2014
Penn Medicine - University of Pennsylvania, January 2015
Anesthesia Business Group, January 2015
McKesson, February 2015
Vertex Pharmaceuticals, February 2015
Edwards Life Sciences, March 2015
Securities Industry Institute, March 2015
Princeton Healthcare Conference, May 2015
Genentech, July 2015
Mayo Clinic, September 2015
Genentech, October 2015
Bristol-Myers Squibb, October 2015
Novartis, November 2015
The Health Industry Forum, November 2015
Anesthesia Business Group, February 2016
Securities Industry Institute, March 2016
Novo Nordisk – China, April 2016
Genentech, April 2016
Edwards Life Sciences, May 2016
Sino-American Pharmaceutical Professionals Association (SAPA), June 2016
Janssen Pharmaceuticals, August 2016
Cooper Health System, September 2016
Edwards Life Sciences, November 2016
Massachusetts Association of Health Plans, November 2016
Webinar on China, December 2016
Anesthesia Business Group, February 2017
Center for Therapeutic Effectiveness Research, April 2017
China – U.S. Business Leaders Roundtable, NYC, April 2017
Edwards Life Sciences, April 2017
Lehigh Valley Business Coalition, May 2017
Central Pennsylvania Business Group on Health, September 2017
Healthcare Executives Leadership Network, January 2018
Securities Industry Institute, March 2018
Population Health Colloquium, Jefferson Health, March 2019

Securities Industry Institute, March 2019
Physician Group Practice Strategic Transactions, NYC, April 2019
Novo Nordisk, Philadelphia, June 2019
Veterinary Trends, Philadelphia, June 2019
Association of Academic Health Centers, Boston, July 2019
Teva Pharmaceuticals, September 2019
Central Pennsylvania Business Group on Health, October 2019
Pharma & Healthcare Business Summit, University of the Sciences, February 2021
Securities Industry Institute, March 2021
Medtronic, July 2021

**ACADEMIC DIRECTOR - EXECUTIVE EDUCATION PROGRAMS**

American Society of Ophthalmic Administrators (ASOA), August 2002

Johnson & Johnson Health Care Systems, April 2003

Aventis Pharmaceuticals, January 2003, April 2003, October 2003, February 2004

Humana, June 2003

Eisai Pharmaceuticals, July - December 2007

Novo Nordisk, October 2014

Bristol-Myers Squibb, October 2015

American Association of Orthodontists, Spring-Summer 2021

**FEDERAL/STATE GOVERNMENT: EXPERT WITNESS TESTIMONY**

Federal Trade Commission: "Group Purchasing Organizations and Antitrust Implications." Workshop on Antitrust in Health Care. Federal Trade Commission. September 9, 2002.

Federal Trade Commission: "Hospital Vertical Integration and Antitrust Implications." Joint FTC/DOJ Hearings on Health Care and Competition Law and Policy. April 9, 2003.

Senate Judiciary Committee, Subcommittee on Antitrust, Hearings on Independence Blue Cross, April 12, 2004.

Expert Witness. Federal Trade Commission. *FTC v. Piedmont Health Alliance*. 2004.

Expert Witness. Federal Trade Commission. *FTC v. Evanston Northwestern Healthcare Medical Group*. 2004-2005.

Medicare Payment Advisory Commission. (MedPAC), “Perspectives on Physician Group Practices,” October 2006.

Senate Judiciary Committee, Subcommittee on Antitrust, Hearings on IBC - Highmark Merger. April 9, 2007

Pennsylvania Senate, Committee on Banking and Insurance, Hearings on IBC - Highmark Merger. June 26, 2007.

Federal Trade Commission, "Clinical Integration in Health Care: A Check-up," May 29, 2008

Expert Witness. Department of Justice. *DOJ v. Childrens' Health Associates*, 2009.

Expert Witness. Department of the Treasury. *IRS Commissioner v. Boston Scientific*, January 2013 – 2016.

Federal Trade Commission, Health Care Competition Workshop, February 2015

Expert Witness, Federal Trade Commission, United States v. St. Cloud Medical Group / CentraCare Health, 2016

Expert Witness, Department of Justice, United States and State of Michigan vs. Hillsdale Community Health Center and Allegiance Health, 2016

Expert Witness, Department of Justice, United States V. Aetna and Humana, 2016

Expert Witness, Attorney General, State of Washington, State of Washington v. Franciscan Health System, 2017-18

Expert Witness, Attorney General, State of Rhode Island, Rhode Island Attorney General v. Lifespan/Care New England

**PRIVATE SECTOR: EXPERT WITNESS TESTIMONY**

Cravath, Swaine, and Moore. *Unsecured Creditors of Allegheny Health, Education and Research Foundation v. PricewaterhouseCoopers*. 2004-2005.

Sidley Austin. *ConMed Corporation v. Ethicon/Ethicon Endo-Surgery*. 2005.

Boies, Schiller & Flexner. *Spartanburg Regional Healthcare System v. Hillenbrand Industries*. 2005.

Winston and Strawn. *Rochester Medical Corporation v. C.R. Bard*. 2006.

*ECRI v. Guidant*, 2007

Goodwin Proctor. *USA v. Richard Lane*, 2008.

Winston and Strawn. *Southeast Missouri Hospital and Saint Francis Medical Center v. C.R. Bard*, 2009.

Venable. *Retractable Technologies Inc. v. Abbott Laboratories*, 2009-2010.

Baker and McKenzie. *Medtronic Inc. v. IRS Commissioner*, 2010.

Morgan, Lewis and Bockius. *USA v. Amgen*, 2011.
Greenberg Traurig. *Freedom Medical v. Universal Hospital Services*, 2011.

Akin Gump Hauer Strauss and Feld. *Lenox MacLaren v. Medtronic*, 2012, 2015.

Lowis & Gellen. *Fabiszak v. Silver Cross Hospital*, 2013.

Bubb, Grogan, and Cocca, *AHS Hospital Corporation v. Town of Morristown*, 2013.

Buchanan Ingersoll & Rooney. *Aetna Life Insurance v. Foundation Surgical Associates*, 2015.

Dykema. *Kerrins v. Palos Community Hospital*, 2016.

Hamstead Williams & Shook, Wiles v. West Virginia University Hospitals, 2017-2018

Lowenstein Sandler, Appraisal of Team Health Holdings, 2018

Lowenstein Sandler, Brigade Capital v. Kindred Healthcare, 2018-2019

American Medical Association. CVS Health / Aetna Merger. 2018

Dorsey & Whitney, *Consolidated Class Action Lawsuit – EpiPen ERISA Litigation*, 2019-2020.

Lieff, Cabraser, Heimann & Bernstein. The Hospital Authority of Metropolitan Government of Nashville & American Federation of State, County, and Municipal Employees District Council 37 Health and Security Plan. 2019.

Kirkpatrick Townsend. Premera v. The Everett Clinic, Eastside Family Medical Clinic. 2020.

Oxley Rich Sammons. Jane Doe and West Virginia Residents v. Steven Matulis. 2021.

Wilmer Cutler Pickering Hale & Dorr, Vascular Solutions v. Medtronic 2021-2022

**PROFESSIONAL ACTIVITIES**

**Editorial Board:**

Health Care Management Review (1992-2000). Associate Editor (1994-2000)
Health Services Research (1994-Present)
AUPHA / Health Administration Press

**Governmental Research Review Committees:**

Agency for Health Care Policy & Research:
Health Services Research Review Subcommittee (1994-1998)

**Consulting Reviewer (Journals):**

Academy of Management Journal
Administrative Science Quarterly
Health Affairs
Health Care Management Review
Inquiry
Journal of American Medical Association
Journal of Health Economics
Journal of Management Studies
Medical Care
Milbank Fund Quarterly
Social Science and Medicine
Strategic Management Journal

**Consulting Reviewer (Grants):**

Agency for Health Care Policy and Research (Rockville, MD)
Health Care Financing Administration (Baltimore, MD)
Robert Wood Johnson Foundation
Veterans Administration (Washington, DC)

**Affiliations:**

Academy of Management
American Hospital Association
Association for Health Services Research

**TEACHING**

Integrated Delivery Systems
Analysis of Health Systems
Comparative Health Care Management
Organizational Behavior
Health Care Strategy
Organizational Change
Innovation in India's Health Care System
Life Sciences & Management
Seminar on the Professions
Health Care Policy
Evaluation Research
Issues in Rural Health Care
Managed Care & Industrial Organization of Healthcare
Strategic Implementation
China's Healthcare System & Reform
Health Systems Science

# EXHIBIT B

HONORABLE JUDGE 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,<br><br>Plaintiff,<br><br>vs.<br><br>BLUE CROSS BLUE SHIELD OF ILLINOIS,<br><br>Defendants. | Case No. 3:20-cv-06145-RJB<br><br>**EXPERT DECLARATION OF MICHAEL K. LAIDLAW, M.D.** |

I, Michael K. Laidlaw, M.D., hereby declare as follows:

## I. Expert Witness Background & Qualifications

1. My name is Michael K. Laidlaw. I am over the age of eighteen and submit this expert declaration based on my personal knowledge and experience.

2. I am a board-certified endocrinologist. I received my medical degree from the University of Southern California in 2001. I completed my residency in internal medicine at Los Angeles County/University of Southern California Medical Center in 2004. I also completed a fellowship in endocrinology, diabetes, and metabolism at Los Angeles County/University of Southern California Medical Center in 2006.



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

3. I have been board certified by (1) the National Board of Physicians and Surgeons for Endocrinology, Diabetes & Metabolism, (2) the National Board of Physicians and Surgeons for Internal Medicine, and (3) the American Board of Internal Medicine for Endocrinology, Diabetes and Metabolism.

4. The information provided regarding my professional background are detailed in my curriculum vitae. A true and correct copy of my curriculum vitae is attached as Exhibit A.

5. In my clinical practice as an endocrinologist, I evaluate and treat patients with hormonal and/or gland issues. Hormone and gland disorders can cause or be associated with psychiatric symptoms, such as depression, anxiety, and other psychiatric symptoms. Therefore, I frequently assess and treat patients demonstrating psychiatric symptoms and determine whether their psychiatric symptoms are being caused by a hormonal issue, gland issue, or a different cause. 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. Indeed, the expert witnesses retained by Plaintiffs in this case treat gender dysphoria as presumptively a hormone and gland disorder. The Endocrine Society has issued guidelines for the diagnosis and treatment of gender dysphoria.

## II. Summary of Work Performed

6. I have been retained by Blue Cross Blue Shield of Illinois ("BCBSIL") to provide a rebuttal expert opinion in response to the declarations of the expert declarations of Dr. Randi C. Ettner, Ph.D.; Dr. Dan H. Karasic, M.D.; and Dr. Loren S. Schechter, M.D.

7. If called to testify in this matter, I would testify truthfully and based on my expert opinion. The opinions and conclusions I express herein are based on a reasonable degree of scientific certainty.

8. I am being compensated at an hourly rate of $450 per hour plus expenses for my time spent preparing this declaration and $650 per hour for providing testimony in this matter. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.



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

9. My opinions contained in this report are based on: (1) my clinical experience as an endocrinologist; (2) my clinical experience evaluating individuals who have or have had gender incongruence and/or gender dysphoria; (3) my knowledge of research and studies regarding the treatment of gender dysphoria, including for minors; and (4) my review of the various declarations submitted by Plaintiffs in the present lawsuit, *C.P. et al. v. Blue Cross Blue Shield of Illinois*, Case No. 3:20-cv-06145-RJB (W.D. Wash).

10. I was provided with and reviewed the following case-specific materials: (1) C.P.'s medical records from the Polyclinic; (2) the deposition of Plaintiff Patricia Pritchard; (3) the depositions of C.P.'s treating providers, Kevin Hatfield, M.D.; Jeffrey Kyllo, M.D.; and Sharon Booker, MA, LHMC; and (4) the expert declarations of Dr. Randi C. Ettner, Ph.D.; Dr. Dan H. Karasic, M.D.; and Dr. Loren S. Schechter, M.D., and (5) the deposition of Blue Cross Blue Shield of Illinois Medical Director, Kim Reed, M.D..

## III. Summary of Opinions

11. In my professional opinion, treatment interventions on behalf of individuals diagnosed with gender dysphoria must be held to the same scientific standards as other medical treatments. These interventions must be optimal, efficacious, and safe. Any treatment which alters biological development in children should be used with extreme caution and regarded as a last resort.

12. The Plaintiffs' experts' opinions are substantively the same. They each opine that for patients with gender dysphoria, the only acceptable path forward that meets the standard of care is the approach endorsed by the World Professional Association for Transgender Health ("WPATH").

13. The implication is that if an employer excludes gender affirmative care from coverage, it must be because the employer is prejudiced against transgender individuals. This is demonstrably false.

14. In my opinion, these opinions are too absolute and the product of political advocacy. There is ongoing debate and study in the medical community regarding gender



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

affirmative treatment. 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. This is especially true for minors.

15. For example, Plaintiffs' experts opine that gender dysphoria is an immutable, permanent condition. That is not the consensus in the relevant community and there is much debate and disagreement about whether gender dysphoria is always permanent.

16. A recurring problem is the quality of medical care received by minors who undergo irreversible gender-affirming treatments. This appears to result at least in part because gender dysphoria treatments are so entangled with advocacy. WPATH itself recognizes that it is not only a scientific organization but also as an advocacy organization, and these two objectives are not compatible.

17. Based on the materials I have reviewed and in my professional opinion, the treatment of C.P. is indicative of these quality-of-care problems that I have observed.

## IV. Analysis.

### A. Background

#### 1. The WPATH and The Endocrine Society

18. I have read the reports of expert witnesses retained by Plaintiffs in this case, Randi C. Ettner, Ph.D., Dan H. Karasic, M.D., and Loren S. Schechter, M.D. Drs. Ettner, Karasic, and Schechter all rely almost exclusively on the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People* (7th version) (WPATH *Standards of Care*). *See* Ettner Report, ¶¶ 33-34; Karasic Report, ¶¶ 25-34, 43-44; Schechter Report, ¶¶ 24-27. These experts also briefly cite the Endocrine Society guidelines for support. *See* Ettner Report, ¶ 54; Karasic Report, ¶¶ 35-36; Schechter Report, ¶ 26.

19. Dr. Ettner is the immediate past Secretary of the World Professional Association for WPATH and has been a member of the Board of Directors for 12 years. Dr. Ettner is an author of the WPATH *Standards of Care*.



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

20. Dr. Karasic previously sat on the Board of Directors of WPATH. Dr. Karasic Ettner is also an author of the WPATH *Standards of Care*. Dr. Karasic is also a member of the WPATH Global Education Initiative.

21. Dr. Schechter is also a contributing author to the WPATH *Standards of Care*. Dr. Schechter has taught a number of courses through WPATH's Gender Education Institute.

22. The WPATH *Standards of Care* were produced over a decade ago, in 2011. They were prepared within their advocacy organization and are purported to be a "professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria" (WPATH, 2022). However, there is no "professional consensus" on these issues in the medical community at this time. Furthermore, WPATH's "Standards of Care," unlike the Endocrine Society's guidelines, do not have a grading system for either the strength of their recommendations or the quality of the evidence presented.

23. There is widespread agreement among relevant health care providers that WPATH is not merely a scientific organization but also as an advocacy organization that supports gender affirmative surgery. WPATH explicitly regards itself as such. WPATH has advocated positions on issues that have drawn varying opinions and views in the relevant medical community.

24. WPATH's *Standards of Care*, in contrast to, for example, the Endocrine Society's guidelines, do not follow recognized procedures for establishing the guidelines as the fruit of genuine scientific method. For example, the *Standards of Care* lack a grading system for the strength of its recommendations or the quality of the evidence presented to support its recommendations. WPATH claims to be a scientific organization while explicitly acting as an advocacy group. These are incompatible goals.

25. WPATH no longer considers preoperative psychotherapy to be a requirement before gender affirmative surgery. This follows many years in which the role of WPATH downgraded the role of psychotherapy. Many facilities that follow WPATH standards permit



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

patients to receive counseling from individuals with masters rather than medical or PhD degrees or clinical psychology qualifications.

26. While the Endocrine Society has issued "Endocrine Treatment of Gender-Dysphoric / Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," these are only "guidelines." The Endocrine Society's guidelines specifically state that their "guidelines cannot guarantee any specific outcome, nor do they establish a standard of care" (Hombre *at al.,* 2017, p. 3895).

27. In the Endocrine Society's guidelines, the quality of evidence for the treatment of adolescents is rated "very low-quality evidence" and "low quality evidence." "The quality of evidence for [puberty blocking agents] is noted to be low. In fact, all of the evidence in the guidelines with regard to treating children/adolescents by [gender affirmative therapy] is low to very low because of the absence of proper studies" (Laidlaw et al., 2019).

28. Unlike some other recommendations for adolescent Gender Affirmative Therapy ("GAT"), the Endocrine Society's guidelines do not include any grading of the quality of evidence specifically for their justification of laboratory ranges of testosterone or estrogen or for adolescent mastectomy or other surgeries.

29. Endocrinologists W. Malone and P. Hruz and colleagues have written discussing the limitations of the Endocrine Society's guidelines as well: "Unlike standards of care, which should be authoritative, unbiased consensus positions designed to produce optimal outcomes, practice guidelines are suggestions or recommendations to improve care that, depending on their sponsor, may be biased. In addition, the ES claim of effectiveness of GAT interventions is at odds with several systematic reviews, including a recent Cochrane review of evidence and a now corrected population-based study that found no evidence that hormones or surgery improve long-term psychological well-being. Lastly, the claim of relative safety of these interventions ignores the growing body of evidence of adverse effects on bone growth, cardiovascular health, and fertility, as well as transition regret" (Malone et al., 2021).



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

**2. Gender Dysphoria as a Subjective, Psychological Condition with Unknown Causes**

30. ***According to Dr. Ettner, "A growing assemblage of research documents that gender identity is immutable and biologically based."*** Ettner Report, ¶ 25.

31. This assertion lacks scientific support and therefore impairs the credibility of Dr. Ettner's opinions. There is no objective physical measure to identify either gender identity or gender dysphoria. One cannot do imaging of the human brain to find the gender identity. Likewise, there is no other imaging, laboratory tests, biopsy of tissue, autopsy of the brain, or genetic testing that can identify the gender identity. There is no known gene that maps to gender identity or to gender dysphoria.

32. Gender dysphoria is a psychological diagnosis. It is diagnosed purely by psychological methods of behavioral observation and questioning.

33. Likewise, what is termed gender identity is a psychological concept. It has no correlate in the human body. "There are no laboratory, imaging, or other objective tests to diagnose a 'true transgender' child" (Laidlaw et al., 2019).

34. This is in contrast to all other endocrine disorders which have a measurable physical change in either hormone levels or gland structure which can be confirmed by physical testing. Endocrinology is the study of glands and hormones. Endocrine disorders can be divided into three main types: those that involve hormone excess, those that involve hormone deficiency, and those that involve structural abnormalities of the glands such as cancers.

35. Notably, Noteworthy in these three types is that all three disease conditions are diagnosed by physical observations. In other words, a laboratory test of a hormone, an imaging test of an organ, an examination of cells under a microscope, or all three may be employed in the diagnosis of endocrine disease.

**3. There is Evidence of Substantial Desistance Among Those Who Have Received Gender Affirming Care.**

*36.* ***According to dr. Ettner, "[e]fforts to change an individual's gender identity are therefore both futile and unethical" because [t]he evidence demonstrating that gender identity***



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

***cannot be altered, either for transgender or for non-transgender individuals," and is therefore "innate and immutable."*** Ettner Report, ¶ 25. ***According to Dr. Karasic, "[r]egret among those who are treated with gender-affirming medical care is rare."*** Karasic Report, ¶ 51.

*37.* There is substantial evidence to the contrary.

38. These assertions are not supported by the scientific evidence. Gender dysphoria is a persistent state of distress that stems from the feeling that one's gender identity does not align with their physical sex (American Psychiatric Association, 2013).

39. Desistance is a term indicating that the child, adolescent, or adult who initially presented with gender incongruence has come to experience a realignment of their internal sense of gender and their physical body.

40. "There is currently no way to predict who will desist and who will remain dysphoric." "Children with [gender dysphoria] will outgrow this condition in 61% to 98% of cases by adulthood. (Laidlaw et al., 2019).

41. Because the rate of desistance is so high, gender affirmative therapy will necessarily cause serious and irreversible harm to many children and adolescents who would naturally outgrow the condition if not affirmed.

42. With respect to minors, because there is no physical marker to diagnose gender identity, and because it is not possible to predict which child or adolescent will desist, it is not possible to know which young person will still identify as transgender as an adult.

43. Concern for desistance has increased as, in recent years, there have been very significant increases in referrals for this condition noted around the globe. For example, in the UK, "[t]he number of referrals to GIDS [Gender Identity Development Service] has increased very significantly in recent years. In 2009, 97 children and young people were referred. In 2018 that number was 2519" (Bell v. Tavistock Judgment, 2020). (Littman, 2018).

44. The likelihood of desistance may be greater if there are social causes of gender dysphoria, because those are transient. The French National Academy of Medicine, the premier such academy in the country and founded in 1820 by Louis XVIII, wrote recently: "Parents



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

addressing their children's questions about transgender identity or associated distress should remain vigilant regarding the addictive role of excessive engagement with social media" (SEGM, 2022).

45. The large percentage of individuals suffering from diagnosed mental illnesses also is reason for concern about dissidence. In "a study of the Finnish gender identity service, '75% of adolescents [assessed] had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria' (Kaltiala-Heino, 2015). In fact, '68% had their first contact with psychiatric services due to other reasons than gender identity issues.' The same study also showed that 26% percent had an autistic spectrum disorder and that a disproportionate number of females (87%) were presenting to the gender clinics compared to the past" (Laidlaw in gdworkinggroup.org, 2018).

**4. Biological Sex in Contrast to Gender Identity**

46. ***According to Dr. Ettner, "a number of factors go into the determination of a person's sex." Dr. Ettner then lists a number of physical factors and then adds "gender identity."*** Ettner, ¶ 21.

**a. Human Sexual Development**

**(1) Embryologic development**

47. Another confirmation that there are only two biological sexes comes from what is known about embryologic development and fertilization. The biologic development of the human person begins with a gamete from a female termed an ovum or egg and a gamete from a biological male which is termed sperm. The fertilization of the egg by the sperm begins the process of human biological development. The cells of the fertilized ovum then multiply and the person undergoes the incredible changes of embryologic development.

48. It is noteworthy that the male sperm comes from the biological male and the female egg comes from the biological female. There is no other third or fourth or fifth type of gamete that exists to begin the development of the human person. This is consistent with the binary nature of human sex (Alberts et al., 2002).



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

49. The sex binary of the human embryo is further developed between roughly weeks 8 to 12 of human development. There are two primitive structures present within the developing embryo called the Wolffian duct and Mullerian ducts (Larsen et al., 2003). The Wolffian ducts develop into substructures of the genitalia including the vas deferens and epididymis which belong exclusively to the male sex. For the female, the Mullerian ducts go on to form the uterus, fallopian tubes, cervix and upper one third of the vagina which belong exclusively to the female sex (*Id.*)

50. Significantly, once the male structures are developed from Wolffian ducts, the Mullerian ducts are obliterated. This means that throughout the rest of embryological development the Mullerian ducts will not form into biological female structures. Likewise, in the female, the Wolffian ducts are destroyed by week 12 and will not form male structures at any point in the future (*Id.*).

51. Thus, we can see in very early development that the sex binary is imprinted physically not only in the chromosomes, but also on the very organs that the body produces. Additionally, the potential to develop organs of the opposite sex is eliminated. Thus, in the human being there are only two physical tracts that one may progress along, the one being male and the other being female (Wilson and Bruno, 2022).

**(2) Pubertal Development**

52. At the time of birth, an infant's sex is easily identified through observation of the genitalia. Corresponding internal structures could also be confirmed through imaging if needed.

53. In early childhood, some low level of sex hormones are produced by the sex glands. The male testes produce testosterone. The female ovaries produce primarily the hormone estrogen. These sex glands remain quiescent for the most part, producing low levels of sex hormones until the time of pubertal development.

54. Puberty is a time of development of the sex organs, body, brain, and mind. There are well known changes in physical characteristics of the male such as growth of facial hair, deepening of the voice, and increasing size of the testicles and penis. Importantly, the testicles



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

will develop sperm under the influence of testosterone and become capable of ejaculation. Because of these changes, the male will become capable of fertilizing an egg. The inability to produce sperm sufficient to fertilize an egg is termed infertility.

55. For the female, pubertal development includes changes such as breast development, widening of the pelvis, and menstruation. The female will also begin the process of ovulation which is a part of the menstrual cycle and involves the release of an egg or eggs from the ovary. Once the eggs are released in a manner in which they can become fertilized by human sperm, then the female is termed fertile. The inability to release ovum that can be fertilized is termed infertility (Kuohong and Hornstein, 2021).

**(3) Tanner stages of development**

56. From a medical perspective it is important to know the stage of pubertal development of the developing adolescent. This can be determined through a physical examination of the body. The female will have changes in breast characteristics and pubic hair development. Similarly, the male will have changes in testicular size and pubic hair development. These findings can be compared to the Tanner staging system which will allow the stage of puberty to be known.

57. Tanner stages are divided into five stages. Stage 1 is the pre-pubertal state before pubertal development of the child begins. Stage 5 is full adult sexual maturity. Stages 2 through 4 are various phases of pubertal development (Greenspan and Gardner, 2004).

58. Awareness of the Tanner stage of the developing adolescent is also useful to assess for maturation of sex organ development leading to fertility. For girls, the first menstruation (menarche) occurs about two years after Tanner stage 2 and will typically be at Tanner stage 4 or possibly 3 (Emmanuel and Boker, 2022). The first appearance of sperm (spermarche) will typically be Tanner stages 4 (*Id.*). If puberty is blocked or disrupted before reaching these critical stages, the sex glands will be locked in a premature state and incapable of fertility.



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

**(4) Biological Sex Cannot Be Changed**

59. It is not possible for a person to change from one biological sex to the other, and there is no technology that allows a biological male to become a biological female or vice-versa. It is not technologically possible at this time to change sex chromosomes; these will remain in every cell throughout life. It is not technologically possible to transform sex glands from one to the other. In other words, there are no hormones or other means currently known to change an ovary into a testicle or a testicle into an ovary.

60. Furthermore, as noted earlier, several of the sex specific structures (such as the epidymis of the male or uterus of the female) are produced early in embryological development from around weeks 8 to 12. The primitive ducts which lead to these organs of the opposite sex are obliterated. There is no known way to resuscitate these ducts and continue development of opposite sex structures.

61. It is also not possible to produce gametes of the opposite sex. In other words, there is not any known way to induce the testicles to produce eggs. Nor is there any known way to induce the ovaries to produce sperm. Therefore, creating conditions for a biological female to create sperm capable of fertilizing another ovum is impossible. The induction of opposite sex fertility is impossible.

62. In fact, some gender affirming therapy actually leads to infertility and potential sterilization.

**B. Effectiveness and Safety of Gender Affirmative Therapies Recommended by WPATH**

63. According to Dr. Ettner, ***"[t]here is a large and growing body of evidence that demonstrates that the provision of gender affirming medical and surgical treatment to treat gender dysphoria are both safe and effective."*** Ettner, Report, ¶ 49. According to Dr. Karasic, ***"gender dysphoria is a condition that is highly amenable to treatment, and the prevailing treatment for it is highly effective. . . .Gender-affirming medical and surgical interventions in accordance with the WPATH SOC 7 and Endocrine Society Guidelines are widely recognized***



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

***in the medical community as safe, effective, and medically necessary for many transgender people with gender dysphoria…risks do decline when transgender individuals are supported and live according to their gender identity."*** Karasic Report, ¶¶ 24, 43. Dr. Schechter's testimony is the same. Schechter Report, ¶¶ 37-41.

64. The scientific evidence does not support these unequivocal assertions. Gender affirmative therapy suffers from a lack of a quality evidence base and from poorly-performed studies.

65. The approaches to gender dysphoria may be divided into three main types. (Zucker, 2020). One is psychosocial treatment that helps the young person align their internal sense of gender with their physical sex. Another would be to "watch and wait" and allow time and maturity to help the young person align sex and gender through natural desistance. The third option is referred to as gender affirmative therapy or GAT and is the approach recommended by WPATH.

66. GAT consists of psychosocial, medical, and surgical interventions that attempt to psychologically and medically alter the patient so that they come to believe they may become similar to the physical sex which aligns with their gender identity (but not their biological sex) and thereby reduce gender dysphoria. GAT consists of four main parts: 1) social transition, 2) blocking normal puberty or menstruation, 3) high dose opposite sex hormones, and 4) surgery of the genitalia and breasts.

67. I will describe each stage of GAT and then address scientific evidence regarding the efficacy of GAT to treat gender dysphoria and the safety of these treatments.

**1. Gender Affirmative Therapies Recommended by WPATH**

**a. Social Transition**

68. The first stage of gender affirmative therapy is termed social transition. Social transition is a psychological intervention. The child may be encouraged to adopt the type of clothing and mannerisms or behaviors which are stereotypical of the opposite sex within a culture. For example, in the United States a boy might wear his hair long and wear dresses in



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

order to socially transition. A girl may cut her hair short and wear clothes from the boys' section of a department store.

**b. Medications which Block Pubertal Development**

**(1) Background**

69. A second stage of gender affirmative therapy may involve blocking normal pubertal development. This may be done with puberty blocking medications that act directly on the pituitary.

70. In order to understand what is occurring in this process, it is helpful to be aware of normal hormone function during pubertal development.

71. There is a small pea-sized gland in the brain called the pituitary. It is sometimes referred to as the "master gland," as it controls the function of several other glands. One key function for our purposes is the control of the sex glands. There are two specific hormones produced by the pituitary referred to as luteinizing hormone ("LH") and follicle stimulating hormone ("FSH"). These hormones are responsible for sex hormone production and fertility. The LH and FSH act as signals to tell the sex glands begin or continue their function.

72. In the adult male, the production of LH will cause adult levels of testosterone to be produced by the testicles. In the adult female, the production of LH will cause adult levels of estrogen to be produced by the ovaries.

73. In early childhood, prior to the beginning of puberty, the pituitary function with respect to the sex glands is quiescent. However, during pubertal development, for the female, the interaction of LH with the ovaries increases estrogen production and carries the girl through the stages of development into womanhood. For boys, LH will signal the testicle to increase testosterone production, which carries the boy through the stages of pubertal development into manhood. Likewise for the female, the interaction of LH with the ovaries increases estrogen production, which carries the girl through the stages of development into womanhood.

74. There are conditions diagnosed by endocrinologists which involve a disruption of this normal communication between the pituitary and the sex glands. There is a medical



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

condition called hypogonadotropic hypogonadism. The meaning of this term is that the pituitary is not sending the hormonal signals (LH and FSH) to the sex glands and therefore the sex glands are unable to make their sex hormones. The result is hormonal deficiencies of LH, FSH, and either testosterone or estrogen.

75. If this condition occurs during puberty, the effect will be to stop pubertal development. This is a disease state which is diagnosed and treated by the endocrinologist.

76. Medications such as GnRH agonists act on the pituitary gland to lower the pituitary release of LH and FSH levels dramatically. The result is a blockage of the signaling of the pituitary to the ovaries or the testicles and therefore underproduction of the sex hormones. This will stop normal menstrual function for the female and halt further pubertal development. For the male this will halt further pubertal development. If the male had already reached spermarche, then production of new sperm will stop.

**(2) GnRH Agonist Medication Effects**

77. There are a variety of uses for GnRH agonists. The use and outcome can be very different for different applications.

78. For example, the initial development of the medication called Lupron was for the treatment of prostate cancer. The idea being that blocking pituitary hormones will block the adult male's release of testosterone from the testicles. Since testosterone will promote the growth of prostate cancer, the idea is to lower testosterone levels to a very low amount and therefore prevent the growth and spread of prostate cancer. This is a labeled use of the medication. In other words, there is FDA approval for this use.

79. Another labeled use of GnRH agonist medication is for the treatment of central precocious puberty. In the disease state of central precocious puberty, pituitary signaling is activated at an abnormally young age, say age four, to begin pubertal development. In order to halt puberty which has begun at an abnormally early time, a GnRH agonist may be used. Here the action of the medication on the pituitary will disrupt the signaling to the sex glands, stop early sex hormone production, and therefore stop abnormal pubertal development.



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

80. Then, at a more normal time of pubertal development, say age 11, the medication is stopped and puberty is allowed to proceed. The end result is to restore normal sex gland function and timing of puberty. This is a labeled use for a GnRH agonist medication.

81. What about the use of puberty blockers such as Lupron in gender affirmative therapy? In these cases, we have physiologically normal children who are just beginning puberty or are somewhere in the process of pubertal development. They have healthy pituitary glands and sex organs. However, a puberty blocking medication is administered to stop normal pubertal development.

82. In this case, the condition of hypogonadotropic hypogonadism described above (a medical disease) is induced by medication and is an iatrogenic effect of treating the psychological condition of gender dysphoria. GnRH agonist medications have not been FDA approved for this use.

**c. Opposite Sex Hormones**

83. The third stage of gender affirmative therapy involves using hormones of the opposite sex at high doses to attempt to create secondary sex characteristics in the person's body.

**(1) Testosterone**

84. Testosterone is an anabolic steroid of high potency. It is classified as a Schedule 3 controlled substance by the DEA: "Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence" (DEA, 2022). A licensed physician with a valid DEA registration is required to prescribe testosterone.

85. I prescribe testosterone to men for testosterone deficiency. The state of testosterone deficiency can cause various problems, including problems of mood, sexual function, libido, and bone density. Prescription testosterone is given to correct the abnormally low levels and bring them back into balance. The dose of testosterone must be carefully considered and monitored to avoid excess levels in the male as there are a number of serious concerns when prescribing testosterone.



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

**(2) Estrogen**

86. Estrogen is the primary sex hormone of the female. Prescription estrogen may be used if a woman has low estrogen levels due to premature failure of her ovaries. Estrogen is prescribed to bring these levels back into a normal range for the patient's age. Another labeled use of estrogen is to treat menopausal symptoms.

87. For the male, estrogen is being used at supraphysiologic doses. The high doses are used in an attempt to primarily affect an increase of male breast tissue development known as gynecomastia. Gynecomastia is the abnormal growth of breast tissue in the male. The occurrence of gynecomastia in the male is sometimes corrected by medication or more commonly by surgery if needed. Other changes of secondary sex characteristics may develop such as softening of the skin and changes in fat deposition and muscle development.

**d. Surgeries as Gender Affirmative Therapy**

88. Surgical alterations of the body of various kinds attempt to somehow mimic features of the opposite sex.

89. Individual surgical procedures can be a complex topic. It is helpful to first step back and consider conceptually what any surgery can and cannot accomplish.

90. In its basic form surgery is subtractive. In other words, a portion of tissue, an organ or organs are removed in order to restore health. For example, a diseased gallbladder may be surgically removed to help the patient get back to wellness. An infected appendix may be surgically removed to prevent worsening infection or even death. In both of these cases, an unhealthy body part is surgically removed in order to restore health.

91. In some cases, a diseased tissue or organ is removed so that a foreign replacement part may be substituted for an unhealthy organ or tissue. For example, a diseased heart valve may be replaced with a pig valve or a prosthetic heart valve. Another example is a failed liver may be replaced by liver transplant.

92. Though modern surgical techniques and procedures are astounding, there are very noteworthy limitations. Importantly, surgery cannot *de novo* create new organs. If a person's



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

kidneys fail, the surgeon has no scientific method for creating a new set of kidneys that can be implanted or grown within the patient. This conceptual background is helpful when considering various gender affirming surgeries.

93. There are a variety of gender affirming surgeries for females. These may include mastectomies, metoidioplasty, and phalloplasty.

**2. The Lack of Evidence of Effectiveness of GAT**

94. There is much evidence that questions the long-term benefits of opposite sex hormones and gender reassignment surgery and in fact suggests serious harms.

**a. Sweden's Long-term study of 30 years of data by Dhejne**

95. The most comprehensive study of its kind is from Sweden in 2011. The authors examined data over a 30-year time period (Dhejne, 2011). The Dhejne team made extensive use of numerous Swedish database registries and examined data from 324 patients in Sweden over 30 years who had taken opposite sex hormones and had undergone sex reassignment surgery. They used population controls matched by birth year, birth sex, and reassigned sex. When followed out beyond ten years, the sex-reassigned group had nineteen times the rate of completed suicides and nearly three times the rate of all-cause mortality and inpatient psychiatric care compared to the general population of Sweden.

**b. The Branstrom and Panchankis Retraction**

96. Other published studies of GAT have been shown to have serious errors. For example, a major correction was issued by the American Journal of Psychiatry. The authors and editors of a 2020 study, titled "Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study" (Bränström study, 2020) retracted their original primary conclusion. Letters to the editor by twelve authors, including myself, led to a reanalysis of the data and a corrected conclusion stating that, in fact, the data showed no improvement in mental health for transgender identified individuals after surgical treatment, nor was there improvement with opposite sex hormones ("Correction", 2020; Van Mol et al., 2020).



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

97. The initial reports of this study claimed that the authors found treatment benefits with surgery, and this was shared widely in the media. For example, ABC News posted an article titled "Transgender surgery linked with better long-term mental health, study shows" (Weitzer, 2019). An NBC news/Reuters headline reads "Sex-reassignment surgery yields long-term mental health benefits, study finds" (Reuters, 2019).

98. However, after twelve authors from around the world, including our team, investigated the study in detail, a number of serious errors were exposed, leading to a retraction (Kalin, 2020; Anckarsäter et al., 2020).

99. In our letter to the editor, which I co-wrote with former Chairman of Psychiatry at Johns Hopkins Medical School, Paul McHugh, MD, we noted key missing evidence in the original Branstrom report when compared to the previous body of knowledge yielded from the Swedish Dhejne study. We wrote that "[t]he study supports only weak conclusions about psychiatric medication usage and nothing decisive about suicidality. In overlooking so much available data, this study lacks the evidence to support its pro gender-affirmation surgery conclusion" (Van Mol, Laidlaw, et al., 2020).

100. In another letter, Professor Mikael Landen writes that "the authors miss the one conclusion that can be drawn: that the perioperative transition period seems to be associated with high risk for suicide attempt. Future research should use properly designed observational studies to answer the important question as to whether gender-affirming treatment affects psychiatric outcomes" (Landen, 2020).

101. In another letter to the editor, psychiatrist David Curtis noted that "[t]he study confirms the strong association between psychiatric morbidity and the experience of incongruity between gender identity and biological sex. However, the Branstrom study does not demonstrate that either hormonal treatment or surgery has any effect on this morbidity. It seems that the main message of this article is that the incidence of mental health problems and suicide attempts is especially high in the year after the completion of gender-affirming surgery" (Curtis, 2020).



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

102. In yet another critical letter, Dr. Agnes Wold states that "[w]hether these factors involve a causal relationship (*i.e.*, that surgery actually worsens the poor mental health in individuals with gender dysphoria) cannot be determined from such a study. Nevertheless, the data presented in the article do not support the conclusion that such surgery is beneficial to mental health in individuals with gender dysphoria" (Wold, 2020).

**c. Flawed studies based on the problematic 2015 US Transgender Survey**

103. A 2021 study by Almazan and Keurghlian attempted to address mental health outcomes in relation to surgery as a part of GAT (Almazan & Keurghlian, 2021). This was not a randomized controlled study nor a prospective observational study. Rather, the study relied upon the 2015 US Transgender Survey ("USTS"), which has been severely criticized for its serious limitations and weaknesses.

104. D'Angelo *et al.* have written about the 2015 USTS survey as part of the criticism of another flawed study in the journal Pediatrics by Jack Turban in 2020 titled "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation" (Turban, 2020). They write in their critique of the USTS that it is "a convenience sampling, a methodology which generates low-quality, unreliable data." (Bornstein, Jager, & Putnick, 2013). Specifically, the participants were recruited through transgender advocacy organizations and subjects were asked to "pledge" to promote the survey among friends and family. This recruiting method yielded a large but highly skewed sample. Their analysis is compromised by serious methodological flaws, including the use of a biased data sample, reliance on survey questions with poor validity, and the omission of a key control variable, namely subjects' baseline mental health status." They also state that "[s]tigmatizing non-'affirmative' psychotherapy for GD [gender dysphoria] as 'conversion' will reduce access to treatment alternatives for patients seeking non-biomedical solutions to their distress" (D'Angelo et al., 2021).



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

**d. Centers for Medicare and Medicaid Services Findings**

105. The Centers for Medicare and Medicaid Services ("CMS") has found "inconclusive" clinical evidence regarding gender reassignment surgery. Specifically, the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (June 19, 2019) states: "The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population."

**e. Nations and States Question and Reverse Course on GAT**

106. Also noteworthy is that other nations are questioning and reversing course regarding gender affirmative therapy. For example, in the *Bell v. Tavistock* judgment in the UK, regarding puberty blockers in GAT, they concluded that "there is real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve. This means it is, in our view, properly described as experimental treatment" (*Bell v. Tavistock* Judgment, 2020).

107. The case was appealed, and although the medical decision making was returned to clinicians (rather than the courts), it was noted that great pains should be taken to ensure that the child and parents are properly informed before embarking on such treatments. In its conclusion the appeals court stated that "[c]linicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained" (*Bell v. Tavistock* Appeal, Judgment, 2021).

108. In the bulletin of the Royal College of Psychiatrists in 2021, in a reevaluation of the evidence, Griffin and co-authors write as follows: "As there is evidence that many psychiatric disorders persist despite positive affirmation and medical transition, it is puzzling why transition



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

would come to be seen as a key goal rather than other outcomes, such as improved quality of life and reduced morbidity. When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties. Taking a supportive, exploratory approach with gender-questioning patients should not be considered conversion therapy" (Griffin et al., 2021).

109. In 2020, Finland recognized that "[r]esearch data on the treatment of dysphoria due to gender identity conflicts in minors is limited" and recommended prioritizing psychotherapy for gender dysphoria and mental health comorbidities over medical gender affirmation (Council for Choices in Healthcare in Finland, 2020). Additionally, "[s]urgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors."

110. In 2021, Sweden's largest adolescent gender clinic announced that it would no longer prescribe puberty blockers or cross-sex hormones to youth under 18 years outside clinical trials (SEGM, 2021). "In December 2019, the SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services) published an overview of the knowledge base which showed a lack of evidence for both the long-term consequences of the treatments, and the reasons for the large influx of patients in recent years. These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis. This makes it challenging to assess the risk / benefit for the individual patient, and even more challenging for the minors or their guardians to be in a position of an informed stance regarding these treatments" (Gauffen and Norgren, 2021).

111. Dr Hilary Cass "was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020" (The Cass Review website, 2022). In her interim report dated February 2022, it states that "[e]vidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally" (Cass, 2022).



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

112. In April of 2022, the Florida Secretary of the Agency for Health Care Administration requested that Florida Medicaid program review "whether treatments are consistent with widely accepted professional medical standards."

113. On June 2, 2022, the report was completed and concluded: "Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational" (Florida Medicaid, 2022)

**f. Mastectomy Surgery for Minors**

114. Any serious look at the long-term effects at surgical treatment would follow subjects out at least ten years. For example, an article was published recently examining patients who had mild calcium disorders due to a gland called the parathyroid. They compared a group of patients who had surgical removal of the parathyroid to a control group who had not. They examined data ten years after surgery was completed and concluded that parathyroid surgery in this group "did not appear to reduce morbidity or mortality" in that patient group (Pretorius, 2022).

115. To my knowledge, there exists no comparable studies of minors with gender dysphoria comparing those who had mastectomy surgery to a control group who had not. There are also no known studies of minors followed for 10 years or more to determine the long-term risks and benefits of mastectomy for gender dysphoria.

116. Good quality studies specifically showing that mastectomy surgery is safe, effective, and optimal for treating minors with gender dysphoria do not exist. For example, there is a study titled "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and



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

Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts" (Olson-Kennedy, 2018). The study authors conclude that "[c]hest dysphoria was high among presurgical transmasculine youth, and surgical intervention positively affected both minors and young adults." However, there are a number of problems with this study. First, the term "chest dysphoria" is not found as a diagnosis or even referenced in the DSM-5. Second the "chest dysphoria scale" is a measuring tool created by the authors, but which the authors state "is not yet validated." (*Id.*, p. 435) Third, the mastectomies were performed on girls as young as 13 and 14 years old and who thereby lacked the maturity and capacity of good judgment for truly informed consent for this life altering procedure. For this reason, in my professional opinion, the research and surgeries performed were flawed and unethical.

117. There exists another poorly designed study which suffers from similar methodological and ethical problems as the Olson-Kennedy study. A 2021 study published in Pediatrics examined females aged 13-21 recruited from a gender clinic. Thirty young females had mastectomy procedures and sixteen had not. The average age at surgery was 16.4 years (Mehringer, 2021). The follow up time after surgery was only 19 months and no data is provided or analyzed about key psychiatric information such as comorbid psychological illnesses, self-harming behaviors, psychiatric hospitalizations, psychiatric medication use, or suicide attempts.

118. Information returned from the study surveys were all qualitative and included responses such as "[My chest dysphoria] made me feel like shit, honestly. It made me suicidal. I would have breakdowns." Another respondent stated, "I've been suicidal quite a few times over just looking at myself in the mirror and seeing [my chest]. That's not something that I should have been born with" (Mehringer, 2021). The omission of psychiatric data is a major flaw in the study and also irresponsible given the obviously dangerous psychological states that some of these young people were in.

119. Since such a high proportion of subjects were using testosterone (83%), some of the responses could be attributed to adverse effects of testosterone. For example, as related earlier, high dose testosterone can manifest in irritability and aggressiveness. One study subject



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

responded, “I get tingly and stuff and it kind of makes me want to punch something" (Mehringer, 2022).

120. The testosterone labeling also indicates nausea and depression as adverse reactions which are described by another study subject “There’s a feeling of hopelessness, of desperation, of—almost makes me feel physically sick” (Actavis Pharma, Inc., 2018; Mehringer, 2022).

121. The study appears to have been designed, at least in part, to justify insurance companies paying for mastectomy procedure for minors with gender dysphoria, even though they have provided no long-term statistical evidence of benefit: “These findings...underscore the importance of insurance coverage not being restricted by age” (Mehrniger, 2021). This also appears to be part of the aim of the flawed Olson-Kennedy study, which stated, “changes in clinical practice and in insurance plans’ requirements for youth with gender dysphoria who are seeking surgery seem essential” (Olson-Kennedy, 2018). So these two studies, rather than being a thorough examination of the psychological and physical risks and benefits of mastectomy surgery over the long-term, appear instead to exist, at least in part, to validate the need for insurance companies to insure the costs of these dubious procedures for minors.

### 3. Iatrogenic Harms of GAT

122. The term iatrogenic is used in medicine to describe harms or newly created medical conditions that are the result of medications, surgeries, or even psychological treatments. Each of the four interventions for gender affirmative surgery (social transition, blocking normal puberty, opposite sex hormones, and surgery) lead to iatrogenic harms to the patient. These harms will be described in detail below. GAT interrupts the natural desistence process and instead places the patient on a lifetime regimen of hormonal and surgical care. A good understanding of these harms is also critical to my practice as an endocrinologist, because if I did not understand these harms, I could not advise patients of the risks associated with GAT.



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

**a. Adverse Health Consequences of Blocking Normal Puberty**

123. There are a number of serious health consequences that occur as the result of blocking normal puberty. The first problem is infertility. The Endocrine Society Guidelines recommend beginning puberty blockers as early as Tanner stage 2. As discussed earlier, this is the very beginning of puberty. Fertility development happens later generally in Tanner stage 4. One can see that if the developing person is blocked at Tanner stage 2 or 3 as advocated by the guidelines, this is prior to becoming fertile. The gonads will remain in an immature, undeveloped state.

124. Although procedures to preserve fertility are available, studies show that less than 5% of adolescents receiving GAT even attempt fertility preservation (FP) (Nahata, 2017). Moreover, "ovarian tissue cryopreservation is still considered experimental in most centers and testicular tissue cryopreservation remains entirely experimental. These experimental forms of FP would be the only options in children [with puberty] blocked prior to spermarche and menarche and are high in cost and limited to specialized centers. Even with FP there is no guarantee of having a child" (Laidlaw, Cretella, et al., 2019).

125. Naturally, these children are at a developmental age where they are not thinking about adult related concepts such as having children as they are children themselves. This is only natural and to be expected. The medical problem imposed on them is that if they remain blocked in an early pubertal stage then even the addition of opposite sex hormones will not allow for the development of fertility. In fact, high dose opposite sex hormones may permanently damage the immature sex organs leading to sterilization. Certainly the removal of the gonads, which will be discussed later, will ensure sterilization.

126. Another problem with blocking puberty at an early stage is sexual dysfunction. The child will continue their chronological age progression toward adulthood and yet remain with undeveloped genitalia. This will lead to sexual dysfunction including potential erectile dysfunction and inability to ejaculate and orgasm for of the male. For the female with



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

undeveloped genitalia potential sexual dysfunction may include painful intercourse and impairment of orgasm.

127. In addition to direct effects on the developing genitalia and fertility, there are other important aspects of puberty that are negatively affected. For example, puberty is a time of rapid bone development. This time of development is critical in attaining what we call peak bone density or the maximum bone density that one will acquire in their lifetime (Elhakeem, 2019).

128. Any abnormal lowering of sex hormones occurring during this critical time will stop the rapid accumulation of bone and therefore lower ultimate adult bone density. If a person does not achieve peak bone density, they would be expected to be at future risk for osteoporosis and the potential for debilitating spine and hip fractures as adults. Hip fractures for the older patient very significantly increase the risk of major morbidity and death (Bentler, 2009). Allowing a "pause" in puberty for any period of time leads to an inability to attain peak bone density.

129. Another consideration is maturation of the human brain. Much of what happens is actually unknown. However, "sex hormones including estrogen, progesterone, and testosterone can influence the development and maturation of the adolescent brain" (Arain, 2013). Therefore there are unknown, but likely negative consequences to blocking normal puberty with respect to brain development.

130. A third potential problem with blocking normal puberty involves psychosocial development. Adolescence is a critical time of physical, mental, and emotional changes for the adolescent. It is important that they develop socially in conjunction with their peers. This is well recognized in the psychological literature: "For decades, scholars have pointed to peer relationships as one of the most important features of adolescence." (Brown, 2009). If one is left behind for several years under the impression that they are awaiting opposite sex puberty, they will miss important opportunities for socialization and psychological development. Psychosocial development will be necessarily stunted as they are not developing with their peers. This is a permanent harm as the time cannot be regained.



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

131. Aside from the multiple serious problems that are iatrogenically acquired by blocking normal puberty, there appear to be independent risks of the puberty blocking medication themselves. For example, one can read the labeling of a common puberty blocking medication called Lupron Depot-Ped and find under psychiatric disorders: "emotional lability, such as crying, irritability, impatience, anger, and aggression. Depression, including rare reports of suicidal ideation and attempt. Many, but not all, of these patients had a history of psychiatric illness or other comorbidities with an increased risk of depression" (Lupron, 2022). This is particularly concerning given the high rate of psychiatric comorbidity with gender dysphoria discussed previously.

**b. The Effect of Puberty Blockers on Desistance**

132. As stated earlier, a very high proportion of minors diagnosed with gender dysphoria will eventually desist or come to accept their physical sex. Puberty blockers have been shown to dramatically alter natural desistance.

133. In a Dutch study that included seventy adolescents who took puberty blockers, all seventy decided to go on to hormones of the opposite sex (de Vries, et al. 2011). In a follow-up study, the overwhelming majority went on to have sex reassignment surgery by either vaginoplasty for males or hysterectomy with ovariectomy for females (de Vries, et al. 2014). These surgeries resulted in sterilization. This is why puberty blockers, rather than being a "pause" to consider aspects of mental health, are instead a pathway towards future sterilizing surgeries.

**c. Infertility as a result of Puberty Blockers in GAT**

134. Giving puberty blockers to a four-year-old with central precocious puberty will obviously not impair fertility, as the four-year-old has not yet become fertile. The child will at a later time have the puberty blocker discontinued and then normal pubertal development can proceed. Therefore, when they are no longer taking the medication, they will gain natural fertility.



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

135. In contrast, puberty blocking medication given in GAT occurs at precisely the time that the child will gain reproductive function. This will stop sperm production in the male and ovulation in the female (if these have already occurred, otherwise the functions will not even begin) which produces the infertile condition. Importantly, so long as the minor continues puberty blockers they will remain infertile. Should they continue on to opposite sex hormones as part of GAT then they will remain infertile. There is the additional possibility that cytotoxic effects of high dose opposite sex hormones will damage the immature gonads leading to permanent sterility. This is yet to be discovered.

**d. Adverse Health Effects of Supraphysiologic Doses of Testosterone for Females in GAT**

136. Regarding the potential for abuse, the labeling reads "Testosterone has been subject to abuse, typically at doses higher than recommended for the approved indication . . . Anabolic androgenic steroid abuse can lead to serious cardiovascular and psychiatric adverse reactions . . . Abuse and misuse of testosterone are seen in male and female adults and adolescents . . . There have been reports of misuse by men taking higher doses of legally obtained testosterone than prescribed and continuing testosterone despite adverse events or against medical advice." (Actavis Pharma, 2018)

137. Adverse events with respect to the nervous system include: "Increased or decreased libido, headache, anxiety, depression, and generalized paresthesia." (Actavis Pharm, 2018)

138. With regard to ultimate height, "[t]he following adverse reactions have been reported in male and female adolescents: premature closure of bony epiphyses with termination of growth" (Actavis Pharma, Inc., 2018). What this means is that testosterone applied to the adolescent will cause premature closure of the growth plates, stopping further gains in height in the growing individual and ultimately making the person shorter than they otherwise would have been.



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

139. With respect to the cardiovascular system of men using ordinary doses, "Long-term clinical safety trials have not been conducted to assess the cardiovascular outcomes of testosterone replacement therapy in men" (Actavis Pharma, 2018). No clinical safety trials have been performed for women or adolescent girls to my knowledge.

140. "There have been postmarketing reports of venous thromboembolic events [blood clots], including deep vein thrombosis (DVT) [blood clot of the extremity such as the leg] and pulmonary embolism (PE) [blood clot of the lung which may be deadly], in patients using testosterone products, such as testosterone cypionate" (Actavis Pharma, 2018).

141. A recently published study of adverse drug reactions (ADRs) as part of gender affirming hormone therapies in France states that "[o]ur data show a previously unreported, non-negligible proportion of cases indicating cardiovascular ADRs in transgender men younger than 40 years… In transgender men taking testosterone enanthate, all reported ADRs were cardiovascular events, with pulmonary embolism in 50% of cases" (Yelehe et al., 2022).

142. There are also serious concerns regarding liver dysfunction: "Prolonged use of high doses of androgens ... has been associated with development of hepatic adenomas [benign tumors], hepatocellular carcinoma [cancer], and peliosis hepatis [generation of blood-filled cavities in the liver that may rupture] —all potentially life-threatening complications" (Actavis Pharma, 2018).

143. In GAT, what is termed "cross sex hormones" is the use of hormones of the opposite sex to attempt to create secondary sex characteristics. To do so, very high doses of these hormones are administered. When hormone levels climb above normal levels they are termed supraphysiologic.

144. The female person does produce some smaller amount of testosterone relative to the male. The normal reference range for adult females depending on the lab is about 10 to 50 ng/dL. However, in female disease conditions these levels can be much higher. For example, in polycystic ovarian syndrome levels may range from 50 to 150 ng/dL. PCOS has been associated



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

with insulin resistance (Dunaif, 1989), metabolic syndrome (Apridonidze, 2005) and diabetes (Joham, 2014).

145. In certain endocrine tumors such as adrenal carcinoma these levels may be substantially higher in the 300 to 1000 ng/dl range. Adrenal carcinoma is a serious medical condition and may be treated by surgery and potent endocrine medications.

146. Recommendations from the Endocrine Society's clinical guidelines related to GAT are to ultimately raise female levels of testosterone to 320 to 1000 ng/dL2, which is on the same order as dangerous endocrine tumors for women as described above (Hembree, 2017). A simple calculation shows this level for the adult may be anywhere from 6 to 100 times higher than native female testosterone levels. In doing so they are creating a hormone imbalance known as hyperandrogenism. These extraordinarily high levels of testosterone are associated with multiple risks to the physical and mental health of the patient.

147. "Studies of transgender males taking testosterone have shown up to a nearly 5-fold increased risk of myocardial infarction relative to females not receiving testosterone" (Laidlaw et al., 2021; Alzahrani et al., 2019). A female can also develop unhealthy, high levels of red blood cells referred to as erythrocytosis. These high red blood cell counts in young women have been shown to be an independent risk factor for cardiovascular disease, coronary heart disease and death due to both (Gagnon, 1994).

148. Other permanent effects of testosterone therapy involve irreversible changes to the vocal cords. Abnormal amounts of hair growth which may occur on the face, chest, abdomen, back and other areas is known as hirsutism. Should the female eventually change her decision to take testosterone, this body hair can be very difficult to remove. Male pattern balding of the scalp may also occur.

149. Changes to the genitourinary system include polycystic ovaries and atrophy of the lining of the uterus. The breasts have been shown to have an increase in fibrous breast tissue and a decrease in normal glandular tissue (Grynberg et al., 2010). Potential cancer risks from high dose testosterone include ovarian and breast cancer (Hembree, 2017).



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

150. According to research regarding testosterone abuse, high doses of testosterone have been shown to predispose individuals towards mood disorders, psychosis, and psychiatric disorders. The "most prominent psychiatric features associated with AAS [anabolic androgenic steroids, *i.e.* testosterone] abuse are manic-like presentations defined by irritability, aggressiveness, euphoria, grandiose beliefs, hyperactivity, and reckless or dangerous behavior.

151. Other psychiatric presentations include the development of acute psychoses, exacerbation of tics and depression, and the development of acute confusional/delirious states (Hall, 2005). Moreover, "[s]tudies... of medium steroid use (between 300 and 1000 mg/week of any AAS) and high use (more than 1000 mg/week of any AAS) have demonstrated that 23% of subjects using these doses of steroids met the DSM-III-R criteria for a major mood syndrome (mania, hypomania, and major depression) and that 3.4% — 12% developed psychotic symptoms" (Hall, 2005).

**e. Adverse Health Effects of Supraphysiologic Estrogen for Males in GAT**

152. The doses of estrogen given to males for GAT are high and may vary from two to eight or more times higher than normal adult male levels. This produces the endocrine condition called hyperestrogenemia. Long-term consequences include increased risk of myocardial infarction and death due to cardiovascular disease (Irwig, 2018). Also "[t]here is strong evidence that estrogen therapy for trans women increases their risk for venous thromboembolism[1] over 5 fold" (Irwig, 2018).

153. Breast cancer is a relatively uncommon problem of the male. However, the risk of a male developing breast cancer has been shown to be 46 times higher with high dose estrogen (Christel *et al.*, 2019).

154. It is clear that supraphysiologic doses of either testosterone for the female or estrogen for the male can have detrimental health consequences. This is only now being borne out in the literature for adults. However, as more children and adolescents are put on these

[1] Venous thromboembolism is a blood clot that develops in a deep vein and "can cause serious illness, disability, and in some cases, death" (CDC, 2022).



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

medications one would expect these consequences to become more frequent and to occur earlier in their lives.

**f. Adverse Effects of Mastectomy GAT**

155. Mastectomies are the surgical removal of the breasts. The procedure is used in GAT in an attempt to make the chest appear more masculine. The surgery results in a permanent loss of the ability to breastfeed and significant scarring of 7 to 10 inches. The scars are prone to widening and thickening due to the stresses of breathing and arm movement. Other potential complications include the loss of normal nipple sensation and difficulties with wound healing (American Cancer Society, 2022).

156. It is important to note that this operation cannot be reversed. The person will never regain healthy breasts capable of producing milk to feed a child (Mayo Clinic, Top Surgery, 2022).

157. Another important consideration is that compared to the removal of an unhealthy gallbladder or appendix, in the case of gender dysphoria the breasts are perfectly healthy and there is no organic disease process such as a cancer warranting their removal. The future person who later desists is left with regret about what happened to her at an age before she could provide true informed consent. Functioning breasts cannot be created by a surgeon and restored to a patient in case of regret. She is left with permanent injury and loss of function with respect to her breasts.

**g. Adverse Effects of GAT Surgeries of the Female Pelvis and Genitalia**

158. Other types of surgery for females include those of the genitalia and reproductive tract. For example, the ovaries, uterus, fallopian tubes, cervix, and vagina may be surgically removed. Removal of the ovaries results in sterilization.

159. Importantly, removing female body parts does not produce a male. Rather, the female has had sex specific organs permanently destroyed with no hope of replacement.



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

160. There have also been attempts to create a pseudo-penis. This procedure is known as phalloplasty. It is not possible to de novo create a new human penis. Instead, a roll of skin and subcutaneous tissue is removed from one area of the body, say the thigh or the forearm, and transplanted to the pelvis. An attempt is made to extend the urethra or urinary tract for urination through the structure. This transplanted tissue lacks the structures inherent in the male penis which allow for erection; therefore, erectile devices such as rods or inflatable devices are placed within the tube of transplanted tissue in order to simulate erection (Hembree, 2017). The labia may also be expanded to create a simulated scrotum containing prosthetic objects to provide the appearance of testicles.

161. Complications may include urinary stricture, problems with blood supply to the transplanted roll of tissue, large scarring to the forearm or thigh, infections including peritonitis, and possible injury to the sensory nerve of the clitoris (Mayo Clinic, Masculinizing Surgery, 2022).

**h. Adverse Effects of GAT Surgeries on the Male**

162. GAT surgeries for the male include removal of the testicles alone to permanently lower testosterone levels. This is by nature a sterilizing procedure. Further surgeries may be done in an attempt to create a pseudo-vagina which is called vaginoplasty. In this procedure, the penis is surgically opened and the erectile tissue is removed. The skin is then closed and inverted into a newly created cavity in order to simulate a vagina. A dilator must be placed in the new cavity for some time so that it does not naturally close.

163. Potential surgical complications may include urethral strictures, infection, prolapse, fistulas, and injury to the sensory nerves with partial or complete loss of erotic sensation (Mayo Clinic, Feminizing Surgery, 2022).

**C. Life Threatening Physical Medical Conditions Versus Suicidal Ideation**

164. ***According to both Dr. Ettner and Dr. Karasic, the denial of gender affirmative care to transgender people results in the prolonging of their gender dysphoria, and causes***



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

***additional distress and other health risks, such as depression, posttraumatic stress disorder, and suicidality.*** Karasic Report, ¶ 57; Ettner Report, ¶ 65-66.

165. It is important to contextualize gender dysphoria and the need to balance the potential advantages and disadvantages of GAT.

166. Any child or adolescent who has suicidal ideation or has attempted suicide should receive immediate, appropriate psychiatric care. Psychologists and psychiatrists are trained in the recognition and treatment of suicidal ideation and prevention of suicide.

167. A child or adolescent with gender dysphoria who also has suicidal ideation should not be treated any differently. They require compassionate care and a full psychological evaluation of comorbidities such as depression, anxiety, and self-harming behaviors.

168. However, suicidal ideation or attempts are categorically different than other life-threatening situations, such as a rapidly expanding brain tumor or a severe infection. In these situations, a medication or a surgery is used to stop the progression of an organic physical condition. In contrast, the danger to the self with suicidal ideation relates to a condition of the mind.

169. Gender affirmative therapy does not treat any life-threatening physical condition. In fact, it creates a number of new medical conditions as described above. It is also not an appropriate treatment for suicidal ideation. Neither puberty blocking medications, nor testosterone, nor estrogen have been FDA approved for suicide prevention. Moreover, the hormone imbalances generated by the medications used in GAT may actually increase psychological conditions that lead to suicidal ideation and completed suicide.

**D. Informed Consent**

170. According to Dr. Karasic, ***"[a]s part of the treatment process for gender dysphoria, patients provide informed consent to their care. In addition, a treating doctor will not offer gender-affirming medical treatments unless they have concluded after weighing the risks and benefits of care that treatment is appropriate. The risks and benefits of care are discussed with the transgender patient, who must assent."*** Karasic Report, ¶ 50.



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

171. Any person who is to take a medication, undergo a surgical procedure, or have a psychological intervention should understand the risks and benefits before proceeding. A discussion of these risks and benefits should be provided by medical professionals and then the person of sufficient intellectual capacity and maturity can consent to the treatment.

172. However, difficulties arise when a minor is involved in the process of medical decision-making. Their intellect, emotions, and judgment are not fully developed and they are not capable of fully appreciating permanent, life altering changes such as described above. Therefore, they cannot provide informed consent. Naturally, they may sometimes "assent" to a procedure or medication with a parent or guardian making the final decision.

173. With respect to GAT, in my opinion, it is not possible for the parent or guardian to make a true informed consent decision for the child because of the poor quality of evidence of benefit, the known risks of harm, and the many unknown long-term risks of harm which could only truly be known after years and decades of gender affirmative therapy. A parent or guardian cannot consent to dubious treatments which result in irreversible changes to their child's body, infertility, sexual dysfunction, and in many cases eventual sterilization.

174. Because this age group is still undergoing brain development and they are immature with respect to intellect, emotion, judgment, and self-control, in my professional opinion there is a significant chance a young person may later regret the irreversible bodily changes that result from hormones or from removing an organ or organs that will no longer function and cannot be replaced.

175. Adolescents are more prone to high-risk behavior and less likely to fathom the risks and consequences of these decisions (Steinberg, 2008).

**E. Assessment of the Patient with Gender Dysphoria**

176. According to Dr. Ettner, ***"[o]nce a diagnosis of gender dysphoria is established, individualized treatment should be initiated. Without treatment, individuals with gender dysphoria experience anxiety, depression, suicidality, and other attendant mental health issues***



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

***and are often unable to adequately function in occupational, social, or other areas of life."*** Ettner Report, ¶ 32.

177. Unfortunately, too often there is a rush to GAT before essential criteria are applied to determine a course of treatment based on a complete understanding of the patient's diagnosis and needs. In light of the very serious medical concerns and potential harms of gender affirmative therapy, there are several criteria that are important to fulfill before applying the GAT model to a patient:

- Patients should be evaluated to determine if they will follow the natural pattern of desistance which 50 to 98% of pediatric age children will follow.
- Patients, parents, and guardians should be made aware of other options for treatment of gender dysphoria including active psychosocial treatment or watching and waiting with support in order to accommodate natural desistance.
- The patient should be provided an assessment by a qualified psychologist or psychiatrist who does not follow the WPATH GAT model. If underlying psychological conditions are diagnosed then these should be adequately evaluated and treated before proceeding to hormones and surgery.
- If a medicalized approach with hormones such as testosterone or medications to stop menstruation is being considered then a clear description of the risks and benefits needs to be conveyed to the minor and the parent or guardian. It needs to be verified that they fully understand these risks.
- If surgical procedures such as mastectomy, hysterectomy, ovariectomy, orchiectomy, or vaginoplasty are being considered then clear descriptions of the risks and benefits need to be conveyed to the minor and the parent or guardian.

178. However, even if a minor and their parents or guardian are made fully aware of the risks and benefits of hormones and surgeries, in my opinion, the minor does not have adequate maturity and judgment to make permanent changes to their body that may result in



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

infertility/sterility and the permanent loss of organs such as breasts whose functions will not be fully utilized (such as breastfeeding) until adulthood.

**F. C.P.'s Medical Care**

179. According to Dr. Ettner, ***"with the support of parents and extended family, C.P. was able obtain the medically necessary care he required, thereby avoiding the negative sequelae of female puberty and attendant menses and unwanted secondary sex characteristics."*** Ettner Report, ¶ 77. According to Dr. Karasic, ***"the 2019 BlueCross BlueShield Medical Policies Gender Reassignment Surgery and Related Services for Children and Adolescents . . . states that puberty-suppressing hormones or masculinizing hormones, as well as chest surgery for transmasculine individuals, may be considered medically necessary," and in his opinion, "[t]hese treatments were medically necessary for C.P."*** Karasic Report at ¶ 76.

180. In my professional opinion, it is not possible to make a single, categorical statement about the proper treatment of minors presenting with gender dysphoria. A provider cannot reasonably opine on the proper treatment of a particular minor presenting with gender dysphoria unless he or she has had more than one working sessions with the minor and has taken a thorough developmental history of the minor's gender-related issues before attempting to decide on a course of therapy for that individual.

181. For these reasons, in my professional opinion, an irreversible chest reconstruction surgery should not have been performed on minor C.P. Based on the studies and research cited above, in my professional opinion there is insufficient quality of evidence at this time demonstrating the benefit of bilateral mastectomy with chest wall recontouring surgery on individuals diagnosed with gender dysphoria in any age group. For those under 21, there is an additional reason to avoid irreversible procedures: there are no laboratory, imaging, or other objective tests to predict whether a young person with gender dysphoria will outgrow this condition. Because this age group is still undergoing brain development and as such, they are immature with respect to intellect, emotion, judgment, and self-control, in my professional



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

opinion this means there is a significant chance that a young person may later regret removing an organ that cannot be replaced. Thus, in my professional opinion, it is never appropriate to provide bilateral mastectomy with chest wall recontouring surgery on individuals diagnosed with gender dysphoria, particularly those under the age of 21. In my opinion, a substantial percentage of physicians would agree. The following summarizes my specific concerns.

182. None of the reports offered by Plaintiffs' experts address whether any of the steps I have identified above were undertaken before a course of GAT was started. There is no mention of any psychiatric evaluation. *See* Ettner Report, ¶ 77; Karasic Report at ¶¶ 66-77.

183. Based on the declarations, depositions, and medical records I reviewed, there is insufficient evidence to establish that C.P.'s psychiatric issues have been thoroughly evaluated and adequately treated by a qualified psychiatrist or clinical psychologist.

184. Depression, if not properly treated before surgery, may result in an increase in morbidity and mortality post-surgery: "Several studies reported increased rate of postoperative infections in patients suffering from depression." With respect to depression treatment for patients before major surgery, where it is "[n]on-alleviated, it may predict increased morbidity and mortality after the operation. It may be associated with greater postoperative pain, higher incidence of postoperative infections, progression of malignant tumors, poor health-related quality of life as well as other complications." Ghoneim & O'Hara, "Depression and Postoperative complications: an overview," *BMC Surg.* 2016; 16:5 (Feb. 2, 2016).

**Medical course and complications**

185. All three expert reports refer to Endocrine Society's 2017 guidelines (ESG) as an exemplary model for gender affirmative therapy. **"A clinical practice guideline from the Endocrine Society (the Endocrine Society Guideline) provides similar protocols for the medically necessary treatment of gender dysphoria. (Hembree et al., 2017)."** Karasic Expert Report ¶ 27**. "The Endocrine Society—the leading professional organization devoted to research on hormones and the clinical practice of endocrinology—has also issued clinical**



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

**guidelines for the treatment of transgender individuals."** Schechter Expert Report, ¶ 26. Dr. Ettner also references the same guidelines. Ettner Expert Report 2022, ¶ 34.

186. However, Dr. Hatfield's consult and progress notes from the medical records provided do not refer to the Endocrine Society's guidelines at all. He notes that he had been a member of WPATH and does refer to a "standard of care"—apparently WPATH's—in several places in his deposition (Hatfield Deposition, p. 20, 54, 57). However, there is no reference to the Endocrine Society's 2009 or 2017 guidelines.

187. This is very unfortunate because the 2017 ESG emphasize the critical importance of a mental health evaluation, particularly for children and adolescents: "Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, a mental health provided ("MHP") who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex." (Hembree et al., 2017)

188. Indeed, the 2009 ESG guidelines (which were available when Dr. Hatfield first started C.P. on puberty blockers) specifically state that a qualified mental health professional (MHP) should make the diagnosis of gender dysphoria (at that time referred to as gender identity disorder, or GID): "Because GID may be accompanied with psychological or psychiatric problems, it is necessary that the clinician making the GID diagnosis be able 1) to make a distinction between GID and conditions that have similar features; 2) to diagnose accurately psychiatric conditions; and 3) to undertake appropriate treatment thereof. Therefore, the SOC guidelines of the WPATH recommend that the diagnosis be made by an MHP. For children and adolescents, the MHP should also have training in child and adolescent developmental psychopathology" (Hembree et al., 2009). Note that the ESG refers directly to WPATH's guidelines recommending that "the diagnosis be made by a MHP" and also that "the MHP should also have training in child and adolescent developmental psychopathology."



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

189. From the available records, there is no evidence that Dr. Hatfield consulted with a qualified psychiatrist or psychologist prior to initiating puberty blocking medications or testosterone. Although Dr. Hatfield's initial note of 9/27/16 states, "Ongoing recommendations for continued counseling strongly reinforced today," there is no evidence that C.P. was being seen by a qualified psychiatrist or psychologist.

190. With regards to future fertility, the guideline states, "We recommend that all transsexual individuals be informed and counseled regarding options for fertility prior to initiation of puberty suppression in adolescents and prior to treatment with sex hormones of the desired sex in both adolescents and adults" (*Id.*) However, in the medical records, prior to initiating puberty-blocking medication, there is only a single reference to a discussion of fertility during the patient's initial visit. It is unclear what a child of age 11 would be able to comprehend during this single first visit with respect to the complex issues of attempting to preserve fertility and had not yet undergone puberty.

191. Regarding follow up after initiating blocking of normal pubertal development, the ESG state: "[T]his protocol [of suppression of pubertal development] requires a MHP skilled in child and adolescent psychology to evaluate the response of the adolescent with GID after pubertal suppression" (*Id.*, p 3140). There is no evidence in the medical records that a qualified MHP evaluated C.P. after pubertal suppression was initiated and continued.

192. The ESG very explicitly state that puberty blocking medications should not be started before puberty has begun (Tanner stage 2): "We recommend that suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty, but no earlier than Tanner stages 2–3." *Id.* at 3133.

193. This is consistent also with WPATH's recommendation: "Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2." (WPATH SOC, 2011, p. 18).



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

194. The Tanner stage of pubertal development is assessed by physical exam of the body. A description of the physical findings would be found in the physical exam description of the clinical notes. For the female this would involve a description of the breasts and genitalia. From these findings an assessment of the Tanner stage is made. For example, a Tanner stage 2 description would describe "breast buds palpable beneath the areola" (Emmanuel and Boker, 2022).

195. However, in the initial consult visit, Dr. Hatfield did not describe the breasts at all, nor a description of the genitals. He jumped to an assessment which states: "Phenotype Tanner 2." Therefore, it is not clearly stated to what degree the C.P. had breast development, if at all, at that time, because there is no physical exam description. However, on a subsequent visit dated 05/22/17, the physical exam states "no breast budding noted," which would indicate that there had been no breast development at all up to that point. This is consistent with Tanner 1 staging, which is prepubertal. Therefore, it appears that Dr. Hatfield had begun pubertal suppression at Tanner stage 1, which was not advised by either the ESG or even the WPATH's SOC.

**Testosterone**

196. As for starting hormones of the opposite sex, the ESG also have a number of criteria to be fulfilled. The first is that a qualified MHP has confirmed (a) "the persistence of gender dysphoria"; (b) that "any coexisting psychological, medical, or social problems that could interfere with treatment ... have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment"; (c) "the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment" (Hembree et al., 2017). The medical records do not show that C.P. had seen a qualified MHP who had ensured that any of these criteria were met prior to initiating testosterone treatment.



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

197. The ESG also recommend that "a pediatric endocrinologist or other clinician experienced in pubertal induction: agrees with the indication for sex hormone treatment, has confirmed that there are no medical contraindications to sex hormone treatment" (*Id.*) This does not appear to have happened either.

**Absence of a proper diagnosis of gender dysphoria**

198. Gender dysphoria was not diagnosed by a MHP and was also not entered into the medical record as a diagnosis by Dr. Hatfield in his initial consult. Instead, the consult visit of 9/27/16 states "No diagnosis found" in the assessment section. The 5/22/17 visit has a diagnosis of "Hormone deficiency - Testosterone?" It is not clear on what basis he has diagnosed a testosterone deficiency. The diagnosis in the assessment of 02/28/18 is "Hormone deficiency."

199. It seems that the only time that Dr. Hatfield has used the diagnosis of gender dysphoria is in conjunction with procedures requiring approval for coverage such as the Vantas implant. In Dr. Hatfield's deposition he states: "We simply include the code of gender dysphoria on the . . . prior authorization request and that is actually what allows it to be covered" (Hatfield Depo, p. 32).

200. Therefore, the procedure note for the Vantas implant on 11/18/16 has the diagnosis of gender dysphoria, but the preceding and following progress notes do not. Also, Dr. Hatfield's letter for surgery on 05/29/29 states that there has been a "long-standing medical diagnosis of gender dysphoria/transgender identity (F64.0)"; however, the preceding date of service 02/18/19, and date of service following the letter 07/11/19, do not have gender dysphoria as a diagnosis in the assessment and plan.

**Estradiol promotes breast tissue growth**

201. On 6/9/18, Dr. Hatfield prescribed estradiol "to improve bone growth." But what is significant for C.P. is that estradiol will cause breast tissue growth. Testosterone can also cause breast tissue growth by conversion to estrogen. There is no further record of a breast exam by Dr. Hatfield leading up to the time of his 05/29/19 letter to the surgeon Dr. Kyllo. Given that



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

the patient was receiving estrogen and testosterone, it would have been important to monitor development of the patient's chest and breast development.

202. As noted previously, Dr. Hatfield's 05/22/17 physical exam of C.P. states "no breast budding noted" indicating there had been no breast development. But by the time C.P. had seen the surgeon Dr. Kyllo for consult on 04/30/2019, Dr. Kyllo's physical exam describes: "Very small breasts with minimal development." In my opinion, Dr. Hatfield's prescription of estradiol in addition to testosterone led C.P. to progress from having no breast budding at all to small minimally, developed breasts.

**Major discrepancy in breast size description**

203. On 5/29/19, Dr. Hatfield wrote a letter to Dr. Kyllo regarding C.P. In the letter, Dr. Hatfield describes a "severe case of gynecomastia" and "extremely large breasts/gynecomastia." Again, in contrast to Dr. Hatfield's description, Dr. Kyllo in his initial consult note describes "[v]ery small breasts with minimal development."

204. It appears to me that Dr. Hatfield grossly exaggerated the size of the patient's breasts. Further supporting evidence for this is found in the pathology report of 12/19/19 (Pritchard POL, 56). The right breast tissue was described as "8 x 4 x 2 cm" which equates to a volume of 64 cubic cm (64 ml). The left breast tissue was described as "9.5 x 5 x 2 cm which equates to a volume of 95 cubic cm (95 ml)".

205. However, the average volume of breast tissue after mastectomy has been shown to be 623.5 ml with a range of 150-1490 ml (Kayar et al., 2011). Therefore, C.P.'s breast size has been confirmed by pathology exam to be very considerably below average and even below the lowest reference range for adult females, which contradicts Dr. Hatfield's description.

**Informed Consent**

206. Dr. Hatfield has been a member of WPATH and follows the WPATH model. According to WPATH, before initiating medical treatment it is important that "[t]he adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and



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

are involved in supporting the adolescent throughout the treatment process." SOC WPATH p 25.

207. As to informed consent for puberty blockers, there is no signed documentation regarding benefits, adverse effects or alternatives, and so it is not clear as to exactly what C.P. and parents were informed of regarding the numerous side effects of PB. There also does not appear to be any alternative presented to C.P. such as watching and waiting with support to see if the patient desists or active psychotherapy with a non-biased, non-WPATH psychologist or psychiatrist.

208. With respect to testosterone, the ESG state that it is essential that "the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment" (Hembree et al., 2017).

209. There is no indication that C.P. had been assessed by a qualified MHP to assess for sufficient mental capacity to estimate the consequences and weigh the benefits and risks of testosterone.

210. The patient's mother signed the testosterone consent form on 2/28/18, two days after the patient turned 13. Although Mrs. Pritchard initialed next to the statement "My medical provider has discussed my questions and concerns with me" and signed that day, the provider's signature is dated 18 days later, and calls into question the provider's availability to answer any questions and concerns on 2/28/18.

211. The ESG also recommends that the adolescent "has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility)" (Hembree et al., 2017, p. 3878).

212. The consent form for testosterone from The Polyclinic states under risks and side effects: "Possible loss of fertility; you may not be able to get pregnant after being on testosterone therapy for some time; how long this might take to be a permanent effect is unknown. Some persons choose to harvest and bank eggs before starting on testosterone therapy" (Pritchard POL,



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

117). It goes to say that "[o]ther effects of testosterone on the ovaries and on developing eggs are not fully known." *Id.*

213. Infertility or permanent sterilization are drastic long-term consequences that are difficult for a person just turning 13 to comprehend. C.P. had not had enough time and maturity to grasp this complication. Thirteen-year-old girls are generally not thinking about their future family planning as they are still children themselves under the care of another. It is known that fertility preservation is very low in this age group, being less than 5%. It would also be difficult to understand the complex, physically and emotionally difficult procedure of egg preservation. Also, because C.P. appeared to have been pre-pubertal at the initiation of puberty blockers, C.P. by definition had immature eggs which would require advanced and expensive fertility techniques of uncertain outcome for ovum preservation (Laidlaw, Cretella, et al., 2019 AJOB).

214. With respect to cardiovascular disease, the consent form states: "Possible changes in cholesterol, higher blood pressure and other changes to the body that might lead to an increased risk of cardiovascular disease (heart attacks, strokes and blockages in the arteries" (Pritchard POL, 117). These risks are important as they were amplified in C.P.'s cases by combining testosterone with estrogen and by an increase in C.P.'s red blood cell count which will be discussed further below.

215. Other portions of the consent form point to the still experimental nature of using high dose testosterone on young females. For example, "all of the long-term consequences and effects of hormone therapy may not be fully understood." *Id.* "The effects of hormones on the brain are not fully understood" *Id.* "Some trans men, after being on testosterone for a number of months, may develop pelvic pain; often this will go away after some time, but it may persist; the cause of this is not known." *Id.*

216. There is no discussion of alternatives such as watching and waiting to follow a natural course of desistance or active psychotherapy to help with potential mental health issues such as ADHD or family or school issues that may be affecting C.P.'s mental health. There is a statement, "Hormone therapy is not the only way that a person may appear more masculine and



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

live as a male, your medical provider and/or a mental health provide can help you think about these other options." *Id.* at 118. However, there is no discussion of what these other options are.

217. The consent form states that "[t]he effect on the risk of breast, uterine and ovarian cancer is not any higher than the background occurrence for people with these body organs." *Id.* at 117. However, the ESG state that the patient should be prepared for a potential total hysterectomy for cancer prevention: "Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender affirming surgery to prevent reproductive tract cancer," including ovariectomy "after the completion of hormone transition" (Hembree et al., 2017, p. 3892, 3890).

218. This drastic, sterilizing procedure for a young person is not mentioned in the consent form. This is particularly concerning given the fact that Dr. Hatfield commented in his progress note that C.P.'s "mom has a strong history of ovarian cancer on her side of the family . . . His mom is wondering if there is anything [C.P.] needs to do for testing/prevention" (Pritchard POL, 15). The ESG adds that "Studies have reported cases of ovarian cancer" (Hembree, 2017). But no particular guidance from Dr. Hatfield regarding these serious issues are found in the medical record.

**Mastectomy**

219. In contrast to the many criteria listed prior to initiating PB or opposite sex hormones in the ESG, there is little guidance and no evidence presented as to the benefits of mastectomy specifically for the minor.

220. However, analogously, the ESG advise that before initiating testosterone for the minor, it is necessary that "a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent." It follows that for something as permanently altering as surgical removal of organs, such as the



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

breasts, a patient should be seen by a psychiatrist or psychologist to assess for "sufficient mental capacity to give informed consent."

221. This did not happen here. Instead, C.P. saw Sharon Booker who is a licensed mental health counselor for a one-hour evaluation and who produced an assessment letter dated 07/24/19 (Pritchard CFT, 3-4). There is no mention in the letter that C.P. had sufficient mental capacity to provide informed consent. There is also no discussion of the fact that C.P. was 14 and had not reached the age of majority.

222. In Dr. Schechter's declaration, he states that "[f]or individuals seeking male chest reconstruction, the criteria are: The patient has the capacity to make fully informed decisions and to consent for treatment." (Schecter depo, p. 11). Again, from the records it does not appear that C.P. had an adequate assessment by a qualified psychiatrist or psychologist prior to signing a consent form for the mastectomy procedure.

223. C.P. was only 14 years old when C.P. signed the consent form for a bilateral mastectomy surgery on 12/10/19 (Pritchard POL, 139). Nolle Pritchard signed as a witness. The surgeon, Dr. Kyllo, did not sign the form. It is not clear to what degree he was involved (if at all) in the informed consent process. As part of the consent for surgery there is a listing of "Surgical Risks and Advisories." There is no listing of the complication that the patient would be unable to breastfeed. Nor is there evidence of a discussion with the patient by the involved clinicians of this problem, nor could C.P. have had sufficient capacity at that age to fully appreciate the future ramifications of such a complication.

**Difficulty in assessing C.P.'s complete hormonal and medical condition given absence of labwork provided in the record**

224. Although Dr. Hatfield's medical records refer to labwork on multiple occasions, these have not been provided and therefore cannot be assessed.

225. The following are quotes from the medical record by visit date and for which corresponding labwork was not provided as part of the record:

- 09/27/16 "Baseline blood work ... have been discussed and ordered today."



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

- 11/08/16 "First blood work to be repeated in 6 months. This checks the efficacy of the implant."
- 05/22/17 "Return to clinic sometime in the Fall (Oct 31-Jan l) for repeat blood work."
- 02/28/18 "Please have blood work done in 3 to 3.5 months (early June)."
- 06/09/18 "Please call the family and inform the testosterone values very good at 76.
- 08/14/18 "return around November 2018 for his next set of blood work."
- 02/18/19 "We will send you the results of your labs from today. - We may increase your dose based on these results."
- 07/11/19 "I will contact you with your lab results from today."

226. The absence of laboratory records makes assessing C.P.'s complete hormonal and medical condition difficult.

**Side effects of puberty blocking medication**

227. In my opinion, the patient developed side effects of puberty blocking medication as evidenced in Dr. Hatfield's medical records. "He is getting headaches almost every day and this is new since the hormone blocker was placed." DOS 02/28/18. "His mother notes he is a lot less active than he was when he was younger. She is wondering if this is related to low hormone levels." DOS 02/28/18. The Vantas implant labeling describes both headaches and fatigue as side effects (Vantas implant labeling, table 1). Rather than stopping puberty blockers because of headaches and fatigue, C.P. was given a prescription for testosterone cream.

**Side effects of estrogen and the conversion of testosterone to estrogen**

228. Another side effect of estrogen is vaginal spotting which is found as a diagnosis in the consult note of Dr. Kyllo on 4/30/19. This indicates development of the endometrial lining of the uterus. Typically, this would be prevented by the addition of progesterone. The administration of progesterone is also important for the long term prevention of endometrial cancer. Dr. Hatfield does not appear to have prescribed progesterone at any time.

229. Testosterone was prescribed to be taken simultaneously with the estradiol medication. As an endocrinologist I am concerned that both hormonal medications were being



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

used off label and in combination. This combined use has not been studied to my knowledge and would be considered high risk. As discussed previously, warnings for both estradiol and testosterone included thrombosis (blood clots which may be deadly such as clots of the lungs).

**Chronic high dose testosterone**

230. The progress notes indicate the initiation of a testosterone cream, later followed by testosterone injections. Again, the Endocrine Society Guidelines provide no evidence for why any particular dose should be given to females. However, one can see from the limited labwork provided that the dose was exceedingly high.

231. The normal reference range for testosterone for adult females depending on the lab is about 10 to 50 ng/dL. For adolescents, the range is lower. On 12/16/20 C.P.'s testosterone level was 227 ng/dL. A simple calculation shows that this was 4.5 to 23 times higher than an adult female level. On 6/24/21, C.P.'s testosterone level was 443. This was approximately 9 to 44 times higher than an adult female level. This is evidence that C.P. had been receiving chronically high levels of testosterone leading to hyperandrogenism. High testosterone levels can result in erythrocytosis.

232. Erythrocytosis is a condition in which the blood contains abnormally high amounts of red blood cells. This can be detected by doing blood tests of hematocrit.

233. "Current guidelines on the management of secondary erythrocytosis in trans men on testosterone therapy refer to the guideline for testosterone-treated hypogonadal cis men and consider hematocrit levels > 0.509 [50%] L/L as potentially dangerous, as it has a very high risk of adverse outcome " (Madsen, 2021). This was written by a team in favor of transitioning and in their estimation a hematocrit level above 50% is potentially dangerous. We have written a response letter to this study in JCEM. In our letter we state that for females who identify as trans males, physicians should use the normal female range of hematocrit as levels above the female range have been shown to be an independent risk factor for heart disease and death due to heart disease (Laidlaw et al, 2021).



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

234. For adult women, the normal hematocrit range is 35.5 to 44.9 percent. On 12/16/2020, the hematocrit level was elevated above the adult female reference range at 45.5 as a result of very high dose testosterone. This is consistent with the development of erythrocytosis.

235. We can see from this that over time the patient had developed erythrocytosis, meaning harmful high red blood cell levels due to chronic high dose testosterone. This exposes C.P. to increased long-term cardiovascular risk and other possible unknown harms. This serious problem does not appear to have been assessed or addressed adequately by Dr. Hatfield.

236. Erythrocytosis was not written as a diagnosis in any problem list. There is no differential diagnosis to determine if there are other causes or factors such as breathing difficulties could have contributed to this problem. There is no discussion of either stopping testosterone injections or lowering the dose to help treat the condition. There are also no follow up labs available to track this problem.

**Mental Health**

237. C.P. had undergone a psychological evaluation at age 16 years and 7 months by the psychologist Steve Tutty, MA, PhD. This was after having been on puberty blockers followed by high dose testosterone for nearly five years. C.P. has developed serious issues with anger as a result of chronic high dose testosterone. "'Sometimes I will be angry for no reason.'. . . This agitation typically manifests in [C.P.] yelling at his mom and dad. 'I also burst out on my friends.' [C.P.'s] mother stated they are 'walking on eggshells at home.'" (PLA, 3066).

238. C.P.'s mood was assessed using the Beck Youth Inventories. Dr. Tutty states that C.P.'s "endorsements resulted in a mildly elevated indication of anger problems." However, this is likely to be an underestimation of C.P.'s actual level of anger, because the diagnostic scales are gendered, and Dr. Tutty refers to C.P. as a male rather than a natal female.

239. C.P. also experiences significant problems with inattention "with more inattention related symptoms present than for 97 percent" of C.P.'s same aged peers (PLA, 3074). C.P. was diagnosed by Dr. Tutty with attention deficit disorder.



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

240. Rather than seeing an improvement in the patient's mental health by gender affirmative therapy, it seems to be worsening. In my opinion, this is consistent with adverse psychological effects of puberty blockers followed by chronic high dose testosterone use.

**Sterilization**

241. C.P. started receiving puberty blockers before puberty had started. C.P.'s ovaries and eggs were by definition in an immature state. C.P. was later placed on high dose testosterone which has the effect of inhibiting the normal communication between the pituitary ovaries, thus "freezing" C.P.'s ovaries in an immature state. Additionally high dose testosterone has unknown, but likely cytotoxic effects on the immature ovaries.

242. There is a very high probability that C.P. has been or will be permanently sterilized by these treatments. The potential reasons are several. 1) The ovaries are locked in an immature state while C.P. takes testosterone; 2) the cytotoxic effects of testosterone on the ovaries; 3) the pituitary is inhibited from communicating with the ovaries from allowing for a normal menstrual cycle and release of an ovum; 4) and, as mentioned above, the ESG have a recommendation for a total abdominal hysterectomy for cancer prevention and ovariectomy after hormone transition which necessarily eliminates any chance of pregnancy (Hembree et al., 2017, p. 3890, p. 3892).

**Abnormal sexual function**

243. There is a high probability that C.P. will have permanent abnormal sexual function due to the fact that C.P.'s pelvic genitalia were not allowed to develop fully under the influence of the pituitary directing proper estrogenization of the genitalia. Furthermore, high dose testosterone leads to abnormal enlargement of the clitoris and also vaginal atrophy (Hembree et al., 2017).

**V. Conclusion.**

244. As explained above, there is ongoing debate and study in the medical community regarding gender affirmative treatment. The opinions of Plaintiffs' experts in this matter do not



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

represent the medical consensus. The medical community is divided on many issues related to gender identity and the necessity or value of gender affirmative care.

245. The Plaintiffs' experts' opinions, which are substantively the same, do not represent the diversity of opinions in the medical community, nor account for the fact-based inquiry that must occur, in my opinion. Their opinions that the only acceptable path forward that meets the standard of care is the approach endorsed by the WPATH is inconsistent with scientific standards, and diverges from the standard of care for other medical treatments.

246. The implication is that if an employer excludes gender affirmative care from coverage, it must be because the employer is prejudiced against transgender individuals is therefore not correct.

247. C.P.'s case illustrates the recurring problem that quality of medical care received by minors who undergo irreversible gender-affirming treatments results at least in part because gender dysphoria treatments are so entangled with advocacy. Much of this advocacy comes from WPATH, which not only attempts to do scientific work, but is also as an advocacy organization, and these two objectives are not compatible.

248. Based on the materials I have reviewed and in my professional opinion, the treatment of C.P. is indicative of these quality-of-care problems that I have observed.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge and belief.

August 3, 2022, at Brockway, CA.

By Michael K. Laidlaw, M.D.

Michael K. Laidlaw, M.D.



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

**CERTIFICATE OF SERVICE**

I certify that on the date indicated below I caused a copy of the foregoing document, EXPERT DECLARATION OF MICHAEL K. LAIDLAW, M.D. to be served on the following attorneys of record:

Eleanor Hamburger
Daniel S. Gross
SIRIANNI YOUTZ SPOONEMORE HAMBURGER
3101 WESTERN AVENUE STE 350
SEATTLE, WA 98121
206-223-0303
Fax: 206-223-0246
Email: ehamburger@sylaw.com
Email: dgross@sylaw.com

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

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

DATED this 4th day of August, 2022.

**Kilpatrick, Townsend & Stockton LLP**

By: /s/ Gwendolyn C. Payton
Gwendolyn C. Payton, WSBA #26752
gpayton@kilpatricktownsend.com

Counsel for Defendant Blue Cross and Blue Shield of Illinois



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

KILPATRICK TOWNSEND 76350748 2

# EXHIBIT C

HONORABLE JUDGE 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,<br><br>Plaintiff,<br><br>vs.<br><br>BLUE CROSS BLUE SHIELD OF ILLINOIS,<br><br>Defendants. | Case No. 3:20-cv-06145-RJB<br><br>**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



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

**CONFIDENTIAL**

disproportionate to the needs of the litigation.

3. BCBSIL interprets the Requests as excluding documents and information subject to the attorney-client privilege, work-product privilege, joint-defense/common-interest privilege, and any other applicable privileges or protections.

5. BCBSIL objects to the Requests to the extent they require BCBSIL to use more than reasonable diligence in preparing their objections and responses based on an examination of those files that reasonably may be expected to yield responsive information and an inquiry of those persons who reasonably may be expected to possess responsive information.

6. BCBSIL objects to the Requests to the extent the discovery sought is unreasonably cumulative, duplicative, or obtainable from some other source that is more convenient, less burdensome, or less expensive, including if the discovery sought is already in the Plaintiffs' possession.

7. BCBSIL objects to each and every Request to the extent it seeks to require BCBSIL to identify or produce documents not currently in their possession, custody, or control, on the grounds that such a request seeks to require more of BCBSIL than any obligation imposed by law, would subject it to unreasonable and undue annoyance, oppression, burden, and expense, or would seek to impose upon it an obligation to discover information or materials from third parties or sources that are equally accessible to the Plaintiffs.

8. BCBSIL objects to the Requests to the extent they seek information outside the applicable three-year statute of limitations for Plaintiffs' Section 1557 claims. *See Smith v. Highland Hosp. of Rochester*, No. 17-CV-6781-CJS, 2018 WL 4748187, at *3 (W.D.N.Y. Oct. 2, 2018); *Solis v. Our Lady of the Lake Ascension Cmty. Hosp., Inc.*, No. CV 18-56-SDD-RLB, 2020 WL 2754917, at *4 (M.D. La. May 27, 2020); *Ward v. Our Lady of the Lake Hosp., Inc.*, No. CV 18-00454-BAJ-RLB, 2020 WL 414457, at *2 (M.D. La. Jan. 24, 2020); RCW 4.16.080(2). Moreover, Plaintiffs' class claims, added via amended complaint, do not relate back to the filing of the initial complaint because BCBSIL was not put on sufficient notice at the time that Plaintiffs intended to seek relief on a class-wide basis. *See McClelland v. Deluxe Fin. Servs.*,



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

*Inc.*, 431 F. App'x 718, 731 (10th Cir. 2011); *Corns v. Laborers Int'l Union of N. Am.*, No. 09-CV-4403 YGR, 2014 WL 1319363, at *5 (N.D. Cal. Mar. 31, 2014) (finding the notice requirement unmet where the original complaint did not give "clear notice" of plaintiff's intent to allege and certify a class); *Perry v. Beneficial Finance Co. of N.Y.*, 81 F.R.D. 490, 495 (W.D.N.Y. 1979) (amended complaint adding class claims did not relate back to initial individual complaint). Nonetheless, per the agreement between the parties and for discovery purposes only, BCBSIL will conduct and produce discovery from November 23, 2016 to the present.

10. BCBSIL incorporates by reference these "General Objections" into each of the Specific Responses and Objections set forth below, as if fully set forth therein

**B. OBJECTIONS TO INSTRUCTIONS**

1. BCBSIL objects to Instruction One because it purports to require BCBSIL to provide documents or information outside of its own possession, custody or control. BCBSIL will interpret these Requests to require BCBSIL to draw upon the information reasonably ascertainable to it, in accordance with the Federal Rules of Civil Procedure.

2. BCBSIL objects to Instruction Two because it purports to require BCBSIL to provide documents or information outside of its own possession, custody or control. BCBSIL will interpret these Requests to require BCBSIL to draw upon the information reasonably ascertainable to it, in accordance with the Federal Rules of Civil Procedure.

**C. OBJECTIONS TO DEFINITIONS**

1. BCBSIL objects to the terms "Defendant," "you" or "your," as overly broad and as calling for information outside of its own possession, custody, or control. BCBSIL also objects that these terms as defined seek information protected by the attorney-client privilege, work product doctrine, or any other applicable privilege or protection.

2. BCBSIL further objects that the term "Plan," as defined, fails to identify a specific policy year. BCBSIL interprets this term to mean the Summary Plan Description, with an effective



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

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

**D. REQUESTS FOR ADMISSION**

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

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

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

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

**E. INTERROGATORIES**

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

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

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

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



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

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

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

SECOND SUPPLEMENTAL ANSWER: *See* revised Addendum A.

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

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

INITIAL ANSWER: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. Notwithstanding the foregoing objections, BCBSIL states that it will



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

meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

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

| | |
|---|---|
| January 2016-December 2016 | 35,802 |
| January 2017-December 2017 | 34,437 |
| January 2018-December 2018 | 34,224 |
| January 2019-December 2019 | 34,883 |
| January 2020-December 2020 | 37,641 |
| January 2021-December 2021 | 37,222 |

*See* BCBSIL_CP_0010824.

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

INITIAL ANSWER: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL further objects to the term "same or similar" as vague and ambiguous. BCBSIL also objects to the time frame set forth in this Interrogatory as seeking



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

irrelevant information beyond the applicable statute of limitations. For the reasons stated above, BCBSIL will conduct and produce discovery from November 23, 2016 to the present.

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

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

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

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

ANSWER: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL objects that the terms "creation" and "preparation" are vague



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

and ambiguous. Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

**INTERROGATORY NO. 10: To the extent that BCBSIL's response to Request for Admission No. 1 is not a complete admission, please identify the complete factual bases for BCBSIL's denial, either in whole or in part, including the source of the factual bases for the denial.**

ANSWER: BCBSIL has admitted Request for Admission No. 1.

**F. REQUESTS FOR PRODUCTION**

**REQUEST FOR PRODUCTION NO. 12: All contracts, Benefit Program Applications or other kinds of applications or agreements between BCBSIL and any other entity, including the self-funded plans and/or the self-funded plans' sponsors, pertaining to the plans identified in response to Interrogatories Nos. 3 and 6 in effect as of January 1, 2014, up to and including the present.**

INITIAL RESPONSE: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL objects to this Request as unduly burdensome and not reasonably calculated to lead to the discovery of admissible evidence in seeking "all contracts, Benefit Program Applications or other kinds of applications or agreements" between BCBSIL and "any other entity," without regard to the materiality of such documents to the facts at issue in this lawsuit. For example, this Request as drafted could encompass agreements between BCBSIL and a whole number of third parties that have nothing to do with coverage for any beneficiaries. BCBSIL further objects to the time frame set forth in this Request as seeking irrelevant information beyond the applicable statute of limitations.

Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

SUPPLEMENTAL RESPONSE: BCBSIL has produced its Administrative Services Agreement, *see* BCBSIL_CP_0003912. BCBSIL has also produced a number of responsive



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

Benefit Program Applications from 2013-2021, *see, e.g.*, BCBSIL_CP_0008556; BCBSIL_CP_0010652; BCBSIL_CP_0011135; BCBSIL_CP_ 0011147; BCBSIL_CP_ 0008567; BCBSIL_CP_0010664; BCBSIL_CP_0008419; BCBSIL_CP_0010632; and BCBSIL_CP_ 0010621.

**REQUEST FOR PRODUCTION NO. 13: All documents, emails, and other communications relating to covering or excluding treatment related to gender dysphoria and/or a gender-affirming care exclusion with regards to any plan identified in response to Interrogatories Nos. 3 and 6, including but not limited to, treatment with puberty blockers, hormone treatment, and/or surgery.**

RESPONSE: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL also objects to this Interrogatory to the extent it seeks information protected by the attorney-client privilege, the work product doctrine, and/or other applicable privileges. BCBSIL further objects to this Request as unduly burdensome and not reasonably calculated to lead to the discovery of admissible evidence in seeking "all documents, emails, and other communications" without regard to the materiality of such documents to the facts at issue in this lawsuit. For example, this Request as drafted could encompass documents, emails, and communications related to the plans identified in response to Interrogatory Nos. 3 and 6 but which do not directly concern treatment for gender dysphoria and/or a gender-affirming care exclusion.

Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

**REQUEST FOR PRODUCTION NO. 14: To the extent not already provided, please produce all copies of the "Benefit Program Application" submitted to BCBSIL in relation to**



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

**any plan identified in response to Interrogatories No. 3 and 6, at any time since January 1, 2014.**

RESPONSE: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL further objects to the time frame set forth in this Request as seeking irrelevant information beyond the applicable statute of limitations.

Notwithstanding the foregoing objections, BCBSIL states that it will meet and confer with Plaintiffs regarding the relevance of this request to the allegations in the complaint.

**REQUEST FOR PRODUCTION NO. 15: To the extent not already provided, please produce all documents relating to any plan identified in response to Interrogatories Nos. 3 and 6 which reflect any determination that BCBSIL could administer such plan in a manner that did not and/or does not comply with the Affordable Care Act's Section 1557, 42 U.S.C. § 18116.**

RESPONSE: BCBSIL incorporates by reference its responses and objections to Interrogatory Nos. 3 and 6. BCBSIL also objects to this Request to the extent it implicates attorney-client privilege, work-product privilege, or any other applicable privileges or protections.

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

DATED this 29th day of July, 2022.

KILPATRICK TOWNSEND & STOCKTON LLP

By */s/ Gwendolyn C. Payton*

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

*Counsel for Defendant Health Care Service*

*Corporation, a Mutual Legal Reserve Company, doing business in Illinois as Blue Cross and Blue Shield of Illinois*



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

**CONFIDENTIAL**

**CERTIFICATE OF SERVICE**

I certify that on the date indicated below I caused a copy of the foregoing document, FIFTH SUPPLEMENTAL RESPONSES AND OBJECTIONS TO PLAINTIFFS' SECOND DISCOVERY REQUESTS TO DEFENDANT BLUE CROSS AND BLUE SHIELD OF ILLINOIS has been sent via e-mail 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

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

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

DATED this 29th day of July, 2022.

**Kilpatrick, Townsend & Stockton LLP**

By: */s/ Gwendolyn C. Payton*
Gwendolyn C. Payton, WSBA #26752
gpayton@kilpatricktownsend.com

*Counsel for Defendant Health Care Service Corporation, a Mutual Legal Reserve Company, doing business in Illinois as Blue Cross and Blue Shield of Illinois*



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

**ADDENDUM A**

| Effective Date | Exclusion/Limitation Language |
|---|---|
| 1/01/2017 | ["Exclusions - What is Not Covered"]<br>"Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies." |
| 1/1/2019 | ["Exclusions"] "This Plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following: . . . Treatment or services, except for the initial diagnosis, for a primary diagnosis of Mental Retardation, Learning, Motor Skills and Communication Disorders, Conduct Disorder, Dementia, Sexual, Paraphilia and Gender Dysphoria, and Personality Disorders, as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by Blue Cross and Blue Shield of Illinois."<br><br>["Short Term Disability Benefits"] "This Plan will not cover any disability . . . a gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change."<br><br>[“Long Term Disability Benefits"] "This Plan will not cover any disability: . . . a gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change." |
| 1/01/2020 | [GENDER REASSIGNMENT SURGERY]<br>Benefits will be provided for Covered Services for gender reassignment the same as any other for persons 18 and older. Benefits for gender reassignment Surgery will be limited to a lifetime maximum of $75, 000.<br><br>Gender reassignment Surgery will be provided when all of the following criteria are met:<br>1. The Individual is at least 18 years of age;<br>2. The individual has been diagnosed with the Gender Identity Disorder (GID) of transsexualism;<br>3. The individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and such therapy is provided under the supervision of a Physician;<br>4. The individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, with no returning to their original gender;<br>5. A letter from the individual’s physician and mental health provider, who has treated the individual for a minimum of 18 months, documenting the treatment and that the treatment is Medically Necessary.<br>Coverage will also be provided for cosmetic Surgery. The following surgeries |



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

| | |
|---|---|
| | are considered cosmetic and will be covered for an individual who has undergone or is planning to undergo gender reassignment Surgery:<br>1. Reduction thyroid chondroplasty;<br>2. Liposuction;<br>3. Rhinoplasty;<br>4. Facial bone reconstruction;<br>5. Face lift;<br>6. Blepharoplasty;<br>7. Voice modification surgery;<br>8. Hair removal/hairplasty; and/or<br>9. Breast augmentation.<br>However, no benefits will be provided for transportation or lodging expenses or for any reversal of gender reassignment Surgery.<br><br>[EXCLUSIONS – WHAT IS NOT COVERED]<br>• Transportation and lodging expenses for gender reassignment Surgery<br>• Reversal of gender reassignment surgery. |
| 1/1/2016 | ["What is Not Covered by the Medical Plan"]<br>"Transsexual surgery or any treatment of gender identity disorders." |
| 1/1/2013 | [Gender Reassignment Surgery]<br>“Benefit is provided to associates only. All of the following criteria must be met:<br>- Associate is at least 18 years old;<br>- Associate has met criteria for the diagnosis of "true" transsexualism, including:<br>- A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant;- A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of<br>the other sex for at least 2 years, that is, not limited to periods of stress;<br>- Absence of physical inter-sex of genetic abnormality;<br>- Does not gain sexual arousal from cross-dressing;<br>- Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood;<br>- Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia;<br>- Wishes to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and<br>- Associate has completed a recognized program of transgender identity treatment as evidenced by all of the following:<br>- A qualified mental health professional*who has been acquainted with the member for at least 18 months recommends sex reassignment surgery documented in the form of a written comprehensive evaluation;<br>- For genital surgical sex reassignment, a second concurring recommendation by another qualified mental health professional * must be documented in the form of a written expert opinion**; |



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

-For genital surgical sex reassignment, member has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract (urological examination is not required for persons not undergoing genital reassignment);
- Associate has demonstrated an understanding of the proposed male-to-female or female-to-male sex reassignment surgery with its attendant costs, required lengths of hospitalization, likely complications, and post-surgical rehabilitation requirements of the planned surgery; - Psychotherapy is not an absolute requirement for surgery unless the mental health professional's initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months);
- The associate has successfully lived and worked within the desired gender role full-time for at least 12 months(so-called real-life experience), without periods of returning to the original gender; and
- Unless medically contraindicated, associate has received at least 12 months of continuous hormonal sex reassignment therapy recommended by a mental health professional and carried out by an endocrinologist (which can be simultaneous with the real-life experience)."

"*At least one of the two clinical behavioral scientists making the favorable recommendation for surgical (genital) sex reassignment must possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.).
Note: Evaluation of candidacy for sex reassignment surgery by a mental health professional is covered under the member's medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the associate's behavioral health benefit. Please check benefit plan descriptions."

**Either two separate letters or one letter with two signatures is acceptable.

"Notes:
(1) Medically necessary core surgical procedures for female to male persons include: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.
(2) Medically necessary core surgical procedure for male to female persons include: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.
(3) Rhinoplasty ,face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair"

"Gender Reassignment Surgery- Travel & Lodging Gender reassignment surgery



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

| | |
|---|---|
| | is performed at limited locations in the United States, and most patients will need to travel outside their immediate home area. If travel is required for surgery because it is not offered in your immediate home area, travel to an in-network surgery provider and lodging expenses will be reimbursed up to a maximum of $10,000. To be eligible for reimbursement:<br>- Travel must be over 100 miles away from your home and must be by air, rail, bus or car. The $10,000 covers you and one caretaker to travel with you for in-network surgery only.<br>- You are only allowed to travel in-network within the 48 contiguous United States.<br>- Lodging expenses include hotel or motel room, car rental, tips and cost of meals while you are not hospitalized and for your caretaker.<br>- Itemized receipts will be required." |
| 1/1/2015 | [Schedule of Benefits Gender Reassignment Surgery]<br>LIFETIME MAXIMUM OF $75,000 PPO 85% after deductible 60% of eligible charges after deductible HRA 85% after deductible 60% of eligible charges after deductible HSA 85% after deductible 60% of eligible charges after deductible. Gender reassignment surgery benefits will be provided for covered services rendered to persons age 18 and over. Conditions for coverage apply:<br>•The individual is at least 18 years of age•<br>The individual has been diagnosed with the gender identity disorder (GID) of trans-sexualism<br>•The individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician<br>•The individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, with no returning to their original gender<br>•A letter from the individual's physician or mental health provider documenting treatments and medical necessity<br><br>[Exclusions] Benefits for gender reassignment surgery exclude transportation and lodging expenses, reversals, and surgeries that are considered to be cosmetic. The following surgeries are considered cosmetic and will not be covered for an individual who has undergone or is planning to undergo gender reassignment surgery: reduction thyroid, chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty and breast augmentation.<br><br>[STD Exclusions] Cosmetic surgery (defined as procedures or services that change or improve appearance without significantly improving physiological function) except for reconstructive surgery or gender reassignment surgery and the subsequent cosmetic surgery to enhance the transformation, as determined by Leave Administration and the medical plan. |



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

| | |
|---|---|
| 6/1/2021 | ["Exclusions - What is Not Covered"]<br>"Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies."<br><br>"["Exclusions - What is Not Covered"]<br>Transgender Coverage" |
| 1/1/2022 | ["Other Covered Services"]<br>Gender reassignment—Benefits will be provided for services and supplies related to gender reassignment but excluding surgery. |
| 1/1/2019 | ["Other Plan Exclusions and Limitations"]<br>"Services related to gender reassignment" |
| 1/1/2016 | ["Gender Reassignment Surgery"]<br>"Benefits will be provided for the gender reassignment surgery for persons age 18 and over with a Gender Identity Disorder, undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician. Benefits for gender reassignment will be limited to a lifetime maximum of $75,000."<br><br>Gender Reassignment Surgery is covered; with the exception of the following:<br>- Transportation and lodging expenses relating to gender reassignment surgery;<br>- Reversals of gender reassignment Surgery. |
| 1/1/2015 | ["Participating Provider"]<br>"When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Participating Provider, benefits will be provided at 90% of the Maximum Allowance or 90% of the Eligible Charge after you have met your program deductible.<br><br>However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000."<br><br>["Non-Participating Provider"]<br>"When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Non- Participating Provider, benefits will be provided at 70% of the Maximum Allowance or 70% of the Eligible Charge after you have met your program deductible.<br><br>However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000." |



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

| | |
|---|---|
| | [EXCLUSIONS – WHAT IS NOT COVERED]<br>"Reversal of gender reassignment surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies." |
| 1/1/2014 | ["Participating Provider"]<br>"When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Participating Provider, benefits will be provided at 80% of the Maximum Allowance or 80% of the Eligible Charge after you have met your program deductible.<br><br>However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000."<br><br>["Non-Participating Provider"]<br>"When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Non- Participating Provider, benefits will be provided at 60% of the Maximum Allowance or 60% of the Eligible Charge after you have met your program deductible.<br><br>However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000."<br><br>["Exclusions - What is Not Covered"]<br>"Reversal of gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies." |
| 1/1/2014 | ["Participating Provider"]<br>"When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance or 100% of the Eligible Charge after you have met your program deductible.<br><br>However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000."<br><br>["Non-Participating Provider"]<br>"When you receive Covered Services for gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery) and counseling and related services and supplies, from a Non- Participating Provider, benefits will be provided at 70% of the Maximum Allowance or 70% of the Eligible Charge after you have met your program deductible. |



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

| | |
|---|---|
| | However, benefits for gender reassignment Surgery, including counseling, related services and supplies, are subject to a lifetime maximum of $75,000."<br><br>["Exclusions - What is Not Covered"]<br>"Reversal of gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies." |
| 1/1/2018 | [EXCLUSIONS – WHAT IS NOT COVERED]<br>"Reversal of gender reassignment surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies." |
| 1/1/2016 | The following exclusions apply generally to all services, drugs and supplies for BCBSIL and CVS Caremark. Specific limitations and exclusions related to certain types of care also appear in the Schedule of Benefits. Please refer to the Schedule of Benefits for specific coverage, limitations and exclusions.<br><br>***<br>10. Charges for sex transformation surgery, hormones related to the surgery, and any related expenses. |
| 1/1/2022 | [Gender Reassignment Surgery]<br><br>"Benefits will be provided for gender reassignment surgery for persons age 18 and over with gender dysphoria, Gender dysphoria (formerly known as 'gender identity disorder') is a condition recognized by the Diagnostic and Statistical Manual (DSM) of Mental Disorders and commonly known as transsexualism. The diagnostic criteria describe many individuals who experience dissonance between their sex at birth and personal gender identity, which is not the same as having ambiguous genitalia. Gender reassignment surgery-- also known as transsexual surgery or sex reassignment surgery-- and related services may be considered medically necessary when meeting the criteria for gender dysphoria listed below. Otherwise, gender reassignment surgery and related services will be considered not medically necessary. Benefits for gender reassignment surgery will be unlimited. Benefits for gender reassignment surgery are the same as benefits for any other condition. Benefits will be provided for Covered services rendered to persons age 18 and over. Criteria for Coverage of Gender Reassignment Surgery and Related Services: The individual being considered for surgery and related services must meet ALL the following criteria. The individual must have: Reached the age of majority- at least 18 years of age AND The capacity to make a fully informed decision and to consent for treatment; AND Been diagnosed with persistent, well-documented gender dysphoria, AND Undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician. Completed a minimum of 12 months of successful continuous full time real−life experience in their new gender, with no returning |



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

| | |
|---|---|
| | to their original gender. A letter from the individual's physician or mental health provider documenting treatments and medical necessity. Has the required referrals prior to any surgery or related service(s): o Prior to feminizing or masculinizing hormonal therapy, one required referral from the individual's qualified mental health professionals competent in the assessment and treatment of gender dysphoria; and/or o Prior to breast/chest surgery, e.g., mastectomy, chest reconstruction, or breast augmentation, one required referral from the individual's qualified mental health professionals competent in the assessment and treatment of gender dysphoria; and/or o Prior to any genital surgery, e.g., hysterectomy, salpingooophorectomy, orchiectomy, and/or other genital reconstructive procedures, two separate required independent referrals (or one signed by both referring providers) from the individual's qualified mental health professionals competent in the assessment, treatment of gender dysphoria, and addressing the identical/same surgery to be performed. Gender Reassignment Surgeries and Related Services: Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan may be considered medically necessary for the treatment of gender dysphoria ONLY. These procedures may include the following: Abdominoplasty; • Blepharoplasty; • Brow lift; • Calf implants; • Cheek implants; • Chin or nose implants; • External penile prosthesis (vacuum erection devices); • Face lift (rhytidectomy); • Facial bone reconstruction/sculpturing/reduction, includes jaw shortening; • Forehead lift or contouring; • Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty); • Laryngoplasty; • Lip reduction or lip enhancement; • Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction; • Neck tightening; • Pectoral implants; • Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple); • Redundant/excessive skin removal; • Rhinoplasty (nose correction); • Skin resurfacing;<br><br>Benefits for gender reassignment surgery exclude: Transportation and lodging expenses, Reversals<br><br>[Not payable under the plan]<br>"Gender Reassignment Surgery is covered; with the exception of the following: Transportation and lodging expenses relating to gender reassignment surgery; reversals of gender reassignment surgery." |
| 1/1/2016 | ["Specific Limits, Criteria and Exclusions"]<br><br>Gender Identity Disorder Treatment<br>Benefit Limits: Network only - 50% $75,000 per Member Lifetime Maximum Non-Network– 0%<br>Includes psychotherapy, continuous hormone replacement(not oral – see Prescription Drug Details section) (including laboratory testing to monitor safety), Genital Surgery, Surgery to Change Secondary Sex Characteristics. |



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

| | |
|---|---|
| | Excludes:- reversal of genital surgery or reversal of surgery to revise secondary sex characteristics; -sperm preservation in advance of hormone treatment or gender surgery; -cryopreservation of fertilized embryos.<br>- voice modification surgery; -facial feminization surgery, including but not limited to: facial bone reduction, face "lift", facial hair removal, and certain facial plastic procedures; -suction-assisted lipoplasty of the waist;<br>-drugs for hair loss or growth;-drugs for sexual performance or Cosmetic purposes (except for hormone therapy described above); -voice therapy; and -transportation, meals, lodging or similar expenses.<br><br>Criteria for Coverage of Continuous Hormone Replacement. In order to receive hormones (not oral– see Prescription Drug Section) of the desired gender, the Member must: - have a diagnosed Gender Identity Disorder; - be at least age 18; -demonstrate knowledge of what hormones medically can and cannot do and their social benefits and risks; and -have already had completed:<br>- a documented real-life experience living as the desired gender of at least three months; and<br>- a period of psychotherapy of a duration specified by the Mental Health Professional after the initial evaluation (usually a minimum of three months).<br><br>Gender Identity Disorder means a disorder characterized by the following diagnostic criteria: -a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex); -the member's persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex; -the disturbance is not concurrent with a physical intersex condition; and -the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.<br><br>Criteria for Coverage of Surgery. In order to receive Genital Surgery or Surgery to Change Secondary Sex Characteristics: -the Member must have a diagnosed Gender Identity Disorder;-the Surgery must be performed by a Provider at a Hospital or Alternate Facility with a history of treating persons with Gender Identity Disorder; - the treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH, an advocacy group) standards; - the Member must be at least age 18 years or older for irreversible surgical interventions; - the Member must complete 12 months of Continuous Hormone Therapy for those without contraindications; and - the Member must complete 12 months of successful continuous full time real life experience in the desired gender.<br><br>Genital Surgery means one of the following: complete hysterectomy, orchiectomy, penectomy, vaginoplasty, vaginectomy, clitoroplasty, labiaplasty, salpingo-oophorectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prosthesis, phalloplasty. |



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

| | |
|---|---|
| 1/1/2013 | "Gender reassignment surgery – Benefits will be provided for gender reassignment Surgery for persons diagnosed with a Gender Identity Disorder and will be limited to a lifetime maximum of $75,000."<br><br>"Gender reassignment Surgery is covered; with the exception of the following:<br>ffl Transportation and lodging expenses relating to gender reassignment Surgery;<br>ffl Reversals of gender reassignment Surgery;<br>ffl Surgeries which a reconsidered to be cosmetic including, but not limited to, reduction tyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification Surgery, hair removal/hairsplasty, and breast augmentation." |
| 1/1/2013 | ["Exclusions - What is not covered"]<br>"Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment." |



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

# EXHIBIT D

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

---

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

---

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

TELISA DRAKE 30(B)(6)

---

9:30 a.m.

May 13, 2022

REPORTED BY: Pat Lessard, CCR #2104

Page 98

Q. That's okay. So tell me what Exhibit 8 is.
A. The January 2018 Benefit Program Application for Common Spirit Health.
Q. Okay. And the year, the effective date is 1/1/2018, correct?
A. Correct.
Q. Let's scroll down to the Additional Provisions. Again, it's all underlined again.
Let's talk about where it starts discussing transgender coverage.
Do you see that?
A. Okay. I do.
Q. All right. Who drafted this language related to the transgender coverage in the BPA?
A. The language was drafted in, you know, a cooperation between the Blue Cross Blue Shield legal staff and the Common Spirit or Catholic Health Initiatives at that time legal staff.
Q. Does similar language appear in other BPAs where there is an exclusion of coverage for gender dysphoria?
A. I can't speak to other BPAs for other clients. Common Spirit is the only client that I have that has this custom language.
Q. And you didn't prepare for today's

Page 99

deposition by looking at BPAs for other plans that have similar exclusions?
A. I did not.
Q. So the first part here under "Transgender Coverage, effective January 1, 2017," it says "Catholic Health Initiatives (CHI) has informed Claims Administrator."
That's Blue Cross Blue Shield of Illinois, correct?
A. That's correct.
Q. "That neither the Employer nor the Employer's Benefit Plan is regulated by Section 1557 of the Affordable Care Act, including but not limited to the related final rule."
Do you see that?
A. I do.
Q. Did Blue Cross Blue Shield of Illinois do anything to investigate whether CHI was regulated by Section 1557 of the Affordable Care Act?
MS. PAYTON: I'm going to object to the form of the question. It calls for information that is privileged.
And I'm going to instruct the witness not to answer.
Q. (By Ms. Hamburger) I'm going to say, apart

Page 100

from anything that is attorney-client privileged, do you, as the account rep for CHI, know of anything that Blue Cross Blue Shield of Illinois did to investigate whether CHI is regulated by Section 1557 of the Affordable Care Act?
MS. PAYTON: I'm going to object to the question. It calls for privileged information about legal analysis and instruct the witness not to answer.
MS. HAMBURGER: But Counsel I asked apart from anything that's attorney-client privileged.
MS. PAYTON: Well, I mean who else would do legal analysis other than lawyers?
MS. HAMBURGER: She could provide the assurance. CHI could have provided some documentation that they didn't sign an assurance with the federal government or a letter from the federal government.
There's all sorts of things that Blue Cross Blue Shield of Illinois could have asked for that has nothing to do with attorney-client privilege.
And that's what I'm asking about.
MS. PAYTON: Okay. I'm not understanding the question, then.
Q. (By Ms. Hamburger) Ms. Drake, as the account representative for CHI and on behalf of Blue Cross Blue Shield of Illinois, apart from

Page 101

communications with attorneys or between attorneys, did Blue Cross Blue Shield of Illinois ask for, receive or undertake any analysis of whether CHI is regulated by Section 1557 of the Affordable Care Act?
MS. PAYTON: I'm going to object to the form of the question. Calls for privileged information, compound, and instruct her not to the answer.
I thought you were going with did they ask for anything from CHI which I think you can ask.
MS. HAMBURGER: Well, I did ask that. Counsel. You know, we'll take this up with a motion to compel, okay?
MS. PAYTON: Why don't you narrow -- the problem is your question. It asks for did you do legal analysis or ask for any?
I mean it was a super complicated compound question.
Just ask one thing in the question and then -- if the question is did you ask for something from CHI, I think you get to ask that question.
Q. (By Ms. Hamburger) All right. Did you ask for anything from CHI that demonstrated that it is not regulated by 1557 of the Affordable Care Act?
A. No.
Q. Have you seen anything from CHI that

# EXHIBIT E

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

---

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

---

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

TELISA DRAKE 30(B)(6)

---

9:30 a.m.

May 13, 2022

REPORTED BY: Pat Lessard, CCR #2104

Page 118

And, so you know, I don't agree that there's anything short about this deposition.

But I agree with you that you're entitled to the 2022 document. I didn't know it existed and we're going to get that to you.

So if you want to ask questions about it you can do that.

MS. HAMBURGER: Can you turn to Exhibit 7, please.

(Marked Deposition Exhibit No. 7.)

MS. PAYTON: Do you need a second to get the 2022?

MS. HAMBURGER: It's okay.

Q. (By Ms. Hamburger) Have you seen Exhibit 7 before?

A. I have, yes.

Q. Okay. And can you tell me what it is?

A. This is a letter to Common Spirit. We're just going to say Common Spirit, is that okay?

Q. Yes. I understand you mean CHI.

A. Okay. To a Common Spirit member that was produced in 2017 as a result of services for transgender services.

And due to an error of a claims processing this was the letter to inform her of that error and

Page 119

the rectification of that error.

Q. Okay. And did you play a role in drafting this letter?

A. I did not personally draft anything but I did review it.

Q. Okay. And this is to Pattie Pritchard who is one of the plaintiffs in this case, correct?

A. That is correct, yes.

Q. Can you describe what happened that led to this letter?

A. We did have a claim on file for a service that would fall within the surgery benefits and that surgery claim did process.

Or, I'm sorry, let me rephrase that. We did misquote that benefit, and in order to rectify that situation we sent her a letter letting her know that that claim is not covered under the normal Common Spirit benefits, but we are going to hold the member harmless due to the fact that we misquoted those benefits. And we made payment for that claim.

Q. And it says "Any future transgender services will not be covered under the medical plan."

Do you see that?

A. I do see that, yes.

Q. And so it doesn't indicate that only surgery

Page 120

would be excluded, correct?

A. I do see that.

Q. And it indicates anything related to transgender services would be excluded, is that right?

A. That is what the letter states, yes.

Q. And was this letter reviewed by CHI?

A. This letter was reviewed by Common Spirit, yes.

Q. And they approved it?

A. That is correct.

MS. PAYTON: I just want to interrupt. I'm sorry to interrupt you.

I just wanted to let you know that you should have now in your Inbox the 2022 version of the document.

Q. (By Ms. Hamburger) Okay. And so then Blue Cross Blue Shield of Illinois also approved this letter, correct?

A. Correct.

Q. Okay. I want to have you turn to Exhibit 18, please.

(Marked Deposition Exhibit No. 18.)

Q. (By Ms. Hamburger) Have you seen Exhibit 18 before?

A. Yes.

Page 121

Q. What is it?

A. This is a predetermination form that we receive from providers for a review of benefits.

Q. Okay. And is this the request for coverage of a service that was considered a transgender service by -- is this the request that was misquoted in the letter we just looked at?

A. Yes.

Q. Okay. And this was a request for a Vantas implant, right?

A. That's correct.

Q. Okay. And I want you to take a look at Exhibit 17.

(Marked Deposition Exhibit No. 17.)

A. Okay.

Q. (By Ms. Hamburger) Can you tell me what it is?

A. You said 17, correct?

Q. Yes, 17, Plaintiffs' Exhibit 17.

A. This is the same letter that we -- oh, I apologize. This is not.

This is a letter to the actual physician that shows that the service would have been covered. So this was the misquote that we did.

Q. Okay. And so when the Request for

Page 122

Predetermination came in to Blue Cross Blue Shield of Illinois, what happens?
A. Catholic Health Initiatives' benefit is very custom and it's a manual process because it has to be reviewed by Common Spirit before the denial is issued or the approval is issued.
And this was just done by human error, someone not paying attention to the scope of the benefit and appropriately sending this particular procedure on and sending that approval letter.
Q. Okay. So there was sufficient information provided to Blue Cross Blue Shield of Illinois to determine that, but for the exclusion, the Vantas implant would have been covered, is that right?
MS. PAYTON: Object to the form.
A. I'm going to restate just to make sure I understand. So the provider sent us a letter or a Predetermination Request.
Once we received that Predetermination. Request we determined that the services were covered.
However, that was an error on the part of the actual person working that particular case and a letter was sent out to the providers stating such.
Q. (By Ms. Hamburger) Right. If the same documentation had been sent on behalf of someone who

Page 123

had a plan that covered gender-affirming care, was there sufficient medical information in that predetermination letter to determine that the service was medically necessary?
MS. PAYTON: I'm going to object to the form of the question. It's outside the scope.
This is not the correct witness to answer that. That's really a medical question.
You can answer.
THE WITNESS: Okay.
Q. (By Ms. Hamburger) You can answer.
A. Yes. I don't think that I have the medical background to be able to answer that question.
Q. So when Blue Cross Blue Shield receives claims requesting predetermination, if they send a letter back saying "Based on the documentation this would be covered under the member's plan," that would mean that it was reviewed both for whether coverage exists generally under the plan and whether there was sufficient documentation to show it would be covered in that particular instance, right?
MS. PAYTON: Object to the form of the question. Same objection.
A. That is correct. So we would receive the medical records, we would receive the information, and

Page 124

then we would have our medical director review it or our medical staff based on our medical policy. And that's how the claims would be adjudicated.
However, they do have to take into consideration what the plan covers and what the client's plan excludes.
MS. HAMBURGER: Fair enough.
So let's go to Exhibit 19.
(Marked Deposition Exhibit No. 19.)
Q. (By Ms. Hamburger) Have you seen Exhibit 19 before?
A. I have, yes.
Q. And can you tell me what it is?
A. This is a sampling of the letter that we send out to members when they ask for particular benefits.
And this particular letter notates that the patient was looking for a mastectomy and it's stating that it's a contract exclusion and that there's no benefits available for that procedure.
Q. And this is for the plaintiff in this case, correct, C.P.?
A. Yes. That is correct, yes.
Q. And mastectomies are covered under the CHI plan for cisgender women, is that correct, when

Page 125

medically necessary?
A. That is correct.
Q. So it's not accurate that mastectomies are excluded always, is that right?
A. That is correct.
Q. This letter was provided because it was a mastectomy to treat gender dysphoria, is that correct?
A. That is correct. That's what qualified that as a contract exclusion was the diagnosis.
Q. Right. It didn't say that in this letter, but that's the reason for the exclusion, the diagnosis, right?
MS. PAYTON: Object to the form.
A. Correct.
MS. HAMBURGER: Okay. Let's look at Exhibit 20, please.
(Marked Deposition Exhibit No. 20.)
Q. (By Ms. Hamburger) Okay. Can you tell me what Exhibit 20 is?
A. This is another letter that was based on a predetermination that we received from a provider for this particular member for the Vantas implant and it also states that it's a contract exclusion.
Q. Okay. And this is for the named plaintiff C.P. in this matter, right?

# EXHIBIT F

International Journal of Transgender Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wijt21

# Correction

**To cite this article:** (2022) Correction, International Journal of Transgender Health, 23:sup1, S259-S261, DOI: 10.1080/26895269.2022.2125695

**To link to this article:** https://doi.org/10.1080/26895269.2022.2125695

Published online: 15 Sep 2022.

INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH
2022, VOL. 23, NO. S1, S259–S261
https://doi.org/10.1080/26895269.2022.2125695

Taylor & Francis
Taylor & Francis Group



# Correction

**Article title:** Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

**Authors:** E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata … J. Arcelus

**Journal:** *International Journal of Transgender Health*

**Bibliometrics:** Volume 23, no. S1, pp. S1-S258

**DOI:** https://doi.org/10.1080/26895269.2022.2100644

Some sections of text have been removed or added. Please see below.

- On page S45, at the end of the sentence finishing "are criticized." The following was added: "However, these findings have not been replicated."
- On page S48: the following text was removed:
  - "With the aforementioned criteria fulfilled (6.12.a–6.12.g), the following are suggested minimal ages for gender-affirming medical and surgical treatment for adolescents:
  - 14 years and above for hormone treatment (estrogens or androgens) unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - 15 years and above for chest masculinization unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - 16 years and above for breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty) as part of gender-affirming treatment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - 17 and above for metoidioplasty, orchidectomy, vaginoplasty, hysterectomy, and fronto-orbital remodeling as part of gender-affirming treatment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - 18 years or above for phalloplasty unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame."
- On page S54, the following text was removed:
  - "Many youth who bind may require chest masculinization surgery in the future (Olson-Kennedy, Warus et al., 2018).
- On page S65, the following text was removed:
  - "With the aforementioned criteria fulfilled (6.12.a–6.12.g), the following are suggested minimal"
  - And the subtitle in bold was changed to read as follows:
  - "Consideration of ages for gender-affirming medical and surgical treatment for adolescents"

- On page S65, the following text was removed:
  - "14 years and above for hormone treatment (estrogens or androgens) unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - 15 years and above for chest masculinization unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - 16 years and above for breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty) as part of gender-affirming treatment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - 17 and above for metoidioplasty, orchidectomy, vaginoplasty, hysterectomy, and fronto-orbital remodeling as part of gender-affirming treatment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - 18 years or above for phalloplasty unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
  - The ages outlined above provide general guidance for determining the age at which gender-affirming interventions may be considered. Age criteria should be considered in addition to other criteria presented for gender-affirming interventions in youth as outlined in Statements 6.12a-f. Individual needs, decision-making capacity for the specific treatment being considered, and developmental stage (rather than age) are most relevant when determining the timing of treatment decisions for individuals.
- On page S65, the phrase:
  - Higher (i.e.., more advanced) ages are provided for treatment with greater irreversibility, complexity, or both.
- Was changed to read:
  - Higher (i.e.., more advanced) ages may be required for treatment with greater irreversibility, complexity, or both.
- On pages S65-S66, the following text was removed:
  - "The recommendations above are based on available evidence, expert consensus, and ethical considerations, including respect for the emerging autonomy of adolescents and the minimization of harm within the context of a limited evidence base. Historically, there has been hesitancy in the transgender health care setting to offer gender-affirming treatments with potential irreversible effects to minors. The age criteria set forth in these guidelines are younger than ages stipulated in previous guidelines and are intended to facilitate youth's access to gender-affirming treatments (Coleman et al., 2012; Hembree et al., 2017). Importantly, for each gender-affirming intervention being considered, youth must communicate consent/assent and be able to demonstrate an understanding and appreciation of potential benefits and risks specific to the intervention (see Statement 6.12c)."
- On page S66, the following text was removed:
  - "It should also be noted the ages for initiation of GAHT recommended above are delayed when compared with the ages at which cisgender peers initiate puberty with endogenous hormones in most regions (Palmert & Dunkel, 2012)."
- On page S66, the following text was removed:
  - "Age recommendations for irreversible surgical procedures were determined by a review of existing literature and the expert consensus of mental health providers, medical providers, and surgeons highly experienced in providing care to TGD adolescents."

- On page S258, the following text was removed:
  - "The following are suggested minimal ages when considering the factors unique to the adolescent treatment time frame for gender-affirming medical and surgical treatment for adolescents, who fulfil all of the other criteria listed above.
    - Hormonal treatment: 14 years
    - Chest masculinization: 15 years
    - Breast augmentation, Facial Surgery: 16 years
    - Metoidioplasty, Orchiectomy, Vaginoplasty,
    - Hysterectomy, Fronto-orbital remodeling: 17 years
    - Phalloplasty: 18 years"

# EXHIBIT G

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

---

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

---

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

TELISA DRAKE 30(B)(6)

---

9:30 a.m.

May 13, 2022

REPORTED BY: Pat Lessard, CCR #2104

Page 50

A. I do.
Q. So there is no definition for any word starting with the letter G, correct?
A. That is correct.
Q. Okay. So it appears that gender reassignment is not a defined term under the standard plan, right?
A. That is correct.
Q. Okay. And so where would people have to look to know whether a service is considered gender-affirming treatment in the Blue Cross Blue Shield of Illinois standard plan?
MS. PAYTON: Object to the form.
A. At this point normally members do contact our customer service and we send them to the medical policy which is listed on our public website.
MS. HAMBURGER: Okay. I want to turn to Exhibit 2 now, please.
(Marked Deposition Exhibit No. 2.)
Q. (By Ms. Hamburger) I'm going to stop sharing.
A. Okay.
Q. I can see you again.
All right. Do you know what Exhibit 2 is?
A. I do.

Page 51

Q. Can you tell me what it is?
A. Yes. It is the Catholic Health Initiatives Summary Plan Description.
Q. For 2019, correct?
A. Yes, this is 2019.
Q. Okay. And in 2019 did Blue Cross Blue Shield of Illinois draft this Summary Plan Description?
A. No, we did that.
Q. But Blue Cross Blue Shield of Illinois administered it, right?
A. Yes. We do administer the benefits that are located within this document.
Q. Okay. Did Blue Cross Blue Shield of Illinois review this document in order to understand how to administer it?
A. Yes, we did. We do match the benefits up to our system to make sure that we're administering as they have depicted to their employees.
Q. All right. Let's take a look at the quick reference on page 14.
It's page 14. I'm sorry, page twelve in the document itself. Oh, it starts on page twelve but the part I want is page 14. I apologize.
I want to draw your attention to where it

Page 52

says "Transgender Reassignment Surgery."
Do you see that?
A. Yes.
Q. And under the chart it has a null sign and it lists page 61.
Do you see that?
A. I do.
Q. And what does that say about transgender reassignment surgery?
A. Within the chart it appears that it's saying that it's in the non-covered field.
Q. Okay. Then let's go down to -- I think it's page 61.
And do you see that Transgender Reassignment Surgery language on page 61?
A. Yes, I do.
Q. And it says "Not Covered. Benefits shall not be provided for gender reassignment surgery, including, but not limited, to any treatments, drugs, medicines, therapy, counseling services or supplies related to such surgeries."
Do you see that?
A. I do.
Q. And who drafted that?
A. Catholic Health Initiatives.

Page 53

Q. But Blue Cross Blue Shield of Illinois reviewed and administered it, correct?
A. That is correct.
Q. And is the term "transgender reassignment surgery" defined?
A. Within their documents?
Q. Yes.
A. It is not.
Q. Okay. And where would someone have to go to find what is included as transgender reassignment surgery and the services leading to it?
A. That also would result more than likely from a call from the member to our customer advocates, and they would be directed to our medical policy.
Q. Okay. And does Blue Cross Blue Shield of Illinois administer the transgender reassignment surgery exclusion -- does it treat the word "gender reassignment surgery" and "transgender reassignment surgery" as the same?
MS. PAYTON: Object to the form.
A. Can you clarify your question?
Q. (By Ms. Hamburger) Yes. From Blue Cross Blue Shield of Illinois's perspective is there a difference between gender reassignment surgery and transgender reassignment surgery?

# EXHIBIT H

Page 26

are they eligible to apply to a fire department?
**A. He's eligible -- he gets credits where he can go to like a community college for their fire science program, so his credits can transfer.**
Q. So he's on his way to getting a degree in fire science?
**A. Yeah.**
Q. How far along is he?
**A. He's -- you know, he just started his junior year, so he's -- I don't know exactly how many credits he has so far.**
Q. Do they do additional things than just academic work to get prepared for a firefighting career?
**A. They do.**
Q. Like what are those?
**A. I mean, I'm not there with him, but he -- you know, he talks about like they do like drills, I guess, similar to what firefighters do. He puts on the firefighter clothing, the mask and they do drills that way, and they get in and out of the trucks and -- yeah.**
Q. How long has C.P. wanted to be a firefighter?
**A. At least for the last few years.**
Q. So for a while?
**A. Yes.**
Q. Sounds like.

Page 27

Okay. What are C.P's pronouns, he, him?
**A. They are.**
Q. How old was C.P. when you first learned that he was a boy?
**A. We started seeing some of the signs around age 9.**
Q. What were those signs?
**A. It was more of a social transition, I guess. He didn't really have the language at the time, but he changed his name to a more, quote-unquote, male sounding name. He wanted his hair to be cut short. He rejected anything that was, quote-unquote, girly, and he had -- he had been playing softball for a really long time, and he just quit and we had no idea what was happening. So those were some of the signs at the time.**
Q. What name did he want to be known by?
**A. He went by Mikey.**
Q. And C.P. was his given name at birth, right?
**A. No.**
Q. No. Oh, okay. So when did you settle on C.P.?
**A. In around the summer of 2016, he came to us with a list of names and he said, I want our family to figure -- you know, to agree on a name for him. And so we -- we voted as a family.**
Q. That was my question: Was it his decision or was it a joint family decision?

Page 28

**A. From --**
Q. Sounds like it was everybody.
**A. Mm-hm.**
Q. So what did you do at first in response? What actions did you take as a parent?
MS. HAMBURGER: Object as to form.
**THE WITNESS: Well, in the beginning, you know, we -- I mean, he was only nine, so there was -- we just talked and listened to him and asked questions. And -- and it wasn't until -- I don't remember the year of, you know, when he was nine, but it wasn't until the summer going into middle school where he really solidified. You know, he came to us and said, I want to start middle school as a boy.**
Q. (By Ms. Payton) And did you seek out any services or help or support beyond just your family support?
MS. HAMBURGER: Object as to form.
**THE WITNESS: I found Gender Diversity. It's a local organization based out of Seattle.**
Q. (By Ms. Payton) And what does Gender Diversity do?
**A. They provide support for families raising trans and gender diverse kids.**
Q. What kind of support do they provide?
**A. They provide support groups. They do a lot of online resources and just communication for, you know, families to ask questions and find more resources. Yeah.**

Page 29

Q. What -- a better question was: What services did you use from Gender Diversity?
**A. We used their support groups.**
Q. Anything else?
**A. Not at that time.**
Q. Did you get any other -- this sort of beginning of middle school time, any other external assistance?
MS. HAMBURGER: Object as to form.
**THE WITNESS: For a few months that summer, we just went to support groups for Gender Diversity.**
Q. (By Ms. Payton) Anything else?
**A. Not until the fall -- not until that fall.**
Q. And then what happened in the fall?
**A. We found -- we found Dr. Hatfield.**
Q. Anything else?
**A. Not at that time.**
Q. Is it fair to say that your family has been working with Dr. Hatfield since the beginning of C.P.'s middle school?
**A. Yes.**
Q. Okay. Help me -- help orient me: About how old is that?
**A. He was -- he was going into middle school, so he was 10.**
Q. Did you have any other medical care providers for

# EXHIBIT I

Page 58

Q. Do you know who they are?
**A. I can't recall right now.**
Q. Okay. And I think you already told me this.
Did you do any other consults or get second recommendations?
**A. No. Dr. Hatfield gave us a few names and -- and we started with Dr. Kyllo and that's who we went with.**
Q. Did Dr. Hatfield tell you to get a second recommendation?
**A. Nope.**
Q. So when you got Exhibit 3, which is the 2016 Summary Plan Description, and you read it, did you see any exclusion for transgender services?
**A. I would have to go through this one again, but I believe this one had no mention of any transgender treatment at all.**
Q. And so in response to that, what did you do?
MS. HAMBURGER: Object as to form.
**THE WITNESS: I called Blue Cross Blue Shield.**
Q. (By Ms. Payton) And what happened?
MS. HAMBURGER: Object as to form.
**THE WITNESS: I asked for clarification, if, you know -- I mean, I'd have to remember all those notes, but I spoke with -- at the time, I spoke with both CHI and**

Page 59

**with Blue Cross Blue Shield, just trying to clarify, you know, coverage or lack thereof and that it wasn't in this book.**
Q. (By Ms. Payton) Would -- do you recall that there's just no mention of transgender services in the 2016 Summary Plan Description at Exhibit 3; is that your recollection?
**A. That's my recollection. Yeah.**
Q. When you tried to sort it out whether there was coverage or not with both CHI and Blue Cross Blue Shield of Illinois, did you get a response?
MS. HAMBURGER: Object as to form.
**THE WITNESS: I got a lot of response -- I got a lot of responses from both Blue Cross Blue Shield and CHI and -- and it was -- you know, spun my head in circles, but I don't believe I ever -- it was never very clear on what was happening.**
Q. (By Ms. Payton) Did you get contradictory responses?
**A. Well, we received the, you know -- for his -- when this all started, it was in regards to his implant, which required an authorization from Blue Cross Blue Shield. And the first letter we got in the mail said, you know, he's -- this has been approved, and so we thought, Great, this is something that's covered.**

Page 60

**And then subsequently, you know, every other mailing and letter that said otherwise, that, Oh, we made a mistake, it wasn't supposed to be covered. And -- and so, you know, it was constant communication back and forth with Blue Cross Blue Shield and CHI and so on and so forth.**
Q. Did CHI ever tell you it was covered?
**A. I believe they -- no, they -- they told me it was not covered.**
Q. And Blue Cross Blue Shield of Illinois sent you a letter saying it was preapproved, right?
**A. Right.**
Q. And then they subsequently told you that was a mistake, it shouldn't have been approved and it's not covered; is that right?
**A. Yes.**
Q. And as I'm understanding it, they said, We'll pay for the past treatments because we told you it was covered, but we're not going to be paying it going forward; is that fair?
MS. HAMBURGER: Object as to form.
**THE WITNESS: That's what I remember.**
Q. (By Ms. Payton) Okay. I have the documents too, and we can look at it just to clarify that.
But I want to show you something in Exhibit Number 3 and ask you about it. And it's on Page 70 of the

Page 61

plan. Tell me when you're there.
**A. Yep.**
Q. I wanted to call your attention to the subheading there, "Services Not Mentioned," on Page 70 of Exhibit Number 3; do you see that?
**A. I do it.**
Q. And it says: "You are not covered for any service, supply or device that is not specifically mentioned in this SPD."
Do you see that?
**A. I do.**
Q. Did you read that when you read it -- when you first got the Summary Plan Description?
**A. I did.**
Q. And what did you understand that to mean, if anything?
**A. I think specifically to that sentence, I had conversations with Blue Cross Blue Shield about how this book could be, you know, ten times the width if it actually like -- there's a lot of things in here that's, you know, not mentioned that is covered. I don't have any examples right now.**
**But every single thing that's covered is not actually in this plan, as extensive as it is, and so -- so the sentence didn't necessarily make a lot of sense to me so**

# EXHIBIT J

BlueCross BlueShield
of Illinois

April 2017

Group Number: C20051
Identification Number: 821448820
Patient Name: Casey Pritchard

Patricia Pritchard
1306 Trenton Avenue
Bremerton, WA 98310

Dear Patricia:

Blue Cross and Blue Shield of Illinois (BCBSIL) strives to provide excellent customer service.

Transgender services are not covered under the terms of your group health plan through Catholic Health Initiatives (CHI). We understand, however, that claims for transgender services dated September 27, 2016, and November 8, 2016, have been paid. We have determined you received inaccurate information that led you to believe these services would be covered.

You will not be responsible for any amounts previously paid with regard to the claims from September and November (except for the deductible and coinsurance amounts). Although those claims are not payable under the Catholic Health Initiatives group health plan, BCBSIL will pay the amounts directly. Therefore, all payments related to those claims will be covered by BCBSIL and not by the Catholic Health Initiatives group health plan. However, please be aware that any future claims for transgender services will not be covered as stated in the plan, and nothing in this letter modifies or waives any provision of the group health plan. We apologize for any confusion this may have caused. We will also follow up with a call to help ensure you understand the terms of the health plan.

If you have any questions or need help, please call Customer Service at **866-776-4244** weekdays between 8 a.m. and 6 p.m. CT.

Sincerely,

Blue Cross and Blue Shield of Illinois
CHI Service Center - 32822