EXHIBIT L

Blue Cross Blue Shield of Illinois
PO Box 805107
Chicago, IL 60680-4112

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TO THE PARENT OR GUARDIAN OF CASEY
PRITCHARD
1306 TRENTON AVE
BREMERTON WA 98310-4940

Number: C20051
iber ID: 821448820
Name: Casey Pritchard

08/08/2019

Dear Kevin Hatfield,

Thank you for your recent inquiry. We have reviewed the information submitted and determined the proposed procedure, J9225 (Vantas implant), is a contract exclusion. No benefits are available for the procedure.

If you have any questions, please feel free to contact us at (800) 972-8088, between the hours of 8:00 AM and 6:00 PM, Central Time, Monday through Friday.

Sincerely,

Your Customer Advocates
Blue Cross Blue Shield of Illinois
This is a courtesy copy for your records.

IMPORTANT INFORMATION
(Retain for your records)

This document applies to your Blue Cross and Blue Shield of Illinois group or individual policy. If you are receiving this notice and your plan is self-insured, your plan may have elected to follow the external review procedure below. Any conflicts between the statements below and rights stated elsewhere in this notice (or in your policy or Benefit Plan), will be resolved so that those rights that are more beneficial to you will apply, unless the law requires otherwise.

If we have denied your claim for benefits, in whole or in part, for a requested treatment or service, rescinded your coverage, or denied or limited your eligibility (if applicable), then this document serves as part of your notice of an adverse determination. Contact us at the number on the back of your ID card if you need assistance understanding this notice or your adverse determination.

Your Internal Appeal Rights

What if I don't agree with this decision? You have a right to appeal an adverse determination. However, you only have 180 days from the date you receive the notice of adverse determination to file an internal appeal.

Who may file an internal appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may designate an authorized representative by completing the necessary forms. For more information on how to do so, contact us at the number on the back of your ID card.

How do I file an internal appeal? For claim appeals, you may contact us at the number on the back of your ID card and request an internal appeal or send a written request.

If your insurance is offered through your employer, send your request to:
Claim Review Section
Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, Illinois 60690

If you purchase your insurance directly from Blue Cross and Blue Shield of Illinois, send your request to:
Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744
Fax: (888)235-2936

What about eligibility-related denials and recissions? Please refer to your benefit booklet for additional specifics. You may also contact us at:

Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744
Phone: (800)538-8833
Fax: (888)235-2936

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted within 24 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor you experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal. Some urgent situations may also qualify for an expedited external review, as described below.

Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information once you initiate your appeal. You may also have the option of presenting evidence and testimony. In addition, we may provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination so you have a reasonable opportunity to respond before a final decision is made.

Can I request copies of information relevant to my claim? Yes, you may request and receive copies relevant to your claim free of charge. For example, upon request, you may receive the diagnosis and treatment codes (and their corresponding meanings) associated with an adverse determination. In addition, if we rely on a rule or guideline (such as a provision excluding certain benefits within your policy booklet) in making an adverse determination, we may provide that rule or guideline to you free of charge upon request. You can request copies of this information by contacting us at the number on the back of your ID card.

What happens next? If you appeal, we will review our decision and send you a written determination.

You External Review Rights

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What qualifies for an expedited external review? You may be eligible for an expedited external review (1) if the failure to obtain treatment in the time necessary to complete a standard external review would seriously jeopardize your life, health or ability to regain maximum function, (2) in connection with emergency services prior to your discharge from a facility or (3) if you are requesting treatment that is experimental or investigational and your health care provider certifies in writing that such treatment would be significantly less effective if not promptly initiated.

How do I request external review? You or your authorized representative may request an expedited external review by notifying the Illinois Department of Insurance by phone (toll-free number (877)850-4740). You or your authorized representative may also file a request for either expedited or standard external review by completing the required forms available at www.insurance.illinois.gov/externalreview and submitting them directly to the address noted below. Blue Cross and Blue Shield of Illinois will also provide the forms upon request.

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, Illinois 62767
Fax: (217)557-8495
Email: DOI.externalreview@illinois.gov

Once an eligible request for external review is complete, the matter will be randomly assigned by the Illinois Department of Insurance to an IRO approved by the Department. There will be no charge to you for the IRO review. The IRO will notify you and your authorized representative of its decision, which will be binding on BlueCross and BlueShield of Illinois, and on you except to the extent you have additional remedies available. Until July 2013, you can appeal the decision of an IRO by filing an appeal with the Illinois Department of Insurance.

Other Resources to Help You

For questions about your rights, this notice, or for assistance, you can contact the Illinois consumer assistance program.

Illinois Department of Insurance
100 Randolph Street 9th Floor
Chicago, IL 60601
www.insurance.illinois.gov
Telephone: (877) 527-9431
Email: DOI.Director@illinois.gov

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SPANISH (Español): Para asistencia en Español, por favor llame al numero ubicado en la parte posterior de su tarjeta de identificación.

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NAVAJO (Dine): Dinék'ehjí áka'a'doowoołt biniiyé, t'áá shǫǫdi ko jį' hodiilnih béésh bee haane'í bi numbo bee nééh ho'dólzinigii biniiyé nanitinigii bine'dęę' bikáá'

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

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PRITCHARD
1306 TRENTON AVE
BREMERTON WA 98310-4940

Number: C20051
iber ID: 821448820
Name: Casey Pritchard

08/08/2019

Dear Jeffrey Kyllo,

Thank you for your recent inquiry. We have reviewed the information submitted and determined the proposed procedure, 19303 (Mastectomy simple complete), is a contract exclusion. No benefits are available for the procedure.

If you have any questions, please feel free to contact us at (800) 972-8088, between the hours of 8:00 AM and 6:00 PM, Central Time, Monday through Friday.

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Chicago, Illinois 60690

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NAVAJO (Dine): Dinék'ehjí áka'a'doowoołbiniiyé, t'áá shǫǫdi koj̨' hodiilnih béésh bee hane'i bi numbo bee nééh o'dólzinigii biniiyé nanitinigii bine'dęę' bikáá'

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300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

EXHIBIT M

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

C.P., by and through his parents, PATRICIA PRITCHARD AND NOLLE PRITCHARD; and PATRICIA PRITCHARD,

Plaintiffs,

vs.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

No. 3:20-cv-06145-RJB

REMOTE
VIDEOTAPED DEPOSITION UPON ORAL EXAMINATION OF
SHARON BOOKER, MA, LMHC
May 6, 2022

Witness location: Poulsbo, Washington

KATIE J. NELSON, RPR, CCR #2971
NELSON COURT REPORTERS, INC.
6513 132nd Avenue NE, #184
Kirkland, Washington 98033
(425) 866-4250
production@nelsonreporters.com

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Our practice has a huge reputation in the community. We've -- we've always had a large presence, you know, for the last 25 years. And so -- so this is what we do at these, you know, quarterly meetings is we -- we let each other -- we give trainings on what each other does so that we can get -- refer people to proper care. So I'm just one of those people and she's one of those people and that's how we know each other.

Q. What is the name of the networking group?

A. Oh, it's terrible. It's the -- it's the Kitsap Mental Health Education and Training Group, but that's not exactly. It gets changed. It's too long, too blah. I can never remember it.

Q. There's no good acronym in other words?

A. No. It's mainly about -- it's mainly about training and it's mainly about referrals. And it's Kitsap County.

Q. And this is a group that -- both you and Pattie Pritchard are involved in?

A. Yes. We have a huge number of providers, both medical, mental health, psychiatrist, everyone, so that everybody has a clear idea what others do. And we -- it has printouts and has descriptions of what people do so that we can give good referrals.

Q. So in addition to C.P., do you have any other

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clients who have come to you as a result of your participation in the networking group?

A. Oh, yeah, lots. I'm well known because I've been -- I'm on the steering community and I've been on it since, like I said, 2003 or something, 2004. So I'm pretty well known.

Q. So just to clarify, C.P. did not first come to see you as a result of any referral from a medical provider?

A. I don't know.

Q. Was there a specific reason that C.P. came to see you?

A. Yes, because there's a second letter that's required and -- and that is also from a mental health provider.

Q. Who is the letter required by?

A. WPATH, World Association of Transgender Health. You know what I mean.

Q. Who would you submit the letter to?

A. Well, I would give a copy back to Hatfield and I would give -- I had a copy mainly to the surgeon.

Q. And who was that?

A. I knew you were going to ask me and I can't remember. You have my letter and assessment; I do not. It's a short name; I can't remember. That's -- yeah, I don't have --

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Q. How many --

A. -- I haven't worked with that surgeon before.

Q. But you had worked with Dr. Hatfield before?

A. Yes. Well, yes, been in the chain. Not directly. I've never spoken to him.

Q. So you've never -- you've never spoken directly to Dr. Hatfield?

A. No.

Q. Have you ever e-mailed with him?

A. To give a copy of what I had done, get a copy of what he'd done, you know, anything -- maybe exchange on that kind of pertinent information. But no, I don't get medical -- I didn't ask for medical records, all of the medical records, and he doesn't either. I don't really encourage that because I don't want to give out my medical records to people because they're very private.

MS. HAMBURGER: Stephanie, how -- I don't want to interrupt your line of thought, if we can, in the next 10 minutes, take a break.

MS. BEDARD: Yes. I think 10 minutes from now will be perfect.

Q. (By Ms. Bedard) Ms. Booker, how many times did you see C.P. as a patient, or I should say client?

A. Okay. I -- I want to give you the process. I did an intake -- initial intake with the parent, which I always

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do when it's a minor, okay?

So an intake with Pattie Pritchard, then I met with C.P. for an hour; then I met with both C.P. and Pattie for an hour as part of doing the assessment letter.

Q. So do -- you met with C.P. for a total of two hours?

A. Correct.

Q. And after that second session, did you meet with C.P. again?

A. No.

Q. How old was C.P. when you first met with him?

A. 15.

Q. And for those two-hour-long sessions -- oh, each session was an hour total, right?

A. Correct.

Q. For the session -- the first session where you met with C.P., was his mother with him or was he by himself?

A. He was by himself.

Q. And that's pretty typical for your minor patients that you would have one just -- one session just with the minor and then one session with the minor and their parent?

A. This was for an assessment. This is different than my normal practice.

Q. So tell me a bit more about that.

What do you mean by an "assessment"? What does the

EXHIBIT N

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FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA

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minors who receive a hormone blocker?
A. Just -- okay. Let's just say: I've never had to do this because they always have been a client for a significant amount of time, but otherwise I'm going to --
Q. What do you mean by that?
A. -- follow -- well, for anybody that has a hormone blocker, you know, you're talking about a young child, and that's somebody like 9, 10, 11. And parents usually always want that person to have support and the parents themselves need support. I work with the families. I work with the individuals and I work with the families.
So it's really not something that I have to go out and say they need because they come to me and want it. So -- but I follow the guidelines, because it can --
Q. So you follow the WPATH guidelines?
A. -- be discriminatory not to follow them.
Q. Okay. I am going to show you what's been marked as Defendant's Exhibit 6.
(Exhibit 6 marked.)
Q. (By Ms. Bedard) I'm going to scroll down so you can see the full exhibit.
A. You kind of went too far. Up. Yeah, a little bit more. There you go. Whoa. Yeah. Now back to -- try the other way. I have a short -- I have a small screen.
Q. Can you see the exhibit okay? Let me know if you

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need me to scroll down.
A. Scroll down, please. Scroll down. There you go. That's pretty good.
Q. Have you seen this letter before?
A. Yes.
Q. And what is this letter?
A. This is the first letter for referral that was done by Dr. Hatfield.
Q. And the date on this letter is May 29th of 2019, right?
A. You know, I can't see that, but yeah. At the moment, I can't see that, but I'd rather see the content. Yeah. Yes, it is.
Q. Would it be helpful if I -- I don't know if I can zoom in any further frankly.
A. No, I mean, I'd rather go down. I don't really need to read the date. The content is more important. There you go.
Q. So let's move on to the content of Dr. Hatfield's letter.
In the second full paragraph, it starts with: "The patient has been in counseling." So in the second full paragraph, it -- the letter says that "he is otherwise free of any other comorbid psychiatric conditions."
Do you see where it says that?

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A. Yes.
Q. Were you consulted regarding this statement before it was put in Dr. Hatfield's letter?
A. Well, that's something I look for in my own assessment.
Q. But were you consulted before this statement was put in Dr. Hatfield's letter?
A. No.
Q. And then the letter goes on to say: "He is otherwise" -- "He is a very well adjusted and otherwise healthy male."
Were you consulted regarding that statement?
A. No.
Q. And later on in that same paragraph, in the second-to-last sentence of that paragraph, it says that: "He is compliant with all medical recommendations for therapy."
Were you consulted regarding that statement?
A. It depends on what therapy you mean. No, I mean, that's -- I mean, therapy can be also medical -- medical therapy, you know what I'm saying? I don't -- I don't know what context you're putting that in.
Q. But, Ms. Booker, were you consulted regarding the statement that C.P. was compliant with all medical recommendations for therapy?

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A. Not me, no. But that's one of the things I look for when I do the second letter.
Q. And did you review this letter before it was sent by Dr. Hatfield?
MS. HAMBURGER: Object as to form.
THE WITNESS: It was supplied to me by the parent.
Q. (By Ms. Bedard) So you were not consulted regarding this letter while it was still a draft, in other words, right?
A. No.
Q. And you received this letter after it was finalized from C.P.'s mother Pattie; is that right?
A. Yes. However, I -- can I talk? Most of the time, doctors themselves are fully able to make assessments about mental health conditions and that -- you know, and if they think they need it, they -- I'm often referred to, but I had not worked with Hatfield directly. So, I mean, I work with --
Q. In this --
A. -- doctors here and we just go back and forth. They have a concern; they let me know. It's more informal.
Q. I'm going to now show you what has been marked as Defendant's Exhibit 7.
(Exhibit 7 marked.)

EXHIBIT O

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the bottom of it.
A. Yes.
Q. Our office only received Page 1 of this document.
MS. BEDARD: And so, Ms. Hamburger, I would ask that to the extent there are additional pages of this document -- the Bates number is Pritchard CFT 00002, that we could receive the additional pages of this document to the extent they exist.
MS. HAMBURGER: We'll -- we'll take a look again to see if there are any missing pages that are not produced, and if there are, we'll let you know.
THE WITNESS: Well --
Q. (By Ms. Bedard) Thank you.
A. Can I say something?
Q. Yes.
A. You looked at the disclosure already, so that was part of it, okay? So the -- I think there are two pages for disclosure. The other page is just the signature page about permission for billing insurances, you know, permission to contact medical people, if necessary, and to agree to, you know, services. So those don't really -- those aren't filled out; they're just paperwork. But if you want copies of them, fine.
Q. Thank you for clarifying.
Just out of an abundance of caution, we would like

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to see the document in its entirety as it appears in your record.
A. Okay.
Q. So, going back to this first page of the document, though, it says that C.P.'s primary care physician is Dr. Garza.
Did you ever consult with Dr. Garza about C.P.?
A. No.
Q. And then I'm scrolling down on same page. It says: "Please describe the main problems that led you to therapy," and filled out on the form, it says: "Assessment for gender dysphoria to obtain letter supporting gender-reaffirming surgery."
Is that right?
A. Yes.
Q. Are there any problems listed here in addition to the need to obtain a letter supporting gender-reaffirming surgery?
A. Just gender -- well, no. No, it's -- that's what they came for; that's what I was aware of during the intake.
Q. So going into your session with C.P., you would have reviewed this document in advance?
A. This document?
Q. This document.
A. Of course.

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Q. And so was it your understanding that the purpose of the visit was to obtain a letter supporting gender-reaffirming surgery?
A. Correct.
Q. Ms. Booker, I'm now going to show you what has been marked as Defendant's Exhibit 10.
(Exhibit 10 marked.)
Q. (By Ms. Bedard) What is this document?
A. These are the medical notes, which are very specifically what is needed by the state for our sessions. It is not to -- it is not -- it is -- it's just what is required for every client medical --
Q. And did you --
THE COURT REPORTER: Crosstalk. Please repeat that, Ms. Booker.
MS. BEDARD: Apologies.
THE WITNESS: A medical note is different than a therapy note. It's specific kind of information that needs to be included: The date, you know, the coding, these are very specific questions.
Q. (By Ms. Bedard) Did you fill out this form?
A. Yes.
Q. And as I look at this form, it appears that there are notes -- medical notes for three separate sessions.
A. Correct.

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Q. So at the top of the page, there is a date for December 20th of 2019?
A. Yeah. As you see is --
Q. In the middle of the -- if you could just let me finish, that would be helpful.
A. Okay.
Q. Thank you.
So at the top of the page, there is a note for December 20th of 2019.
A. Mm-hm.
Q. Middle of the page is June 20th of 2019, and at the bottom of the page is July 23rd of 2019; is that right?
A. Yes. If you look at it, you'll see that the first one is an intake, okay, a parent intake, and that's -- that's what I designated. That's what I was telling you, and that's typical for me.
Q. Why is the date of the parent intake after the other two sessions?
A. Hum? Huh?
Q. Am I reading that correctly? It's a -- oh, right.
A. That could be a mistake. I'm not sure. I'd have to go back and look.
Q. Okay. But for the --
A. That would have been in February.
Q. -- parent intake --

EXHIBIT P

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

C.P., by and through his parents, PATRICIA PRITCHARD AND NOLLE PRITCHARD; and PATRICIA PRITCHARD,

Plaintiffs,

vs.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

No. 3:20-cv-06145-RJB

REMOTE
VIDEOTAPED DEPOSITION UPON ORAL EXAMINATION OF
SHARON BOOKER, MA, LMHC
May 6, 2022

Witness location: Poulsbo, Washington

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about -- and are you talking about primary letters or secondary letters? There's a big difference between --

Q. Thank you for --

A. -- the two.

Q. Thank you for clarifying.

So let's -- let's start big picture: How many letters, primary or secondary, have you been asked to write for chest reconstructive surgery for adults or minors?

A. I don't have a specific count. Maybe 15, you know, around. Don't know specifically.

Q. And --

A. Again, I don't track this.

Q. And of those approximately 15 letters that you've been asked to write for reconstructive chest surgery for adults or minors, did you write a letter on every occasion?

A. For -- for a minor you're asking, or adult?

Q. I'm asking for both, so let me rephrase my question.

So for the letters that you have written for adults -- sorry.

For the letters you've been asked to write for adults or minors for reconstructive chest surgery, how many of those letters have you declined to write?

MS. HAMBURGER: Object as to form; asked and answered.

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Q. (By Ms. Bedard) You can answer.

A. I need to answer this is in a very specific way. Please don't interrupt me.

So basically, I haven't done that many not [sic] letters for top surgery in general. I think I've told you that. And most of -- if it -- if it's a secondary letter, I've done very few of those. But generally, I had very well trained people doing the first letter and, you know, with a -- and -- and the first letter was very thorough, so -- but on none of these did I have the need to say no based on what I, you know, assessed.

Q. How many primary letters have you written for top surgery?

A. Ten, 12. Something in that range.

Q. How many secondary letters have you written for top surgery?

A. I don't know. Five and under. Five or under. Again, we're talking about -- I've been doing this for 14 years.

Q. Turning back to Exhibit 11, Ms. Booker, on Page 2 -- I'm scrolling down -- there's a section of this form titled "Presenting Problem or Symptom."

A. Mm-hm.

Q. And one of the checkmarks is for depression.

Did you conduct an assessment of C.P. and determine that he presented with depression?

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A. Well, it's difficult because dysphoria is a form of depression, so that's why I said "other" to be more specific that it was for dysphoria as far as the kind of depression.

Q. But you diagnosed him as presenting with symptoms of depression. This was a -- your diagnosis, in other words, right?

A. No, I did not diagnose him with depression. You can see by the diagnosis, I did not. I checkmarked that there was some symptoms of depression, but they are more accounted for by dysphoria. Did not -- did not diagnose him with depression, did not meet that -- those criteria.

Q. Okay. So just so I'm understanding, this -- the checkboxes here do not indicate a diagnosis?

A. Right.

Q. They indicate present -- that the client -- that your client is presenting with certain symptoms?

A. Symptoms or problems --

Q. Symptoms or problems?

A. -- has them.

Q. Okay. Thank you.

A. Issues --

Q. For C.P. --

A. It could be issues -- sorry.

Q. Thank you.

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For C.P., you checked the boxes that he was presenting with problems or symptoms of depression, poor concentration and focus and gender dysphoria; is that right?

A. I've already specified about the depression. It's not the way you said it.

Q. And moving on down to "Treatment Goals," under Treatment Goals, it says: "Provide an assessment and letter for gender-affirming reconstructive surgery." Right?

A. Well, that was the purpose that was presented to me. It's --

Q. Are there any --

A. I don't really have a good place to put that, you know, about the letter. You know, these forms are made for other things and ongoing therapy. They're not necessarily made for this, for doing an assessment.

Q. Are there any other treatment goals listed for C.P. other than the letter?

A. No.

Q. Because writing a letter is not a treatment goal, right?

A. As I say, this form is a -- we don't really have a form for those individuals coming in just asking for an assessment letter, so that's when I put that. I didn't have another place to put it on that form.

You have to understand, those forms are made for

EXHIBIT Q

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

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Plaintiffs,

vs.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

No. 3:20-cv-06145-RJB

REMOTE
VIDEOTAPED DEPOSITION UPON ORAL EXAMINATION OF
SHARON BOOKER, MA, LMHC
May 6, 2022

Witness location: Poulsbo, Washington

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A. It could have been February. I'd have to look.
Q. Okay. Thank you.
A. Yeah. For this --
Q. The parent -- Ms. Booker, we've got to be really careful not to talk over each other, okay?
A. I know.
Q. Thank you.
So for this first entry in the medical notes for parent intake, regardless of the date, symptoms addressed, it states: "History of gender dysphoria." Right?
A. Right.
Q. And can you read us what it says for your notes and observations there?
A. It says: "Met with mother to discuss doing -- it's covered up, but -- "assessment letter for C.P. for top surgery." I can't read that because there's covered ups. "Reconstructive surgery. Went over history of symptoms."
Q. Now let's look at the second entry on the page for June 20th of 2019.
A. Mm-hm.
Q. This indicates that you met with C.P. himself from 4 p.m. to 5 p.m., for one hour, right?
A. Correct.
Q. And under "Notes and Observations," it says: "Met with C.P. alone to go over history, treatment and what to

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expect with reconstructive surgery." Right?
A. As part of it. That's a -- that's not necessarily the whole thing. I mean, that's just something -- a part of what we discussed. I didn't put down everything we discussed.
Q. And then on July 23rd, '2019, it says you met with client and mother, right?
A. Correct.
Q. And then under Notes and Observations, it says you "went over the plan for recovery from surgery during break. Client and mother were well educated in what to expect," right?
A. Yeah. Those are all part of the assessment process, required, guidelines and criteria.
Q. And going back up to the top, for your initial intake session, under Notes and Observations, it says: "Met with mother to discuss doing an assessment letter." Right?
A. Correct.
Q. So just to summarize, based on what we see here today, you met with C.P. himself twice on two occasions for an hour each time, correct?
A. Yes.
Q. So the total time that you have spent with C.P. was two hours?
A. Yes.

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MS. HAMBURGER: Object as to form; asked and answered.
Q. (By Ms. Bedard) Ms. Booker, I'm going through some more of the documents that you provided us prior to your deposition today.
I'm showing you what's been marked as Defendant's Exhibit 11.
A. Mm-hm.
(Exhibit 11 marked.)
Q. (By Ms. Bedard) And what is this document?
A. This is that just initial intake. It's a kind of cursory one; it's not a -- it's not in depth, just where we kind of record what initially is discussed.
Q. So you filled out the form?
A. Yes. But -- but I filled this out actually after also meeting with, you know, C.P. You know, I -- it took a -- you know, because I wanted -- I needed to talk -- I'm -- it was kind of after those -- the meeting with C.P., after meeting with the mom, you know, to get, you know, intake, you know, get a feel for what's going on.
Again, it's not like a huge, in-depth evaluation; it's just mainly for our information.
Q. And scrolling down on the first page, under "Reason for Referral," it says that the reason was "assessment letter for reconstructive chest surgery." Right?

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A. Correct.
Q. So the letter -- assessment letter for reconstructive chest surgery was the purpose of the visit, right?
MS. HAMBURGER: Object as to form.
THE WITNESS: Purpose of the visit?
MS. HAMBURGER: Ms. Booker, you can answer --
Q. (By Ms. Bedard) You can answer.
MS. HAMBURGER: -- if you're able.
THE WITNESS: Well, from the initial assessment with the mother, you know, meeting with the mom -- the meeting with the mother, she was straightforward about what she -- what was -- what they were needing.
Q. (By Ms. Bedard) If you had found, based on your assessment of C.P., that C.P. was not a good candidate for reconstructive chest surgery --
A. Yeah.
Q. -- would you have declined to write a letter?
A. Yes.
Q. And have you ever been asked to write a letter for reconstructive chest surgery and declined to write a letter?
A. I have -- no, I have not. Not had to.
Q. How many letters in support of reconstructive chest surgery have you been asked to write?
A. Are you talking about adults? You're talking

EXHIBIT R

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

C.P., by and through his parents, PATRICIA PRITCHARD AND NOLLE PRITCHARD; and PATRICIA PRITCHARD,

Plaintiffs,

vs.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

No. 3:20-cv-06145-RJB

REMOTE
VIDEOTAPED DEPOSITION UPON ORAL EXAMINATION OF
PATRICIA PRITCHARD
** Confidential **
March 11, 2022

Taken remotely
Witness location: Seattle, Washington

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MS. HAMBURGER: Object as to form.
Q. (By Ms. Payton) That's the Vantas implant, right?
MS. HAMBURGER: Object as to form.
THE WITNESS: I don't -- I don't know by this. From just this, I don't know.
Q. (By Ms. Payton) Okay. Is -- do you know, given the date of this, is this the second implant or the first implant?
A. It would have been his -- his -- his second implant wasn't until 2019, so --
Q. Okay.
A. -- anything 2017-related would not be about a second implant.
Q. Okay. So -- so this is -- is this part of the -- this was -- this was the bill that was so puzzling that you went back and forth on why you were owing this bill with Polyclinic and Blue Cross Blue Shield of Illinois; is that right?
MS. HAMBURGER: Object as to form.
THE WITNESS: I don't know.
Q. (By Ms. Payton) Sorry. I'm taking a break because I'm speeding up because sometimes I don't need to ask you things anymore that are on my list because you've answered them.
At some point, your pharmaceutical coverage carrier

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switched to Optum, correct?
MS. HAMBURGER: Object as to form.
THE WITNESS: Yes.
Q. (By Ms. Payton) Have you had any denials from Optum.
A. I don't remember specifically if I've had denials from Optum.
Q. Okay. Look with me, if you would at -- I'm skipping some things as I gather understanding of what the situation is, which is good because we move faster.
So turn now to Exhibit Number 22.
(Exhibit 22 marked.)
THE WITNESS: Okay.
Q. (By Ms. Payton) Do you know what this is?
A. It's the 2018 summary plan.
Q. Okay. And would you agree with me, this is the one where the transgender reassignment surgery exclusion appears in writing?
A. I'd have to look, but --
Q. Okay.
A. -- I believe it was the 2018.
Q. Okay. Look at Page 61.
A. Yes.
Q. Okay. And then when you --
First of all, when did you get this, the 2018

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version of the Summary Plan Description that is in Exhibit 22.
A. I don't know the date, but probably March.
Q. Is that because you said that's generally when they came out, around March?
A. Correct.
Q. Has the 2022 version come out yet?
A. I haven't seen it yet.
Q. Have you asked?
A. I don't think I have.
Q. So when you got this, did you review it and see the exclusion?
A. Yes.
Q. What was your reaction?
A. That I was surprised that it was finally in here in writing.
Q. Did you have any information as to why it was now in writing in the Summary Plan Description?
MS. HAMBURGER: Object as to form.
THE WITNESS: No.
Q. (By Ms. Payton) Did you ask?
MS. HAMBURGER: Object as to form.
THE WITNESS: I don't know exactly if -- if I asked about it, but I probably did.
Q. (By Ms. Payton) Do you recall the response?

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A. I don't.
Q. So the exclusion is for surgery, right?
MS. HAMBURGER: Object as to form.
THE WITNESS: I don't know if -- if it's specifically -- if that's what this means, that it's for surgery.
Q. (By Ms. Payton) What did you understand it to mean?
A. I don't know if I understood it. It says, you know, all these things leading to, so, in my mind, it would still mean those things.
Q. After reading the language of the exclusion, did you expect that some services that C.P. was receiving would be covered?
MS. HAMBURGER: Object as to form.
THE WITNESS: No.
Q. (By Ms. Payton) And why not?
A. By this point, it had been two years and nothing had been covered, so it was -- now there's an exclusion, so why would there be coverage?
Q. Well, some things were covered, right?
MS. HAMBURGER: Object as to form.
THE WITNESS: There were some parts that were covered.
Q. (By Ms. Payton) And some parts were denied, right?

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A. Right.
Q. So what was your understanding of what would be covered?
MS. HAMBURGER: Object as to form; asked and answered.
THE WITNESS: I don't think I had any understanding of what was going to be covered. It was kind of, Oh, look, it was covered. So it was never clear on what specifically would be covered and what wouldn't be covered.
Q. (By Ms. Payton) Did anybody ever tell you what would be covered and what would not be covered?
A. I don't know if that was ever made clear.
Q. Did you ever ask?
A. I mean, I feel like I asked all the time specifically what would be covered or if certain things would be covered.
Q. And never got a response?
A. Well, you see the responses. I mean, they -- you know, if I asked if a certain -- if an implant or a surgery was going to be covered, they would say no, and so that was the response. It would be no.
Q. And speaking of which, look at Exhibit 23.
(Exhibit 23 marked.)
THE WITNESS: Okay.
Q. (By Ms. Payton) So this is -- well, I should ask you.
What is Exhibit 23?
A. It looks like our appeal results from --
Q. And --
A. -- Blue Cross Blue Shield.
Q. And they told you it's not covered because it's a contract exclusion, right?
A. Correct.
Q. Did you discuss this result of the appeal in the April 26, 2018, letter, which is Exhibit 23, with Dr. Hatfield?
A. I don't believe we ever talked to Dr. Hatfield about coverage issues.
Q. What about Polyclinic?
MS. HAMBURGER: Object as to form.
THE WITNESS: We talked to the Poly- -- or we talked to Dr. Kyllo's office about coverage for his top surgery.
Q. (By Ms. Payton) Anyone else?
A. At the Polyclinic?
Q. Yeah.
A. Not that I remember.
Q. Look with me at Exhibit 24.
(Exhibit 24 marked.)
THE WITNESS: Okay.

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Q. (By Ms. Payton) Okay. So Exhibit 24 is information from CVS CareMark, correct?
A. Yeah.
Q. And you also had denials for testosterone cream from CVS, right?
A. Right.
Q. When you were telling me early about the roll-on, was this the roll-on?
MS. HAMBURGER: Object as to form.
THE WITNESS: The testosterone from CVS was the roll-on.
Q. (By Ms. Payton) Okay. So it is your understanding that CVS CareMark is a separate entity from Blue Cross Blue Shield of Illinois; is that right?
MS. HAMBURGER: Object as to form; asked and answered.
THE WITNESS: Yeah, I had said earlier that I wasn't sure --
Q. (By Ms. Payton) Okay.
A. -- how it all works.
Q. Okay. Sorry. I didn't remember your answer on that.
Do you -- is it your position that the issue related to the testosterone cream is an issue in this lawsuit against Blue Cross Blue Shield of Illinois?

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MS. HAMBURGER: Object as to form.
THE WITNESS: I'm not sure.
Q. (By Ms. Payton) Okay. Did you -- you did an appeal with CareMark, right?
A. Yes.
Q. And what was the result of that appeal?
A. I think we went through this already, but it was denied.
Q. And in the denial, did they tell you that it -- the denial wasn't related to the transgender issue, but it was because of the compounding quality of the specific prescription?
A. That's what I remember.
Q. Do you agree with that?
MS. HAMBURGER: Object as to form.
Q. (By Ms. Payton) Not with the denial, but that was the reason that they were saying no?
A. Yes.
Q. Okay. And they -- they said, I believe, that there were other testosterone creams that were covered, correct?
MS. HAMBURGER: Object as to form.
THE WITNESS: I don't remember ever getting another testosterone cream option.
Q. (By Ms. Payton) Is it your position that the denial of the testosterone cream was a result of

EXHIBIT S

The Honorable Robert J. Bryan

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	NO. 3:20-cv-06145-RJB DECLARATION OF FRANK G. FOX IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

I, Frank. G. Fox, Ph.D., declare under penalty of perjury and in accordance with the laws of the State of Washington and the United States that:

1. I am over the age of 18, not a party in the case and competent to testify to all matters stated herein. All statements are made upon my personal knowledge.

2. I am an economist with expertise in quantitative health care planning, statistics and financial modeling.

3. ***Exhibit A*** attached hereto is a true and accurate copy of my Curriculum Vitae that details my professional background in health planning, statistics and finances.

4. My educational experience is as follows:

1977 Ph.D., University of Washington, Seattle, WA (Economics)

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SEATTLE, WASHINGTON 98121
TEL. (206) 223-0303 FAX (206) 223-0246

1972 M.A. , University of Washington, Seattle, WA (Economics)

1970 B.A., University of Washington, Seattle, WA (Economics)

5. I have owned and operated my own consulting firm since 1996, specializing in healthcare statistical analysis and the development of utilization and financial modeling and forecasting. I began my career in econometric modeling in the defense industry, preparing stochastic forecast models. I moved into health care economics in the early 1980s, first working in research and development, then in a large hospital organization as a health care planner, then in applied research and development. Since I have had my own consulting practice, I have provided healthcare planning, statistical analysis and financial simulation modeling to many of the hospitals in the State of Washington and in other parts of the country. I have also been engaged by numerous physician practices as an expert in health economics and financial/statistical modeling.

6. I have extensive experience with forecasting the need for hospital acute care beds, kidney dialysis centers, heart and liver transplant services, home health and hospice services, ambulatory surgery cases, clinical procedures such as GI procedures, cardiac surgery, epilepsy procedures, etc., and evaluating financial performance of health care entities. I have prepared a large number of simulation models for healthcare organizations to forecast utilization and financial performance for new technologies such as MRIs, linear accelerators and minimally invasive surgery, and for discrete projects such as new hospitals, ambulatory surgery centers, urgent care centers, imaging centers, and emergency departments. I have also prepared a large number of business plans for many hospital services and programs. I have extensive experience in designing primary research studies to ensure that the quantitative results generated from those studies

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provide statistically meaningful results, *i.e.,* provide results that can be generalized to the larger universe in a statistically valid way.

7. I have been qualified and have testified as a statistical expert, an expert in health economics and a healthcare planning expert in the following court cases: (1) Florida, 1985; (2) Oregon Federal District Court (2006); (3) Seattle WA Superior Court (2004); (4) in twenty-one separate Washington Department of Health Administrative Law Judge ("DOH ALJ") Hearings—one in 2004, 2008, 2010, two cases in 2011, two cases in 2012, two cases in 2013, four cases in 2014, one case in 2015, two cases in 2016, two cases in 2018; two cases in 2020 and one case in 2021; and (5) in two hearings before the Alaska Office of Administrative Hearings, one in 2016 and another in 2017. These cases also included expert deposition testimony. In addition, I have been deposed as an expert in a number of additional cases that were settled before trial. I have also acted as an expert consultant in the following cases: (1) numerous cases involving the acute care bed need methodology required by the Washington Department of Health under the certificate-of-need rules; (2) an anti-trust case in Oregon (2008); (3) ambulatory surgery center certificate-of-need cases in Washington; (4) kidney dialysis certificate-of need cases in Washington; and (5) nursing home and hospice certificate-of-need cases in Washington.

8. At the request of Plaintiffs' attorneys, I created a statistical model using data sources that are publicly available, as well as information from discovery produced by Defendant. Based on my expert opinion, this information can be reliably used to prepare statistically robust estimates of the number of enrollees who have been or are participants or beneficiaries in Blue Cross Blue Shield of Illinois ("BCBSIL") administered ERISA self-funded group health plans from January 1, 2016 to the present, who required or require treatment with excluded gender affirming health care services.

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9. Discovery from Defendant BCBSIL identified at least 505 unique enrollees in BCBSIL-administered ERISA group health plans that contained gender affirming care exclusions who had claims denied under such exclusions during the proposed class period.

10. Apart from this 505-enrollee figure, which alone, provides numerosity in this matter, Defendant provided the number of enrollees in each ERISA self-funded plan administered by BCBSIL that contained a gender affirming care exclusion, by year, over the time period 2016-2021. As explained in my Report, a true and correct copy of which is attached as ***Exhibit B*** to this declaration, I prepared and utilized simulation models over the 2016-2021 period to estimate the number of enrollees by plan year, who would be expected to utilize medically necessary treatment for gender dysphoria in BCBSIL administered ERISA self-funded group health plans.

11. In summary, in my expert opinion, utilizing either estimating approach (1) direct counts of enrollees in BCBSIL-administered ERISA group health plans who submitted claims for treatment for gender dysphoria that were denied; or (2) simulation models to estimate utilization of medically necessary treatment for gender dysphoria in the same plans over the same class period, indicates that the number of these individuals who are likely to have required or require gender affirming care in these plans during the proposed class period significantly exceeds 40 enrollees.

DATED: August 19, 2022, at Seattle, Washington.

F. G. Fox, PhD

Frank G. Fox, Ph.D.

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Exhibit A

FRANK G. FOX, JR.

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Telephone: 206.366.1550

Website: https://healthtrends.consulting/

Education

1977	Ph.D., University of Washington, Seattle, WA (Economics)
1972	M.A., University of Washington, Seattle, WA (Economics)
1970	B.A., University of Washington, Seattle, WA (Economics)

Professional Experience

May 1996 - Present **HealthTrends, Shoreline, WA**

Principal

Direct work with health care organizations in the development and implementation of actions to improve performance. This work is principally quantitative analysis and simulation modeling.

Projects include demand and financial modeling, including future year budget forecasts and business plan development; statistical survey research and analysis; strategic plan development; asset and program/service valuation, including physician practices and other businesses; new business development; joint ventures; compilation and analysis of information defining internal and market actions; medical staff development plans; technology acquisition/implementation; and expert consultation with clients regarding quantitative analysis and modeling, including evaluation of new technology. Significant expert testimony consultations regarding statistical and health care economics. Engagements have included:

- Development of demand and financial models for organization business planning and future year budgets. Includes developing databases and preparing models that simultaneously link “dependent” and “independent” variables that combined simulate utilization and financial projections. Includes preparing sensitivity analyses to test the effect of changes in key model variables on projected outcomes

- Development of financial statements, including income and expense, cash flow, asset depreciation and balance sheets. These schedules are used to define prior performance and model future growth. Includes engagements assisting small business “start-up” operations, including serving as chief financial officer, but in a consultant role

- Expert consultation regarding statistical/mathematical issues associated with clients’ surveys and other sampling work

- Primary and secondary survey research. Includes formulating best research design, developing survey questionnaires, utilizing in-person or other survey approach(es), preparing statistical analysis of survey responses and report preparation

- Preparation of volume and financial performance models for free-standing emergency departments, urgent care centers, medical clinics, imaging centers and ambulatory surgery centers. Includes preparation of demand and revenue forecasts by type of service, program or physician sub-specialty. Also includes estimation of direct and indirect expenses of business operations, including FTE (“full-time equivalent”) employment forecasts and capital expenditure modeling. Designed to identify key performance statistics and provide risk analysis of alternative utilization, reimbursement and expense scenarios

- Preparation of demand and financial models to define, evaluate and model demand and financial performance for new programs and technologies, e.g., transplantation programs including liver and pancreas transplantation; Gamma Knife program; PET scanner; minimally invasive surgery; and transcranial magnetic stimulation (”TMS”).

- Preparation of demand and financial models to evaluate current performance and prepare service/program forecasts. Representative projects include: imaging centers, including forecasts for all key modalities; emergency services; cardiac services; obstetrics and women’s’ services; sleep lab; oncology programs, including medical oncology and radiation therapy; and ambulatory surgery centers.

- Preparation of medical staff development plans, including integration of quantitative estimates of demand by specialty, current and projected supply, financial modeling, and qualitative interview research. Designed to assist organizations’ alignment/integration with physicians.

- Preparation of performance analyses, where client benchmarks are established and performance, measured. Examples include emergency department physicians, or

practicing physicians in a single or multi-specialty clinic. Work has included development and implementation of "production-based" compensation models.

- Preparation of valuation studies, which require assessment of "fair market value." This has included contractual arrangements, where buyers must meet fair market value standard for federal statutes. It has also included preparation of fair market value estimates of physician practices.

- Preparation of strategic plans, including market demographic and economic profiles, organization performance data across key services/programs, including portfolio analysis, competitor analysis, and identification and prioritization of goals, strategies and implementation actions.

- Preparation of marketplace statistics on population, utilization and market share figures to assist organizations' strategic planning and marketing programs.

- Expert testimony and deposition. I have been qualified and have testified as a statistical expert, an expert in economics and health economics, and a healthcare planning expert in a large number of courts-of-law. This includes deposition and expert testimony in the following: (1) Florida, Federal District Court, 1985; (2) Oregon Federal District Court (2006); (3) Seattle WA Superior Court (2004); (4) in twenty-one separate Washington Department of Health Administrative Law Judge ("DOH ALJ") Hearings—one in 2004, 2008, 2010, two cases in 2011, two cases in 2012, two cases in 2013, four cases in 2014, one case in 2015, two cases in 2016, two cases in 2018, two cases in 2020 and one case in 2021; and (5) in two hearings before the Alaska Office of Administrative Hearings, one in 2016 and another in 2017.

- Expert consultation. I have acted as an expert consultant in the following cases: (1) numerous cases involving the acute care bed need methodology required by the Washington Department of Health under the certificate-of-need rules; (2) an anti-trust case in Oregon (2008); (3) ambulatory surgery center certificate-of-need cases in Washington; (4) kidney dialysis certificate-of need cases in Washington; and (5) nursing home and hospice certificate-of-need cases in Washington.

- Depositions, Expert Declarations, Expert Reports and Rebuttal Reports. I have provided expert declarations and/or expert reports and rebuttals in the following cases: (1) In 2018, I provided an expert declaration ("Declaration") valuing the injunctive relief in a class action settlement in support of the motion for preliminary approval of that settlement in *Kerr v. Kaiser Foundation Health Plan*, Los Angeles Superior Court Case No. BC556863. (2) In May 2019, I provided a Declaration regarding models I prepared estimating utilization and cost for selected treatments for patients with diagnoses identified in the California Mental Health Parity Act and substance abuse in *Ames v. Anthem Blue Cross Life & Health Insurance Company*, Los Angeles Superior Court Case No. BC591623. (3)

In May 2019, I provided Declaration regarding estimates of the number of Plan insureds with a prevalence of Autism Spectrum Disorder ("ASD") who utilized and expended monies for applied behavior therapy ("ABA") in *JR v. CHI et.al.,* United States District Court, Western District of Washington, Seattle, No. 2:18:cv-01191-JLR. (4) In June 2019, I prepared an Expert Report in *DT v. NECA/IBEW Family Medical Plan, Civil Action No. 2:17-cv-00004 (RAJ)*, which estimated utilization and expenditures for ABA and/or physical therapy ("PT"), occupational therapy ("OT") or speech therapy, for Plan insureds with a prevalence of ASD. (5) In July 2019, I prepared a series of Rebuttal Reports in *DT v. NECA/IBEW Family Medical Plan, Civil Action No. 2:17-cv-00004 (RAJ)*. (6) In January 2020, I provided a Declaration valuing coverage for residential treatment for insureds with eating disorders in a class action case in *Rea v. Blue Shield of California*, *Los Angeles Superior Court Case No. B468900*. (7) In July 2020, I prepared an Expert Report in *Crosby v. Blue Shield of California, Magellan Health, et. al., Case No.: 8:17-CV-01970-CJC-JDE;* (8) In August 2020, I prepared a Rebuttal Report also for *Crosby v. Blue Shield of California, Magellan Health, et. al., Case No.: 8:17-CV-01970-CJC-JDE*; (9) In October 2020, I prepared a Declaration in support of a motion for summary adjudication of Health Net's fifth cause of action for intentional interference with contractual relations in *Dual Diagnosis Treatment Center Inc., v. Health Net, Los Angeles Superior Court, Case No. LC104357*; (10) November 2020, I provided a supplemental Declaration *in Rea v. Blue Shield of California, Los Angeles Superior Court Case No. B468900*; (11) In January 2022, I was deposed in in *Dual Diagnosis Treatment Center Inc., v. Health Net, Los Angeles Superior Court, Case No. LC104357*; (12) In June 2022, I was deposed in *Decision by the Department of Health Regarding Two Certificate of Need Applications Proposing to Establish Medicare and Medicaid Certified Hospice Services in Thurston County, No. M2021-923.*

- Preparation of Certificate of Need applications. Projects have included: (1) the development and operation of freestanding ambulatory surgery centers;(2) the purchase and sale of two hospitals in Eastern Washington in Spring 2003; (3) the development and operation of St. Anthony Hospital in Gig Harbor Washington in Fall 2003; (4) the development of a liver transplant program for Swedish Health Services in Seattle WA in Summer 2003; (5) the preparation of 3 kidney dialysis center applications in Spokane County, WA in fall 2003; (6) the preparation of a kidney dialysis center application in Clark County, WA in spring 2005; (7) the development and operation of a new hospital—Swedish Issaquah Hospital--in Issaquah Washington, submitted in 2004; (8) the development and operation of a freestanding hospital in Eugene Oregon, submitted in December 2005; (9) the expansion of acute care beds for St. Francis Hospital, Federal Way, WA submitted in late Fall 2006; (10) the build-out of a hospital tower and the expansion of licensed capacity by 166 acute care beds for Providence Regional Medical Center in Everett WA this represented the largest expansion project in Washington CN history), also submitted in late Fall 2006; (11) the preparation of a certificate of need application for a 152-bed expansion and 21-bed NICU expansion for Sacred Heart Medical Center in Spokane WA, completed in February 2009; (12 & 13) the preparation of two certificate of need applications for percutaneous coronary intervention (PCI) programs

at Stevens Hospital, Edmonds WA and Valley Medical Center, Renton WA—both applications were submitted in February 2009; (14) the preparation of a certificate-of-need application for a 27-bed NICU expansion Kadlec Medical Center, Richland WA, submitted in August 2009; (15) preparation of a certificate of need application for a 114-bed expansion project for Kadlec Medical Center, Richland WA, submitted November 2009; (16) preparation of a certificate of need application for a new 58-bed hospital in the Southeast Planning Area, submitted in December 2009; (17) preparation of a certificate of need request for Swedish Health Services' Lease of Stevens Hospital in Edmonds WA, submitted in May 2010; (18) preparation of a certificate of need for a 25-bed expansion of Mary Bridge Children's Hospital, submitted in July 2010; (19) preparation of a certificate of need request for pancreatic transplantation at Sacred Heart Medical Center; (20) preparation of a certificate-of-need request for a 20-bed expansion of Tacoma General Hospital's Neonatal Intensive Care Unit ("NICU"); (21) preparation of a certificate-of-need request for a 4-bed expansion of Tacoma General Hospital's Intermediate Care Nursery ("ICN"); (22) preparation of a certificate-of-need request for a 16-bed Intermediate Care Nursery ("ICN") at Swedish/Issaquah, submitted in January 2011; (23) preparation of a certificate-of-need request to operate an elective percutaneous coronary intervention ("PCI) program at Swedish/Issaquah; (24) preparation of a certificate-of-need request for an 11-bed expansion of Good Samaritan Hospital, submitted in June 2011; (25) preparation of a certificate of need for a 20-bed expansion of Mary Bridge Children's Hospital, submitted in October, 2011; (26) preparation of a certificate-of-need request for an ambulatory surgery center in Gig Harbor, Washington, submitted October 2011 (27) preparation of a certificate-of-need request for a new 30-bed psychiatric hospital in Everett, Washington, submitted November 2011; (28) preparation of a certificate-of-need request to operate an elective percutaneous coronary intervention ("PCI) program at Swedish/First Hill, submitted in February 2012; (29) preparation of a certificate-of-need request for an additional Level I rehabilitation beds at Providence St. Peter Hospital, submitted in March 2012; (30) preparation of a certificate-of-need request to lease Wenatchee Valley Hospital, submitted in September 2012; (31) preparation of a certificate-of-need request to lease United General Hospital, submitted November 2012; (32) preparation of a certificate of need to operate an ambulatory surgery facility, submitted in July, 2013; (33) preparation of a certificate of need application to operate three additional Level I rehabilitation bed at PeaceHealth St. Joseph Medical Center, Bellingham Washington, September 2013; (34) preparation of a certificate of need application to operate a kidney dialysis facility, submitted in January 2014; (35) preparation of a certificate of need to operate an ambulatory surgery facility, submitted in February 2014; (36) preparation of a certificate-of-need request for a new 34-bed psychiatric hospital in Monroe, Washington, submitted November 2013; (37) preparation of a certificate of need to operate a kidney dialysis facility, submitted in May 2014; (38) preparation of a certificate of need for Level I rehabilitation beds for Wenatchee Valley Hospital, submitted November 2014; (39 and 40) preparation of two separate certificate of need applications to operate kidney dialysis facilities in different planning areas, submitted in November 2014; (41) preparation of a certificate of need application for a 120 bed psychiatric hospital, Tacoma Washington, submitted December 2014; (42) preparation of

a certificate of need application to operate a kidney dialysis facility in Pierce County, submitted in February 2015; (43) preparation of a certificate of need application for an ambulatory surgery center for Swedish Health Services and Proliance, submitted in March 2015; (44) preparation of a certificate of need application for a 100-bed psychiatric hospital, Spokane County, submitted in June 2015; (45) preparation of a certificate of need to operate an ambulatory surgery center in Bellevue in East King Planning Area (2015); (46) preparation of a certificate of need to operate an ambulatory surgery center in Issaquah in East King Planning Area (2015); (47) preparation of a certificate of need to operate an ambulatory surgery center in Seattle in the North King Planning Area (2015); (48) preparation and submittal of a certificate of need application for MultiCare Good Samaritan Hospital for additional Level I rehabilitation beds (2015); (49) preparation and submittal of a certificate of need application for MultiCare Good Samaritan Hospital for additional acute care beds (2015); (50) preparation and submittal of a 100-bed psychiatric hospital certificate of need (Oregon) (2016); (51) preparation and submittal of a certificate of need to operate a kidney dialysis facility in Pierce County (2016); (52) preparation and submittal of a certificate of need to operate an 85-bed psychiatric hospital in Thurston County (2016); (53) preparation of a certificate of need to operate an ambulatory surgery center in Everett in the Central Snohomish Planning Area (2016); (54) preparation of a certificate of need to operate an ambulatory surgery center in the Grant County Planning Area (2016); (55) preparation of a certificate of need to operate an ambulatory surgery center in Okanogan County Planning Area (2016); (56) preparation of a certificate of need for approval of the purchase of Deaconess Hospital in the Spokane Planning Area (2017); (57) preparation of a certificate of need for approval of the purchase of Valley Hospital in the Spokane Planning Area (2017); (58) preparation of a certificate of need to operate an ambulatory surgery center in the Spokane County Planning Area (2017); (59) preparation of a certificate of need to operate an ambulatory surgery center in Central King County Planning Area (2017); (60) preparation and submittal of a certificate of need to expand a kidney dialysis facility in Grays Harbor County (2017); (61) preparation and submittal of a certificate of need to relocate and expand a kidney dialysis facility in Grant County (2017); (62) preparation and submittal of a certificate of need to operate an ambulatory surgery center in the East King Planning Area (2017); (63) preparation and submittal of a certificate of need to expand MultiCare Tacoma General Hospital's Level IV Neonatal Intensive Care Unit (NICU) (2018); (64, 65, 66, 67,68, 69) preparation and submittal of six separate certificates of need to expand kidney dialysis facilities in Pierce County (2018); (70 & 71) preparation and submittal of certificates of need to expand kidney dialysis facilities in Thurston County (2018); (72) preparation and submittal of a certificate of need to establish a kidney dialysis facility in Clark County (2018); (73) preparation and submittal of a certificate of need to expand a kidney dialysis facility in Grant County (2018); (74) preparation and submittal of a certificate of need to develop a kidney dialysis facility in King County (2018); (75) preparation and submittal of a certificate of need to develop a kidney dialysis facility in Cowlitz County (2018); (76) preparation and submittal of a certificate of need to expand a kidney dialysis facility in Adams County (2018); (77) preparation and submittal of a certificate of need to expand a kidney dialysis facility in Okanogan Count (2018); (78) preparation and submittal of a

certificate of need to expand a kidney dialysis facility in Mason County (2018); (79) preparation and submittal of a certificate of need to expand a kidney dialysis facility Thurston County (2019); (80) preparation and submittal of a certificate of need to develop a kidney dialysis facility in King County (2019); (81) preparation and submittal of a certificate of need to expand a kidney dialysis facility (Benton County (2019); (82) preparation and submittal of a certificate of need to operate an ambulatory surgery center in the East King Planning Area (2019); (83) preparation and submittal of a 100-bed psychiatric hospital certificate of need (Oregon) (2019); (84) preparation and submittal of a certificate of need to expand an ambulatory surgery facility in East Pierce Planning Area (2019); (85)) preparation and submittal of a certificate of need to expand an ambulatory surgery facility in the East Pierce Planning Area (2019); (86) preparation and submittal of a certificate of need to expand an ambulatory surgery facility in East King Planning Area (2019); (87) preparation and submittal of a certificate of need to expand an ambulatory surgery facility in the Central Pierce Planning Area (2020); (88) preparation and submittal of a certificate of need to develop an elective PCI program in the Spokane County Planning Area (2020); (89) preparation and submittal of a certificate of need to relocate and expand a kidney dialysis facility Thurston County (2020); (90) preparation and submittal of a certificate of need to develop and operate a kidney dialysis facility in Yakima County (2020); (90) preparation and submittal of a certificate of need to relocate a dialysis facility in Mason County (2020); (92) preparation and submittal to expand a dialysis facility in Cowlitz County (2020); (93) Preparation and submittal to expand a dialysis facility in Stevens County; (94) preparation and submittal of a certificate of need to establish an ambulatory surgery facility in the East Pierce Planning Area (2020); (95) preparation and submittal of a certificate of need to operate a hospice agency in Spokane County (2020); (96) preparation and submittal of a certificate of need to operate a hospice agency in Thurston County Washington (2021); (97) preparation of a certificate of need application to relocate MultiCare Mary Bridge Children's Hospital in Tacoma Washington (2021); (98) preparations and submittal of a certificate of need application for the purchase of Capital Medical Center, Olympia (2021); (99) preparation and submittal of a certificate of need to establish an ambulatory surgery facility in the Spokane Planning Area (2021); (100) preparation and submittal to expand a dialysis facility in Grays Harbor County WA (2021); (101) preparation and submittal of a certificate of need to develop and operate a kidney dialysis facility in Yakima County (2021); (102) preparation and submittal to expand a dialysis facility in Cowlitz County (2021); (103) preparation and submittal of a certificate of need to purchase MPT ownership in Capital Medical Center building (2021); (104) preparation and submittal of a certificate of need to operate a hospice agency in Spokane County (105) preparation and submittal of a certificate of need to add licensed NICU bassinets to Mary Bridge Children's Hospital (2022); (106) preparation and submittal to add OR capacity to an ambulatory surgical facility in East Pierce County (2022:; (107) preparation and submittal for certificate of need approval to operate a Two OR ambulatory surgery facility in Thurston County; (108) preparation and submittal of a certificate of need request to add 160 licensed acute care beds to Good Samaritan Hospital in Puyallup WA.

- These projects included preparation of detailed utilization and financial performance

models, including income and expense, cash flow statements, asset depreciation schedules and balance sheets. They also included preparation and submittal of complete applications to Washington Department of Health.

July 2001-July 2002 ClearMedical, Bellevue WA

Vice President, Finance and Chief Financial Officer

Financial stewardship for ClearMedical, Inc. This included developing and properly using financial reports and performance information, in aggregate, and at the product/service level, to monitor and improve company performance. Performance was measured for contribution margin, cash flow and return on investment. As the company's financial leader, responsible for daily fiscal activities and longer term financial viability and growth. Responsibilities included:

- Preparation of weekly and monthly financial reports for the chief executive officer, the Board of Directors, and other members of the executive team. Financial reports include income and expense statements, cash flow and balance sheet statements. These reports were compiled for year-to-date and annualized estimates.

- Preparation of monthly departmental budgets, then monitoring actual expenditures against budget estimates. Also responsible for budget forecasts, used to guide departmental growth.

- Preparation of 5 year forecast models to estimate financial performance and resource requirements.

- Correct daily operation of accounts payable and accounts receivable activities, as well as company payroll and other routine financial operations

- Monitoring company performance against financial performance forecasts and "key performance indicators" (KPIs) included in the Strategic Plan. This included implementing corrective actions to better assure actual performance matches forecasts and benchmarks.

- Monitoring overall company performance against its Strategic Plan, as defined by performance benchmarks. Responsible for providing annual revisions/updates to the ClearMedical Strategic Plan.

1993 - April 1996 Franciscan Health System (FHS), Aston, PA

Vice President, Research and Development

Responsible for FHS research and development. This included all research to support focused technology and other studies. Selected studies included:

- Stereotactic breast biopsy technology
- Minimally invasive surgery technology

- Advanced healthcare practitioners
- Alternative medicine (healing/wholistic medicine)
- Genetic engineering
- Patient-focused care

Responsible for leadership and staff support to the FHS Technology Steering Committee, a multidisciplinary group, including numerous physicians, that had responsibility for identifying and making technology implementation recommendations across FHS.

Responsible for strategic planning, including the compilation of information, the development of market goals and strategies, and the preparation of focused strategic plans. This also included seminars and workshops to prepare and present plans.

Responsible for compilation, analysis and presentation of quantitative and qualitative information on FHS products, services and markets, including:

- Utilization forecast models, by service line, for each FHS hospital, to model the effect of managed care.
- The development of emergency department care delivery models.
- The development of an ambulatory surgery model.
- Preparation of market share and service line projections.

Responsible for service and program integration/consolidation across 3 FHS-West hospitals, including outsourcing all transcription, saving $750,000 annually, and consolidating laboratory services, saving $3 million over five years.

Responsible for the development and implementation of a Community Health Model for FHS organizations.

1988 - 1993 Franciscan Health Services - Washington, Tacoma, WA

Vice President, Research and Development

Responsible for new product and service identification and development, including the development of a research process, the Technology Model, which was later implemented throughout Franciscan Health System.

Studies included:

- Magnetic resonance imaging
- Laser technologies
- Imaging, including ultrasound, SPECT cameras and CT
- Continuous quality improvement models
- Optical disk technologies
- Flow cytometry equipment

Responsible for the feasibility study, design and implementation of an MRI service at 4 FHS-West hospitals, including:

- Business and operations plan development
- Acquisition of three MRI systems and service contracts, which represented over $8 million in capital and operating expenses
- Recruitment of staff, and day-to-day operational responsibility for the MRI department with an annual budget of $4 million, for two years

1985 - 1988 Franciscan Health Services - Washington, Tacoma, WA

Director, Planning and Research

Responsible for utilization and financial projections for numerous program/services, as key elements of business plan preparation.

Responsible for all regulatory interface, including all certificate-of-need applications, and work with local and state planning agencies.

Responsible for all utilization and service area forecasts and competitor analysis for annual hospital strategic plans and budgets.

Responsible for all primary and secondary market research, including both internal survey projects, e.g., patient satisfaction surveys, and external research, e.g., large, community-wide, surveys.

1984-1985 Washington State Hospital Commission, Olympia, WA

Associate Director, Program Planning and Research

Responsible for technical and staff management of Program Planning and Research Division for the Hospital Commission, including:

- Design, development and management of the Commission Hospital Abstract Reporting System (CHARS), which is still used to compile and analyze patient discharge data from every hospital in the state.

- Design and development of target revenue estimates for statewide hospital revenues, required by the Washington Legislature. This task required compilation and analysis of very large data sets containing cost and revenue data for each Washington hospital.

- Development and implementation of charity care definitions and policies across all Washington hospitals.

- Management of Hospital Commission Certificate-of-Need reviews.

1983 **SysteMetrics, Inc., Santa Barbara, CA**

Senior Health Care Economist

Responsible for acquisition/development of health care data and forecasting models.

1977-1983 **HDR Systems, Santa Barbara, CA**

Senior Economist/Project Manager

Project management of numerous military studies. Responsibilities included proposal preparation, study definition, milestone and budget scheduling. This included: Publication scheduling and deadlines; assignment and coordination of interdisciplinary staff input; and technical review and edit.

Developed and implemented econometric forecasting models. These models forecast key economic and demographic parameters, e.g., employment/unemployment, wage levels, and population, for a defined geographic region.

Responsible for development and analysis of other economic technical studies, including development and use of regional inter-industry (input-output) models.

1971-1977 **University of Washington, Seattle, WA**

Instructor

Taught courses in micro and macroeconomics.

Computer Language Experience

Statistical Analysis System (SAS)

Statistical Package for the Social Sciences (SPSS)

STATA

Access

Honors and Awards

Phi Beta Kappa

Omicron Delta Epsilon (Economics Honor Society)

Magna Cum Laude Graduate

Memberships

American College of Health Executives

Washington State Hospital Association

Published Articles and Presentations

Publications

"Developing A Model for Technology Assessment," Frank Fox, Ph.D. and Ellen Barron, Health Progress, pages 50-58, January-February 1993.

"Linking Technology with Strategic and Financial Plans: A Case Study of Franciscan Health System," Frank Fox, Ph.D. and Ellen Barron, American Hospital Association, Hospital Technology Special Report, Volume 14, Number 11, September 1995.

Presentations

"Assessing Marketplace Impact of Future Clinical Technologies," Technology and Healthcare Marketing--Future Vision Conference, The Alliance for Healthcare Strategy and Marketing, November 10-12, 1996.

"Smart Technology," Real Solutions for Healthcare Materials Management—Annual Conference, American Society for Healthcare Materials Management, August 11-13, 1996.

"Smart Technology," 16th Annual Meeting—Strategy Forum, Society for Healthcare Planning and Marketing, American Hospital Association, April 24-27, 1994.

Exhibit B

The Honorable Robert J. Bryan

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	NO. 3:20-cv-06145-RJB

REPORT OF FRANK G. FOX, Ph.D.

A. Scope of Request

1. At request of counsel, I have been asked to prepare estimates of the number of persons who:

(1) Identify as transgender and gender diverse ("TGD");

(2) Are enrolled in an ERISA self-funded "group health plan" (as defined in 29 U.S.C. § 1167(1)) administered by Blue Cross Blue Shield Illinois

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("BCBSIL") that contains a categorical exclusion denying or limiting coverage for gender affirming health care;[1] and

(3) Whose enrollment occurred within the Study Period, defined to include January 1, 2016, to December 31, 2021, as provided by legal counsel.[2]

2. This analysis is based on BCBSIL enrollment counts obtained from discovery, as provided by legal counsel.[3] For each year of the Study Period, I have been provided two sets of enrollment files. Based on further discovery and guidance from legal counsel, I have utilized the enrollment data across the two sets of enrollment files, for each year of the Study Period,[4] and calculated a merged enrollment figure, by year. From these merged enrollment figures, I prepare estimates of the likely number of TGD persons in these BCBSIL ERISA self-funded group health plans which include categorical exclusions denying or limiting coverage for gender-affirming health care. In addition, I also estimate the subset of those persons likely to seek gender-affirming care.

3. Based on the methodology outlined below I estimate that, annually, on average, persons enrolled in the affected BCBSIL plans included about 1,740 TGD persons. Of these TGD insureds, I estimate that about 17.5% would have sought gender-affirming care in any given year. This corresponds to, on average, about 300 TGD persons seeking care in each of the relevant years. In my opinion, based on information provided to me and current scientific literature, these are reasonable estimates of these two populations.

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[1] *See* Paragraphs 90 and 91 Class Definitions, *C.P. v. Blue Cross Blue Shield of Illinois*, Amended Complaint (Class Action), No. 3-20-cv-06145-RJB, United States District Court Western District of Washington at Tacoma, November 11, 2021.

[2] Telephone discussion with Ms. Ele Hamburger, August 1, 2022.

[3] E-mail from Ms. Ele Hamburger, August 1, 2022.

[4] Based on instruction from Ms. Payton, Kilpatrick Townsend & Stockton LLP, to Ms. Hamburger in an e-mail exchange, August 10, 2022, we used unique plan counts across the two separate enrollment counts, by plan, by year.

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B. Background

4. Gender dysphoria is a serious medical condition recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5");[5] the World Health Organization's International Classification of Diseases, which is the diagnostic and coding compendia for medical professionals;[6] and by other leading medical and mental health professional groups, including the American Medical Association ("AMA");[7] and the American Psychological Association ("APA").[8]

5. Transgender people often undertake a series of individualized steps to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth. These steps, known as transitioning, typically include social, legal, and medical transitions. The social transition entails a transgender individual living in accordance with their gender identity, the legal transition involves steps to formally align a transgender individual's legal identity with their gender identity, and the medical transition includes gender-affirming care that brings the sex-specific characteristics of a transgender person's body into alignment with their gender. Gender-affirming care can involve counseling to obtain a diagnosis of gender dysphoria, hormone replacement therapy, surgical care, or other medically necessary treatments for gender dysphoria.

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[5] American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. American Psychiatric Association, Arlington, VA.

[6] World Health Organization. 2022. *International Classification of Diseases, 11th Revision*. https://icd.who.int/en, Last Accessed August 17, 2022.

[7] American Medical Association. 2019. *AMA: Leading medical organizations fight for transgender Americans*. AMA Press Releases, July 10, 2019. https://www.ama-assn.org/press-center/press-releases/ama-leading-medical-organizations-fight-transgender-americans, Last Accessed August 17, 2022.

[8] American Psychological Association. 2022. *Patients and Families: Mental Health Topics*. https://www.psychiatry.org/patients-families, Last Accessed August 17, 2022.

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6. In estimating TGD populations, there exist large differences between survey-based self-reported transgender identity and treatment- or diagnosis-based results.[9]

7. Survey-based estimates of transgender prevalence include those from the Williams Institute, UCLA School of Law, which uses data from the CDC's Behavior Risk Factor Surveillance System ("BRFSS") and Youth Risk Behavior Survey ("YRBS") to estimate the population, age distribution, and ethnic distribution of TGD persons for U.S. states.[10] The most recent publication by the Williams Institute, in June 2022, indicates that about 0.52% of persons across the U.S identify as transgender, and that this proportion is highest among the adolescent (13-17; 1.43%) and young adult (18-24; 1.31%) age groups.[11]

8. Treatment- or diagnosis-based estimates of transgender prevalence come from health care providers or health systems where patients have either sought body or hormonal modifications or have been otherwise compelled to disclose their TGD identity to access clinical services. These estimates reflect a subset of the TGD population who are actively seeking gender-affirming health care.[12] Thus, diagnosis-based estimates should be understood as estimates of TGD persons actively seeking health care services related to their transgender identity.

9. Perhaps the best set of diagnosis-based estimates comes from Kaiser Permanente health plans in Georgia ("KPGA"), Southern California ("KPSC"), and Northern California ("KPNC").[13] These plans provide health services to approximately 8 million members, enrolled

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[9] World Professional Association for Transgender Health ("WPATH"). 2021. *Standards of Care: Epidemiology*. https://www.wpath.org/publications/soc, Last Accessed August 17, 2022. See also Collin, Lindsay, Sari L. Reisner, Vin Tangpricha, and Michael Goodman. 2016. *Prevalence of Transgender Depends on the "Case" Definition: A Systematic Review*. The Journal of Sexual Medicine, Vol 13: 613-626.

[10] Herman, Jody L., Andrew R. Flores, and Kathryn K. O'Neill. June 2022. *How Many Adults and Youth Identify as Transgender in the United States?* The Williams Institute, UCLA School of Law. This isa the most recent research publication by the Williams Institute. There were also research studies published in 2016, 2017 and 2020.

[11] Ibid, p. 10.

[12] Meier, Stacy C. and Christine M. Labuski. 2013. *The Demographics of the Transgender Population*. In: International Handbook on the Demography of Sexuality: Springer, 289-327.

[13] Quinn et al. 2017. *Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people.* BMJ Open, 7: e018121.

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through employers or state or federal programs such as Medicare or Medicaid, so represent a large sample across a diverse set of insureds. Through analysis of diagnosis codes and free-text clinical notes, researchers estimated that the prevalence of transgender status ranged from .038% (KPGA) to .075% (KPNC) of Kaiser enrollees.[14] Based off how transgender status was determined, these proportions represent enrollees who sought care related to their transgender identity, a subset of Kaiser TGD enrollees.

C. Analysis

1. Plan enrollment estimates

10. The number of persons enrolled In BCBSIL ERISA self-funded plans and subject to the gender affirming health care exclusion was provided for the period 2016 to 2021 by counsel in the files BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598, BCBSIL_CP_0020599.[15]

11. These files contained enrollment by plan, for two sets of plans. The first set was titled "Account_CP matched to Acct_Nbr," and the second "Account_CP matched to Group_Nbr." For convenience I label the enrollment from the first set of plans "P1" and enrollment from the second set of plans "P2." Annual enrollment counts by year for P1 and P2 are presented in Table 1.

[14] Ibid, p. 9. These figures are from 2014 statistics. The proportions were 38 per 100,000 enrollees at KPGA, 44 per 100,000 enrollees at KPSC and 75 per 100,000 enrollees at KPNC.

[15] E-mail with attachments, from Ms. Ele Hamburger, August 1, 2022. It is my understanding these files were produced during the discovery process.

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Table 1: BCBSIL Enrollment in ERISA Self-Funded Plans Subject to Gender Affirming Health Care Exclusion

	2016	2017	2018	2019	2020	2021
Enrollment						
Account_CP matched to Acct_Nbr (P1)	149,409	159,831	164,679	151,309	148,063	140,621
Account_CP matched to Group_Nbr (P2)	271,865	271,698	292,921	295,289	283,796	273,993

Sources: BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598

12. The enrollment counts from P1 reflect enrollment across about 20 different plans, while enrollment counts from P2 reflect enrollment across about 283 different plans.[16] Thus, while there is some overlap in the included plans between the two estimates of enrollment, most plans included in P2 do not appear in P1.

13. Separating enrollment in P2 between those plans which are included in P1, I present enrollment within "overlapping" plans and "non-overlapping" plans in Table 2.

Table 2: P2 Enrollment in Separating by Overlap Status

	2016	2017	2018	2019	2020	2021
Enrollment						
P2 – Non-Overlapping Plans	241,708	245,447	262,317	266,306	252,779	244,090
P2 – Overlapping Plans	30,157	26,251	30,604	28,983	31,017	29,903

Sources: BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598

Notes: P2 – Non-Overlapping Plans includes enrollment from plans present in P2, but not present in P1. P2 – Overlapping Plans includes P2 enrollment for plans present in both P1 and P2.

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Table 3: BCBSIL Merged Plan Enrollment

	2016	2017	2018	2019	2020	2021
Enrollment						
Merged plan enrollment	391,117	405,278	426,996	417,615	400,842	384,711

Sources: BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598

Notes: Merged enrollment includes all plans from P1, plus non-overlapping plans from P2.

2. Methodology to Estimate the Number of Enrolled TGD Persons

15. From the enrollment counts in Table 3, I apply age-specific population estimates of the proportion of persons who identify as TGD to population by age, where the age distribution is assumed to equal that of Illinois overall for each of the given years.[17] Estimates of the overall number of TGD persons by year, from Table 3, is presented in Table 4.

Table 4: Population Weighted Estimates of Affected Insureds

Year	Row	2016	2017	2018	2019	2020	2021
Enrollment Counts	1	391,117	405,278	426,996	417,615	400,842	384,711
Population Proportions by Age (Illinois Population Structure)							
0 to 12	2	16.30%	16.12%	15.96%	15.79%	15.62%	15.62%
13 to 17	3	6.62%	6.59%	6.54%	6.50%	6.50%	6.50%
18 to 24	4	9.34%	9.21%	9.12%	9.03%	8.94%	8.94%
25 to 64	5	52.95%	52.86%	52.71%	52.52%	52.31%	52.31%
65 and older	6	14.79%	15.21%	15.67%	16.16%	16.63%	16.63%
Proportion by Age							
0 to 12	7	N/A	N/A	N/A	N/A	N/A	N/A
13 to 17	8	0.65%	0.65%	0.65%	0.65%	0.65%	0.65%

[17] I do not know where BSBCIL insureds in these plans reside so have assumed, for purposes of modeling, the majority live in the state of Illinois.

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18 to 24	9	0.57%	0.57%	0.57%	0.57%	0.57%	0.57%
25 to 64	10	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
65 and older	11	0.46%	0.46%	0.46%	0.46%	0.46%	0.46%
Numerosity	**12**	**1,678**	**1,741**	**1,837**	**1,799**	**1,729**	**1,659**
Average Proportion	**13**	**0.43%**	**0.43%**	**0.43%**	**0.43%**	**0.43%**	**0.43%**

Sources:
Row 1: BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598. See Table 3.
Row 2 – Row 6: SC-EST2020-AGESEX-CIV: Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States, States, and the District of Columbia: April 1, 2010, to July 1, 2020.
Row 7 – Row 11: Herman, Jody L., Andrew R. Flores, and Kathryn K. O'Neill. 2022. How Many Adults and Youth Identify as Transgender in the United States? The Williams Institute, UCLA School of Law.
Row 12: Weighted sum of merged enrollment, distributed according to rows 2-6 and weighted by rows 7-11.
Row 13: Row 12 divided by Row 1.

3. Methodology to Estimate the Number of Enrolled TGD Persons who sought gender-affirming care

16. From the methodology in Table 4, I estimate about 1,740 TGD persons per year were enrolled in one of the BCBSIL affected plans. These estimates represent the number of BCBSIL insureds who met the definition of gender-affirming care and were included in such plans that had plan exclusions for such care. Below, I estimate the proportion of these insureds who are estimated to have sought gender-affirming care, based on current scientific literature.[18]

Table 5: Estimates of TGD Insureds, Health Care Users Only

Year	Row	2016	2017	2018	2019	2020	2021
Numerosity	**12**	**1,678**	**1,741**	**1,837**	**1,799**	**1,729**	**1,659**
Average Proportion	**13**	**0.43%**	**0.43%**	**0.43%**	**0.43%**	**0.43%**	**0.43%**
Population Proportion From Study of Health Care Users Only	14	0.075%	0.075%	0.075%	0.075%	0.075%	0.075%
Ratio of Health Care Users to Overall Population Proportion	15	17.5%	17.5%	17.4%	17.4%	17.4%	17.4%

[18] Quinn et al. 2017.

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Numerosity, Health Care Users Only	16	293	304	320	313	301	289

Sources:
Row 12-13: Table 4.
Row 14: Quinn et al. (2017). *Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people*. BMJ Open, 7: e018121. This 0.075% estimate is for Northern California Kaiser enrollees.
Row 15: Row 14 divided by Row 13.
Row 16: Row 12 multiplied by Row 15.

17. From Table 5, of the TGD persons estimated to have been enrolled in the identified BCBSIL plans, I estimate about 17.5% would be likely to seek gender-affirming care in any given year. This indicates that, on average, about 300 persons would have been expected to seek gender-affirming care each year.

Dated: August 19, 2022, in Seattle, Washington.

Frank Fox, PhD.

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APPENDIX A – RATE AND LITIGATION EXPERIENCE

I am paid at the rate of $275 per hour in this litigation.

Depositions, Expert Declarations, Expert Reports and Rebuttal Reports.

I have provided expert declarations and/or expert and rebuttal reports in the following cases over the past four years: (1) In 2018, I provided a declaration ("Declaration") valuing the injunctive relief in a class action settlement in support of the motion for preliminary approval of that settlement in *Kerr v. Kaiser Foundation Health Plan*, Los Angeles Superior Court Case No. BC556863. (2) In May 2019, I provided a Declaration regarding models I prepared estimating utilization and cost for selected treatments for patients with diagnoses identified in the California Mental Health Parity Act and substance abuse in *Ames v. Anthem Blue Cross Life & Health Insurance Company*, Los Angeles Superior Court Case No. BC591623. (3) In May 2019, I provided Declaration regarding estimates of the number of Plan insureds with a prevalence of Autism Spectrum Disorder ("ASD") who utilized and expended monies for applied behavior therapy ("ABA") in *JR v. CHI et.al.,* United States District Court, Western District of Washington, Seattle, No. 2:18:cv-01191-JLR. (4) In June 2019, I prepared an Expert Report in *DT v. NECA/IBEW Family Medical Plan, Civil Action No. 2:17-cv-00004 (RAJ)*, which estimated utilization and expenditures for ABA and/or physical therapy ("PT"), occupational therapy ("OT") or speech therapy, for Plan insureds with a prevalence of ASD. (5) In July 2019, I prepared a series of Rebuttal Reports in *DT v. NECA/IBEW Family Medical Plan, Civil Action No. 2:17-cv-00004 (RAJ)*. (6) In January 2020, I provided a Declaration valuing coverage for residential treatment for insureds with eating disorders in a class action case in *Rea v. Blue Shield of California*, *Los Angeles Superior Court Case No. B468900*. (7) In July 2020, I prepared an Expert Report in *Crosby v. Blue Shield of California, Magellan Health, et. al., Case No. 8:17-CV-01970-CJC-JDE.* (8) In August 2020, I prepared a Rebuttal Report also for *Crosby v. Blue Shield of California, Magellan Health, et. al., Case No. 8:17-CV-01970-CJC-JDE*. (9) In October 2020, I prepared a Declaration in support of a motion for summary adjudication of Health Net's

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fifth cause of action for intentional interference with contractual relations in *Dual Diagnosis Treatment Center Inc., v. Health Net, Los Angeles Superior Court, Case No. LC104357*. (10) In November 2020, I provided a supplemental Declaration *in Rea v. Blue Shield of California, Los Angeles Superior Court Case No. B468900.* (11) In January 2022, I was deposed in in *Dual Diagnosis Treatment Center Inc., v. Health Net, Los Angeles Superior Court, Case No. LC104357*. (12) In June 2022, I was deposed in *Decision by the Department of Health Regarding Two Certificate of Need Applications Proposing to Establish Medicare and Medicaid Certified Hospice Services in Thurston County, No. M2021-923.*

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EXHIBIT T

The Honorable Robert J. Bryan

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	NO. 3:20-cv-06145-RJB

REPORT OF FRANK G. FOX, Ph.D.

A. Scope of Request

1. At request of counsel, I have been asked to prepare estimates of the number of persons who:

(1) Identify as transgender and gender diverse ("TGD");

(2) Are enrolled in an ERISA self-funded "group health plan" (as defined in 29 U.S.C. § 1167(1)) administered by Blue Cross Blue Shield Illinois

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("BCBSIL") that contains a categorical exclusion denying or limiting coverage for gender affirming health care;[1] and

(3) Whose enrollment occurred within the Study Period, defined to include January 1, 2016, to December 31, 2021, as provided by legal counsel.[2]

2. This analysis is based on BCBSIL enrollment counts obtained from discovery, as provided by legal counsel.[3] For each year of the Study Period, I have been provided two sets of enrollment files. Based on further discovery and guidance from legal counsel, I have utilized the enrollment data across the two sets of enrollment files, for each year of the Study Period,[4] and calculated a merged enrollment figure, by year. From these merged enrollment figures, I prepare estimates of the likely number of TGD persons in these BCBSIL ERISA self-funded group health plans which include categorical exclusions denying or limiting coverage for gender-affirming health care. In addition, I also estimate the subset of those persons likely to seek gender-affirming care.

3. Based on the methodology outlined below I estimate that, annually, on average, persons enrolled in the affected BCBSIL plans included about 1,740 TGD persons. Of these TGD insureds, I estimate that about 17.5% would have sought gender-affirming care in any given year. This corresponds to, on average, about 300 TGD persons seeking care in each of the relevant years. In my opinion, based on information provided to me and current scientific literature, these are reasonable estimates of these two populations.

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[1] *See* Paragraphs 90 and 91 Class Definitions, *C.P. v. Blue Cross Blue Shield of Illinois*, Amended Complaint (Class Action), No. 3-20-cv-06145-RJB, United States District Court Western District of Washington at Tacoma, November 11, 2021.

[2] Telephone discussion with Ms. Ele Hamburger, August 1, 2022.

[3] E-mail from Ms. Ele Hamburger, August 1, 2022.

[4] Based on instruction from Ms. Payton, Kilpatrick Townsend & Stockton LLP, to Ms. Hamburger in an e-mail exchange, August 10, 2022, we used unique plan counts across the two separate enrollment counts, by plan, by year.

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B. Background

4. Gender dysphoria is a serious medical condition recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5");[5] the World Health Organization's International Classification of Diseases, which is the diagnostic and coding compendia for medical professionals;[6] and by other leading medical and mental health professional groups, including the American Medical Association ("AMA");[7] and the American Psychological Association ("APA").[8]

5. Transgender people often undertake a series of individualized steps to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth. These steps, known as transitioning, typically include social, legal, and medical transitions. The social transition entails a transgender individual living in accordance with their gender identity, the legal transition involves steps to formally align a transgender individual's legal identity with their gender identity, and the medical transition includes gender-affirming care that brings the sex-specific characteristics of a transgender person's body into alignment with their gender. Gender-affirming care can involve counseling to obtain a diagnosis of gender dysphoria, hormone replacement therapy, surgical care, or other medically necessary treatments for gender dysphoria.

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[5] American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. American Psychiatric Association, Arlington, VA.

[6] World Health Organization. 2022. *International Classification of Diseases, 11th Revision*. https://icd.who.int/en, Last Accessed August 17, 2022.

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6. In estimating TGD populations, there exist large differences between survey-based self-reported transgender identity and treatment- or diagnosis-based results.[9]

7. Survey-based estimates of transgender prevalence include those from the Williams Institute, UCLA School of Law, which uses data from the CDC's Behavior Risk Factor Surveillance System ("BRFSS") and Youth Risk Behavior Survey ("YRBS") to estimate the population, age distribution, and ethnic distribution of TGD persons for U.S. states.[10] The most recent publication by the Williams Institute, in June 2022, indicates that about 0.52% of persons across the U.S identify as transgender, and that this proportion is highest among the adolescent (13-17; 1.43%) and young adult (18-24; 1.31%) age groups.[11]

8. Treatment- or diagnosis-based estimates of transgender prevalence come from health care providers or health systems where patients have either sought body or hormonal modifications or have been otherwise compelled to disclose their TGD identity to access clinical services. These estimates reflect a subset of the TGD population who are actively seeking gender-affirming health care.[12] Thus, diagnosis-based estimates should be understood as estimates of TGD persons actively seeking health care services related to their transgender identity.

9. Perhaps the best set of diagnosis-based estimates comes from Kaiser Permanente health plans in Georgia ("KPGA"), Southern California ("KPSC"), and Northern California ("KPNC").[13] These plans provide health services to approximately 8 million members, enrolled

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[9] World Professional Association for Transgender Health ("WPATH"). 2021. *Standards of Care: Epidemiology*. https://www.wpath.org/publications/soc, Last Accessed August 17, 2022. See also Collin, Lindsay, Sari L. Reisner, Vin Tangpricha, and Michael Goodman. 2016. *Prevalence of Transgender Depends on the "Case" Definition: A Systematic Review*. The Journal of Sexual Medicine, Vol 13: 613-626.

[10] Herman, Jody L., Andrew R. Flores, and Kathryn K. O'Neill. June 2022. *How Many Adults and Youth Identify as Transgender in the United States?* The Williams Institute, UCLA School of Law. This isa the most recent research publication by the Williams Institute. There were also research studies published in 2016, 2017 and 2020.

[11] Ibid, p. 10.

[12] Meier, Stacy C. and Christine M. Labuski. 2013. *The Demographics of the Transgender Population*. In: International Handbook on the Demography of Sexuality: Springer, 289-327.

[13] Quinn et al. 2017. *Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people.* BMJ Open, 7: e018121.

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13. Separating enrollment in P2 between those plans which are included in P1, I present enrollment within "overlapping" plans and "non-overlapping" plans in Table 2.

Table 2: P2 Enrollment in Separating by Overlap Status

	2016	2017	2018	2019	2020	2021
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P2 – Non-Overlapping Plans	241,708	245,447	262,317	266,306	252,779	244,090
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Sources: BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598

Notes: P2 – Non-Overlapping Plans includes enrollment from plans present in P2, but not present in P1. P2 – Overlapping Plans includes P2 enrollment for plans present in both P1 and P2.

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Sources: BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598

Notes: Merged enrollment includes all plans from P1, plus non-overlapping plans from P2.

2. Methodology to Estimate the Number of Enrolled TGD Persons

15. From the enrollment counts in Table 3, I apply age-specific population estimates of the proportion of persons who identify as TGD to population by age, where the age distribution is assumed to equal that of Illinois overall for each of the given years.[17] Estimates of the overall number of TGD persons by year, from Table 3, is presented in Table 4.

Table 4: Population Weighted Estimates of Affected Insureds

Year	Row	2016	2017	2018	2019	2020	2021
Enrollment Counts	1	391,117	405,278	426,996	417,615	400,842	384,711
Population Proportions by Age (Illinois Population Structure)							
0 to 12	2	16.30%	16.12%	15.96%	15.79%	15.62%	15.62%
13 to 17	3	6.62%	6.59%	6.54%	6.50%	6.50%	6.50%
18 to 24	4	9.34%	9.21%	9.12%	9.03%	8.94%	8.94%
25 to 64	5	52.95%	52.86%	52.71%	52.52%	52.31%	52.31%
65 and older	6	14.79%	15.21%	15.67%	16.16%	16.63%	16.63%
Proportion by Age							
0 to 12	7	N/A	N/A	N/A	N/A	N/A	N/A
13 to 17	8	0.65%	0.65%	0.65%	0.65%	0.65%	0.65%

[17] I do not know where BSBCIL insureds in these plans reside so have assumed, for purposes of modeling, the majority live in the state of Illinois.

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18 to 24	9	0.57%	0.57%	0.57%	0.57%	0.57%	0.57%
25 to 64	10	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
65 and older	11	0.46%	0.46%	0.46%	0.46%	0.46%	0.46%
Numerosity	**12**	**1,678**	**1,741**	**1,837**	**1,799**	**1,729**	**1,659**
Average Proportion	**13**	**0.43%**	**0.43%**	**0.43%**	**0.43%**	**0.43%**	**0.43%**

Sources:
Row 1: BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598. See Table 3.
Row 2 – Row 6: SC-EST2020-AGESEX-CIV: Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States, States, and the District of Columbia: April 1, 2010, to July 1, 2020.
Row 7 – Row 11: Herman, Jody L., Andrew R. Flores, and Kathryn K. O'Neill. 2022. How Many Adults and Youth Identify as Transgender in the United States? The Williams Institute, UCLA School of Law.
Row 12: Weighted sum of merged enrollment, distributed according to rows 2-6 and weighted by rows 7-11.
Row 13: Row 12 divided by Row 1.

3. Methodology to Estimate the Number of Enrolled TGD Persons who sought gender-affirming care

16. From the methodology in Table 4, I estimate about 1,740 TGD persons per year were enrolled in one of the BCBSIL affected plans. These estimates represent the number of BCBSIL insureds who met the definition of gender-affirming care and were included in such plans that had plan exclusions for such care. Below, I estimate the proportion of these insureds who are estimated to have sought gender-affirming care, based on current scientific literature.[18]

Table 5: Estimates of TGD Insureds, Health Care Users Only

Year	Row	2016	2017	2018	2019	2020	2021
Numerosity	**12**	**1,678**	**1,741**	**1,837**	**1,799**	**1,729**	**1,659**
Average Proportion	**13**	**0.43%**	**0.43%**	**0.43%**	**0.43%**	**0.43%**	**0.43%**
Population Proportion From Study of Health Care Users Only	14	0.075%	0.075%	0.075%	0.075%	0.075%	0.075%
Ratio of Health Care Users to Overall Population Proportion	15	17.5%	17.5%	17.4%	17.4%	17.4%	17.4%

[18] Quinn et al. 2017.

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Numerosity, Health Care Users Only	16	293	304	320	313	301	289

Sources:
Row 12-13: Table 4.
Row 14: Quinn et al. (2017). *Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people*. BMJ Open, 7: e018121. This 0.075% estimate is for Northern California Kaiser enrollees.
Row 15: Row 14 divided by Row 13.
Row 16: Row 12 multiplied by Row 15.

17. From Table 5, of the TGD persons estimated to have been enrolled in the identified BCBSIL plans, I estimate about 17.5% would be likely to seek gender-affirming care in any given year. This indicates that, on average, about 300 persons would have been expected to seek gender-affirming care each year.

Dated: August 19, 2022, in Seattle, Washington.

Frank Fox, PhD.

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APPENDIX A – RATE AND LITIGATION EXPERIENCE

I am paid at the rate of $275 per hour in this litigation.

Depositions, Expert Declarations, Expert Reports and Rebuttal Reports.

I have provided expert declarations and/or expert and rebuttal reports in the following cases over the past four years: (1) In 2018, I provided a declaration ("Declaration") valuing the injunctive relief in a class action settlement in support of the motion for preliminary approval of that settlement in *Kerr v. Kaiser Foundation Health Plan*, Los Angeles Superior Court Case No. BC556863. (2) In May 2019, I provided a Declaration regarding models I prepared estimating utilization and cost for selected treatments for patients with diagnoses identified in the California Mental Health Parity Act and substance abuse in *Ames v. Anthem Blue Cross Life & Health Insurance Company*, Los Angeles Superior Court Case No. BC591623. (3) In May 2019, I provided Declaration regarding estimates of the number of Plan insureds with a prevalence of Autism Spectrum Disorder ("ASD") who utilized and expended monies for applied behavior therapy ("ABA") in *JR v. CHI et.al.,* United States District Court, Western District of Washington, Seattle, No. 2:18:cv-01191-JLR. (4) In June 2019, I prepared an Expert Report in *DT v. NECA/IBEW Family Medical Plan, Civil Action No. 2:17-cv-00004 (RAJ)*, which estimated utilization and expenditures for ABA and/or physical therapy ("PT"), occupational therapy ("OT") or speech therapy, for Plan insureds with a prevalence of ASD. (5) In July 2019, I prepared a series of Rebuttal Reports in *DT v. NECA/IBEW Family Medical Plan, Civil Action No. 2:17-cv-00004 (RAJ)*. (6) In January 2020, I provided a Declaration valuing coverage for residential treatment for insureds with eating disorders in a class action case in *Rea v. Blue Shield of California*, *Los Angeles Superior Court Case No. B468900*. (7) In July 2020, I prepared an Expert Report in *Crosby v. Blue Shield of California, Magellan Health, et. al., Case No. 8:17-CV-01970-CJC-JDE.* (8) In August 2020, I prepared a Rebuttal Report also for *Crosby v. Blue Shield of California, Magellan Health, et. al., Case No. 8:17-CV-01970-CJC-JDE*. (9) In October 2020, I prepared a Declaration in support of a motion for summary adjudication of Health Net's

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fifth cause of action for intentional interference with contractual relations in *Dual Diagnosis Treatment Center Inc., v. Health Net, Los Angeles Superior Court, Case No. LC104357*. (10) In November 2020, I provided a supplemental Declaration *in Rea v. Blue Shield of California, Los Angeles Superior Court Case No. B468900.* (11) In January 2022, I was deposed in in *Dual Diagnosis Treatment Center Inc., v. Health Net, Los Angeles Superior Court, Case No. LC104357*. (12) In June 2022, I was deposed in *Decision by the Department of Health Regarding Two Certificate of Need Applications Proposing to Establish Medicare and Medicaid Certified Hospice Services in Thurston County, No. M2021-923.*

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Addendum—Report of Frank G. Fox, Ph.D

Upon reviewing my Report, I have identified a revision to Tables 4 and 5 of my Report based on updated 2022 statistics from The Williams Institute, upon whose population estimates I rely.[1] These revisions are provided below and should be used to substitute the prior tables in my earlier Report.

Updated Table 1: Population Weighted Estimates of Affected Insureds

Year	Row	2016	2017	2018	2019	2020	2021
Enrollment Counts	1	391,117	405,278	426,996	417,615	400,842	384,711
Population Proportions by Age (Illinois Population Structure)							
0 to 12	2	16.30%	16.12%	15.96%	15.79%	15.62%	15.62%
13 to 17	3	6.62%	6.59%	6.54%	6.50%	6.50%	6.50%
18 to 24	4	9.34%	9.21%	9.12%	9.03%	8.94%	8.94%
25 to 64	5	52.95%	52.86%	52.71%	52.52%	52.31%	52.31%
65 and older	6	14.79%	15.21%	15.67%	16.16%	16.63%	16.63%
Proportion by Age							
0 to 12	7	N/A	N/A	N/A	N/A	N/A	N/A
13 to 17	8	1.66%	1.66%	1.66%	1.66%	1.66%	1.66%
18 to 24	9	1.94%	1.94%	1.94%	1.94%	1.94%	1.94%
25 to 64	10	0.24%	0.24%	0.24%	0.24%	0.24%	0.24%
65 and older	11	0.24%	0.24%	0.24%	0.24%	0.24%	0.24%
Numerosity	**12**	**1,774**	**1,830**	**1,920**	**1,871**	**1,791**	**1,719**
Average Proportion	**13**	**0.45%**	**0.45%**	**0.45%**	**0.45%**	**0.45%**	**0.45%**

Sources:
Row 1: BCBSIL_CP_0020594, BCBSIL_CP_0020595, BCBSIL_CP_0020596, BCBSIL_CP_0020597, BCBSIL_CP_0020598. See Table 3.

[1] The updated source is the following: Herman, Jody L., Andrew R. Flores, and Kathryn K. O'Neill. 2022. *How Many Adults and Youth Identify as Transgender in the United States?* The Williams Institute, UCLA School of Law.

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Row 2 – Row 6: SC-EST2020-AGESEX-CIV: Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States, States, and the District of Columbia: April 1, 2010, to July 1, 2020.
Row 7 – Row 11: Herman, Jody L., Andrew R. Flores, and Kathryn K. O'Neill. 2022. *How Many Adults and Youth Identify as Transgender in the United States?* The Williams Institute, UCLA School of Law.
Row 12: Weighted sum of merged enrollment, distributed according to rows 2-6 and weighted by rows 7-11.
Row 13: Row 12 divided by Row 1.

Table 5 utilizes Table 4 TGD insureds' prevalence estimates. Thus, Table 5 is also revised. It is presented below. Revisions to Table 5 include Rows 12 and 13, which are directly from Table 4, as well as Rows 15 and 16. They follow from the revisions to numerosity calculations in Table 4, shown in Rows 12 and 13.

Updated Table 5: Estimates of TGD Insureds, Health Care Users Only

Year	Row	2016	2017	2018	2019	2020	2021
Numerosity	**12**	**1,774**	**1,830**	**1,920**	**1,871**	**1,791**	**1,719**
Average Proportion	**13**	**0.45%**	**0.45%**	**0.45%**	**0.45%**	**0.45%**	**0.45%**
Population Proportion From Study of Health Care Users Only	14	0.075%	0.075%	0.075%	0.075%	0.075%	0.075%
Ratio of Health Care Users to Overall Population Proportion	15	16.5%	16.6%	16.7%	16.7%	16.8%	16.8%
Numerosity, Health Care Users Only	16	293	304	320	313	301	289

Sources:
Row 12-13: Table 1.
Row 14: Quinn et al. (2017). *Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people*. BMJ Open, 7: e018121. This 0.075% estimate is for Northern California Kaiser enrollees.
Row 15: Row 14 divided by Row 13.
Row 16: Row 12 multiplied by Row 15.

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These updates do not affect or change the conclusions set forth in paragraph 17 of my original report, which remain that, on average, about 300 persons would have been expected to seek gender-affirming care each year.

Addendum dated: September 29, 2022, at Seattle, Washington.

F. Fox, PhD

Frank Fox, PhD.

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EXHIBIT U

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

Case Number: 3:20-cv-06145-RJB

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

v.

BLUE CROSS BLUE SHIELD OF ILLINOIS (Defendant)

EXPERT REBUTTAL REPORT OF SCOTT CARR, PH.D.

October 21, 2022

EXPERT REBUTTAL REPORT OF SCOTT CARR, PH.D.

Table of Contents

EXPERT REBUTTAL REPORT OF SCOTT CARR, PH.D.

I. Introduction and Summary of Opinions

A. Overview of Credentials

I am Scott Carr, Ph.D., a Senior Managing Director and leader of the Competition and Class Actions Practice at Ankura Consulting Group ("Ankura"). I was engaged by the Defendant, Blue Cross Blue Shield of Illinois ("BCBSIL") to respond to materials prepared by Dr. Frank Fox on behalf of Plaintiffs, C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and Patricia Pritchard. Dr. Fox submitted a report ("Fox Report") on August 19, 2022. He subsequently submitted a short addendum ("Fox Addendum") on September 29, 2022, in which he updated portions of his data and numerical results.[1] Thus, throughout this report, I primarily refer to Dr. Fox's report, but I refer to his addendum when discussing the data and results that he updated.

I hold a Ph.D. in Business Administration and in Industrial and Operations Engineering, an M.S.E. in Industrial and Operations Engineering, an M.S.E. in Construction Management and Engineering, and a B.S.E. in Mechanical Engineering. These degrees are from the University of Michigan. In my current position at Ankura, I provide consulting and expert services on a variety

[1] The Fox Addendum contains two tables. The first table, labeled "Updated Table 1," updates the data and results in Table 4 (not Table 1) of his original report. The second table, labeled "Updated Table 5," updates the data and results in Table 5 of his original report. Dr. Fox states, "These updates do not affect or change the conclusions set forth in paragraph 17 of my original report." (Fox Addendum, p. 3)

of economic and engineering topics, including in the context of litigation. To perform these services, I regularly perform complex economic analyses, often using sophisticated computer and analytical tools. Prior to joining Ankura, I was a Director at Navigant Consulting, Inc., a Senior Managing Director at ARPC, a Principal at LECG, and a professor at the UCLA Anderson School of Management in the Department of Decisions, Operations, and Technology Management. As a professor, I taught courses in the areas of Operations Management and Quantitative Analysis to M.B.A. and Ph.D. students and to business executives. I also performed and published research related to Operations Management and Industrial Economics.

I have extensive experience in the analysis and modeling of complex business, financial, and health-related circumstances and events. For example, my prior projects included forecasting the future incidence of diseases and cognitive impairments due to concussions in National Football League players; developing a machine-learning algorithm to predict outcomes of asbestos-related litigation; testimony regarding accommodations for people with physical disabilities; and forecasting of future personal injury liabilities due to environmental contamination. My areas of expertise include probability and statistics, data analytics, and predictive modeling. Exhibit 1 contains my current *curriculum vitae*.

B. Terminology Used in This Report

Dr. Fox uses the terms "transgender" and "transgender and gender diverse," abbreviated "TGD", throughout his report. However, the materials on which he relies, as well as the Amended Complaint and Plaintiff C.P.'s Motion for Class Certification ("Motion for Class

Certification"), use the term "transgender" exclusively and appear to disregard gender-diverse people that are not transgender. Thus, I use the term "transgender" exclusively in this report.

I understand that this proceeding relates to ERISA self-funded health plans administered by BCBSIL during the class period that contain some form of exclusion for transgender-related services.[2] For brevity, I refer to these plans as the "relevant plans" or "relevant Group Plans." Further, my references to "Group Members" or "enrollees" exclusively refer to people enrolled in the relevant plans.

I use the term "relevant period" to refer to the six-year period from 2016 through 2021 because that is the period covered in Dr. Fox's analysis.

Dr. Fox and the Plaintiffs are inconsistent in how they refer to the Group Members who sought transgender-related services or who would have sought such services but for exclusions in the relevant Group Plans. For example: (1) in paragraph 3 of his report, Dr. Fox states that these are "TGD persons seeking care"; (2) in paragraph 16 of his report, he refers to them as "insureds who are estimated to have sought gender-affirming care"; (3) in paragraph 17, he refers to them as persons who "would have been expected to seek gender-affirming care"; and (4) the Motion for Class Certification at page 14 refers to them as individuals "likely to seek care" (with no characterization of the type or timing of the care involved). For brevity and consistency, I refer to all such people as Group Members or enrollees who "sought transgender-related services."

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[2] Motion for Class Certification, p. 4, which defines the class period as "November 23, 2016, through the termination of the litigation."

Dr. Fox occasionally refers to "medically necessary" transgender-related services (as opposed to all transgender-related services or non-medically necessary transgender-related services). For example, he refers to enrollees "who would be expected to utilize *medically necessary* treatment for gender dysphoria."[3] (italics added) However: (1) Dr. Fox's report and analyses make no distinction between care that is medically necessary and care that is not; (2) the Quinn Study relied upon by Dr. Fox makes no characterization of whether the transgender-related services studied were medically necessary; (3) Dr. Fox did not review the relevant plans to determine whether or not the exclusions are specifically for medically necessary transgender-related services;[4] and (4) Dr. Fox is not a medical doctor and did not perform the "extensive literature review" that would be needed for him to opine on which transgender-related services are medically necessary and which are not.[5] Thus, Dr. Fox's references to medically necessary transgender-related services are baseless and gratuitous.

C. Summary of Opinions

This report sets forth the conclusions I have reached to date in this proceeding. To summarize, I have reached the following primary conclusions based on my review of Dr. Fox's report, the documents he cites, other data and documents I reviewed, and factors discussed herein:

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[3] Fox Report, ¶10. *See also* Fox Report, ¶5 and ¶11.

[4] Deposition of Dr. Frank Fox, September 12, 2022, pp. 31-35, (hereafter "Fox Deposition").

[5] Fox Deposition, pp. 22-23.

1. Dr. Fox's estimates of the number of transgender people enrolled in the relevant Group Plans is misleading and unreliable because Dr. Fox fails to account for the marked uncertainty in the published data upon which he relies, assumes that the prevalence of transgender people in the relevant Group Plans is identical to the prevalence of transgender people in the general population, assumes that all Group Members in these plans reside in Illinois, and failed to exclude duplicate data entries in the data on which he relies.
2. Dr. Fox's estimates of the number of transgender Group Members who sought transgender-related services is methodologically incorrect because Dr. Fox misinterprets, misuses, and overstates the published data upon which he relies. Thus, Dr. Fox's estimate of the number of transgender enrollees who sought transgender-related services is misleading and unreliable.

II. Dr. Fox's Estimated Number of Transgender Enrollees in the Relevant Group Plans

In Updated Table 1 of his addendum,[6] Dr. Fox estimates the number of transgender enrollees in the relevant plans using a three-step process for each year in the relevant period.[7] First, he estimates the number of enrollees in the relevant Group Plans using data produced by

[6] As discussed above, the Fox Addendum contains two tables. The first table, labeled "Updated Table 1," updates the data and results in Table 4 (not Table 1) of his original report. The second table, labeled "Updated Table 5," updates the data and results in Table 5 of his original report.

[7] Fox Report, ¶¶ 2-15; Fox Addendum, Updated Table 1.

BCBSIL.[8] Second, he estimates the percentage of individuals who identify as transgender.[9] Third, he multiplies together the estimates from the first two steps to get his final estimates of the number of transgender enrollees in the relevant plans. Dr. Fox summarizes his estimates as "about 1,740 TGD persons per year were enrolled in one of the BCBSIL affected plans."[10]

Dr. Fox does not address the assumptions and uncertainties underlying his analysis, yet these assumptions and uncertainties call into question the reliability of his estimates. I describe four significant deficiencies in Dr. Fox's estimates of transgender enrollees below.

A. Uncertainty in the Percentage of Individuals Who Identify as Transgender

Dr. Fox estimates the number of transgender enrollees from the relevant Group Plans enrollment counts by adopting "age-specific population estimates of the proportion of persons who identify as [transgender] to population by age" from a 2022 study conducted by The Williams Institute ("Williams Study").[11] Table 1 below shows the percentage of individuals who identify as transgender by age in Illinois as reported in the Williams Study. Dr. Fox assumes that

[8] Fox Report, ¶¶ 10-14, Table 3.

[9] Fox Report, ¶ 15; Fox Addendum, Updated Table 1.

[10] Fox Report, ¶ 16. In the second sentence of paragraph 16 of his report, Dr. Fox erroneously describes this number as "the number of BCBSIL insureds who *met the definition of gender-affirming care* and were included in such plans that had plan exclusions for such care." (italics added)

[11] Fox Report, ¶ 15; Fox Addendum, Updated Table 1; Jody L. Herman et. al, "How Many Adults and Youth Identify as Transgender in the United States?" The Williams Institute, UCLA School of Law, June 2022 (hereafter "Williams Study").

these percentages reflect the percentage of transgender individuals within the relevant Group Plans in each year of the relevant period.

Table 1
Percentage of Individuals who Identify as Transgender in Illinois, by Age

Age	13 to 17	18 to 24	25 to 64	65 and older
Dr. Fox's Assumption	1.66%	1.94%	0.24%	0.24%

Source: Fox Addendum, Updated Table 1, Rows 7 through 11, citing Williams Study, Table 4.

The Williams Study from which Dr. Fox took these values indicates that they are merely estimates, with substantial uncertainty remaining about the actual percentage of persons in Illinois, and elsewhere, who identify as transgender. Dr. Fox fails to even mention this uncertainty despite it being quantified within the study and despite the fact that the actual percentages of persons identifying as transgender may be very different than Dr. Fox assumes.

The Williams Study quantifies this uncertainty using "credible intervals." In particular, it uses a 95 percent credibility interval which, a previous version of the study explains, "represents the upper and lower bounds [for the reported value] where there is a 0.95 probability an estimate falls between them."[12] Table 2 below gives the Williams Study's credible intervals for the number of people identifying as transgender in Illinois (*i.e.*, the percentages

[12] Jody L. Herman et. al, "Age of Individuals Who Identify as Transgender in the United States," The Williams Institute, UCLA School of Law, January 2017., p.9 and Table A1. The study also explains, "A credible interval is a Bayesian equivalent of a confidence interval." For additional information about credible intervals, see American Association for Public Opinion Research (AAPOR), "Understanding a 'credibility interval'", October 7, 2012, https://www.aapor.org/Publications-Media/Public-Statements/Understanding-a-credibility-interval%E2%80%9D.aspx.

shown in Table 1 above and assumed by Dr. Fox). For example, the table indicates that the true percentage of individuals who identify as transgender in the 13 to 17 age bracket is between 0.46 percent and 5.85 percent (based on a 95 percent confidence threshold).

Table 2
Credible Interval For Percentage of Individuals who Identify as Transgender in Illinois, by Age

Age	13 to 17	18 to 24	25 to 64	65 and older
Lower Bound	0.46%	0.42%	0.11%	0.07%
Upper Bound	5.85%	3.46%	0.38%	0.40%
(Upper Bound) ÷ (Lower Bound)	12.72	8.24	3.45	5.71

Source: Williams Study, Table A4

These credible intervals are very wide – with the upper bounds more than 3 times as large as the lower bounds for every age bracket – and are sufficiently large to undermine the reliability of Dr. Fox's estimates. Had Dr. Fox considered the large credible intervals in his analysis, his estimate of transgender enrollees would be as low as 555 or as high as 3,885 on average across the relevant period – compared to Dr. Fox's estimate of 1,740.[13]

B. Dr. Fox's Use of General Population Proportions

As discussed above, Dr. Fox relies on the Williams Study, which uses "state-level, population-based surveys to estimate the proportion of the population that identifies as

[13] In his addendum, Dr. Fox does not update his estimate from his original report that "about 1,740 TGD persons per year were enrolled in one of the BCBSIL affected plans." When updated using the data from the 2022 version of the Williams Study, his estimate is 1,817 vs 1,740.

transgender by age group."[14] As a result of Dr. Fox's reliance on this study, his analysis inherently assumes that the prevalence of transgender persons in the relevant Group Plans is identical to the prevalence of transgender persons in the general population.

Multiple factors indicate that this is not the case. First, transgender adults are twice as likely as cisgender adults to be unemployed.[15] Second, transgender adults are more likely to be uninsured than cisgender adults.[16] Third, many of the Group Members have a choice of health insurance plans,[17] and, if given the choice between two healthcare plans, one that contains some form of exclusion for transgender-related services and one without such an exclusion,

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[14] This quotation is from a previous version of the study: Jody L. Herman et. al, "Age of Individuals Who Identify as Transgender in the United States," The Williams Institute, UCLA School of Law, January 2017, p.1.

[15] McKinsey & Company, "Being transgender at work," *McKinsey Quarterly*, November 10, 2021, https://www.mckinsey.com/featured-insights/diversity-and-inclusion/being-transgender-at-work. *See also,* Kaiser Family Foundation, "Demographics, Insurance Coverage, and Access to Care Among Transgender Adults," October 21, 2020, https://www.kff.org/health-reform/issue-brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults/. "Among adults still in the labor force, a higher share of cisgender adults report being employed compared to transgender adults (56% vs. 48% respectively). Nearly one in ten (9%) of transgender adults reports they were unemployed from 2017-2018, a share much higher than that of cisgender adults (5%)."

[16] Kaiser Family Foundation, "Demographics, Insurance Coverage, and Access to Care Among Transgender Adults," October 21, 2020, https://www.kff.org/health-reform/issue-brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults/. "A larger share of transgender than cisgender adults (19% vs. 12% respectively) report that they were uninsured over the 2017-2018 period."

[17] Third Supplemental Answer 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." Additionally, married Group Members may have an option of enrolling in their spouse's healthcare plan.

transgender persons will tend to choose the option without the exclusion. These factors all indicate, contrary to Dr. Fox's assumption, that the prevalence of transgender people is smaller within the relevant Group Plans than in the general population.

The following example illustrates the importance of Dr. Fox's failure to account for disparities in employment and insurance experienced by transgender persons. A recent study using data from the U.S. Centers for Disease Control and Prevention concluded that "transgender adults are more likely to be uninsured [than cisgender adults] (19% vs. 12%)."[18] Adjusting Dr. Fox's analysis to account for this disparity in insurance rates (but not correcting any other infirmities in his analysis) causes his estimate of the number of transgender enrollees in the relevant plans to fall by 8.6 percent, or approximately 150 people.

C. Dr. Fox's Use of Population Proportions for the State of Illinois

In estimating the number of transgender persons enrolled in the relevant Group Plans, Dr. Fox uses population proportions for the state of Illinois only. He states, "I do not know

[18] Kaiser Family Foundation, "Demographics, Insurance Coverage, and Access to Care Among Transgender Adults," October 21, 2020, https://www.kff.org/health-reform/issue-brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults/. "Our analysis finds that transgender adults are more likely to be uninsured (19% vs. 12%) and report cost-related barriers to care (19% vs. 13%) than cisgender adults"; also, "A larger share of transgender than cisgender adults (19% vs. 12% respectively) report that they were uninsured over the 2017-2018 period." This study used data from the 2017 and 2018 Behavioral Risk Factor Surveillance System (BRFSS) administered by the U.S. Centers for Disease Control and Prevention.

where BSBCIL [*sic*] insureds in these plans reside so have assumed, for purposes of modeling, the majority live in the state of Illinois."[19]

Dr. Fox does not assume the *majority* of Group Members live in the state of Illinois, he assumes that *all* Group Members live in the state of Illinois. Dr. Fox is aware that his assumption is wrong, or at least baseless.[20] I understand from counsel for BCBSIL that BCBSIL administers healthcare plans for companies domiciled in Illinois. However, I further understand from counsel for BCBSIL that employees of companies domiciled in Illinois may work and reside in other states, and many do.

These facts are exemplified by the named plaintiffs in this matter. Plaintiff Patricia Pritchard receives health coverage through her employer, St. Michael Medical Center in the state of Washington.[21] Plaintiff C.P. receives health coverage as a dependent of Ms. Pritchard.[22] Ms. Pritchard's employer is part of the Catholic Health Initiatives Franciscan Health System, now known as CommonSpirit Health, whose national office is located in Chicago, Illinois.[23] Despite working and residing in the state of Washington,[24] Ms. Pritchard's healthcare plan is administered by BCBSIL because CommonSpirit Health is domiciled in Illinois. Because Dr. Fox's

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[19] Fox Report, fn. 17.

[20] Fox Report, fn. 17, quoted above.

[21] Amended Complaint, ¶ 13.

[22] Amended Complaint, ¶ 13.

[23] Amended Complaint, ¶ 13; CommonSpirit, Contact Us, https://www.commonspirit.org/contact-us.

[24] Amended Complaint, ¶ 13.

analysis assumes that all Group Members live in the state of Illinois, Ms. Pritchard, and her dependent C.P., would not be accounted for in Dr. Fox's estimates of transgender enrollees in the relevant Group Plans.

Additionally, Plaintiff C.P.'s Motion for Class Certification states that the "putative class members are geographically dispersed across the country."[25] Dr. Fox's estimates of transgender enrollees in the relevant Group Plans is unreliable because his estimates depend solely on population proportions for Illinois which do not reflect the wide geographic spread of the Group Members. The Williams Study, which Dr. Fox relies upon, includes percentages of individuals who identify as transgender by age for all 50 states and the District of Columbia, as well as regionally and nationally.[26] These percentages vary considerably on a state-by-state basis. For example, in the 13 to 17 age bracket, the percentage of individuals who identify as transgender is highest for New York (3.00 percent) and lowest for Wyoming (0.56 percent).[27] Dr. Fox did not evaluate where Group Members reside or how their geographic dispersion impacts his estimates of transgender enrollees in the relevant Group Plans. Instead, Dr. Fox assumes that all Group Members live in Illinois and provides no justification for why this

[25] Motion for Class Certification, p. 15.

[26] Williams Study, Table 4.

[27] Williams Study, Table 4. In the three remaining age brackets, the percentages of individuals who identify as transgender are highest for Arkansas (3.59 percent) for the 18 to 24 age bracket, the District of Columbia (0.77 percent) for the 25 to 64 age bracket, and New Mexico (0.73 percent) for the 65 and older age bracket. The lowest percentages are for Iowa (0.45 percent) for the 18 to 24 age bracket, Missouri (0.07 percent) for the 25 to 64 age bracket, and Nevada (0.04 percent) for the 65 and older age bracket.

demonstrably incorrect assumption should be accepted in his analysis when his assumption fails to reflect the facts in this matter.

D. Duplicate Observations in Dr. Fox's "Enrollment Counts"

As discussed above, one of the inputs into Dr. Fox's analysis is the total number of enrollees in the relevant Group Plans during each year in the relevant period; Dr. Fox refers to these values as "Enrollment Counts."[28] Dr. Fox compiled his Enrollment Counts from data provided by BCBSIL. However, when processing this data, he double- or triple-counted some entries because he failed to remove duplicate entries from the data. Specifically, he failed to remove some entries that had the same "group number" and the same number of enrollees as other entries. I note that these duplicate entries have different group names within the data (often, only slightly different), but I understand from Counsel for BCBSIL that the group number, not the group name, is the more accurate data field for identifying unique Group Plans in a given year. Thus, Dr. Fox should have removed these duplicate entries from the data before compiling his Enrollment Counts.

Table 3 below shows the effect of removing the duplicate entries. This table shows Dr. Fox's Enrollment Counts, the number of enrollees in the duplicate entries ("Duplicate Enrollments"), and the Enrollment Counts that remain after removing the duplicate entries

[28] Fox Addendum, Updated Table 1.

("Enrollment Counts with Duplicate Enrollments Removed"). As the table shows, Dr. Fox overstates his Enrollment Counts by 8,299 to 13,461 per year, or 2.0 to 3.6 percent per year.

Table 3
Dr. Fox's Duplicate Enrollment Counts

Year	2016	2017	2018	2019	2020	2021
Dr. Fox's Enrollment Counts (Table 3)	391,117	405,278	426,996	417,615	400,842	384,711
Duplicate Enrollments	8,299	8,478	8,572	8,713	9,284	13,461
Enrollment Counts With Duplicate Enrollments Removed	382,818	396,800	418,424	408,902	391,558	371,250
Overstatement % by Dr. Fox	2.2%	2.1%	2.0%	2.1%	2.4%	3.6%

III. Dr. Fox's Estimated Number of Transgender Enrollees Who Sought Transgender-Related Services

For each year of the relevant period, Dr. Fox presents an estimate of the number of transgender enrollees in the relevant Group Plans who sought transgender-related services, and he summarizes that this number is "about 300."[29] The table below shows these estimates.

[29] Fox Report, ¶¶ 16-17, cited in the Motion for Class Certification, p. 14. Dr. Fox and the Plaintiffs are inconsistent in how they refer to these estimates. For example: (1) in paragraph 3 of his report, Dr. Fox states that these are "TGD persons seeking care"; (2) in paragraph 16 of his report, he refers to them as "insureds who are estimated to have sought gender-affirming care"; (3) in paragraph 17, he refers to them as persons that "would have been expected to seek gender-affirming care"; and (4) the Motion for Class Certification at page 14 refers to them as individuals "likely to seek care" (with no characterization of the type or timing of the care involved).

Table 4
Dr. Fox's Estimated Number of Transgender Enrollees
Seeking Transgender-Related Services

	2016	2017	2018	2019	2020	2021
Fox Row 16: Enrollees That Sought Gender-Affirming Care	293	304	320	313	301	289

Source: Fox Addendum, Updated Table 5, Row 16. Dr. Fox labels the values "Numerosity, Health Care Users Only"

This section of my report discusses these estimates in more detail. Subsection A below demonstrates that Dr. Fox includes meaningless variables in his calculations of these estimates. Subsection B shows that these estimates are fatally flawed because Dr. Fox misinterprets and misuses the published data on which he relies, and Subsection C shows that these estimates are additionally flawed because they are inappropriately biased upwards for other reasons.

A. Dr. Fox's Inclusion of Meaningless Variables in Calculations

In Updated Table 1 and Updated Table 5 of his addendum, Dr. Fox sets forth his revised estimation of the number of transgender enrollees in the relevant Group Plans who sought transgender-related services. Dr. Fox describes his estimation as a "two-stage model," where the first stage "estimate[d] the prevalence of transgender persons" and the second stage estimated "which proportion of them utilized some sort of medically necessary care."[30] However, in effect, Dr. Fox's analysis is not a two-stage model. As discussed below, his

[30] Fox Deposition, p. 75.

estimation of the number of transgender enrollees who sought transgender-related services is just a simple multiplication, not a two-stage model.

In his text, tables, notes, and deposition testimony, Dr. Fox appears to indicate that his estimates mathematically depend on all the variables appearing in his Updated Tables 1 and 5 (*i.e.,* Rows 1 through 15 of his tables). For example, Dr. Fox appears to indicate that his estimates depend on "Population Proportions by Age" (Rows 2 through 6), "Proportion [of the Illinois Population that identifies as transgender] by Age" (Rows 7 through 11), "Numerosity" (*i.e.*, Dr. Fox's estimated number of transgender enrollees in Row 12), and the "Average Proportion" of transgender individuals within the relevant plans (Row 13).

However, despite the appearance of a complicated mathematical analysis, Dr. Fox's calculations do not depend on these variables at all. As a matter of basic mathematics, Dr. Fox's estimates of transgender enrollees who sought transgender-related services is a simple multiplication of just two variables:

1. Dr. Fox's Row 1, "Enrollment Counts," which is Dr. Fox's estimate of the number of enrollees in the relevant plans.
2. Dr. Fox's Row 14, "Population Proportion,"[31] which equals 0.075 percent for every year. Dr. Fox does not describe or discuss this value which, as discussed below, he takes from a published research article and misuses.

[31] Dr. Fox's full heading for Row 14 is "Population Proportion From Study of Health Care Users Only", but I truncate this heading to just "Population Proportion" for brevity.

Table 5 below, which I created from values in Dr. Fox's addendum,[32] demonstrates this observation. Rows (A) and (B) of the table are the two variables listed just above (Dr. Fox's Enrollment Counts and Population Proportions). Row (C) is these two variables multiplied together, and this row is the same as Dr. Fox's final estimates.[33] This equivalence means that Dr. Fox's estimates of the number of transgender enrollees who sought transgender-related services depend solely on his Enrollment Counts and Population Proportion variables. In other words, Dr. Fox's estimate of the number of transgender enrollees who sought transgender-related services is mathematically independent of all the other variables (Rows 2 through 13) in Updated Table 1 of his analysis, and his inclusion of those variables in his calculations is meaningless.

[32] Dr. Fox's report contains identical values.

[33] *I.e.,* the same as Row 16 in Dr. Fox's analysis and Table 4 above.

Table 5
Simplified Computation of Dr. Fox's Estimated Number of Transgender Enrollees Seeking Transgender-Related Services

		2016	2017	2018	2019	2020	2021
Fox Row 1: Enrollment Counts	**(A)**	391,117	405,278	426,996	417,615	400,842	384,711
Fox Row 14: Population Proportion	**(B)**	0.075%	0.075%	0.075%	0.075%	0.075%	0.075%
Fox Row 16: Enrollees Who Sought Gender-Affirming Care	**(C) = (A) x (B)**	293	304	320	313	301	289

Source: Fox Addendum: (A) Updated Table 1, Row 1; (B) Updated Table 5, Row 14; (C) is identical to Updated Table 5, Row 16.

B. Dr. Fox's Invalid "Population Proportion" Assumption

In Section III.A of this report (immediately above), I showed that Dr. Fox's estimates of the number of transgender enrollees in the relevant plans who sought transgender-related services[34] actually depend on just two variables, Rows (A) and (B) in the table above. In Section II, I discussed the flaws in the first of these two variables, which is Dr. Fox's estimate of the total number of enrollees in the relevant Group Plans.[35] In particular, Dr. Fox failed to delete duplicate entries in the data on which he relied. Below, I discuss the second of these variables which is Dr. Fox's assumption that 0.075 percent[36] of enrollees sought transgender-related services in each year. In this discussion, I show that this assumption is a misinterpretation and

[34] Row 16 of Dr. Fox's analysis and Row (C) in Table 5.

[35] Row 1 of Dr. Fox's analysis, and Row (A) in Table 5.

[36] Row 14 of Dr. Fox's analysis, and Row (B) in Table 5.

misuse of the published research on which Dr. Fox relies. As a result, Dr. Fox's assumption is invalid, his analysis is incorrect, and his results are unreliable.

1. The "Quinn Study" on Which Dr. Fox Relies

The source of Dr. Fox's assumption that 0.075 percent of enrollees in the relevant Group Plans sought transgender-related services annually is a research article published by Virginia P. Quinn, PhD, and other researchers that is titled "Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people" (henceforth, the "Quinn Study").[37] The objectives of the study were to develop methods for using computerized searches of electronic medical records to identify transgender people and assess their health status.[38]

The Quinn Study identified 6,456 transgender people across three different Kaiser Permanente health plans in Northern California, Southern California, and Georgia based on medical health record information from 2006 through 2014, a nine-year period. The study describes the methodology used to identify transgender people, and it reports numerous

[37] Virginia P Quinn et al., "Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people," *BMJ Open*, 2017;7:e018121. doi:10.1136/bmjopen-2017-018121, ("Quinn Study") cited in Fox Report at p. 4, note 13; p. 8, note 18; pp. 8-9, 12; and Fox Addendum, Updated Table 5 notes. I use the term "Quinn Study" to refer to both the published research article and the underlying research.

[38] Quinn Study, p. 1 ("Purpose [: the study] was initiated to assess the health status of transgender people in general and following gender-affirming treatments at Kaiser Permanente health plans in Georgia, Northern California and Southern California. The objectives of this communication are to describe methods of cohort ascertainment and data collection and to characterise the study population".)

demographic and health-related statistics. For example, the Quinn Study reports the following estimated percentages of transgender enrollees in the Kaiser Permanente health plans studied, as of 2014: [39] (1) 0.075 percent in Northern California,[40] (2) 0.044 percent in Southern California, and (3) 0.038 percent in Georgia. The Quinn Study defines these values as the "proportions of transgender enrollees" as of 2014.[41]

2. Dr. Fox's Misinterpretation and Misuse of the Quinn Study

The precise source of Dr. Fox's assumption about the annual rate at which enrollees in the relevant Group Plans sought transgender-related services is the Quinn Study's 0.075 percent estimate for the prevalence of transgender people in the Northern California Kaiser Permanente health plan.[42] In his analysis, Dr. Fox assumes that this value is the *annual rate* at which these Kaiser Permanente enrollees sought transgender-related services. It is not. The Quinn Study's 0.075 percent value is the "proportion of transgender enrollees"[43] in the Kaiser plan; *i.e.,* it is a measure of the number of transgender enrollees. It is not a measure of the

[39] Quinn Study, p. 9 and Figure 3 (where the values appear graphically). In the Quinn Study, these percentages are expressed as the number of transgender people per 100,000 enrollees.

[40] As discussed in detail below, this 0.075 percent value for the Northern California Kaiser Permanente health plan is the source of Dr. Fox's assumption.

[41] Quinn Study, p. 9. *Also*, Quinn Study, p. 6, Figure 3, showing these values graphically for 2014 with heading "Prevalence of transgender status by site and year of health plan enrolment."

[42] Fox Addendum, Updated Table 5, citing the Quinn Study and stating, "This 0.075% estimate is for Northern California Kaiser enrollees."

[43] Quinn Study, p. 9.

amount or frequency of transgender-related services that these enrollees sought, which is how Dr. Fox uses the percentage.

In fact, the Quinn Study does not present any conclusion about the rate at which Kaiser Permanente enrollees sought transgender-related services. While the study does report evidence of "gender-affirming treatment" for 63 percent of the transgender people and no evidence of "gender-affirming treatment" for the remaining 37 percent,[44] it does not indicate the year in which these treatments were provided or the number of treatments provided, and it does not provide sufficient information to derive annual treatment rates.

In sum, Dr. Fox assumes the 0.075 percent value from the Quinn Study is something that it is not, and he then misuses the 0.075 percent value in the analysis. Consequently, the analysis in Dr. Fox's Updated Table 5 is incorrect, and his conclusions, which he summarizes as "about 300 persons would have been expected to seek [transgender-related services] each year," are unreliable.

C. Dr. Fox's Estimates are Biased Upwards

As discussed above, Dr. Fox's estimates are irrecoverably flawed due to his misuse of the 0.075 percent value from the Quinn Study. Additionally, his estimates are unreliable even if we disregard that flaw, *arguendo.* Specifically, they are inappropriately biased upwards for three reasons discussed below.

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[44] Quinn Study, p. 8, Table 4.

1. No Evidence of Transgender-Related Services

Dr. Fox fails to account for the study's finding that there was no evidence of "gender-affirming treatment" for 37 percent of transgender Kaiser Permanente enrollees. That is, he incorrectly assumes that every transgender Kaiser Permanente enrollee had received transgender-related services despite the fact that the study explicitly states that the was "no evidence" of "gender-affirming treatments" for 37 percent of them.

2. Dr. Fox Disregards Results for Southern California and Georgia

Dr. Fox relies solely on Kaiser Permanente data in the Quinn Study for Northern California, and he ignores analogous data in that same study for Southern California and Georgia. In other words, he uses the higher value for the Northern California Kaiser Permanente plan (0.075 percent) while ignoring the values for the Southern California plan (0.044 percent) and the Georgia plan (0.038 percent), which are much lower.[45] Dr. Fox stated in deposition that he used the value for Northern California because "[i]t had the largest sample size," and therefore, he claims, the "highest level of confidence."[46] This rationale is both incorrect and irrelevant.

Dr. Fox's rationale is incorrect because the sample size for the Northern California data is actually smaller than for the Southern California data. While the Quinn Study does not explicitly state the sample sizes, they can be inferred as follows: for each region, the sample

[45] Quinn Study, p. 9.

[46] Fox Deposition, p. 93.

size is the number of transgender enrollees identified in the study divided by the fraction of the total sample that these enrollees represent. For Northern California, the study identified 3,842 transgender enrollees which amounts to 0.075 percent of the total sample, so the sample size is 5.12 million.[47] For Southern California, the study identified 2,440 transgender enrollees which amounts to 0.044 percent of the total sample, so the sample size is 5.54 million[48] -- which is larger than the sample size for Northern California. Moreover, the Quinn Study reports confidence intervals associated with its prevalence estimates – and the confidence interval for Northern California is wider than for Southern California.[49] Mathematically, *wider* confidence intervals indicate *lower* levels of confidence, so Northern California provides a lower level of confidence than Southern California, contrary to Dr. Fox's claim. Therefore, based on Dr. Fox's stated criteria of using the region with the "largest sample size" and "highest level of confidence," he should have used the transgender prevalence value for Southern California (0.044 percent), not Northern California (0.075 percent).

Dr. Fox's rationale for using the transgender percentage value for Northern California is not only incorrect, but also irrelevant. It is irrelevant because the appropriate criterion for selecting among the three regions discussed in the Quinn Study is the extent to which the

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[47] 3,842 ÷ 0.075% = 5.12 million. The number of transgender enrollees identified is shown in Table 3 of the study, and the percentages these enrollees represent is shown in Figure 3 and p. 9 of the study.

[48] 2,440 ÷ 0.044% = 5.54 million.

[49] Quinn Study, p. 9. The 95 percent confidence interval for the Southern California estimate is 0.042 percent to 0.046 percent. For the Northern California estimate, the 95 percent confidence interval is 0.072 to 0.078.

enrollee populations studied by Dr. Quinn and her co-authors is representative of the enrollee population within the relevant plans. Dr. Fox did not consider this criterion,[50] so his decision to use the Northern California data and exclude the Southern California and Georgia data is baseless.

3. Bias Due to Duplicate Observations

As discussed in Section II.D of this report, Dr. Fox overestimates the number of enrollees in the relevant Group Plans because he failed to account for duplicate entries in the data he processed.

4. Quantifying Dr. Fox's Bias

Table 6 below illustrates the degree to which Dr. Fox's estimates are overstated due to the three factors discussed immediately above. The first row of this table is Dr. Fox's estimated number of transgender enrollees in the relevant Group Plans who sought transgender-related services. The remaining rows indicate how these estimates change when Dr. Fox's analysis is adjusted to remove the sources of bias discussed above. First, I reduced Dr. Fox's estimates by 37 percent to account for the 37 percent of transgender patients in the Quinn Study for which there was no evidence of "gender-affirming treatments." Second, I reduced Dr. Fox's estimates by 2.0 to 3.6 percent, depending on the year, to reflect the duplicate observations in the BCBSIL data that Dr. Fox used. Third, I show how Dr. Fox's estimates change (with these other

[50] Fox Deposition, p. 93, stating that "largest sample size" and "highest level of confidence" were the only reasons he chose to use the Northern California data and exclude the Southern California and Georgia data.

adjustments also in place) depending on whether the analysis is based on the Quinn Study's conclusions for Northern California, Southern California, or Georgia. As the table indicates, these adjustments result in markedly lower estimates than Dr. Fox reports, especially for the Southern California and Georgia analyses, when the analysis is adjusted to remove Dr. Fox's bias.

Table 6
Dr. Fox's Estimated Number of Transgender Enrollees
Who Sought Transgender-Related Services:
Corrected to Remove Bias,[51] by Kaiser Permanente Plan

	Kaiser Permanente Plan	2016	2017	2018	2019	2020	2021
Dr. Fox's Estimate:	**Northern California**	293	304	320	313	301	289
Dr. Fox's Estimate, Corrected:							
	Northen California	180	186	196	192	184	174
	Southern Californa	105	109	115	113	108	102
	Georgia	91	94	99	97	93	88

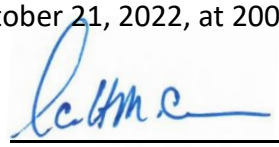
IV. Conclusions

Dr. Frank Fox, on behalf of the plaintiffs in this litigation, provides estimates of both the number of transgender people enrolled in the relevant Group Plans and the number of these enrollees who sought transgender-related services annually during the relevant period. As discussed herein, Dr. Fox's analysis is deficient in numerous ways including: (1) he failed to

[51] As discussed above, Dr. Fox's misuse of the Quinn Study cannot be corrected because the study does not provide annual treatment rates. Thus, while this table demonstrates the bias in Dr. Fox's estimates, the values show are not reliable annual estimates of the number of transgender enrollees who sought transgender-related services.

account for the marked uncertainty in the published data upon which he relies; (2) he incorrectly assumes that the prevalence of transgender people in the relevant Group Plans is identical to the prevalence of transgender people in the general population and that all Group Members in these plans reside in Illinois; (3) he failed to exclude duplicate data entries in the data on which he relies; and (4) he misinterprets, misuses, and overstates published data upon which he relies. Consequently, Dr. Fox's estimates are misleading and unreliable.

October 21, 2022, at 2000 K Street NW, Washington, DC.

By 

Scott Carr, Ph.D.

ankura

Exhibit 1
Curriculum Vitae

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Education

PhD Business Administration and Industrial & Operations Engineering, University of Michigan

MS Engineering, Industrial & Operations Engineering, University of Michigan

MS Engineering, Construction Management and Engineering (Civil and Environmental Engineering), University of Michigan

BS Engineering, Mechanical Engineering, University of Michigan

Affiliations

American Bar Association

Scott Carr, Ph.D., is a Senior Managing Director and leader of the Competition and Class Actions Practice at Ankura Consulting Group. His areas of expertise include data analytics, statistics, and predictive modeling; manufacturing, supply chain and distribution systems; energy economics; and financial modeling.

Dr. Carr has extensive experience in the analysis and modeling of complex business, financial, and health-related circumstances and events. His projects include forecasting the future incidence of diseases and cognitive impairments due to concussions in National Football League players, developing a machine-learning algorithm to predict outcomes of asbestos-related litigation, testimony regarding accommodations for people with physical disabilities, forecasting of future personal injury liabilities due to environmental contamination, expert testimony in contractual disputes within manufacturing supply chains, and economic analysis of crude oil, gasoline, and ethanol distribution systems.

Dr. Carr was formerly a professor at the UCLA Anderson School of Management in the Department of Decisions, Operations, and Technology Management. As a professor, he taught courses on operations management, supply chain management, and quantitative analysis to MBA and Ph.D. students and to executives, and he performed and published research on industrial economics and supply chain and distribution systems. Prior to joining academia, Dr. Carr traded and managed portfolios of foreign exchange and Treasury bond options as a member of both the Chicago Board of Trade and the Chicago Mercantile Exchange.

Dr. Carr has provided expert testimony to state and federal courts and regulatory bodies and to arbitration panels.

ankura

AREAS OF EXPERTISE

- Supply chain management, logistics, production and operations management
- Energy economics, competition economics, environmental economics
- Process design and analysis
- Financial modelling
- Risk modeling, analysis, and management
- Probability and statistics
- Optimization, modeling, simulation, pricing, forecasting, and data analytics

PROFESSIONAL EXPERIENCE

Faculty and Expert Services Experience

Ankura Consulting Group, August 2018 – Present

Senior Managing Director and Competition and Class Actions Practice Leader, April 2019 - Present

Managing Director, August 2018 – March 2019

Navigant Economics, Director, 2014 – August 2018

ARPC, 2011 – 2013

Senior Managing Director, 2012 – 2013

Managing Director, 2011

LECG, 2006-2010

Principal, 2009 – 2010

Senior Managing Economist, 2006 – 2009

UCLA Anderson School of Management, Faculty, 1999 – 2007

Professional Activities – representative examples

Economic modeling and analysis including:

- Testimony in a supply chain dispute on behalf of a major consumer goods packaging manufacturer
- Testimony in a supply chain dispute related to the distribution of rum in Puerto Rico

- Testimony for Saddlehorn Pipeline Company regarding competition in crude oil transportation as part of a market-based rates application for its pipeline running between Rocky Mountain crude oil production regions and Cushing, Oklahoma.
- Testimony regarding gasoline and ethanol distribution on behalf of Joint Defendants in environmental litigation
- Testimony for the New York State Department of Health regarding the availability of accessible housing for people with mobility disabilities in New York City
- Analysis of the pricing and profitability of the United States Postal Service's (USPS's) ten largest Negotiated Service Agreements on behalf of the USPS Board of Governors
- Testimony for BridgeTex Pipeline Co. involving disputed rates and capacity allocation procedures for the transportation of crude oil
- Testimony in a supply chain dispute involving the manufacture and distribution of women's shoes in Australia and New Zealand
- Engaged as Testifying Expert regarding supply chain management and manufacturing issues involved in an $800 million light rail project in Canada
- Testimony for Wells Fargo regarding the valuation of oil-producing properties
- Testimony for Scotiabank regarding financial modeling practices in the investment banking industry and damages in a failed Build-Operate-Transfer construction project in Chile
- Testimony for Rayonier Advanced Materials regarding the pricing and supply of raw materials in the chemicals industry
- Testimony for the Tennessee Fuel and Convenience Store Association to the Tennessee Regulatory Authority regarding competition in the market for compressed natural gas as a transportation fuel
- Testimony for TransCanada regarding competition in crude oil transportation as part of a market-based rates application for its Marketlink Pipeline running between Cushing, Oklahoma, and Houston, Texas
- Testimony for Buckeye Pipe Line Company to the Federal Energy Regulatory Commission regarding competition in wholesale gasoline markets as part of a market-based rates protest of a refined products pipeline running from Delaware City, Delaware, to Pittsburgh and Harrisburg, Pennsylvania
- Testimony for Tyson Foods regarding production and supply chain practices in U.S. Dept. of Agriculture litigation brought under the Packers and Stockyards act
- Testimony to Federal District Court regarding a new business valuation in a breach of contract matter
- Testimony to the Federal Energy Regulatory Commission regarding credit issues in the New England ISO on behalf of Constellation Energy and other electricity generators

- Arbitration testimony in support of a Tier-1 automotive supplier's claim that its profits were negatively impacted by a partner firm's inability to reliably supply raw materials to their joint venture manufacturing plant
- Damages analysis (submitted in arbitration) for a delayed Guatemalan hydroelectric construction project
- Preparation of market-based rate applications for
    - Saddlehorn Pipeline Company, LLC (crude oil pipeline running from Fort Laramie, Wyoming, and Denver, Colorado, to Cushing, Oklahoma)
    - Marketlink, LLC (crude oil pipeline running from Cushing, Oklahoma, to the U.S. Gulf Coast)
    - Osage Pipeline Company (crude oil pipeline running from Cushing, Oklahoma, to El Dorado, Kansas)
    - Buckeye Pipe Line Company, Long Island System (refined products pipeline running from Linden, New Jersey, to Long Island, New York)
    - Seaway Crude Pipeline Company (crude oil pipeline running from Cushing, Oklahoma, to the U.S. Gulf Coast)
    - Enterprise TEPPCO (refined products pipeline running from the U.S. Gulf Coast to Louisiana and Arkansas)
    - Magellan Pipeline Mountain System (refined products pipeline running from Kansas to Colorado)
- Testimony to the California Air Resources Board regarding the financial impact of automotive emissions control regulations for the Alliance of Automobile Manufacturers
- Forecasting of the future incidence of diseases and cognitive impairments due to concussions for the National Football League players
- Analysis of fuel costs for an electric generation firm in bankruptcy litigation
- Analysis of gasoline and ethanol supply chain economics for Tesoro Corporation in several cases involving MTBE groundwater contamination
- Creation of a machine-learning algorithm to predict outcomes of asbestos-related litigation
- Estimation of lost income and other financial damages due to the BP oil spill in the Gulf of Mexico for the $20 billion Gulf Coast Claims Facility
- Probabilistic modeling of future mass tort litigation at environmental contamination sites for Anadarko Petroleum Corporation
- Analysis of large data sets in class action litigation related to labor disputes, antitrust claims, and insurance litigation.
- Analysis of the cost-of-capital implications of subsidies provided to Persian Gulf airlines by their respective governments on behalf of several major U.S. airlines

- Financial analysis of natural gas pipeline leases for the U.S. Department of Justice and the Internal Revenue Service
- Estimation of the likelihood of injury from home electrical devices for Underwriter Laboratories
- Probabilistic modeling and simulation of private equity funds' performance
- Analysis of demand variability within the automobile supply network for Brembo Brakes
- Valuation and depreciation analysis of crude oil pipelines for Imperial Oil
- Bond, stock, and derivative analyses for bankruptcy litigation in the electricity industry
- Valuation of supply contracts for a new mining venture
- Analysis for class-certification and merits stages of antitrust litigation for Dow Chemical
- Analysis of alleged monopolization of industrial chemicals for Honeywell
- Managed, advised, or performed strategic projects for firms/organizations including:
    - Rio Tinto Energy America (coal mining)
    - TRW Aerospace (semiconductor manufacturing technology and equipment)
    - Broadcom (Bluetooth chipsets)
    - Meade Instruments (night vision technology)
    - Macy's (retail clothing)
    - Los Angeles Community Redevelopment Agency
    - Los Angeles County Metropolitan Transportation Authority
    - Pilkington (glass manufacturing)
    - Deutsch Advertising
    - Six Flags (amusement parks)

Numerous Speeches/presentations delivered at academic conferences

Principal investigator in a project and grant to improve small enterprises' access to business expansion capital

Member of editorial board for *Decision Sciences Journal* and frequent reviewer for *Management Science, Operations Research,* and other academic journals

Professional Affiliations

- American Bar Association – Infrastructure and Regulated Industries Section; Section of Litigation and its Environmental & Energy Litigation Committee
- LECG, Los Angeles (Affiliate) – Professional services for antitrust litigation and competition policy, 2005–2006

Graduate-Level Courses Taught at the UCLA Anderson School of Management

Competition and Industrial Organization [Ph.D.] – Game theoretic models of inter-firm interaction. Classic and seminal oligopoly models. Pricing theory. Advanced game theory. Models of strategic interaction within complex production networks. Antitrust. Analysis and proof techniques, 2006

Managerial Model Building [MBA] – Mathematical modeling, analysis, and optimization. Linear, non-linear, and integer programming/optimization. Monte-Carlo simulation. Forecasting methods. Project Management models and tools. Application of optimization models in business settings, 2005-2006

Simulation Theory and Applications [Ph.D.] – Monte-Carlo, discrete event, and agent-based simulation for finance, marketing, and operations. The use of simulation in empirical research. Simulation of stochastic processes. Option valuation (both financial and real) using simulation. Applications (*e.g.*, simulation of intellectual property piracy over the Internet), 2004-2006

Management in the Information Economy [MBA] – Internet and telecommunication technology. Internet business models and strategy. Economics of information products and processes, 2003

Fundamentals of Operations Management [MBA] – Analysis of business processes. Formulating and executing business strategy. Service and performance measurement and metrics. Managing risk, variability, and uncertainty. Management of supply chains and production processes. 1999-2003, 2006

Dynamic Programming and Sequential Optimization [Ph.D.] – Dynamic programming, Markov chains and decision processes, solution and proof techniques, and structural results and proofs, 2000

Other Teaching

Ph.D. Dissertation Committees (including Dissertation Advisor) – topic areas including: competition economics, operations management, information technology, international business, simulation

Executive Education at UCLA Anderson – Various topics in the following programs (1999 to 2007):

- Managing the Information Resource
- Creating and Leading the Project-Centered Organization (faculty director)
- Supply Chain Management
- Head Start – Johnson & Johnson Management Fellows Program
- UCLA Strategic Leadership Institute
- California HealthCare Foundation's Health Care Leadership Program
- Johnson & Johnson Healthcare Leadership Program

University of Michigan, Ross School of Business [BBA] – Operations Management, 1997

University of Michigan, College of Engineering [BSE] – Computer Programming, 1995

Research

Sriram Dasu, Reza Ahmadi, and Scott Carr, "Gray Markets, A Product of Demand Uncertainty and Excess Inventory," *Production and Operations Management*, vol. 21, April 2012, 1102-1113

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Ram Bala and Scott Carr, "Pricing Software Upgrades: The Role of Product Improvement and User Costs," *Production and Operations Management*, September-October 2009, 560-580

Scott Carr and Uday Karmarkar, "Competition in Multi-Echelon Assembly Supply Chains," *Management Science,* vol. 51, January 2005, 45-59

Scott Carr, "Online Auctions with Costly Bid Evaluation," *Management Science* (special issue on e-Business) vol. 49, November 2005, 1521-1528

Dissertation Advisor for Ram Bala, Ph.D. (faculty, Santa Clara University), Dissertation title: *Pricing and Contracting Strategies for Software Products and Services,* 2004

Scott Carr and William Lovejoy, "Choosing an Optimal Demand Portfolio for Capacitated Resources," *Management Science*, vol. 46, July 2000, 912-927

Scott Carr and Izak Duenyas, "Optimal Admission Control and Sequencing in a Make-to-Stock/Make-to-Order Production System," *Operations Research*, vol. 48, Sept.-Oct. 2000, 709-719

Scott Carr, *Essays on the Allocation of Scarce Capacity Among Multiple Market Segments*, Ph.D. dissertation

Other Relevant Experience

Automotive Supply Chain and Manufacturing – Libbey-Owens-Ford (1995–1998)

- Consulting and research related to contracting and demand management, information systems, data-mining, production planning and scheduling, demand forecasting, and materials management
- Analysis to determine which of the firm's products to manufacture using a joint venture manufacturing plant instead of the client firm's own fully-owned facilities

Legal – Case management and expert-witness preparation (1995–1998)

- Researched case and administrative law on employers' and owners' safety responsibilities in multi-employer construction jobsites
- Developed case theories and strategies, wrote briefing materials, and engaged in trial preparation

Finance – Traded and managed portfolios of foreign exchange and Treasury bond options (1986–1991)

- Member of Chicago Board of Trade
- Member of Chicago Mercantile Exchange

Information Technology – Computer Associates, Chicago Illinois (1991–1992)

- Mainframe software systems (datacenter management, security, database management, finance and production applications)

EXPERT TESTIMONY AND SUBMISSIONS

Arbitration testimony of Scott Carr, Ph.D. on behalf of Ball Corporation and Rexam Beverage Can Company; Arizona Beverages USA LLC v. Ball Corporation and Rexam Beverage Can Company; American Arbitration Association, Case Number 01-21-0017-2481; June 2, 2022.

Deposition Testimony of Scott Carr, Ph.D. on behalf of Brugal & CO., S.A.; Ballester Hermanos, Inc. v. Brugal & CO., S.A.; United States District Court, District of Puerto Rico, Docket No. 3:19-cv-02100; May 11, 2022.

Deposition Testimony of Scott Carr, Ph.D. on behalf of Joint Defense Group; Commonwealth of Pennsylvania, etc. v. Exxon Mobil Corporation, et al, Docket No. 1:14-cv-06228-SAS, MDL No. 1358, May 20, 2022.

Prepared Direct Testimony of Scott Carr, PhD, on behalf of Saddlehorn Pipeline Company, LLC, in support of the Application of Saddlehorn Pipeline Company, LLC for Authorization to Charge Market-Based Rates; April 12, 2022.

Expert Report of Scott Carr, Ph.D. on behalf of Brugal & CO., S.A.; Ballester Hermanos, Inc. v. Brugal & CO., S.A.; United States District Court, District of Puerto Rico, Docket No. 3:19-cv-02100; March 29, 2022.

Rebuttal Expert Report of Scott Carr, Ph.D. on behalf of Ball Corporation and Rexam Beverage Can Company; Arizona Beverages USA LLC v. Ball Corporation and Rexam Beverage Can Company; American Arbitration Association, Case Number 01-21-0017-2481; March 7, 2022.

Expert Report of Scott Carr, Ph.D. on behalf of Ball Corporation and Rexam Beverage Can Company; Arizona Beverages USA LLC v. Ball Corporation and Rexam Beverage Can Company; American Arbitration Association, Case Number 01-21-0017-2481; February 25, 2022.

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Deposition Testimony of Scott Carr, Ph.D.; Michelle Bagley et al. against The New York State Department of Health et al.; United States District Court, Eastern District of New York; Case No. 15-cv-4845 (FB) (CLP); February 4, 2021, and February 25, 2021.

Expert Report of Scott Carr, Ph.D.; Michelle Bagley et al. against The New York State Department of Health et al.; United States District Court, Eastern District of New York; Case No. 15-cv-4845 (FB) (CLP); December 16, 2020.

United States Postal Service, Negotiated Service Agreement Review, Solicitation 2A-20-A-0029; October 2020.

Prepared Direct Testimony of Dr. Scott M. Carr on behalf of Marketlink, LLC, in support of the Application of Marketlink, LLC, for Authorization to Charge Market Based Rates. F.E.R.C. Docket No. OR19-30; July 24, 2019.

Expert Report of Scott Carr, PhD, and Michal Malkiewicz Regarding the 2019 Roland Garros Code Violation Against Anna Tatishvili; Grand Slam Board (for tennis); June 20, 2019.

Prepared Rebuttal Testimony of Dr. Scott M. Carr on behalf of BridgeTex Pipeline Company, LLC; Occidental Energy Marketing, Inc. v. BridgeTex Pipeline Company, LLC; Railroad Commission of Texas GUD No.10675; December 21, 2018.

Prepared Rebuttal Testimony of Dr. Scott M. Carr on behalf of BridgeTex Pipeline Company, LLC; Occidental Energy Marketing, Inc. v. BridgeTex Pipeline Company, LLC; F.E.R.C. Docket Nos. IS18-102-001, IS18-147-000, and OR18-6-001; October 25, 2018.

Prepared Answering Testimony of Dr. Scott M. Carr on behalf of BridgeTex Pipeline Company, LLC; Occidental Energy Marketing, Inc. v. BridgeTex Pipeline Company, LLC; F.E.R.C. Docket Nos. IS18-102-001, IS18-147-000, and OR18-6-001; July 10, 2018.

Prepared Direct Testimony of Dr. Scott M. Carr on behalf of BridgeTex Pipeline Company, LLC; Occidental Energy Marketing, Inc. v. BridgeTex Pipeline Company, LLC; Railroad Commission of Texas GUD No.10675; June 29, 2018.

Prepared Direct Testimony of Dr. Scott M. Carr on behalf of BridgeTex Pipeline Company, LLC; Occidental Energy Marketing, Inc. v. BridgeTex Pipeline Company, LLC; F.E.R.C. Docket Nos. IS18-102-001, IS18-147-000, and OR18-6-001; May 11, 2018.

Expert Report of Scott Carr, Ph.D., on behalf of Lew Footwear Holdings Pty Ltd; Madden International, Ltd., v. Lew Footwear Holding Pty Ltd; Supreme Court of the State of New York, County of New York; Index No. 650209/2015; March 2018.

Engaged as Testifying Expert on behalf of Metrolinx; Bombardier Transportation Canada Inc. v. Metrolinx; November 2017.

Financial analysis by Scott Carr, Ph.D., and Cliff Hamal on behalf of OHL Industrial; OHL Industrial S.L. and OHL Industrial Delegacion Guatemala, Sociedad Anonima disclosed in Claimants' Rejoinder to Counterclaim; OHL Industrial S.L. and OHL Industrial Delegacion Guatemala, Sociedad Anonima, v. Energia Limpia De Guatemala, S.A.; International Chamber of Commerce International Court of Arbitration, September 19, 2017.

Expert Report of Scott Carr, Ph.D., on behalf of Wells Fargo Bank, N.A.; Extex Energy Partners, Ltd., v. Wells Fargo, N.A.; American Arbitration Association, Case No. 01-16-0003-7384; August 25, 2017.

Deposition Testimony of Scott Carr, Ph.D., on behalf of The Bank of Nova Scotia, Scotiabank Global Banking and Markets, and Scotia Capital; S.A. de Obras y Servicios, COPASA v. The Bank of Nova Scotia, and Scotiabank Global Banking and Markets f/k/a Scotia Capital Inc.; Supreme Court of the State of New York, County of New York; IAS Part 49, Index No. 651649/2013; December 20, 2016.

Expert Report of Scott Carr, Ph.D., on behalf of The Bank of Nova Scotia, Scotiabank Global Banking and Markets, and Scotia Capital; S.A. de Obras y Servicios, COPASA v. The Bank of Nova Scotia, and Scotiabank Global Banking and Markets f/k/a Scotia Capital Inc.; Supreme Court of the State of New York, County of New York; IAS Part 49, Index No. 651649/2013; September 28, 2016.

Expert Disclosure of Scott M. Carr, Ph.D., on behalf of Rayonier Advanced Materials, Inc.; Eastman Chemical Company v. Rayonier Advanced Materials Inc., Rayonier Performance Fibers, LLC, and Rayonier A.M. Sales and Technology Inc.; Chancery Court for Sullivan County, Tennessee, Case No. 15-ck-40024(C); October 22, 2015.

Live Testimony of Dr. Scott M. Carr on Behalf of Buckeye Pipe Line Company; Guttman Energy v. Buckeye Pipe Line Company, L.P. and Laurel Pipe Line Company, L.P.; F.E.R.C. Docket No. OR14-4-000 and -001; October 13, 2015.

Answering Testimony to Commission Trial Staff of Dr. Scott M. Carr on Behalf of Buckeye Pipe Line Company; Guttman Energy v. Buckeye Pipe Line Company, L.P. and Laurel Pipe Line Company, L.P.; F.E.R.C. Docket No. OR14-4-000 and -001; June 26, 2015.

Answering Testimony of Dr. Scott M. Carr on Behalf of Buckeye Pipe Line Company; Guttman Energy v. Buckeye Pipe Line Company, L.P. and Laurel Pipe Line Company, L.P.; F.E.R.C. Docket No. OR14-4-000 and -001; January 20, 2015.

Live Testimony of Scott M. Carr, Ph.D. on behalf of the Tennessee Fuel and Convenience Store Association; Petition of Piedmont Natural Gas Company, Inc. for Approval of a CNG Infrastructure Rider to its Approved Rate Schedules and Service Regulations; Tennessee Regulatory Authority, Docket No. 14-00086; January 12, 2014.

Direct Written Testimony of Scott M. Carr, Ph.D. on behalf of the Tennessee Fuel and Convenience Store Association; Petition of Piedmont Natural Gas Company, Inc. for Approval of a CNG Infrastructure Rider to its Approved Rate Schedules and Service Regulations; Tennessee Regulatory Authority, Docket No. 14-00086; December 11, 2014.

Live Testimony of Scott M. Carr, Ph.D. on behalf of Tyson Farm's Inc. before the U.S. Department of Agriculture, P&S Docket No. D-12-0123, December 10, 2012.

Written Testimony of Scott Carr, Ph.D., on behalf of Summit Point Automotive Research Center and William Scott Inter Vivos Trust. Homeland Training Center LLC v. Summit Point Automotive Research Center and William Scott Inter Vivos Trust. U.S. District Court for the Northern District of West Virginia, Case No. 3:07-cv-00160-JPB, September 15, 2010.

Affidavit of Scott Carr, Ph.D., in support of the New England Credit Policy Coalition; U.S. Federal Energy Regulatory Commission, Docket No. ER10-942-000; April 16, 2010.

Prepared Testimony of Scott M. Carr, Ph.D. on behalf of Brembo North America and Affiliated Companies; Sanluis Rassini S.A. de C.V. and Rassini Frenos S.A. de C.V. vs. Brembo North America, Brembo Participations S.A. and Brembo S.p.A., Brembo International S.A., and Brembo-Rassini, S.A. de C.V.; International Centre for Dispute Resolution, Case No. 50 154 T 00450 07; July 2008.

Comments by Scott Carr, Ph.D., to the California Air Resource Board Regarding California's Emission Warranty Information Reporting and Recall Regulations and Emission Test Procedures on behalf of the Alliance of Automobile Manufacturers, March 20, 2007.

Exhibit 2
Bibliography

Legal Filings
Amended Complaint. *Pritchard et. al v. Blue Cross Blue Shield of Illinois* . Case No. 3:20-cv-06145-RJB. November 2, 2021.
Defendant Blue Cross Blue Shield of Illinois Answer to Plaintiffs' First Amended Complaint. *Pritchard et. al v. Blue Cross Blue Shield of Illinois* . Case No. 3:20-cv-06145-RJB. December 9, 2021.
Fifth Supplemental Responses and Objections to Plaintiffs' Second Discovery Requests to Defendant Blue Cross and Blue Shield of Illinois. *Pritchard et. al v. Blue Cross Blue Shield of Illinois* . Case No. 3:20-cv-06145-RJB. July 29, 2022.
Plaintiff C.P.'s Motion for Class Certification. *Pritchard et. al v. Blue Cross Blue Shield of Illinois* . Case No. 3:20-cv-06145-RJB. August 25, 2022.

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CommonSpirit, Contact Us, https://www.commonspirit.org/contact-us
Jody L. Herman et. al, "Age of Individuals Who Identify as Transgender in the United States," The Williams Institute, UCLA School of Law, January 2017.
Jody L. Herman et. al, "How Many Adults and Youth Identify as Transgender in the United States?" The Williams Institute, UCLA School of Law, June 2022.
Kaiser Family Foundation, “Demographics, Insurance Coverage, and Access to Care Among Transgender Adults,” October 21, 2020, https://www.kff.org/health-reform/issue-brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults/
McKinsey & Company, “Being transgender at work,” *McKinsey Quarterly* , November 10, 2021, https://www.mckinsey.com/featured-insights/diversity-and-inclusion/being-transgender-at-work
Virginia P Quinn et al., “Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people,” *BMJ Open* , 2017;7:e018121. doi:10.1136/bmjopen-2017-018121

Data
BCBSIL20594.xlsx
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