

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

CODY FLACK and
SARA ANN MAKENZIE,

Plaintiffs,

v.

Case No. 18-CV-0309

WISCONSIN DEPARTMENT OF
HEALTH SERVICES and
LINDA SEEMEYER, in her official
capacity as Secretary of the Wisconsin
Department of Health Services,

Defendants.

**DECLARATION OF COLIN ROTH IN SUPPORT OF
DEFENDANTS' SUPPLEMENTAL BRIEF REGARDING
EXPANDING THE PRELIMINARY INUNCTION
TO APPLY TO ALL MEDICAID BENEFICIARIES**

I, **COLIN ROTH**, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am employed as an Assistant Attorney General at the Wisconsin Department of Justice (DOJ). I am one of the attorneys for Defendants Wisconsin Department of Health Services (DHS) and its Secretary Linda Seemeyer in the above-captioned matter.

2. This declaration is based on my personal knowledge.

3. Attached as Exhibit A to this declaration is a true and correct copy of a report authored by David V. Williams titled “Gender Reassignment Benefits – Wisconsin Medicaid Benefits” dated August 22, 2018.

I declare under penalty of perjury that the forgoing is true and correct.

Executed on August 22, 2018.

s/ Colin T. Roth _____
COLIN ROTH

EXPERT REPORT

Gender Reassignment Benefits Wisconsin Medicaid Benefits

August 22, 2018

David V. Williams, Consultant



EXPERT REPORT

Table of Contents

PROFESSIONAL QUALIFICATIONS.....	1
SUMMARY OF OPINIONS.....	3
MEDICAID PRICING OF BENEFIT	4
DEFINE THE BENEFIT	5
GATHER ENROLLMENT, OR EXPOSURE DATA.....	5
ESTIMATE AVERAGE COST	6
OTHER CONSIDERATIONS	8
BIBLIOGRAPHY	9

I have reviewed the civil rights complaint for sex discrimination filed in United States District Court, W.D. Wisconsin: Cody Flack and Sara Ann Makenzie, Plaintiffs, v. Wisconsin Department of Health Services.

Professional Qualifications

I am a Healthcare Consultant working in the Hartford, Connecticut office of Milliman, the largest independent actuarial consulting firm in the United States with offices worldwide. I have 30 years' experience in areas related to medical economics including director positions at two health plans. I hold a degree in Economics from Brigham Young University and have completed graduate course work in statistics, data mining, public health, and software development.

My employment as a Milliman Healthcare Consultant began in 1997. Milliman Healthcare Consultants consist of actuaries, medical professionals, information technology experts, and other professionals who serve clients that include health plans, insurance companies, healthcare providers, employers, governments, pharmaceutical companies, medical device manufacturers and others. Milliman qualifies consultants through a rigorous evaluation process that designates a consultant as an approved professional, which means the consultant is approved to work directly with clients, and/or has signature authority, which means the consultant may sign reports and approve other professional's work products: I am both an approved professional and have signature authority. My professional responsibilities include provider contracting, pricing, insurance premium rate-setting, return on investment analysis for wellness programs and medical devices, value-based insurance design, forecasting and budgeting of health plans, and medical claims data warehousing.

As a result of my technical experience in medical economics, benefit pricing, and data analysis, I have developed an understanding of benefit pricing techniques and approaches used in the healthcare industry.

I have previously serviced, and continue to work as an expert witness for Reasonable Fee Methodologies, particularly for fees paid by automobile related medical claims where there is no contract between the insurer and provider of care. I have developed an understanding of medical provider billing patterns across the healthcare industry.

The opinions set forth in this report are based on my education, training and experience including my knowledge of medical insurance, benefit design and benefit pricing as commonly used by employers in the U.S. market.

My practice is being compensated \$390 per hour for my services as an expert witness. I may use charts or tables attached to or included in the body of this report as demonstrative exhibits if I testify in this matter. I understand that the parties may obtain further information relating to the matters addressed in this report and that I may be asked to review further information. I reserve the right to review, modify, or expand upon my opinions based on any further information provided to me. I may also develop additional charts or other exhibits to use in my testimony.

Publications

Milliman Reasonable Fee Methodology on behalf of United Services Automobile Association (USAA), 2012

Analysis of Medical Bill Audit Services prepared on behalf of United Services Automobile Association (USAA), June 21, 2004

Frykberg, RG., Williams DV., Negative-Pressure Wound Therapy and Diabetic Foot Amputations: A retrospective study of Payer Claims Data. J. Am Podiatr Med Assoc. Sept/Oct 97(5)2008, P. 351-9.

Prior Expert Litigation Work

Expert Report: 2012-02016-PAB-MJW; Lindsey Parks, representative of a class of injured persons insured with USAA, plaintiff, vs. USAA and AUTO INJURY SOLUTIONS, (AIS), defendants.

Deposition: MySpine, PS Plaintiff v USAA Casualty Insurance Company, et al. Defendant, Civil Action No. C12-1973RAJ

Expert Report: Alina Boyden and Shannon Andrews Plaintiffs v. State of Wisconsin Department of Employee Trust Funds, et. Al, defendants; Gender Reassignment Benefits 19 April 2018. Case No. 17-CV-264

Summary of Opinions

1. Examining retrospective claims data is the preferred starting point for pricing healthcare benefits for procedures, services, and supplies related to surgery and hormone therapy associated with gender reassignment. In the absence of retrospective claims data, other published sources may be used. I was unable to obtain claims data for Wisconsin Medicaid enrollees for this report. This report uses retrospective claims data for a commercial transgender population who underwent surgical procedures, and applies published data to adjust the expected utilization and costs.
2. In a population of 1.2 million Wisconsin Medicaid beneficiaries, I estimate that 63, or .005% of the beneficiaries will undergo some form of surgery related to gender transformation in a given year. This estimate is based on a commercial population's experience of 629 individuals out of around 20 million who received gender transformation surgery in 2016, and adjusted for the ages and Medicaid status of the two populations.
3. The distribution and intensity of services from my prior report dated April 19, 2018, in *Boyden, et al. v. ETF, et al.*, No. 17-cv-264 (W.D. Wis.) (Dkt. 91) (the "*Boyden Report*") that reflect the expected commercial costs are adjusted for Wisconsin's fixed fee schedules to obtain an expected cost per surgical patient of \$5,988 in 2016 dollars.
4. The resulting estimated costs of treating Medicaid transgender surgical patients is approximately \$379,000. As in my previous report, and given the small proportion of members expected to obtain gender dysphoria surgical treatments, I would expect volatile costs from year to year. Therefore, it is fiscally prudent to add a risk margin to the final calculated benefit to account for the volatility in expected costs.
5. In my professional opinion, adding a risk margin of 50% for the expected utilization of services and a 30% risk margin for the average cost per person would be a reasonable way to price this risk margin. This results in a total expected yearly cost of roughly \$739,000.
6. The State of Wisconsin pays, on average, 40.6% of these costs, with the federal government contributing the balance. The expected cost to the State of Wisconsin is therefore approximately \$300,000.

Medicaid Pricing of Benefit

Medicaid is a federal and state entitlement program that pays for medical assistance for certain individuals and families with limited income and resources. Medicaid is jointly funded by states and the federal government. In Wisconsin, approximately 60% of costs are paid by the federal government, and the rest are funded by the state of Wisconsin. Medicaid is not a cash support program—that is, it does not provide cash payments directly to patients for their medical services. Rather, it pays medical providers directly for care.

Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Medicaid and the Children's Health Insurance Program provide health coverage to nearly 73.6 million Americans¹, including children, pregnant women, parents, seniors, and individuals with disabilities.²

The State of Wisconsin determines which services are covered in the state plan. Covered benefits are described in Wisconsin Administrative Code DHS 107 - Covered Services.

The majority of Wisconsin Medicaid enrollees are served by Medicaid managed care plans, which in many ways function like commercial insurers. Health plan benefits are typically priced using data that includes the covered population and their historical medical claims. A capitation rate is paid to the managed care plan, which uses the data mentioned above and an additional factor to cover health plan costs, administrative costs, care coordination, and a margin for risk and profit.

Claims for the remainder of Wisconsin Medicaid enrollees are paid directly by the state on a fee-for-service basis, and the state takes direct risk for expenditures.

Regardless of who takes the risk, new benefits impose a cost paid by the state, either through an increased capitation rate that reflects the health plans' increased claims risk (for managed care enrollees) or through medical claims expenses paid directly by the state (for fee-for-service enrollees).

The following steps are used to estimate the cost of a benefit³:

1. Define the benefit by stating what services can be included and what services are excluded.
2. Gather enrollment data, also known as exposure data. This would be the number of covered enrollees.
3. Calculate the average cost of the benefit, per enrollee, using historical base claim data for the covered services. In the absence of historical claims data, other published sources are sought.
4. Estimate the number of the relevant healthcare services using a) how many individuals have the medical disorder at issue (here, gender dysphoria); b) how many of these individuals might seek covered treatments (here, procedures, services, and supplies related to surgery and sex

¹ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

² <https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2015-Medicaid-and-the-Childrens-Health-Insurance-Program-Workbook.pdf> page 4

³ For a more detailed description, see Group Insurance Chapter 33.

hormones associated with gender reassignment); and c) for individuals who seek that treatment, the average cost of the treatment.

5. Add a reasonable risk margin based on uncertainties associated with the number of members who will seek the relevant treatments and the expected costs of those treatments.

Define the Benefit

Wisconsin Department of Human Services states excludes benefits as follows:

Wisconsin Administrative Code DHS 107.03 Services not covered: (23) Drugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics; (24) Transsexual surgery;

I start with a broad definition of gender reassignment surgery as described in my *Boyden* Report that includes individuals with a diagnosis of gender dysphoria (ICD-10 F64.0 – F64.9) and services that may be related to gender reassignment surgery, both in preparation for surgery or post-surgical treatment.

I will use the database analysis also described in my prior expert report as the foundation for my analysis. In short, that analysis examined all health insurance claims in 2016 from around 20 million patients contained in the Truven MarketScan commercial dataset who likely had insurance coverage for gender reassignment surgical procedures.

Gather Enrollment, or Exposure Data

I used the utilization of 469 surgical patients in the entire Truven dataset from my prior expert report as the starting point for estimating the number of expected surgical patients in Wisconsin's Medicaid population.

Table 1 below describes the distribution of surgical patients by age and the estimated number per 100,000 commercially enrolled eligible. I combine ages 12 to 18 and calculate a single utilization rate to apply to the youth populations of Medicaid enrollees, and similarly an adult population expected utilization for ages 19 to 65.

Table 1

Commercial Population Sample
Surgical Patients By Age

Age	Commercial Count	Per 100,000
12-18	37	0.88
19-65	432	3.50
Total	469	2.84

Table 2 presents Wisconsin's Medicaid population by category. I project the commercial utilization from Table 1 onto the Medicaid population by category.

Table 2
Expected Enrollment

	July 2018 Enrollees	Expected Number of Transgender Surgical Patients
Enrollment with Children	582,025	5.1
Enrollment with Adults	601,264 +	21.1
Total	1,183,289 =	26.2
Medicaid Population Usage Factor	x	2.4
Medicaid Adjusted Expected Surgical Patients	=	63.3

I apply an adjustment for the Medicaid population based on the transgender survey where 29% of Individuals with transgender dysphoria are reported to be in poverty compared to 12% cis gender, a ratio of 2.4 to 1⁴. I apply this ratio number of expected surgical patients to assume an expected number of annual surgical patients in Wisconsin's Medicaid population.

The above projections of expected transgender surgical patients are estimates. While the figures applied are based in fact, their application is somewhat subjective. Application of the reported utilization of adult commercially enrolled transgender population for transgender surgery may not accurately project the expected number of Medicaid enrollees in, for example, the Elderly and Disabled Coverage category that would seek transgender surgery. In that example, the requirements before undergoing gender reassignment surgical procedures, including clinical and physiological readiness as outline in the WPATH guidelines, likely differ between commercially insured populations and that specific Medicaid subpopulation. However, at this time I am unable to locate additional facts that would further refine these projections with respect to the various subpopulations within Wisconsin's Medicaid program.

Estimate Average Cost

Costs described here are the estimated amounts that would be paid by Wisconsin DHS to providers using maximum fee schedules. I develop these costs using relationships between costs for treating patients enrolled in commercial insurance plans and Wisconsin Medicaid beneficiaries.

I develop these costs by selecting procedures for commercial surgical patients electing transgender surgical treatment and adjusting those costs by the relative reimbursement levels between commercial payers and Wisconsin's Medicaid fee schedules.

⁴ https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf
<https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>

Because Wisconsin's Medicaid fee schedules do not include some procedures used to treat commercial patients who undergo gender reassignment surgeries, I apply an average relative payment relationship to the overall commercial reimbursements to estimate the amount Medicaid would pay for a similar collection of procedures.

The Average cost for commercial surgical patients is \$21,302 from the *Boyden* Report. When the expected Medicaid payment per person is considered, the average cost is \$5,988.

Table 3
Development of Expected Cost

	Percentage of Members Electing Treatment	Commercial Payment per Person	Ratio Medicaid Reimbursement to Commercial	Expected Medicaid Payment per Person
Counseling	0.55	1641	85%	\$ 1,400
Hormone Therapy	0.89	551	78%	\$ 428
Reassignment Surgery[2]	1	15604	31%	\$ 4,837
Total				\$ 5,988

Note: Reassignment Surgery Costs assume 37% Medicaid to Commercial Ratio for Inpatient services, 30% ratio for outpatient services; 30% and 14.7% of the patients were treating inpatient in the inpatient setting.

Total Expected Costs: 63.3 individuals x 5,988 average cost per patient = \$378,971.

The following contingencies for potential variations are considered, similar to the *Boyden* Report. These contingencies provide a reserve in the event of adverse experience and reflect the potential sources of variance which include.

1. Number of expected patients
2. Intensity of services, include adverse outcomes
3. Variation in service mix
4. Fixed Medicaid Schedules, which means there is less uncertainty in pricing variance, which reduces the cost-specific contingency from the prior report.

As noted above, the state of Wisconsin funds approximately 40.6% of the Medicaid costs.⁵

Table 4 summarizes the estimated costs with the estimated contingency calculations, and estimates how much of these expected costs will be borne by the State of Wisconsin.

⁵ <https://www.gpo.gov/fdsys/pkg/FR-2017-11-21/pdf/2017-24953.pdf>

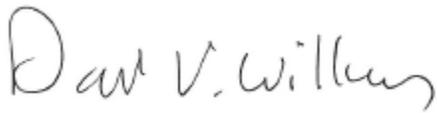
Table 4⁶
Summary of Estimated Costs with Contingencies and State Share

Estimated Cost	\$	378,931
Member Contingency		1.5
Cost Contingency		1.3
Final Estimate with Contingency	\$	738,916
State Share Percentage		40.6%
Final Estimate to State with Contingency	\$	300,221

Other Considerations

1. The base data is subject to the considerations mentioned in the *Boyden* Report, including pent up demand, limited duration of experience, and variations in scope of surgical procedures related to gender reassignment surgery.
2. Medicaid patients may utilize a different mix of services than commercial patients.
3. Medicaid prevalence may be materially different from the estimates in this report. We have adjusted the observed commercial rate of surgeries for the lower income of Medicaid enrollees, but have not reflected other factors, such as a higher rate of co-morbidities, including depression and other physical and mental conditions.
4. Uncertainty in the reimbursement for surgical procedures. Since some services are not currently covered under Medicaid, we are relying on the discount from commercial reimbursement for similar services.⁷

Respectfully Submitted



David V. Williams

Date: August 22, 2018

⁶ Numbers may not add precisely due to rounding

⁷ <https://www.bna.com/medicare-pay-uncertainty-n73014477688/>

Bibliography

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th Edition). Washington DC; American Psychiatric Association; 2013

Bernstein, GR., Brandel, SS.. Chapter 33: Estimating Medical Claims Costs. Group Insurance. Skwire DD. Principal Editor. ACTEX Publications, New Hartford, CT. 2016

Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. Injustice at Every Turn: A Report of the National Transgender.Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.

Naugle AL. Phillip S. Transgender healthcare coverage: Prevalence, recent trends, and considerations for payers. Milliman Insight, 2016

Padula, WV. Heru, S., Campbell, JD. Societal Implications of Health Insurance coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis. J Gen Intern Med 31(4): 394-401; doi: 10.1007/s11606-015-3529-6. 2015.

Olyslager, F., Conway L., On the Calculation of Prevalence of Transsexualism. Presented at WPATH 20th International Symposium, Chicago, IL. September 5-8, 2007.

Schatten, KR., Vieira, KC., Transgender Cost Estimate. Letter to Lisa Ellinger. January 23, 2017

Standards of Care for the Health of Transsexual, Transgender, and Gender nonconforming People. The World Professional Association for Transgender Health. 7th Edition. 2011.

Stephanie Budge, PhD. Expert Witness Report. 2/19/2018

Zuker, ZJ., Epidemiology of gender dysphoria and transgender identify, Sexual Health 2017; 14, 404-411. doi: 10.1071/SHI7067.