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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. State of Arizona; Arizona Board of Regents, D/B/A University of Arizona, a governmental body of the State of Arizona; et al., Defendants.	No.19-cv-00035-TUC-RM (LAB) **REPLY IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT** **(ORAL ARGUMENT REQUESTED)**

Plaintiff Dr. Russell B. Toomey, on behalf of himself and the certified classes ("Dr. Toomey"), submits the following Reply in Support of Plaintiff's Motion for Summary Judgment ("Reply") to Defendants State of Arizona's, Andy Tobin's, and Paul Shannon's Opposition to Plaintiff's Motion for Summary Judgment (Doc. 315).[1] This Reply is accompanied by the Transmittal Declaration of Christine K. Wee, and exhibits thereto. [2]

ARGUMENT

I. THE "GENDER REASSIGNMENT SURGERY" EXCLUSION VIOLATES TITLE VII.

A. The "Gender Reassignment Surgery" Exclusion is Facially Discriminatory.

1. The Court's reasoning for denying State Defendants' Motion to Dismiss applies equally here.

In resolving Dr. Toomey's Motion for Summary Judgment, the Court should employ the same reasoning it employed in denying the Motion to Dismiss. Doc. 69. As this Court previously explained, in evaluating whether the Exclusion is facially discriminatory, the question is not whether the Plan makes certain procedures available to men, but not to women (or makes certain procedures available to women but not to men). Rather, the question is whether the "harm occurred because [Dr. Toomey's] natal sex does not match his gender identity." Doc. 69 at 10. Exclusions that are based on the incongruence between sex assigned at birth and gender identity are—by definition—facially sex-based because "[t]he characteristics of sex and gender are directly implicated; it is impossible to refer to

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[1] Capitalized terms used below and not otherwise defined have the same meaning given to them in Dr. Toomey's opening brief. Doc. 298.

[2] Immediately prior to the submission of this Reply, State Defendants filed a Response to Plaintiff's Countervailing Statement of Facts (Doc. 335). This is plainly improper. L. R. Civ. P. 56.1(b) ("No reply statement of facts may be filed."); *Am. Express Co. v. Ponnambalam*, No. CV-18-03237-PHX-SMM, 2020 WL 13442489, at *4 (D. Ariz. Apr. 7, 2020) ("Any objections to the admissibility of Plaintiffs' evidence should have been included in Defendants' reply in support of their motion for summary judgment, not in a separate filing.") Plaintiff has requested that State Defendants immediately withdraw the submission. If State Defendants will not do so, Plaintiff will move to strike as soon as reasonably possible in light of the intervening Thanksgiving holiday. Plaintiff reserves all rights otherwise.

the Exclusion without referring to them." *Kadel v. Folwell*, 446 F. Supp. 3d 1, 18 (M.D.N.C. 2020). And when an exclusion applies sex-based rules, those sex-based rules remain facially sex-based even when they are applied both to men and to women. *See Bostock v. Clayton Cty., Ga.*, 140 S. Ct. 1731, 1741 (2020).

State Defendants assert that the "Gender Reassignment Surgery" Exclusion is facially neutral, yet they make no attempt to reconcile their arguments with this Court's prior decisions. Doc. 315 at 1. Instead, State Defendants repeat the same arguments contained in previous Reports and Recommendations that this Court rejected twice. Doc. 69 (Order Denying Motion to Dismiss); Doc. 162 (Order Denying Motion for Preliminary Injunction). When State Defendants filed a Motion to Dismiss (Doc. 24), the Magistrate Judge issued a Report and Recommendation (Doc. 46) (the "MTD R&R") erroneously concluding that the motion should be granted with respect to the Title VII claim. Relying on *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), the MTD R&R concluded that Dr. Toomey had failed to state a claim by alleging that "he is being discriminated against because his sex [assigned at birth] and gender identity do not match." Doc. 46 at 5-7. According to the MTD R&R, Dr. Toomey had to allege that "the Plan exclusion would not apply if his sex were different," and, since the Exclusion applied to both men and women, Dr. Toomey could not make that showing. *Id.*

This Court expressly rejected that reasoning and concluded that Dr. Toomey had adequately alleged that the Exclusion discriminated based on sex *both* because (a) it treated him in a manner that, but for his sex assigned at birth, would have been different, *and* (b) because it discriminated based on gender nonconformity. Doc. 69 at 10-11. *First*, this Court explained that discrimination based on the incongruence between Dr. Toomey's sex assigned at birth and his gender identity *is* discrimination that would not occur if his sex assigned at birth were different: "[H]ad Plaintiff been born a male, rather than a female, he would not suffer from gender dysphoria and would not be seeking gender reassignment surgery." *Id.* at 10; *accord Hammons v. Univ. of Md. Med. Sys. Corp.*, 551 F. Supp. 3d 567, 591 (D. Md. 2021) (explaining that "gender dysphoria [is] a condition inextricably linked to

being transgender," and the plaintiff was denied a hysterectomy "specifically because it [is] linked to this condition") (emphasis added). *Second*, this Court explained that "[t]his narrow exclusion of coverage for 'gender reassignment surgery' is directly connected to the incongruence between Plaintiff's natal sex and his gender identity," which "implicates the gender stereotyping prohibited by Title VII." *Id.* at 10-11; *accord Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018) (explaining that excluding transition-related care "implicates sex stereotyping by . . . requiring transgender individuals to maintain the physical characteristics of their natal sex").

When Dr. Toomey filed a Motion for a Preliminary Injunction (Doc. 115), the Magistrate Judge issued another Report and Recommendation (the "PI R&R") again relying on *Gilbert* and erroneously concluding that the Exclusion is facially neutral. Doc. 134. In doing so, the PI R&R failed to apply—or even acknowledge—the Court's reasoning on the Motion to Dismiss. When it reviewed the PI R&R, the Court again rejected the reasoning contained in that portion of the report. Doc. 162 at 11; *see also Fain v. Crouch*, No. CV 3:20-0740, 2022 WL 3051015, at *7 (S.D.W. Va. Aug. 2, 2022) (noting that the reasoning in the PI R&R was rejected by the district court). This Court should adhere to its reasoning when it denied the Motion to Dismiss and, once again, reject State Defendants' assertion that the "Gender Reassignment Surgery" Exclusion is facially neutral.

2. Every court to consider the question has rejected State Defendants' position.

Eight other district courts have held that similar exclusions of coverage for gender-affirming surgery discriminate based on sex, in violation of Title VII (or Section 1557 of the Affordable Care Act). Doc. 309 at 14 n.6. By contrast, State Defendants are unable to identify *any* case applying *Gilbert* to exclusions of gender-affirming care, or any case otherwise accepting their argument that excluding gender-affirming surgery is facially neutral under Title VII. And State Defendants utterly fail to respond to the cases cited by Dr. Toomey explaining why *Gilbert* is irrelevant here. *See, e.g., Lange v. Houston Cty, Ga.*, No. 5:19-CV-392 (MTT), 2022 WL 1812306, at *13 n.14 (M.D. Ga. June 2, 2022) (refusing to apply *Gilbert* to Title VII claim because Congress "not only overturned *Gilbert*, but it

also made clear that its *Geduldig*-based reasoning had no place in Title VII analysis").[3]

Faced with a unanimous body of precedent rejecting their position, State Defendants attempt to whittle down the number of adverse district court rulings to "only" four cases based on a series of irrelevant distinctions. Doc. 315 at 9. *First*, State Defendants note that *Hammons*, *C.P. v. Blue Cross Blue Shield of Illinois*, 536 F. Supp. 3d 791, 793 (W.D. Wash. 2021), *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 951 (D. Minn. 2018), and *Flack v. Wisconsin Dept. of Health Services*, 328 F. Supp. 3d 931, 934 (W.D. Wis. 2018), were motions to dismiss or for preliminary injunction—not motions for summary judgment. Doc. 315 at 8-9. But whether the plain text of the policy facially discriminates based on sex is a question of law that does not depend on subsequent factual development. *See* Doc. 315 at ("Courts look to the language of the policy to determine facial discrimination.")

Second, State Defendants note that *Fain*, *Hammons*, *C.P.*, and *Tovar* involved claims under Section 1557 of the ACA, but they do not explain why this renders the cases inapplicable. Doc. 315 at 9. *Fain*, *Hammons*, and *Pritchard* all based their analysis on the Supreme Court's decision in *Bostock*, which is the same standard that applies to Title VII claims. Those decisions did not depend on the presence or absence of any ACA

[3] State Defendants offer two additional cases that purportedly continue to apply *Gilbert*. Doc. 315 at 7. One is a South Dakota state-law case about whether *Obergefell* applied retroactively to provide survivor benefits to someone whose same-sex partner died before they were able to legally marry. *Anderson v. S. Dakota Ret. Sys.*, 924 N.W.2d 146, 152 (S.D. 2019). State Defendants do not explain how this is relevant to Dr. Toomey's Title VII claim. The second case held that Title VII and the PDA did not require an employer to grant personal leave to an employee who needed more time to breastfeed before returning to work. *Wallace v. PyroMin. Co.*, 789 F. Supp. 867, 868 (W.D. Ky. 1990), *aff'd,* 951 F.2d 351 (6th Cir. 1991). Yet, the Sixth Circuit did not adopt that reasoning and instead affirmed on the alternative grounds that plaintiff failed to establish that her breast feeding was medically necessary. 1991 WL 270823, at *1 (6th Cir. 1991) (unpublished). To the extent that *Wallace* reasoned that lactating and breastfeeding are not conditions related to childbirth under the PDA, that reasoning has not been adopted by courts in the District of Arizona. *Behan v. Lolo's Inc.*, No. CV-17-02095-PHX-JJT, 2019 WL 1382462, at *6 (D. Ariz. Mar. 27, 2019); *Shelton v. Tucson Unified Sch. Dist.*, No. CV-18-00187-TUC-JGZ, 2019 WL 2193736, at *3 n.7 (D. Ariz. May 3, 2019), *aff'd*, 804 F. App'x 770 (9th Cir. 2020).

implementing regulations. And this Court relied on Section 1557 cases when it denied the Motion to Dismiss Dr. Toomey's Title VII claim. *See* Doc. 69 at 9 (citing *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017)).

Third, State Defendants blatantly misrepresent the policies at issue in *Lange* and *Boyden* to argue that those cases, unlike this one, involved a complete ban on all types of gender-affirming care. Doc. 315 at 9-10. That is false. In *Lange*, the employer wrongly believed that the exclusion covered all treatments for gender dysphoria, but the exclusion actually covered only "sex change surgery and drugs related to sex change surgery." 2022 WL 1812306, at *11. Similarly, in *Boyden*, it was undisputed "that the Exclusion [did] *not* apply to hormone therapy or mental health counseling when used to treat gender dysphoria unless specifically made a course of treatment leading to or involving gender confirming surgery." 341 F. Supp. 3d at 988.[4]

In any event, even if State Defendants could show that some illegal exclusions were broader than others across these precedents, the cases did not turn on the breadth of the exclusions, but on the fact that the exclusions explicitly classified based on sex-based criteria such as "gender reassignment" or "sex change." *See Lange*, 2022 WL 1812306, at *14 (rejecting argument that precedent from other courts "turn[ed] on the blanket exclusion of benefits" and emphasizing that "Title VII does not exempt 'partial' violations"); *Fain*, 2022 WL 3051015, at *7 (rejecting argument that surgery exclusion is not facially discriminatory because other gender dysphoria treatments are covered). State Defendants offer no response.

Fourth, State Defendants attempt to distinguish *Fletcher v. Alaska*, 443 F. Supp.3d 1024 (D. Alaska 2020), by noting that in that case, a transgender woman who required a vaginoplasty as part of medically necessary gender-affirming surgery would have been eligible for a vaginoplasty if her sex assigned birth had been female instead of male. Doc.

[4] State Defendants assert that the policy in *Kadel* also excluded psychotherapy (Doc. 315 9-10), but that portion of the exclusion "ha[d] never been implemented and [was] no longer part of the Plan." *Kadel*, 2022 WL 3226731, at *3.

315 at 10. But the same is true here. The Plan covers medically necessary masculinizing reconstructive surgery (including hysterectomies) for people with a male sex assigned at birth, but not for people who have a female sex assigned at birth. To use the same language excerpted by State Defendants: "If [Dr. Toomey's] natal sex were [male] and it was medically necessary for [him] to have a [hysterectomy] to correct a congenital defect, coverage would have been available under [the Plan]. But, because [Dr. Toomey's] natal sex is [female] and [he] was seeking to transition to a [male], coverage was not available." *Fletcher*, 443 F. Supp. 3d at 1027; *accord Kadel*, 2022 WL 3226731, at *19 ("[T]he broad language of the Plan distinguishes between medically necessary treatments that align with the member's biological sex and medically necessary treatments—often the same medically necessary treatments—that do not align with his sex") (footnote and emphasis omitted).

Moreover, as other decisions have made clear, exclusions of coverage for gender-affirming surgery are discriminatory because the diagnosis and surgery at issue are defined by the incongruity between gender identity and sex assigned at birth—not because surgeries are offered to one sex but not another. Although State Defendants repeatedly note that the Plan would provide a hysterectomy to Dr. Toomey if it were medically necessary for a different condition (Doc. 315 at10-11), that does not somehow make the Plan facially neutral. Rather, as this Court explained in its ruling on the Motion to Dismiss, the availability of hysterectomies for other medical conditions shows that Dr. Toomey's "harm occurred because his natal sex does not match his gender identity." Doc. 69 at 10. "Had Plaintiff required a hysterectomy for any medically necessary purpose other than gender reassignment, the Plan would have covered the procedure. This narrow exclusion of coverage for 'gender reassignment surgery' is directly connected to the incongruence between Plaintiff's natal sex and his gender identity." *Id.* And—as explained above—that is all that is necessary to establish that the Exclusion facially discriminates based on sex.[5]

[5] State Defendants object to the admissibility of Dr. Schechter's expert testimony that the surgeries that are used to treat gender dysphoria (like hysterectomies) are utilized in similar or identical fashion to treat other diagnoses, such as cancer. Doc. 316 ¶ 27(a) (citing FRE

B. Dr. Toomey's Summary Judgment Motion Does Not Depend on Alleged Factual Disputes Regarding Defendants' Discriminatory Intent.

As explained in Dr. Toomey's opening brief, because the "Gender Reassignment Surgery" Exclusion facially discriminates on the basis of sex, Dr. Toomey does not have to independently prove that Defendants were motivated by discriminatory intent to win summary judgment. Doc. 298 at 13-14. However, "there is more than sufficient evidence for a reasonable factfinder to conclude that Defendants maintained the 'Gender Reassignment Surgery' Exclusion because of dislike and disapproval of gender transition" although he did not seek summary judgment on that basis. *Id*. at 13-14 n.5. For reasons articulated in Dr. Toomey's Response in Opposition to State Defendants' Motion for Summary Judgment (Doc. 321), these facts likewise preclude summary judgment in State Defendants' favor. Moreover, although the *McDonnell Douglas* framework is not the only method of proving discriminatory intent, Dr. Toomey easily satisfies *McDonnell Douglas* here. Doc. 321 at 16 n.7.[6]

II. THE "GENDER REASSIGNMENT SURGERY" EXCLUSION VIOLATES THE EQUAL PROTECTION CLAUSE.

A. The Exclusion Facially Discriminates Based On Sex and Transgender Status, Automatically Triggers Heightened Scrutiny.

State Defendants argue that the Exclusion is not facially discriminatory because it targets a service, "gender reassignment surgery," rather than transgender individuals. Doc. 315 at 19. This Court has already rejected that argument: "[T]ransgender individuals are

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703). State Defendants suggest that Dr. Schechter cannot testify about hysterectomies because his "experience with performing hysterectomies is in the context of medical research into uterine transplants." *Id*. To the contrary, Dr. Schechter's expert testimony meets the requirements of Evidentiary Rule 703 as it is based on his extensive and broad-ranging experience as a surgeon and medical researcher. Doc. 300-1 at Exhibit 1 (Schechter Report) at ¶ 4, 6-19. *See Fain*, 2022 WL 3051015, at *4 (admitting similar testimony from Dr. Schechter).

[6] State Defendants wrongly allege that Dr. Toomey's Motion asserts a disparate treatment claim that he did not assert before. Doc. 315 at 11, n. 6. Dr. Toomey has always argued that the Exclusion is facially discriminatory under Title VII and the Equal Protection Clause.

the only people who would ever seek gender reassignment surgery. No cisgender person would seek, or medically require, gender reassignment. Therefore, as a practical matter, the Exclusion singles out transgender individuals for different treatment." Doc. 69 at 11. Courts in the Ninth Circuit have employed precisely the same reasoning to conclude that classifications targeting gender non-conformity facially discriminate against transgender people. *See D.T. v. Christ*, 552 F.Supp.3d 888, 895-96 (D. Ariz. 2021); *Morris v. Pompeo*, No. 219-CV-00569, 2020 WL 6875208, at *7 (D. Nev. Nov. 23, 2020). State Defendants ignore these cases, as well as this Court's prior reasoning, arguing that that the Exclusion is facially neutral under *Geduldig v. Aiello*, 417 U.S. 484 (1974). Doc. 315 at 19. Yet, State Defendants are able to identify one—and only one—decision applying *Geduldig* to equal protection claims regarding exclusions of gender-affirming care, while ignoring that at least three *other* district courts have expressly rejected that reasoning. *See Fain*, 2022 WL 3051015, at *8; *Kadel*, 2022 WL 3226731, at *20-21; *Boyden*, 341 F. Supp. 3d at 999-1000.

The "Gender Reassignment Surgery" Exclusion is different from discrimination based on pregnancy or abortion for at least four reasons. Doc. 298 at 20-23. *First*, the Exclusion incorporates explicit classifications based on sex and gender as part of the definition of "gender reassignment." State Defendants say the Exclusion is neutral because it applies equally to males and females. Doc. 315 at 20. But the policies in *Bostock* also applied equally to males and females. They nevertheless violated Title VII because they explicitly classified based on the incongruence between gender identity and sex-assigned at birth, and thus "unavoidably discriminate[d] against persons with one sex identified at birth and another today." *Bostock,* 140 S. Ct. at 1746. State Defendants offer no response.

Second, the Exclusion does not merely regulate a medical procedure available for only one sex; it provides coverage for surgeries to treat other health conditions but denies coverage for the same surgeries when performed for the purpose of gender reassignment. Doc. 298 at 21-22. State Defendants state that "neither transgender nor cisgender persons receive coverage for all treatments they believe are 'medically necessary.'" Doc. 315 at 20. But the discrimination alleged in this case in not that State Defendants fail to cover all

medically necessary procedures for transgender people. The discrimination flows from State Defendants' refusal to cover particular surgical procedures for transgender people based on criteria directly connected to their transgender status, while providing the same surgical procedures to treat medical conditions not connected to transgender status.

Third, the Exclusion facially discriminates as a form of proxy discrimination. Doc. 298 at 22-23. When a "defendant discriminates against individuals on the basis of criteria that are almost exclusively indicators of membership in the disfavored group," the discrimination is treated as a facial classification. *Pac. Shores Props., LLC v. City of Newport Beach*, 730 F.3d 1142, 1160 n.23 (9th Cir. 2013). Just as discrimination based on wearing yarmulkes is a proxy for discrimination against Jews, *see Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993), discrimination based on the need for gender-affirming surgery is a proxy for discrimination against transgender people. State Defendants assert there is no proxy discrimination because not every transgender person requires gender-affirming surgery. Doc. 315 at 21. But that is not the test. Not every Jewish person wears a yarmulke either. Nevertheless, proxy discrimination exists in both instances because the bases for the discrimination are "criteria that are almost exclusively indicators of membership in [a] disfavored group." *Pac. Shores Props.*, 730 F.3d at 1160 n.23.

Fourth, the Exclusion enforces gender stereotypes by covering medically necessary reconstructive procedures to align a person's body with their sex assigned at birth, while excluding coverage for the same medically necessary reconstructive procedures to align a person's body with a gender identity different from the person's sex assigned at birth. Doc. 298 at 23. State Defendants fail to provide any response to this argument.

B. The Exclusion Does Not Survive Heightened Scrutiny.

State Defendants have failed to meet their burden under heightened scrutiny. State Defendants' only purported justification for maintaining the Exclusion is cost containment. Doc. 315 at 13-14. Tellingly, State Defendants do not cite a single equal protection case for the proposition that this justification can withstand heightened scrutiny. This is not surprising as the Supreme Court has repeatedly rejected vague and unsubstantiated claims

of cost containment such as State Defendants' as a sufficient governmental interest when heightened scrutiny applies. *See* Doc. 298 at 24.

Further, the undisputed record belies State Defendants' assertions that costs were a factor here: State Defendants' own internal analysis and external research showed that the cost of coverage would be immaterial to the Plan. Doc. 298 at 6-9, 24. State witnesses also testified that costs were not the deciding factor in maintaining the Exclusion and that the associated cost increase "would not have mattered" to their decision-making. *Id*. at 24 (internal quotations omitted). State Defendants also failed to challenge Joan Barrett's undisputed expert testimony that the projected cost increase posed by covering gender reassignment surgery was less than 0.1%, "an amount so low that it would be considered immaterial from an actuarial perspective." *Id.* State Defendants' cost concerns plainly fails under heightened scrutiny.[7]

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[7] State Defendants' various evidentiary objections are meritless. State Defendants assert that testimony from their *own witnesses* about the projected cost of covering gender affirming surgery should be excluded as inadmissible expert opinion testimony. *See, e.g.*, Doc. 316 ¶ 40. But, despite State Defendants' assertions to the contrary, ADOA employees' testimony is admissible lay-opinion testimony under Federal Rule of Evidence 701. "Such opinion testimony is admitted not because of experience, training or specialized knowledge within the realm of an expert, but because of the particularized knowledge that the witness has by virtue of his or her position [at the ADOA]." *In re ComUnity Lending, Inc.*, No. C 08-00201 JW, 2011 WL 7479165, at *5 (N.D. Cal. June 6, 2011) (permitting lay testimony from employees regarding specialized issues such as the defendant entity's financial condition and solvency (citing advisory committee note to Rule 701)); *Slaughter-Payne v. Principi*, 03-2300-PHX-ROS, 2006 WL 8422927, at *3 (D. Ariz. Sept. 14, 2006) (rejecting Rule 701 objection and permitting VA employees to testify re "VA policies, rules, regulations and practices" and how they "apply to [the plaintiff's] allegations").

State Defendants also object to the evidence regarding the cost assessments from other states and other outside sources as inadmissible hearsay. *See, e.g.*, Doc. 316 ¶ 43. This evidence is not offered to prove the truth of the matter asserted, but instead to establish State Defendants' subjective *understanding* of potential costs at the time of their decision-making in 2016. Moreover, the cited estimates were incorporated into the ADOA Research Summary, which State Defendants themselves have cited and relied on. *See id.* ¶¶ 95-96.

State Defendants also ask this Court to disregard their *own* cost analysis, which was requested for purposes of this litigation and calculated by ADOA actuary Michael Meisner,

C. The Exclusion Does Not Survive Even Rational Basis Review.

The Exclusion fails even rational basis review. While this Court has held that limiting health care costs is a legitimate state interest, "that interest cannot be furthered by arbitrary classifications." Doc. 69 at 16; *see also Diaz v. Brewer*, 656 F.3d 1008, 1014 (9th Cir. 2011) (finding state's purported cost savings rationale "cannot survive rational basis review" because "the savings depend upon distinguishing between homosexual and heterosexual employees [who are] similarly situated").[8]

As noted above, State Defendants have offered no support that cost actually factored into their decision-making, and the record firmly establishes that it did not. State Defendants also offer no explanation for why the ADOA has added coverage (either by adding benefits or removing prior exclusions) for other treatments despite the potential cost-increase associated with them, yet maintained the Exclusion, supposedly, on the same ground. *Compare* Doc. 299 ¶ 23 (a)-(g), *with* Doc. 316 ¶ 23(a)-(g) (either not disputing that other benefits were added, or labeling as "disputed," but then going on to admit that respective benefit was added, or that exclusion was removed). State Defendants admit that between 2012 and 2021, ADOA removed exclusions for orthonagnic surgery, laproscopic sleeve

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as "irrelevant evidence." Doc. 315 at 25 n.17. But State Defendants specifically relied upon Mr. Meisner's cost analysis in their responses to Dr. Toomey's interrogatories. Wee Decl. Ex. 50 at 14. The utter strangeness of State Defendants attacking their own evidence is precisely why this Court must consider it—Mr. Meisner's analysis, and its deep flaws, represents a post-hoc rationalization, that not only fails to support that the State had any legitimate cost concerns, but is itself evidence of pretext. Doc. 321 at 22-23 (*citing Vulpis v. Republic Servs. of Arizona Hauling, LLC.*, No. CV 07-092-TUC-RCC, 2008 WL 11338813, at *5 (D. Ariz. July 9, 2008)).

[8] Despite State Defendants' assertion to the contrary, the defendants in *Diaz* absolutely *did* "challenge the trial court's rejection of its cost rationale in the appeal." Doc. 315 at 28. As the Ninth Circuit stated: "Defendants . . . contend on appeal that this law is rationally related to the state's interests in cost savings and reducing administrative burdens." *Diaz*, 656 F.3d at 1014. The Ninth Circuit rejected that argument because "the savings depend upon distinguishing between homosexual and heterosexual employees, similarly situated, and such a distinction cannot survive rational basis review." *Id.*

gastrectomy, compression garments for treatment of burns, manipulations under anesthesia, midwife services, and treatment for benign gynecomastia, and 3D mammograms (because 3D mammograms were no longer deemed experimental). Doc. 316 ¶ 23.[9] These additions of coverage—which were not mandatory, and which inevitably imposed some additional cost to the Plan—belie State Defendants' suggestion that the Exclusion can be explained by a strict policy of only adding coverage for benefits that were mandatory. The record shows that, to the extent ADOA maintained such a strict policy (of adding benefits only when absolutely mandatory), the policy was applied only to "transgender benefits."

CONCLUSION

Plaintiff's Motion for Summary Judgment should be granted.

Respectfully submitted this 23rd day of November, 2022.

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[9] State Defendants falsely assert that ADOA completed a cost analysis in connection with removing the exclusion for the laproscopic sleeve gastrectomy. Doc. 316 ¶ 23(b). In fact, the cited portion of Ms. Isaacson's testimony actually states that she did "not recall" whether a cost analysis was prepared and did not "know one way or the other." Similarly, Mr. Bender did not testify that removing the exclusion for 3D mammograms "did not add cost to the plan." Doc. 316 ¶ 23(e). He testified that the "cost [was] fairly similar" to the cost of traditional mammograms and "wouldn't have been an extreme cost burden to the plan." Wee Decl., Ex. 51 (Bender Depo Tr.) at 124:5-14. Of course, removing the exclusion of coverage for "gender reassignment surgery" would not have been an extreme burden either.

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CERTIFICATE OF SERVICE

I hereby certify that on November 23, 2022, I electronically transmitted the attached document to the Clerk's office using the CM/ECF System for filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system.

/s/ Christine K. Wee
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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona; Arizona Board of Regents, D/B/A University of Arizona, a governmental body of the State of Arizona; et al.,

Defendants.

Case No.19-cv-00035-TUC-RM (LAB)

DECLARATION OF CHRISTINE K. WEE IN SUPPORT OF PLAINTIFF'S REPLY IN FURTHER SUPPORT OF MOTION FOR SUMMARY JUDGMENT

I, Christine K. Wee, submit this declaration under penalty of perjury pursuant to 28 U.S.C. § 1746 and declare as follows:

1. I am a Senior Staff Attorney at ACLU Foundation of Arizona, licensed to practice law in the State of Arizona, and represent Plaintiff Russell B. Toomey and the certified classes ("Dr. Toomey" or "Plaintiff").

2. I submit this declaration in support of Plaintiff's Reply in support of his Motion for Summary Judgment as to Defendants State of Arizona's, Andy Tobin's, and Paul Shannon's Opposition to Plaintiff's Motion for Summary Judgment (the "Reply"), filed concurrently herein.

3. I base this declaration on my personal knowledge and on information obtained in the course of the above-captioned matter.

4. I incorporate and rely on my declaration submitted in support of Russell B. Toomey's Motion for Summary Judgment (Doc. 300), which refers to Exhibits 1-28, and my declaration submitted in support of Plaintiff's Response In Opposition to State Defendants' Motion for Summary Judgment (Doc. 323), which refers to Exhibits 29-49. I supplement as follows:

5. **Exhibit 50** as attached to Plaintiff's Reply is a true and correct copy of State Defendants' Responses to Plaintiff's Second Set of Interrogatories, dated April 12, 2021.

6. **Exhibit 51** as attached to Plaintiff's Motion is a true and correct copy of excerpts of the Scott Bender Deposition Transcript, dated March 31, 2021.

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

Dated: November 23, 2022

/s/ Christine K. Wee
Christine K. Wee

Exhibit 50

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. State of Arizona, et al., Defendants.	No. 4:19-cv-00035 **DEFENDANTS STATE OF ARIZONA'S, ANDY TOBIN'S, AND PAUL SHANNON'S RESPONSES TO PLAINTIFF'S SECOND SET OF INTERROGATORIES**

Propounding Party: Russell B. Toomey
Answering Parties: State of Arizona, Andy Tobin, and Paul Shannon
Set No.: Two

PRELIMINARY STATEMENT

Defendants State of Arizona, Andy Tobin, and Paul Shannon (collectively, the "State Defendants") have not fully completed their investigation of the facts relating to this case, discovery is underway, and the State Defendants have not begun preparing for trial. All answers contained herein are based only upon the information presently available to and specifically known by the State Defendants and they disclose only those conclusions and contentions which presently occur to them. Further investigation, legal research and

analysis may supply additional facts, add meaning to the known facts, and may establish entirely new factual conclusions and legal contentions, all of which may lend substantial additions to, changes, and variations from the responses herein set forth.

The following answers are given without prejudice to or waiver of the State Defendants' right to introduce evidence of subsequently discovered and developed conclusions or contentions. The answers contained herein are made in a good faith effort to supply as much factual information and as much specification of legal contentions as is presently known, but in no way should be to the prejudice of the State Defendants in relation to discovery, research or analysis. The State Defendants specifically reserve the right to supplement, amend and/or modify any or all of the answers contained herein as discovery progresses.

GENERAL OBJECTIONS

1. The State Defendants object that the Interrogatories require a response within 14 days of service, which is in conflict with Federal Rule of Civil Procedure 33(b)(2).

2. The State Defendants object to each interrogatory to the extent that it is vague and/or ambiguous and agrees to respond to Plaintiff's interrogatories based solely on their interpretation of any vague or ambiguous language.

3. The State Defendants object to each interrogatory to the extent that it is overly broad, unduly burdensome, or oppressive.

4. The State Defendants object to each interrogatory to the extent that it seeks privileged information.

5. The State Defendants object to each interrogatory to the extent that it seeks information that is irrelevant to Plaintiff's claims or any defendants' defense and is not reasonably calculated to lead to the discovery of admissible evidence.

6. The State Defendants object to each interrogatory to the extent that it requires any action or response beyond that required by the Federal Rules of Civil Procedure, the

Scheduling Order, or the Local Rules.

ANSWERS TO INTERROGATORIES

INTERROGATORY NO. 9: Defendants' Opposition to Plaintiffs' *(sic)* Motion for Preliminary Injunction (Doc. 123 at p.7) states that "the Plan excludes several procedures, any of which might be considered 'medically necessary, including certain bariatric procedures, surgery to treat hyperhidrosis (excessive sweating), and phase 3 cardiac rehabilitation, among other." Please identify and describe all medical procedures that you contend are (as opposed to merely "might be considered") "medically necessary" as that term is defined by the Plan (Doc. 86-1 at p.58) but are nevertheless categorically excluded from coverage.

ANSWER TO INTERROGATORY NO. 9: The State Defendants object to Interrogatory No. 9 on the ground that it is vague and ambiguous as to the term "medically necessary." The term "medically necessary" is not defined on page 58 of Doc. 86-1. In addition, "medically necessary" is a fluid standard, which depends on the individual facts of each situation. The State Defendants further object that the Interrogatory is vague and ambiguous as to the term "medical procedure." The term "medical procedure" is undefined. Some of the exclusions in the Plan do not relate to specific medical procedures, but rather exclude coverage of any procedure or treatment to address specific conditions or in specific situations. The State Defendants further object that the Interrogatory is overly broad and unduly burdensome to the extent that it does not include a relevant timeframe. The State Defendants further object to the Interrogatory to the extent that it seeks information that is equally in the Plaintiff's possession. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

The "medically necessary" procedures, meaning procedures or treatments that may be medically necessary under certain facts and circumstances to treat various conditions, that are currently excluded from coverage are as follows:

No.	Excluded Procedure	Description
1.	Services and Supplies which are experimental, investigational, or unproven.	These services may be related to medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan to be: a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal; b. The subject of review or approval by an Institutional Review Board for the proposed use; c. The subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of this Plan under Covered Services and Supplies); or d. Not demonstrated, through existing peer reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
2.	Open Vertical Banded Gastroplasty	Vertical banded gastroplasty, also called stomach stapling, is surgery that divides the stomach into 2 parts to treat obesity. It causes weight loss by decreasing the amount of food a person can eat.
3.	Laparoscopic Vertical Banded Gastroplasty	Vertical banded gastroplasty, also called stomach stapling, is surgery that divides the stomach into 2 parts to treat obesity. It causes weight loss by decreasing the amount of food a person can eat.
3.	Open Sleeve Gastrectomy	During sleeve gastrectomy, about 80% of the stomach is removed, leaving a tube-shaped stomach about the size and shape of a banana.
4.	Open Adjustable Gastric Banding	Adjustable gastric banding, also known as “Lap Band” or “Realize band,” involves placing an implant, a soft silicone ring with an expandable balloon in the center, around the top part of the

		stomach. It effectively creates a two-compartment stomach, with a much smaller top part above the band.
5.	Gender Reassignment Surgery	Gender reassignment surgery.
6.	Treatment of erectile dysfunction and sexual dysfunction.	Treatment of erectile dysfunction and sexual dysfunction.
7.	Foot Orthotics (unless provided in the Diabetic Services and Supplies provision)	An orthotic is a shoe insert that supports the abnormal movement of a foot.
8.	Corrective Orthopedic Shoes (unless provided in the Diabetic Services and Supplies provision)	Corrective shoes are recommended for people with chronic foot injuries, deformities, and medical conditions like diabetes that put them at a higher risk of developing foot problems. Corrective shoes are designed to address trouble areas on the feet.
9.	Arch Supports (unless provided in the Diabetic Services and Supplies provision)	Orthotic arch supports are shoe insoles that feature either a cushioned (completely flexible), a semi-rigid (semi-flexible) or a rigid (completely inflexible) arch support plate to prevent the arch of the foot from collapsing.
10.	Elastic/compression Garments (except for treatment of lymphedema and burns)	Elastic/compression garments are made of breathable elastic fabrics such as nylon, cotton, spandex or natural rubber. They are occasionally referred to as "graduated compression garments." Compression garments are available in various degrees of pressure, or classes of compression.
11.	Garter Belts	Garter Belts are used to keep compression stockings from bunching, slipping down the leg, and causing discomfort.
12.	Corsets	A corset is a device that is used to support a person's lower back. A corset is made of soft material. It is usually tightened with laces that may tie in the back, front, or side. There may also be metal pieces that keep the corset from bending easily.
13.	Dentures	A denture is a removable replacement for missing teeth and surrounding tissues.
14.	Wigs/Hair pieces (except when indicated for coverage on Section 7.25)	A covering for the head made of real or artificial hair, typically worn by people for adornment or by people trying to conceal their baldness.

15.	Hair Transplants	A hair transplant is a procedure in which a plastic or dermatological surgeon moves hair to a bald area of the head.
16.	Treatment of alopecia or hair loss	The most common form of alopecia treatment is the use of corticosteroids, powerful anti-inflammatory drugs that can suppress the immune system. Other medications that can be prescribed that either promote hair growth or affect the immune system include Minoxidil, Anthralin, SADBE, and DPCP.
17.	Alternative Treatments	Acupressure, acupuncture, aromatherapy, health spas, hypnotism, massage therapy, mineral baths, rolfing, saunas; and art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
18.	Phase 3 Cardiac rehabilitation	Phase 3 cardiac rehabilitation involves engaging in more intensive exercise and activity. The main treatment during phase 3 cardiac rehabilitation is group exercise and therapy.
19.	Hyperhidrosis (excessive sweating)	Surgery for correction of Hyperhidrosis
20.	Infertility	Any medical treatment and/or prescription related to infertility once diagnosed
21.	Sensory Integration Therapy	Sensory integration therapy is designed to help children with sensory-processing problems to cope with the difficulties they have processing sensory input.
22.	LOVAAS Therapy	LOVAAS Therapy is a form of Applied Behavioral Analysis that is used in early intervention programs for children who have developmental delays or who have been identified as autistic. The therapy consists of breaking skills down into the simplest components and rewarding children positively and then "generalizing" the skills into a natural environment.

INTERROGATORY NO. 10: For each of the medically necessary procedures identified in response to Interrogatory No. 9, please identify and describe the reason why the medically necessary procedure is excluded from coverage.

ANSWER TO INTERROGATORY NO. 10: The State Defendants object to

Interrogatory No. 10 on the ground that it exceeds the maximum number of interrogatories permitted under Rule 33. Each requested explanation equates to a discrete subpart and, therefore, a separate interrogatory. FRCP 33(a)(1); *Reed v. Barcklay*, No. CV111339PHXJATBSB, 2013 WL 12177162, at *2 (D. Ariz. Apr. 30, 2013). The State Defendants further object that the Interrogatory is vague and ambiguous as to timeframe. The State Defendants further object that the Interrogatory is vague and ambiguous as to the term "procedure." The term "procedure" is undefined. Some of the exclusions in the Plan do not relate to specific medical procedures, but rather exclude coverage of any procedure or treatment to address specific conditions or in specific situations. The State Defendants further object that the Interrogatory is overly broad and unduly burdensome to the extent that it does not include a relevant timeframe. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

No.	Excluded Procedure	Reason for Exclusion
1.	Services and Supplies which are experimental, investigational, or unproven.	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
2.	Open Vertical Banded Gastroplasty	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
3.	Laparoscopic Vertical Banded Gastroplasty	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
3.	Open Sleeve Gastrectomy	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.

4.	Open Adjustable Gastric Banding	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
5.	Gender Reassignment Surgery	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion. In 2015-2016, the State of Arizona undertook a review of this exclusion in light of proposed regulations under Section 1557 of the Affordable Care Act. The State modified the prior exclusion so as to provide coverage for therapy and hormone treatment, but determined that it was not required to cover surgery.
6.	Treatment of erectile dysfunction and sexual dysfunction.	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
7.	Foot Orthotics (unless provided in the Diabetic Services and Supplies provision)	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
8.	Corrective Orthopedic Shoes (unless provided in the Diabetic Services and Supplies provision)	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
9.	Arch Supports (unless provided in the Diabetic Services and Supplies provision)	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
10.	Elastic/compression Garments (except for treatment of lymphedema and burns)	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included an exclusion for all elastic/compression garments.

11.	Garter Belts	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
12.	Corsets	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
13.	Dentures	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
14.	Wigs/Hair pieces (except when indicated for coverage on Section 7.25)	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included an exclusion for all wigs/hair pieces.
15.	Hair Transplants	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
16.	Treatment of alopecia or hair loss	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
17.	Alternative Treatments	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included an exclusion for "alternative treatments." In 2021, the State of Arizona revised the exclusion to identify what specific "alternative treatments" are excluded.
18.	Phase 3 Cardiac rehabilitation	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including

		the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
19.	Hyperhidrosis	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
20.	Infertility	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included an exclusion for "counseling, diagnosis, and any medical and/or prescription" for infertility. In 2012, the State of Arizona evaluated and revised the exclusion to expand coverage for counseling and diagnosis of infertility based on recommendations from health plan vendors and as needed to align with standard medical coverage guidelines.
21.	Sensory Integration Therapy	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.
22.	LOVAAS Therapy	At the time that the State of Arizona moved its healthcare coverage to a self-funded health plan, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers, which included this exclusion.

INTERROGATORY NO. 11: Please identify and describe all procedures that have been removed from the Plan's list of exclusions with in the past 10 years.

ANSWER TO INTERROGATORY NO. 11: The State Defendants object to Interrogatory No. 11 on the ground that it exceeds the maximum number of interrogatories permitted under Rule 33, as noted in State Defendants' objections to Interrogatory 10. Each requested explanation equates to a discrete subpart and, therefore, a separate interrogatory. FRCP 33(a)(1); *Reed v. Barcklay*, No. CV111339PHXJATBSB, 2013 WL 12177162, at *2 (D. Ariz. Apr. 30, 2013). The State Defendants further object that the Interrogatory is vague

and ambiguous as to the term "procedure." The term "procedure" is undefined. Some of the exclusions in the Plan do not relate to specific medical procedures, but rather exclude coverage of any procedure or treatment to address specific conditions or in specific situations. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

No.	Excluded Procedure	Description
1.	Benign Gynecomastia	A benign proliferation of glandular breast tissue in men.
2.	Orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction and dental, orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral).	Treatment designed to correct conditions of the jaw and lower face related to structure, growth, airway issues including sleep apnea, TMJ disorders, malocclusion problems primarily arising from skeletal disharmonies, other orthodontic dental bite problems that cannot be easily treated with braces, as well as the broad range of facial imbalances, disharmonies, asymmetries and malproportions where correction can be considered to improve facial aesthetics and self esteem.
3.	Laparoscopic sleeve gastrectomy	During sleeve gastrectomy, about 80% of the stomach is removed, leaving a tube-shaped stomach about the size and shape of a banana.
4.	Medical or psychological counseling and hormonal therapy for the treatment of gender dysphoria	Medical or psychological counseling and hormonal therapy for the treatment of gender dysphoria
5.	Elastic/compression garments used for treatment of lymphedema and burns	Elastic/compression garments are made of breathable elastic fabrics such as nylon, cotton, spandex or natural rubber. They are occasionally referred to as "graduated compression garments." Compression garments are available in various degrees of pressure, or classes of compression.
5.	Wigs/Hair pieces when indicated for coverage on Section 7.25	A covering for the head made of real or artificial hair, typically worn by people for adornment or by people trying to conceal their baldness.

7.	Services rendered by a midwife for the purpose of home delivery.	Services rendered by a midwife for the purpose of home delivery.
9.	Charges made by any covered provider who is a member of your family or your Dependent's family.	Charges made by any covered provider who is a member of your family or your Dependent's family.
10.	Manipulations under anesthesia.	A noninvasive stretching and manipulative technique used to offer relief from chronic and recurrent back pain and other types of pain that have not responded to long-term conservative (i.e., nonsurgical) care.
11.	Counseling and diagnosis related to infertility	Counseling and diagnosis related to infertility

INTERROGATORY NO. 12: For each of the procedures identified in response to Interrogatory 11. *(sic)* Please identify the reasons why the procedure was removed from the Plan's list of exclusions and identify and *(sic)* analysis or calculations Defendants made with respect to the cost of removing the procedure from the list of exclusions.

ANSWER TO INTERROGATORY NO. 12: The State Defendants object to Interrogatory No. 12 on the ground that it exceeds the maximum number of interrogatories permitted under Rule 33, as noted above. Each requested explanation equates to a discrete subpart and, therefore, a separate interrogatory. FRCP 33(a)(1); *Reed v. Barcklay*, No. CV111339PHXJATBSB, 2013 WL 12177162, at *2 (D. Ariz. Apr. 30, 2013). The State Defendants further object that the Interrogatory is vague and ambiguous as to the term "procedure." The term "procedure" is undefined. Some of the exclusions in the Plan do not relate to specific medical procedures, but rather exclude coverage of any procedure or treatment to address specific conditions or in specific situations. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

No.	Excluded Procedure	Reason for Removal
1.	Benign Gynecomastia	The Arizona Department of Administration ("ADOA") evaluated and revised the exclusion based on recommendations from its health plan

		vendors. ADOA elected to keep the exclusion for cosmetic surgery, but to expand coverage to provide treatment for benign gynecomastia. No independent cost analysis was completed by ADOA related to this change.
2.	Orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction and dental, orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral).	The ADOA evaluated and removed the exclusion based on recommendations from its health plan vendors. No independent cost analysis was completed by ADOA related to this change.
3.	Laparoscopic sleeve gastrectomy	ADOA evaluated and revised the exclusion. ADOA elected to keep the exclusion for certain bariatric procedures, but decided to expand coverage to laparoscopic sleeve gastrectomy. No independent cost analysis was completed by ADOA related to this change.
4.	Medical or psychological counseling and hormonal therapy for the treatment of gender dysphoria	In 2015-2016, the State of Arizona undertook a review of this exclusion in light of proposed regulations under Section 1557 of the Affordable Care Act. The State modified the prior exclusion so as to expand coverage to therapy and hormone treatment, but determined that it was not required to cover surgery. Cost analysis and calculations have already been produced, including, but not limited to, ABOR-TOOMEY003460, AZSTATE.004283, AZSTATE.004291, AZSTATE.085480, AZSTATE.004350, AZSTATE.086167, AZSTATE.006077, AZSTATE.006081, AZSTATE.006090, AZSTATE.006091, AZSTATE.006095,

		AZSTATE.006097, AZSTATE.006136, AZSTATE.006137, AZSTATE.006141, AZSTATE.006143, AZSTATE.006145, AZSTATE.006152, AZSTATE.006154, AZSTATE.006155, AZSTATE.006159, AZSTATE.006323, AZSTATE.006538, AZSTATE.129513, AZSTATE.006694, AZSTATE.006704, AZSTATE.006709, AZSTATE.008022, AZSTATE.010326, AZSTATE.011523, AZSTATE.011544, AZSTATE.146155, AZSTATE.151091, AZSTATE.151092, AZSTATE.151093, AZSTATE.151094, AZSTATE.151099, AZSTATE.151707, AZSTATE.151720, AZSTATE.151721, AZSTATE.151737, and AZSTATE.151748.
5.	Elastic/compression garments used for treatment of lymphedema and burns	ADOA evaluated and revised the exclusion based on recommendations from its health plan vendors and as necessary to conform with standard coverage guidelines. ADOA elected to keep the exclusion of compression garments but to expand coverage for such garments as needed to treat burns. No independent cost analysis was completed by ADOA related to this change.
6.	Wigs/Hair pieces when indicated for coverage on Section 7.25	ADOA evaluated and revised the exclusion based on recommendations from its health plan vendors and as necessary to conform with standard coverage guidelines. ADOA elected to keep the exclusion, but to expand coverage as provided on Section 7.25. No independent cost analysis was

		completed by ADOA related to this change.
8.	Services rendered by a midwife for the purpose of home delivery.	ADOA evaluated and removed the exclusion based on recommendations from its health plan vendors to remove the reference to midwives. ADOA further revised the exclusion to refer to "birth," rather than "delivery." No independent cost analysis completed by ADOA related to this change.
10.	Charges made by any covered provider who is a member of your family or your Dependent's family.	ADOA evaluated and elected to remove exclusion due to changes under Arizona law, which allows treatment by family members. No independent cost analysis was completed by ADOA related to this change.
11.	Manipulations under anesthesia.	ADOA evaluated and elected to revise the exclusion to expand coverage to manipulation under anesthesia when considered medically necessary. No independent cost analysis was completed by ADOA related to this change.
12.	Counseling and diagnosis related to infertility	ADOA evaluated and revised the exclusion based on recommendations from its health plan vendors and as necessary to comply with standard coverage guidelines. ADOA elected to keep the exclusion, but to expand coverage to treatments for the underlying cause. No independent cost analysis was completed by ADOA related to this change.

DATED this 12th day of April, 2021.

FENNEMORE CRAIG, P.C.

By: *s/ Ryan Curtis*
Timothy J. Berg
Amy Abdo
Ryan Curtis
Shannon Cohan
Attorneys for Defendants State of Arizona, Andy Tobin, and Paul Shannon

COPY of the foregoing e-mailed this 12th day of April, 2021 to:

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18286470

Exhibit 51

In The Matter Of:

Toomey vs.

State of AZ

Scott Bender, Videotaped

March 31, 2021

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

RUSSELL B. TOOMEY, Plaintiff, vs. STATE OF ARIZONA; ARIZONA BOARD OF REGENTS, d/b/a UNIVERSITY OF ARIZONA, a governmental body of the State of Arizona; et al., Defendants.	4:19-CV-00035

VIDEOTAPED DEPOSITION OF SCOTT BENDER

Via Zoom Videoconference
March 31, 2021
8:00 a.m.
Phoenix, Arizona

Glennie Reporting Services, LLC
1555 East Orangewood Avenue
Phoenix, Arizona 85020
602.266.6535
www.glennie-reporting.com

Prepared by:
Robin L. B. Osterode
CSR, RPR
CA CSR No. 7750
AZ CR No. 50695

Q. So, Mr. Bender, you said that the process was similar at Sprouts Farmers Market as well as at Amkor Tech and as at Dial Soap. Is it fair to say that there is a general process to, you know, facilitating the implementation of a plan change?

A. I would say so, yeah. Just not any official documented process, but the -- the annual cycle of things that happen, is pretty much the same in most organizations that I've been part of.

Q. And when you say there's no official process, you mean there's nothing written down anywhere that tells you how to go about facilitating the implementation of a plan change?

A. Not for those organizations, no.

Q. Is there anything written down for any organization you worked at?

A. There are different requirements for the State of Arizona. We're required to, for example, any plan changes that are recommended would need to be presented to the Joint Legislative Budget Committee, the legislature. So it's just a little bit different, and obviously, with the size of the state, there's more layers of leadership to consider.

Q. So appreciating those differences with respect to the ADOA and its health plan, would you say that

general process includes -- and I'm going to name things and I'd like you to tell me if I'm right -- so would the general process for, you know, assessing a proposed change to the plan include a cost analysis?

A. Yes.

Q. And would it include market analysis?

A. Yes.

Q. What about the impact to members', let's say, health and well-being?

A. Yes.

Q. Is there anything else it would include?

A. Off the top of my head, I can't think of really anything else. But you have to consider all factors, so --

Q. And to go back, when we were talking about how this isn't written down or at least it wasn't written down at places you've worked at --

A. Right.

Q. -- are there general professional standards with respect to this process?

A. I'm -- I don't know if there are general standards. I know how it's worked everywhere I've been, and it's -- it's been sort of the -- what we call it at the State is the contribution strategy, sort of lays out what are -- what are the benefits going to be and who is

decision-making?

A. It may be.

Q. But the governor's office is not always involved in the decision making when there's a change that is optional to the plan?

A. Correct. Anything that would potentially have a significant cost to the plan, we -- we need to consult the governor's budget office.

Q. If something didn't have a significant cost to the plan, would you expect the governor's office to be involved in the decision making?

A. I would say it depends on what it is.

Q. And what is it exactly that depends?

A. I think is there anything that's, aside from the cost, is there -- is there something that the governor's office has a particular feeling one way or the other about.

Q. So you would expect the governor's office's position -- when you say "feeling," what do you mean by that?

A. If anyone has a -- anybody in leadership has a particular feeling one way or another.

Q. And a feeling one way or another, do you mean political position on an issue?

A. Could be political, personal views.

And we need to make decisions each year as to how we're going to spend that money. And, unfortunately, it sort of ends up in an erosion of benefits for the employees and more cost sharing to the employees. That's just the nature of this business, unfortunately.

Q. Would the removal of a plan exclusion affect the contribution strategy?

A. It could, depending upon the cost.

Q. At what point would the removal of a plan exclusion affect the contribution strategy?

A. I can't give you a number.

Q. Is there a thre -- is there a ballpark threshold?

A. There's not a stated threshold that I'm aware of, no.

Q. What about an unstated threshold?

A. I'm not aware of that either. But I am --

Q. Practically --

I'm sorry, go ahead.

A. What I am aware of is that there's insufficient funds to manage the plan as it is, and there is not much appetite for any additional changes that would increase costs.

Q. Practically, in your experience working at the ADOA, what cost would cause a change to the contribution

strategy?

A. The biggest focus lately is around specialty medications and how do we handle those challenges. I mean, you can't watch TV without seeing three ads for new specialty drugs that are coming to the market. They've become an extremely expensive part of the plan. That is a focus of ours.

We follow recommendations of a pharmacy and therapeutics committee with our pharmacy benefit manager with those. But at some point we're going to have to have the realistic conversation of what do we exclude and are we going to continue to add everything that comes down the pike.

There are therapies that cost hundreds of thousands of dollars a year. For one person. And we need to make hard decisions as to are we going to continue to cover these things, or are we going to put limits on them.

Q. What are the costs of those specialty medications?

A. The -- first of all, the definition of what's considered a specialty varies from organization to organization. We sort of view it as over 500 or a thousand dollars a month or at least our PBM does. And they can go, you know, up to $500,000 a year or more.

When might the removal -- when might the removal of a plan exclusion not impact the contribution strategy? And actually, let me clarify, I think we're getting hung up on the word "impact."

When might the removal of a plan exclusion not change the contribution strategy?

A. I think it would not change if it were a minimal cost. And I believe we discussed between, you know, more than $500,000.

Q. Oh, okay. So I think that's -- so if a cost were around a million, I think that's where we landed, or above, that would impact the contribution strategy?

A. That could impact the contribution strategy, and it's something noteworthy.

Q. It's more likely to impact the contribution strategy than not at a million?

A. It's more likely at a million than it is at 500,000.

Q. Does the governor's office ever get involved in the decision-making process about a plan change before you've presented the change to them?

A. I can't think of a case like that.

Q. So, for instance, if you don't know -- say you're -- the network providers come to you with a proposed change to the plan, and you don't know the cost

her on. Gosh, I can't remember. It was right when I started. We had conversations with her on something. I'm sorry, I don't remember. And I know that she was involved in the discussion in our redesign of our new wellness program, and what the governor's office would be interested in from the perspective of a new vendor and what kind of capabilities they wanted for the wellness program, but my -- my interaction with her is very limited.

Q. Have you ever interacted with her with respect to the plan's coverage of transgender benefits?

A. I have not, no.

Q. So I think I understand now, you know, the structure of who reports to who. I'd like to understand it better, the decision-making process at the ADOA. So with respect to the plan's exclusion, a change to a plan exclusion, a removal of a plan exclusion, which is what is at issue in this case, how would you first learn -- how would it come to the ADOA's attention a proposal about removing a plan exclusion?

A. I'm trying to -- could you rephrase your question? I think -- this is not something that happens often.

Q. Sure. Well, let me ask you about that. How often does -- is a proposal to remove a plan exclusion,

how often does that occur?

A. Not very frequently.

Q. Twice a year?

A. No, not even that often.

Q. Once every two years?

A. I'd say that's probably more -- more likely. And, typically, it's done in conjunction with change in law that we have to, you know, cover something in particular.

Q. Was the removal of the plan's exclusion of 3-D mammography the last plan exclusion you dealt with?

A. No, it was the -- the clinical cancer trial. And that was something that we had to cover. 3-D mammography was more of a change in medical coverage guidelines.

Q. So what do you mean it -- what do you mean by it was a "change in medical coverage guidelines"?

A. The vendors themselves determine what is considered a medically necessary service. As I mentioned, Aetna was the first organization to make the determination that 3-D mammography was an appropriate service and not experimental. They had seen enough evidence to determine that that is something that should be covered. And they were covering it on their -- on their medical guidelines. And slowly, but surely, the

record?

MR. WALL: Sorry, could you take us off the record while we fix this? And this actually might be a good time to take another break.

THE VIDEOGRAPHER: Off the record at 11:20 a.m.

(Recessed from 11:20 a.m. until 11:31 a.m.)

THE VIDEOGRAPHER: Back on the record at 11:31 a.m. Please proceed when ready.

BY MR. WALL:

Q. So, Mr. Bender, before we went on break, we were discussing the most recent changes to plan exclusions that you've encountered.

Do you recall that?

A. Yes.

Q. And so I think you said the most recent one was the clinical cancer trials.

A. Yes.

Q. And when was that -- when was that change to the plan? Well, let me ask, was the plan exclusion for that removed?

A. It was, yes.

Q. And when was that?

A. It was within the last six months.

Q. And then prior to that you'd spoke about 3-D mammography treatment?

A. Right.
Q. And when was that exclusion removed?
A. That was probably two years ago. Maybe 2019.
Q. And then before that, was there anything else -- was the transgender benefits exclusion the last modification before that?
A. I believe so, yes.
Q. And that was in 2017?
A. Yes.
Q. Or, rather, I should say --
A. Move forward to 2017, yes.
Q. So just to be clear, the plan was changed in 2017, the transgender benefits covered or excluded were changed in 20 -- for the 2017 plan year?
A. Correct.
Q. So let's take the 3-D mammography as an example, for instance. So there, Aetna came forward and said that they're going to start covering 3-D mammography. Correct?
A. Right.
Q. And then Blue Cross Blue Shields, UHC, and Cigna about a year later decided that they were going to start covering that service?
A. Right.
Q. So this was presented to the ADOA how? How did

who is not, and what is the basis for that.

Q. Did you ask Ms. Medina to do a cost analysis of covering the treatment?

A. I don't recall. I don't believe so.

Q. Would you have likely asked her to do a cost analysis?

A. Very likely. Either her or our actuary. But my recollection was the cost is fairly similar, so it wouldn't have been an extreme cost burden to the plan.

Q. Fairly similar to what?

A. Excuse me, similar to a standard mammogram. So the standard mammogram that was replaced by a 3-D mammography. And the standard is still being used out there very broadly, even though 3-D's available.

Q. And it was important that the cost of the 3-D mammography was similar to a service the plan was already covering?

A. Any time you're considering additional costs, it's important to understand what that is. My recollection was that the cost for a 3-D mammography was very similar to the cost of a standard mammogram.

Q. And the fact that it was similar meant that it would be less impactful?

A. Correct.

Q. Now, Mr. Bender, you said earlier you expect

than that, we typically query our health plans to determine, you know, is this a standard service. And that's all part of that medical director meeting.

Q. Okay. So the ADOA doesn't affirmatively consider, you know, guideline or standards of care for treatment; it relies on its network providers?

A. Correct.

Q. So once Ms. Medina had collected or did this research for the team, she -- what does she then do with it?

A. We would have a discussion -- and this is just my assumption in how we did this; I don't recall specifically -- we would have a discussion as to, you know, this is now an appropriate service, according to our -- according to our vendors. It's not necessarily a high cost driver. We present it to our director and the decision would be made whether to include or exclude.

Something like that, where all four programs are aligned that this is now a standard course of treatment, and it's zero -- you know, limited cost to the plan. That's, I think, a fairly easy decision, and we don't necessarily need to run to the governor's office or to the director to make those decisions.

Q. So where the -- all four network providers are aligned, you think it's an easy decision on whether to

extend coverage?

A. Correct. That's if -- that's if -- and I'll caveat that with if the cost is reasonable.

Q. So when you say this is a discussion, would you and Ms. Medina have a discussion first?

A. Yes, just to review her findings.

Q. And let me be more specific. On the 3-D mammography treatment, did you and Ms. Medina have a discussion first about the findings of her research?

A. I -- I don't recall -- I presume we did. I don't recall it specifically, but that's typically how things happen. She researches and updates me on what she finds.

Q. And so once you and Ms. -- once you and Ms. Medina have that discussion, do you all form a recommendation that you take to the -- to Mr. Shannon or did you?

A. That's typically how it works, yes. I don't recall specifically in that case.

Q. And so when you say "typically," you mean when you're assessing whether to remove a plan exclusion, you and your team come to a recommendation, and then you take that to the benefit services director?

A. And not necessarily just removing a plan exclusion, which is fairly rare. But just any -- any

it as such and it is their recommendation that we -- we include it, so we did.

Q. And the 3-D mammography treatment, that wasn't required by law, was it?

A. Not that I'm aware of, no. It is a preventative service, and we're required to offer mammograms, but I don't believe that particular type of mammogram is required by law.

Q. So on the 3-D mammography, you don't recall the governor's office being involved, but hypothetically say they were involved, once the governor's office makes the decision, do they then advance that to the JLBC for their favorable or disfavorable vote?

A. Something on a one-off like that, typically not. The JLBC is more concerned about, since they are a budget agency, they're more concerned about things that are going to have a material impact to the budget. And the treatment of one mammogram versus another would not have a material impact on the budget.

Q. What impact did that extension of that treatment have on the budget?

A. I don't recall. But I know that the pricing was close between 3-D and the standard.

Q. Was the additional cost of 3-D mammography below a million per year to the plan?

A. Correct.

Q. And so you cannot recall whether you made a recommendation that you would, in the ordinary course make, about transgender benefits?

A. In the ordinary course of business, it would have been a bottom-up approach, and this clearly was not. She brought this to us. So there was obviously some concern by someone somewhere about this program and these specific benefits.

Q. And so -- so -- so because this is -- this was not a bottom-up approach, you can't remember whether you made a recommendation to Ms. Isaacson of whether the plan should cover transgender benefits?

A. Correct.

Q. Now, are those two things connected? The fact that it was not a bottom-up approach and your memory of whether you made a recommendation?

MR. CURTIS: Objection; form of the question.

You can answer.

BY MR. WALL:

Q. You can answer, Mr. Bender.

A. So can you reask that?

Q. Sure. Are those two things connected, the fact that it was not a bottom-up approach, and your memory of whether you made a recommendation?

A. Are they connected? I don't really know how to respond to that question. I --

Q. Well, I do want to be clear, Mr. Bender, is it that you do not remember whether you made a recommendation or you did not make a recommendation to Ms. Isaacson?

A. I do not remember if I made a recommendation. I don't believe I did. It was clear that this was a sensitive topic.

Q. Why was it clear that this was a sensitive topic?

A. Just in the amount of work that was put into it, and we were -- my team was not really included in any discussions outside of our office. We were not included in any discussions with the governor's office. Which made me think that this was very sensitive.

Q. And your team not being included in any of those discussions was out of the ordinary. Correct?

A. As we discussed, yes, for a benefit change or a significant benefit issue that this is, it seemed unusual.

Q. Why was the plan's exclusion of transgender benefits a significant benefit issue?

A. It's -- well, I -- I know that -- I believe it was viewed -- it may have been viewed more along

political lines, if you will, different ideologies. And, obviously, in a political environment, that's -- many people consider those things.

Q. Was the plan's exclusion of transgender benefits viewed along political lines?

A. That was my sense, but I don't know for sure.

Q. What was that sense based on?

A. Well, my sense is based on where we were a fairly conservative state with conservative leadership, in the legislature and governor, and transgender benefits are not necessarily something that's a super important factor to many conservatives.

Q. And, Mr. Bender, earlier you mentioned that there were obviously some concerns about this topic. Correct?

A. Yes, just in my discussion and interaction with Marie Isaacson, it was clearly something that was being seriously debated.

Q. Did you hear from anyone else about these concerns?

A. I -- I sensed that our team was well aware that this was not necessarily an easy decision.

Q. And it wasn't an easy decision because of the political considerations around it?

A. Correct. That was my sense.

are referring to gender reassignment surgery, as well as hormone therapy and counseling in connection therewith. Correct?

A. Correct.

Q. So the network -- so to back up, the ADOA asked the network providers to provide you with a cost-impact analysis; is that right, Mr. Bender?

A. Yes.

Q. And that cost-impact analysis showed that the marketplace and industry were going to cover tran -- gender reassignment surgery, as well as counseling and hormone therapy in connection therewith?

A. That's correct. And their estimates were varied. Some gave us an estimate of per employee per month cost, additional to our -- our current plans, others gave a percentage of cost increase is my recollection.

Q. So with this information available, the ADOA decided to maintain the exclusion on gender reassignment surgery. Correct?

A. I don't know that that was the ADOA's decision, but that was the decision that was communicated to us to implement.

Q. If not the ADOA's decision, whose decision would it have been?

A. Someone up the food chain from ADOA. I'm not certain who made that decision.

Q. When we're referring to someone up the food chain, to whom are you referring, Mr. Bender?

A. Could be anyone in the governor's office.

Q. Is there anyone else outside of the governor's office who could have made that decision?

A. No. ADOA bears responsibility for managing the program, and we report to the governor's office, so no.

Q. So just to back up a bit. So once the decision was made, Ms. Isaacson informed you of that decision. Correct?

A. She asked us to -- I'm sorry --

Q. I'm sorry, let me clarify. Once the decision was made on whether to continue the plan's exclusion of transgender benefits, Ms. Isaacson communicated to you that the plan would continue its exclusion of gender reassignment surgery, but not counseling or --

THE REPORTER: I'm sorry, Mr. Wall, can you repeat that, please?

MR. WALL: Sure.

Q. So once a decision was made on whether the plan would continue its exclusion of transgender benefits, Ms. Isaacson communicated that decision to you and your team. Correct?

or deleted the exclusions and absorbed the costs associated with that, for sure.

BY MR. WALL:

Q. So if the ADOA had removed the exclusion listed in paragraph 16, would there have been any other question about the ADOA's compliance with Section 1557?

A. From a compliance standpoint, no. If we voluntarily opted in, there's no compliance issue.

Q. So why didn't the ADOA remove the exclusion for all transgender benefits under the plan?

A. Can you rephrase?

Q. Why didn't the ADOA remove the plan's exclusion of transgender benefits, inclusive of gender reassignment surgery?

A. I believe there are several reasons, one being cost and the other being we didn't feel it was required for us to include -- or to eliminate the exclusion for.

Q. So the ADOA did not remove the plan's exclusion of gender reassignment surgery because of cost, and it didn't feel it was required to remove that exclusion?

A. Those are both reasons. I think, primarily, is we weren't required to, and if we're not required to, then we weren't interested in taking on additional costs in a plan that's already under water.

Q. The ADOA's primary reason for not removing the

and if you don't understand, you can let me know. Okay?
A. Okay.
Q. So except when a medically necessary hysterectomy is sought in connection for the treatment of gender dysphoria.
A. It's excluded if it's in connection with a transgender surgery.
Q. So but for being in connection with a transgender surgery, a medically necessary hysterectomy would be covered under the plan?
MR. CURTIS: Objection; form of the question.
THE WITNESS: Correct.
BY MR. WALL:
Q. You can answer.
Under --
A. That's correct.
Q. Are you aware of any procedures that are medically necessary that are covered -- of any procedures that are covered -- uh -- let me restate this.
Are you aware of any other instances under the plan where a medically necessary procedure is covered in some instances, but not others?
A. Off the top of my head, I'm not aware.
Q. Mr. Bender, would you turn for me to Exhibit -- Tab 1 in this binder, which is premarked as Bender

different estimates from the four different health plans, and just anecdotally from our actuary as to what he felt our exposure was, based on what he was seeing in the marketplace.

Q. So just to sum up, the ADOA had numerous different estimates of the cost from the various -- from the four network providers?

A. Right.

Q. And also, the in-house actuary, Mr. Meisner, had a different calculation of the cost?

A. Correct.

Q. So now I'm looking at the bottom-most bullet in this box on cost, that says, "Based on input from the vendors and ADOA's research, ADOA feels it can" safe -- "it can be safely say if transgender coverage is implemented, the cost would be under a dollar per employee per month. Approximately 50 cents per employee per month seems to be an agreed-upon amount based on ADOA's research."

Did I read that correctly, Mr. Bender?

A. Yes.

Q. So appreciating that you saw different estimates and a different estimate from Mr. Meisner later, would you consider this estimate here to be high?

A. A dollar per employee per month, is

approximately $60,000 [sic] a month, so $120,000 a year. In the overall scheme of the plan, I -- I would not say that that is a high cost.

Q. And if a dollar per month is not a high cost, then you would agree 50 cents per employee per month is also not a high cost?

A. That's right.

Q. When the ADOA is assessing the cost of a particular treatment, does it matter whether it's being calculated on a per employee per month basis or a per member per month basis?

A. I don't know that it necessarily matters. Both of them will get you to sort of an annual cost.

Q. And what about calculating as a percentage of total plan cost?

A. Same. We know what our annual plan costs, and if the recommendations are in various methodologies, we can account for that and convert everything to an annual total impact.

Q. So if you turn now, Mr. Bender, to the fourth physical page of this document, Bates number AZSTATE.009272.

A. Got it.

Q. Do you see that bottom box that says A-H-C-C-C-S?