Li Nowlin-Sohl*
(admitted only in Washington)
Leslie Cooper*
Taylor Brown*
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad St.
New York, NY 10004
Tel: (212) 549-2584
Lnowlin-sohl@aclu.org
lcooper@aclu.org
tbrown@aclu.org

Brad S. Karp*
Alexia D. Korberg*
Jackson Yates*
Dana L. Kennedy*
PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP
1285 Avenue of the Americas
New York, NY 10019
Tel: (212) 373-3000
bkarp@paulweiss.com
akorberg@paulweiss.com
jyates@paulweiss.com
dkennedy@paulweiss.com

Richard Eppink (ISB no. 7503)
Casey Parsons (ISB no. 11323)
David A. DeRoin (ISB no. 10404)
WREST COLLECTIVE
812 W. Franklin St.
Boise, ID 83702
Tel: (208) 742-6789
ritchie@wrest.coop
casey@wrest.coop
david@wrest.coop

*Admitted *pro hac vice*

Attorneys for Plaintiffs

Additional counsel for Plaintiffs identified on the following page

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et. al.,

Defendants.

Case No. 1:23-cv-00269-BLW

PLAINTIFFS' REPLY MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR A PRELIMINARY INJUNCTION [DKT. NO. 32]

Eric Alan Stone*
Ariella C. Barel*
Kyle Bersani*
GROOMBRIDGE, WU, BAUGHMAN AND STONE LLP
565 5th Avenue, Suite 2900
New York, NY 10017
Tel: (332) 269-0030
eric.stone@groombridgewu.com
ariella.barel@groombridgewu.com
kyle.bersani@groombridgewu.com

Philip S. May*
GROOMBRIDGE, WU, BAUGHMAN AND STONE LLP
801 17th St. NW, Suite 1050
Washington, DC 20006
Tel: (202) 505-5830
philip.may@groombridgewu.com

*Admitted *pro hac vice*

Jordan Orosz*
PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP
2001 K Street, NW
Washington, DC 20006-1047
Tel: (202) 223-7300
jorosz@paulweiss.com

Dina Flores-Brewer (ISB no. 6141)
ACLU OF IDAHO FOUNDATION
P.O. Box 1897
Boise, ID 83701
Tel: (208) 344-9750
dfloresbrewer@acluidaho.org

Attorneys for Plaintiffs

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INTRODUCTION

The State[1] has not come close to meeting its heavy burden under heightened scrutiny to justify overriding parents' medical decisions made in consultation with their children's doctors and following treatment protocols endorsed by ***every*** major U.S. medical association. The State misreads settled equal protection and due process precedent concerning the level of scrutiny. And its asserted justifications for H.B. 71 (the "Ban") are unsupported by the evidence and fail to explain why the Ban prohibits all, and ***only***, gender-affirming medical care, when it is supported by the same type of evidence and presents the same type of risks as many other medical treatments. The Ban lacks a close means-end fit to any asserted justification. Even the State's own expert agrees that the care prohibited by the Ban could sometimes be appropriate and beneficial. Cantor Dep. at 130:8–25, 146:1–147:2. In its baseless protest that it just wants to protect kids, the State overlooks the severe harms experienced by adolescents with gender dysphoria who are unable to access the medical treatments it bans.

FACTUAL BACKGROUND

A. Gender-Affirming Medical Care Is Effective

The record evidence shows that gender-affirming medical care can alleviate gender dysphoria in adolescents and the State's proffered evidence fails to refute that.

There are at least a dozen empirical, peer-reviewed studies on the use of puberty blockers and gender affirming hormones to treat adolescents with gender dysphoria and this research shows that these treatments provide significant mental health benefits. Rebuttal Declaration of Jack Turban ("Turban Reb.") ¶ 11. The State's response is to quibble with the methodology of some

[1] Plaintiffs refer to Defendants Attorney General Labrador and the Individual Members of the Idaho Code Commission collectively as "the State".

of these studies.[2] While all studies in medicine have strengths and limitations, the body of research as a whole shows clear mental health benefits of this care.[3] Turban Reb. ¶ 12.[4] There is ***no evidence*** that psychotherapy alone treats gender dysphoria. The studies suggest the opposite: that minors treated with both medical and psychological care benefitted from the medical care. Turban Reb. ¶¶ 13–15. To be sure, psychological support can improve psychosocial functioning (which both WPATH and the Endocrine Society endorse and encourage). But even the study the State cites (Costa 2015) actually concludes those patients who went on to puberty blockers improved to be comparable with their cisgender peers while those who received only psychological support did not. *Id*. ¶¶ 14–15; Rebuttal Declaration of Christine Brady ("Brady Reb.") ¶ 14.

This research showing the benefits of the banned care is consistent with decades of clinical experience, including the experience of Plaintiffs' experts. *E.g.*, Dkt. 32-6 ¶ 38; Dkt. 32-7 ¶¶ 30, 31.[5] And each Minor Plaintiff has provided sworn, unrebutted testimony about how gender-

[2] The State's expert, Dr. Weiss, complains that the research is unreliable because it is "low quality" under the GRADE assessment of the quality of evidence. Dkt. 56-3 ¶¶ 59–61. But that label is generally used for studies that lack a randomized placebo control; it would be unethical to conduct a study depriving treatment to minors with gender dysphoria. Rebuttal Declaration of Kara Connelly ("Connelly Reb.") ¶ 16; *see also* Dkt. 32-7 ¶¶ 55–56; Turban Reb. ¶ 18. For this reason, many medical treatments are recommended based on "low quality" evidence. Connelly Reb. ¶ 15.

[3] The State insists that Dr. Connelly's own study, which did not show impact on patients' depression and anxiety in the first few months of treatment contradicts her opinion that gender affirming care has mental health benefits. But those patients *did* improve over time, as their bodies began to match their gender. Connelly Reb. ¶ 17.

[4] Notably, the State's experts cannot agree even with each other about whether hormone therapy benefits adult patients. Dr. Cantor believes the research demonstrates the effectiveness of hormone therapy for adults with gender dysphoria. Cantor Dep. at 144:18–24; *see also id*. at 135:11–138:12. Dr. Weiss, in contrast, believes hormone therapy does not help and, instead, harms adults as well. Weiss Dep. 190:23–192:18.

[5] The State dismisses the clinical experience of Drs. Connelly and Brady, who together have seen more than 1700 minors with gender dysphoria and the impact of gender-affirming medical care on their patients' well-being. Dkt. 32-7 ¶ 10; Dkt. 32-6 ¶12. Such valuable experience is often relied on by courts. *See, e.g.*, *Primiano* v. *Cook*, 598 F.3d 558, 565–67 (9th Cir. 2010).

affirming medical care "saved [her] life," Dkt. 32-2 ¶ 20; Dkt. 32-4 ¶ 21, and their parents attested to the benefits they observed in their children from the care. Dkt. 32-3 ¶¶ 16, 19; Dkt. 32-5 ¶¶ 12, 15–16, 19. Every major medical association in the U.S. therefore supports gender-affirming medical care for adolescents with gender dysphoria. Dkt. 32-7 ¶ 19; *see also* Amicus Br. Dkt. No. 33. Without anything to counter this uniform support, the State points to European systematic reviews discussing certain limitations in the research and, trumpeting systematic reviews as the "highest form of medical evidence." Dkt. 66 at 8–9. But a systematic review just means the authors pre-defined the search terms they used when conducting literature reviews in databases, and it is not guaranteed to identify every study. Turban Reb. ¶ 24. The reliability of the review authors' description and analysis of the literature can also vary. *Id.*; *see also* Cantor Dep. at 198:9–199:17 (with systematic reviews, there can be "discrepant judgments between intelligent and well-informed review authors.").

More fundamentally, identifying limitations in evidence does not mean treatment should be prohibited. Clinical practice guidelines, such as the WPATH SOC and the Endocrine Society Guideline, advise doctors on how to provide care based on the available evidence.[6] Dkt. 32-7 ¶ 16. And unlike Idaho, none of the European countries the State points to has ***banned*** care; rather, their health organizations have made changes to how care is delivered, e.g. some providing that care should occur in clinical research settings. Turban Reb. ¶ 23.[7]

Finally, lack of FDA approval for a specific indication of a medication says nothing about

[6] WPATH and the Endocrine Society engaged in reviews of the evidence when preparing their clinical practice guidelines. Dkt. 32-7 ¶ 15.

[7] Courts have recognized this. *See*, *e.g.*, *Brandt* v. *Rutledge*, 47 F.4th 661, 671 (8th Cir. 2022); *K.C.* v. *Individual Members of Med. Lic. Bd. of Ind.*, --- F. Supp. 3d ---, 2023 WL 4054086, at *11–12 (S.D. Ind. June 16, 2023) ("[N]o European country that has conducted a systematic review responded with a ban on the use of puberty blockers and cross-sex hormone therapy.").

the FDA's views of the treatment. *See* Dkt. 66 at 9 (citing *L.W.* v. *Skrmetti*, 73 F.4th 408, 418 (6th Cir. 2023)). Off-label use is pervasive in medicine and does not imply anything about evidence of efficacy or safety. Connelly Reb. ¶ 19. That is because the FDA approves a drug for a particular indication only if a pharmaceutical company seeks that approval. Where a drug has already been approved, there is a markedly lower incentive to expend the resources to seek further approvals. Instead, "[o]nce the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient." *Id.* (quoting FDA publication).

B. The Risks of Gender-Affirming Medical Care for Adolescents Are Similar to the Kinds of Risks Families Weigh When Considering Other Medical Treatments

No one contends that gender affirming medical care is risk-free. As the State concedes, risk is inherent in medical care and a medical treatment's risks must be viewed in the context of its benefits. Dkt. 66 at 7–8. As with other medical treatments, the potential risks and benefits are explained to parents and patients as part of the informed consent process. *See* Dkt. 32-7 ¶ 29.

Moreover, the drugs used for puberty blockade and gender-affirming hormone therapy are well known and have been used for decades with youth. Dkt. 32-7 ¶¶ 56, 58. Puberty blockers when used for central precocious puberty do not result in any observed or measured negative impact on cognitive development. Connelly Reb. ¶ 2. Although the State speculates there may be some unknown impact on cognitive development when puberty is delayed,[8] the evidence shows no such risk. *Id*. ¶ 3. As for the asserted concern about osteoporosis, while pubertal suppression can delay the peak accrual of bone mineralization that occurs during puberty, bone mineral density

[8] Adolescents with gender dysphoria treated with blockers start puberty at ages when some of their peers are still starting puberty. *Id.* ¶ 3.

increases again when blockers are stopped and puberty resumes endogenously, or with gender-affirming hormone therapy. *Id.* ¶ 5.

Potential risks of testosterone or estrogen therapy, such as cardiovascular risks and hormone dependent cancers are identical when given to transgender or cisgender adolescents. *Id.* ¶ 7. And these risks are minimal (for cisgender or transgender patients) when treatment is monitored by a doctor. *Id.* Additionally, hormone therapy puts transgender girls' risk profile more in line with that of cisgender girls and puts transgender boys' risk profile more in line with that of cisgender boys. *Id.* Thus, for example, transgender girls will have higher risk of breast cancer than cisgender boys, although less than cisgender girls. *Id.* ¶ 8.

While hormone therapy (but not puberty blockers on their own) can affect fertility, families are counseled about these risks before making treatment decisions, just as cisgender people are counseled about fertility implications of other medical decisions. *See* Dkt. 32-7 ¶¶ 46, 50; Connelly Reb. ¶ 9. Moreover, and contrary to the State's assertion, sterility is ***not*** a "near certainty"[9] and treatment can be tailored to minimize the risk to fertility where that is important to the family; for example, allowing some progression of puberty for transgender girls prior to starting puberty blockers so that they are able to preserve sperm, or temporarily stopping testosterone in transgender males to preserve eggs or try to get pregnant. Connelly Reb. ¶ 9.[10]

C. Risk of Detransition and Regret is Minimal

Studies of "detransitioners" and those who regret gender-affirming medical care

[9] There are many reports of transgender men who, after taking and stopping testosterone, are able to conceive children, with or without fertility treatment. For this reason, Dr. Connelly advises transgender male adolescent patients that testosterone is not an effective contraception and they could become pregnant. Connelly Reb. ¶ 9.

[10] The State also says individuals who receive treatment may never be able to orgasm. Dkt. 66 at 5. But the evidence does not support that. *See* Connelly Reb. ¶¶ 10–11.

demonstrate that their numbers are exceedingly low. Turban Reb. ¶ 37. The State asserts that the rate of regret is as high as 30% because it conflates pausing or stopping medical treatment with a change in gender identity and treatment regret. Turban Reb. ¶ 40. There are many reasons why individuals pause or stop treatment, such as being satisfied with their results or a change in insurance coverage. *Id.* ¶¶ 38, 41; Connelly Reb. ¶ 12. Low rates of regret are consistent with the clinical experience of Drs. Connelly and Brady, who have each seen only two patients out of hundreds come to identify with their birth-assigned sex after treatment; none regretted the care. Brady Reb. ¶ 12; Connelly Reb. ¶ 12. Dr. Weiss could not recall even one of his 100 transgender patients ever expressing regret for their hormone therapy. Weiss Dep. 313:3–313:6.[11]

The State speculates that "social contagion"—peer influence and social media—could be responsible for the increase in birth-assigned females presenting for care. But this increase is not surprising given the increased visibility of transgender people, particularly transgender men, and better information relating to medical care for transgender people, and improvements in insurance coverage. Turban Reb. ¶¶ 35. If there are any youth who seek care at gender clinics because of social influence, under the WPATH and Endocrine Society guidelines, they would be given a comprehensive psychosocial evaluation prior to even considering any medical interventions, and would not be offered such treatments absent a diagnosis of gender dysphoria and a determination

[11] The State's experts also point to the so-called "desistance" research on prepubertal children to suggest that most of those who receive gender-affirming medical care would naturally come to identify with their birth-assigned sex if not treated. *See* Dkt. 56-3 ¶ 35. But the studies they rely on assessed gender non-conforming children who, under the prior diagnosis of Gender Identity Disorder, did not need to identify as a sex that differed from their assigned sex to meet criteria. So it was not surprising that many did not identify as transgender at follow up. Additionally, those studies evaluated prepubertal children and provide no evidence that ***adolescents***—those who would be eligible for gender affirming medical care—are likely to desist. After puberty, it is very unlikely for a transgender person to desist. Turban Reb. ¶¶ 25–28; Brady Reb. ¶ 11; Dkt. 56-4 ¶ 245 (desistance less likely to occur after age 12).

that treatment is appropriate. Brady Reb. ¶ 7; *see* Dkt. 32–7 ¶ 27.

D. The State's "Expert" Witness Opinions Should Not be Given Weight.

Dr. Weiss is an adult endocrinologist who, by his own admission, is not an expert in mental health and has no training or clinical experience in the treatment of gender dysphoria in minors. Weiss Dep. 39:7-10; 42:12–44:10; 51:8–52:6; 57:18–19; 62:13–18; 65:7–18. He offers his own personal views about gender dysphoria that are at odds with those of actual mental health authorities—including the DSM and the American Psychological Association—and even the State's position in this case. Dkt. 66 at 3; Brady Reb. ¶ 5. For example, he opines that gender dysphoria is not a real condition and is exclusively a symptom of other mental health issues which, if resolved, would resolve the gender dysphoria. Weiss Dep. 71:4–72:19; 213:6–215:8. The foundation of his opinions was his "common sense" and "rationality," from which he concocted a theory that young girls who are sexually abused seek out transition so as not to "encourage any more sexual abuse." Dkt. 56-3 ¶ 19; Weiss Dep. 92:15–93:24; 148:11–151:17. He described this as a "straightforward… obvious…explanation" for the existence of trans men. (He had no explanation for why trans ***women***, who were assigned male at birth, would choose to make themselves ***more*** vulnerable to sexual assault, nor for all the cisgender survivors of sexual abuse.) Weiss Dep. 148:11–151:17.

Dr. Weiss also repeatedly misrepresents his sources. As just one example, he cites a paper for the proposition that "desistance is frequent" when the paper specifically states that it did ***not*** assess prevalence. Dkt. 56-3 ¶ 35; Turban Reb. ¶ 39. He also relies on overtly biased materials, basing key claims on various Internet forums (e.g. "parents for inconvenient truths about trans"), and suggests the number of accounts "following" a Reddit forum on the subject of detransition was somehow evidence of the number of people who *have* detransitioned. Weiss Dep. 196:4–196:18; 219:3–19; 322:4–25. Ultimately, he was forced to admit that one of his five primary

opinions—that suicidality is not improved by gender affirming medical care—is not supported by his cited literature, which calls into doubt the reliability of his other opinions. *Id.* at 240:14-245:13.

Most astonishingly, while Dr. Weiss opines that gender-affirming hormone therapy is ineffective and harmful for individuals of any age—a view he says he has held for at least a decade—he continued to provide hormone therapy to adult transgender patients until last year without ever informing them that he believed the treatment he was providing them was ineffective and causing them harm. Weiss Dep. 160:16–161:23; 186:5–188:19.

Dr. Cantor is a psychologist and sexologist who has treated just between 14 and 16 adolescents with gender dysphoria. Cantor Dep. 45:16–54:5. His opinions are proffered in substantially the same form in several cases challenging similar bans across the country, and his testimony has been assigned "less weight as to the medical conclusions that can reasonably be drawn from the evidence for the treatment of gender dysphoria in minors" due in part to his minimal experience in treating adolescents with gender dysphoria and his work's focus on a completely different subject—pedophilia and other "atypical sexualities." *See*, *e.g.*, *Koe* v. *Noggle*, --- F. Supp. 3d ---, 2023 WL 5339281, at *21 n.8 (N.D. Ga. Aug. 20, 2023); *Eknes-Tucker* v. *Marshall*, 603 F. Supp. 3d 1131, 1142–43 (M.D. Ala. 2022), *vacated*, -- F.4th --, 2023 WL 5344981 (11th Cir. Aug. 21, 2023).

ARGUMENT

I. Plaintiffs Have a Likelihood of Success on the Merits

A. Plaintiffs Have a Likelihood of Success on their Equal Protection Claims

1. Heightened Scrutiny Applies

(a) The Ban classifies based on transgender status

The State does not dispute that the law of this Circuit is that classifications based on transgender status are subject to heightened scrutiny. Dkt. 66 at 16. It instead argues that Ninth

Circuit law does not establish that the regulation of treatment for gender dysphoria classifies based on transgender status. But the Ban is not a regulation of treatment for gender dysphoria; it does not even mention gender dysphoria. The law is targeted at treatments that are inconsistent with a person's "biological sex" without regard for the reason. This is a classification based on transgender status. *See M.H.* v. *Jeppesen*, No. 1:22-CV-00409-REP, 2023 WL 4080542, at *12 (D. Idaho June 20, 2023) (excluding gender-affirming medical procedure cannot be understood without reference to sex, gender, or transgender status). The State offers no basis for a rule that says transgender-based classifications trigger heightened scrutiny *unless* the classification involves medical treatments for gender dysphoria.[12] Contrary to the State's arguments, it is irrelevant to the question of applicable level of scrutiny that gender dysphoria is a psychological, rather than physical condition. The nature of a medical condition is irrelevant to whether the law classifies based on transgender status.

(b) The Ban classifies based on sex

"If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex." *Dekker* v. *Weida*, No. 4:22-CV-325-RH-MAF, 2023 WL 4102243, at *11 (N.D. Fla. June 21, 2023) (citing *Bostock* v. *Clayton Country*, 140 S. Ct. 1731, 1737 (2020)). To know whether the treatments at issue in this case are permissible for a patient under H.B. 71, one must know the patient's sex; the relevant provisions of the Ban classify along explicitly sex and gender-based lines, proscribing treatments to "alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." H.B. 71 § 1(3). *See Brandt* v. *Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022) ("the

[12] Even if the Ban were a regulation of treatment of gender dysphoria, this Court has recognized that regulation of treatment of gender dysphoria can be both proxy discrimination and facial discrimination against transgender people. *M.H.*, 2023 WL 4080542 at *12–13.

minor's [assigned] sex at birth determines whether or not the minor can receive certain types of medical care under the law.").

The State contends that the Ban does not discriminate based on sex because "it applies to both males and females the same." Dkt. 66 at 12. But the Supreme Court has already made clear that there is no exception to heightened scrutiny for classifications that apply "equally" to both sexes. *See J.E.B.* v. *Alabama ex rel. T.B.*, 511 U.S. 127, 142 n.13 (1994). Equal application of discriminatory treatment based on sex—injuring both transgender men and transgender women—does not immunize the law from heightened scrutiny.

Citing *Dobbs* v. *Jackson Women's Health Organization*, 142 S. Ct. 2228, 2245 (2022), the State argues that a statute "is not a sex-based classification[]" "solely because it mentions sex". Dkt. 66 at 13–14. But H.B. 71 does not merely "mention" sex—the question of whether medical treatment is permissible or criminal under H.B. 71 turns ***entirely*** on sex.

Relying on *Dobbs* and *Geduldig* v. *Aiello*, 417 U.S. 484 (1974), the State argues that "a statute regulating medical procedures does not trigger heightened scrutiny when it acknowledges sex-based distinctions." Dkt. 66 at 13. But the Supreme Court has merely observed that ***if*** a law is a facially neutral regulation of a medical procedure, that law does not always receive heightened scrutiny solely because it disparately impacts members of one sex. *See Geduldig*, 417 U.S. at 494–96. Here, as discussed, the law at issue is ***not*** facially neutral. And equal protection jurisprudence has long drawn a clear distinction between sex-neutral classifications, which trigger heightened scrutiny only when enacted, at least in part, for a discriminatory purpose, and facial sex classifications—such as the Ban—which *always* trigger heightened scrutiny. *See Pers. Adm'r of Mass.* v. *Feeney*, 442 U.S. 256, 273–74 (1979). Nor is this a law that regulates procedures only one sex can undergo. Dkt. 66 at 13. The procedures at issue are currently undergone by all sexes,

and H.B. 71 bans each procedure only for certain patients and only on the basis of their sex.

The Ban also discriminates based on sex stereotypes—specifically, it bans care that would cause a minor to not conform to sex expectations while "allow[ing] the same treatment for cisgender minors as long as the desired results conform with the stereotype of their biological sex." *Brandt* v. *Rutledge*, 551 F. Supp. 3d 882, 891 (E.D. Ark. 2021), *aff'd*, 47 F.4th 661 (8th Cir. 2022); *Bostock*, 140 S. Ct. at 1741–42. The State responds that biological differences between the sexes are not sex stereotypes, citing *Tuan Anh Nguyen* v. *INS*, 533 U.S. 53 (2001). Dkt. 66 at 14. But in *Nguyen*, the court still applied heightened scrutiny even though the differential treatment of mothers and fathers was based on biological differences. *Id.* at 60–61. The court held that the government satisfied its burden, but the biological differences did not create a carve-out from the rule that sex classifications are subject to heightened scrutiny.

2. The Law Is Unconstitutional Under Any Level of Scrutiny

The State has not met its demanding burden of showing an exceedingly persuasive justification and a close means-ends fit for the law. Dkt. 32-1 at 16. The State asserts it has a compelling interest in "protecting children and adolescents" from medical treatments "for which there is uncertainty regarding benefits, recent surges in use, and irreversible effects." Dkt. 66 at 19 (quoting *Eknes-Tucker*, 2023 WL 5344981 at *13). The State's arguments come down to that the ban is justified by (i) a lack of evidence of efficacy of treatment; (ii) treatment risks; and (iii) the possibility of detransition and regret. None withstand heightened scrutiny because the allegations are either unsupported by the evidence or do not explain why only gender-affirming medical care (and all such care) is singled out for prohibition.

As discussed above, *see* Sections A–B, *supra*, the State's assertion that there is no reliable evidence of efficacy is simply not supported by the evidence. Because research and decades of clinical experience have shown the benefits of gender-affirming medical care to adolescents with

gender dysphoria, this care is supported by every major medical association in the United States. And contrary to the State's suggestion, this care is provided in countries across the globe.

The State's assertions regarding potential health risks of treatment fail to acknowledge that the risks are low and well-managed when treatment is monitored by a doctor, and they apply equally to the use of puberty blockers, testosterone, and estrogen for other purposes for which they are permitted. The potential risk to fertility for hormone therapy (but not puberty blockers alone) is different, but risks—including the risk of infertility—are common in medicine. Patients and their parents, in consultation with their doctors, ordinarily are free to weigh the potential risks and benefits and decide on a course of treatment. *See* Dkt. 32-7 ¶¶ 50–51. In addition, treatment can be tailored to preserve fertility when that is important to the family. Dkt. 32-7 ¶ 50; Connelly Reb. ¶ 9. There is not a close means-end fit between the law and protecting minors from medical treatments that have potential risks.

The State's assertions about "social contagion," increases in gender-affirming medical care, and the risk of detransition and regret, do not meet their burden. As detailed above, no evidence supports their narrative and regret rates are very low. The possibility of regret, which exists in all medical care, does not justify singling out this care for prohibition. Connelly Reb. ¶ 14.

The State's assertion that the Ban of *all* gender-affirming medical care for *all* minors, without exception, is necessary to protect children is also belied by their own expert's admissions that he would favor an exception for research (Cantor Dep. at 130:8–25), and that for some adolescents gender affirming healthcare could possibly be beneficial. *Id*. at 146:1–147:2.

Even if the Ban were subject to only rational basis review, it would fail. It does not protect children; it harms some of the most vulnerable of them. *See* Dkt. 32-1 at 17 There is no rational basis to conclude that allowing minors to receive gender-affirming medical care that they, their

parents, and their doctors agree is medically necessary "would threaten legitimate interests of [Idaho] in a way that" allowing other types of medical care "would not." *City of Cleburne* v. *Cleburne Living Ctr.*, 473 U.S. 432, 448 (1985). Other medical care is supported by comparable evidence and has comparable risks, but is not banned. *See* Section B, *supra*; Dkt. 32-1 at 20–21.

B. Parent Plaintiffs Are Likely to Succeed on Their Due Process Claims

The Fourteenth Amendment's right to direct the upbringing of one's children includes "the right of parents to make important medical decisions for their children, and of children to have those decisions made by their parents rather than the state." *Wallis* v. *Spencer*, 202 F.3d 1126, 1141 (9th Cir. 2000) (citing *Parham* v. *J.R.*, 422 U.S. 584, 602 (1979)). Idaho has recognized that "[t]he interests and role of parents in the care, custody and control of their children are both implicit in the concept of ordered liberty and deeply rooted in our nation's history and tradition," I.C. §32-1010(2), and the State itself recently argued it has "an important and compelling interest in protecting a parent's right to make healthcare decisions for their children." Korberg Decl. Ex. C at 6; Korberg Decl. Ex. D at 37:19–38:4; 44:22–45:25. But the State now argues for an exception to this core principle ***because*** HB 71 outlaws gender-affirming medical care for minors. The State cannot in one breath speak to the fundamental rights of parents, but in the next argue that parents have no rights here *because* the State has trampled on those rights.

The State cites exclusively out-of-circuit, non-binding interpretations of Supreme Court case law and criticizes the Parent Plaintiffs for "rais[ing] the level of generality for the right they are asserting." Dkt. 66 at 17–18. But the plaintiffs are not asserting "a right to new medical treatments" as the State argues. *See id.* at 17–19. At issue are parents' rights to make medical decisions for their children to receive treatments that adults are already permitted to access. And that right—as Idaho law recognizes and as the Supreme Court has affirmed (*see* Dkt. 32-1 at 22–24)—is a fundamental one that the State cannot infringe without surviving strict scrutiny. Because,

for the reasons stated above, the State failed to meet its burden under heightened scrutiny, it has not met the more onerous burden of satisfying strict scrutiny. *See id.* at 24; Section I.B., *supra*.

II. The Remaining Factors Support a Preliminary Injunction

The State has not even attempted to address the harms identified by the Plaintiffs should the law take effect. Plaintiffs will indisputably suffer irreparable harm and the balance of the equities and public interest favor an injunction. The State's contention that Plaintiffs would suffer less harm because they can "draw down their medication" is particularly contemptible. Dkt. 66 at 28. It ignores the uncontested declarations from all Plaintiffs regarding (i) the unquestionable benefits the healthcare has had for the minor Plaintiffs; (ii) the harm caused to the Plaintiffs by the fear of having this healthcare discontinued; and (iii) their intent to uproot their families and lives from Idaho to continue this care if the law takes effect. *See* Dkt. 32-1 at 25–26.

The State implausibly contends it is the State that will suffer irreparable harm here, citing *Latta* v. *Otter*, 771 F.3d 496, 500 (9th Cir. 2014), as "noting authority for the proposition 'that a state suffers irreparable injury whenever an enactment of its people or their representatives is enjoined." Dkt. 66 at 27. But in the very next sentence, the court explicitly ***rejected*** that premise. *See Latta*, 771 F.3d at 500 & n.1. Instead, the court relied on longstanding Supreme Court authority "that a deprivation of constitutional rights, 'for even minimal periods of time, unquestionably constitutes irreparable injury.'" *Id.* (citing *Elrod* v. *Burns*, 427 U.S. 347, 373 (1976)); *see also Hecox* v. *Little*, 79 F.4th 1009, 1035–36 (9th Cir. 2023).

III. Bennetts Does Not Dispute the Merits of Plaintiffs' Claims

Bennetts filed a separate opposition from the State and did not join in their brief. Thus, Bennetts' only argument against granting Plaintiffs' Motion is that "the Court lacks subject matter jurisdiction over claims against her, and that Plaintiffs have failed to state a claim against her," incorporating by reference her own motion to dismiss. Dkt. 55 at 1. Plaintiffs have responded to

these arguments in their opposition to Bennetts' motion to dismiss, Dkt. 60, and incorporate those responses here. The preliminary injunction record further supports Plaintiffs' arguments that Plaintiffs live and receive healthcare in Ada County. *See*, *e.g.*, Dkt. 32-2 ¶¶ 1, 2, 12–14, 17, 19, 20, 23; Dkt. 32-4 ¶¶ 1, 2, 13–17, 24, 26.

IV. The Requested Scope of the Injunction Is Appropriate

An injunction limited to just the Plaintiffs is insufficient because they cannot receive complete relief without an injunction allowing third parties to provide the prohibited medical care. *See Bresgal* v. *Brock*, 843 F.2d 1163, 1170–71 (9th Cir. 1987) (finding a nationwide injunction not "overbroad" because limiting enforcement of the law to a particular group would not give the prevailing parties relief); *see also Easyriders Freedom F.I.G.H.T.* v. *Hannigan*, 92 F.3d 1486, 1501–02 (9th Cir. 1996). Because there are no exceptions in the Ban, healthcare practitioners and pharmacists in the State from whom Plaintiffs may pursue care will predictably cease providing these treatments out of fear of incarceration. Statewide relief is necessary to prevent irreparable harm. *See Brandt*, 47 F.4th at 672. And the Ninth Circuit has recognized that statewide relief is an appropriate remedy where there is a challenge to the constitutionality of a state statute. *See* Dkt. 32-1 at 28–29.

CONCLUSION

Plaintiffs respectfully request that the Court grant their motion for a preliminary injunction.

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Respectfully submitted,

/s/ *Alexia D. Korberg*
Alexia D. Korberg

Li Nowlin-Sohl (admitted only in Washington)
Leslie Cooper
Taylor Brown
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad St.
New York, NY 10004
Tel: (212) 549-2584
lnowlin-sohl@aclu.org
lcooper@aclu.org
tbrown@aclu.org

Richard Eppink (ISB no. 7503)
Casey Parsons (ISB no. 11323)
Idaho State Bar no. 7503
WREST COLLECTIVE
812 W. Franklin St.
Boise, ID 83702
Tel: (208) 742-6789
ritchie@wrest.coop

Dina M. Flores-Brewer (ISB no. 6141)
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF IDAHO
P.O. Box 1897
Boise, ID 83701
Tel: (208) 344-9750
dfloresbrewer@acluidaho.org

Philip S. May
GROOMBRIDGE, WU, BAUGHMAN AND STONE LLP
801 17th St NW Suite 1050
Washington, DC 20006
Tel: (202) 505-5830
philip.may@groombridgewu.com

Brad S. Karp
Alexia D. Korberg
Jackson Yates
Dana L. Kennedy
PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP
1285 6th Avenue
New York, NY 10019
Tel: (212) 373-3000
bkarp@paulweiss.com
akorberg@paulweiss.com
jyates@paulweiss.com
dkennedy@paulweiss.com

Jordan Orosz*
PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP
2001 K Street, NW
Washington, DC 20006-1047
Tel: (202) 223-7300
jorosz@paulweiss.com

Eric Alan Stone
Ariella C. Barel
Kyle N. Bersani
GROOMBRIDGE, WU, BAUGHMAN AND STONE LLP
565 Fifth Avenue, Suite 2900
New York, NY 10017
Tel: (332) 269-0030
eric.stone@groombridgewu.com
ariella.barel@groombridgewu.com
kyle.bersani@groombridgewu.com