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IN THE FOURTH JUDICIAL DISTRICT COURT
MISSOULA COUNTY

SCARLET VAN GARDEREN, a minor by and through her guardians Jessica van Garderen and Ewout van Garderen; JESSICA VAN GARDEREN, an individual; EWOUT VAN GARDEREN, an individual; PHOEBE CROSS, a minor by and through his guardians Molly Cross and Paul Cross; MOLLY CROSS, an individual; PAUL CROSS, an individual; JANE DOE, an individual; JOHN DOE, an individual; JUANITA HODAX, on behalf of herself and her patients; KATHERINE MISTRETTA, on behalf of herself and her patients, **Plaintiffs,** **v.** **STATE OF MONTANA; GREGORY GIANFORTE, in his official capacity as Governor of the State of Montana; AUSTIN KNUDSEN, in his official capacity as Attorney General; MONTANA BOARD OF MEDICAL EXAMINERS; MONTANA BOARD OF NURSING; MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; CHARLIE BRERETON, in his official capacity as Director of DPHHS,** **Defendants.**	**Case No. DV-23-541** **Hon. Judge: Jason Marks** **PLAINTIFFS' REPLY BRIEF IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION**

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INTRODUCTION

Montana Senate Bill 99 (the "Act") categorically bars the provision of a wide range of medical care when—and only when—provided to transgender youth to treat gender dysphoria. The care prohibited by the Act is evidence-based, medically necessary, and essential to the health and well-being of transgender adolescents.

Defendants fail to meet their burden under heightened scrutiny. They offer opinions from purported "experts" suggesting that the Act is justifiable because the care it prohibits is not adequately supported by evidence and is harmful to patients. This is incorrect. Defendants' experts lack any meaningful qualifications or experience relevant to the treatment of transgender adolescents, their opinions are improperly infected with bias, and their lack of credibility is put on full display by the unscientific and unsupported assertions that litter their declarations and are repeated in the State's brief. Their concerns about the accepted medical treatments for adolescents with gender dysphoria are unfounded, the care prohibited by the Act is provided in accordance with applicable standards of care, and the Plaintiff youth and others similarly situated have benefited immensely from receiving this care. And nothing that they offer can justify the sweeping scope of the Act, which bans all gender-affirming care for all transgender adolescents under all circumstances.

Plaintiffs are entitled to the preliminary injunction they seek: they will be irreparably harmed if the Act goes into effect, the balance of equities tips sharply in their favor, an injunction would further the public interest, and they are likely to succeed on the merits of their claims—and certainly raise serious questions as to their claims—that the Act violates several of the fundamental rights guaranteed to Plaintiffs under the Montana Constitution and unconstitutionally discriminates against young transgender Montanans.

RESPONSE TO DEFENDANTS' PROFFERED EVIDENCE

While Defendants have flooded the record with over 1,500 pages of largely redundant materials—including reports of multiple purported experts[1]—these materials coalesce around a few discrete substantive points, each of which can be straightforwardly rebutted.

First, Defendants' proffered experts lack relevant qualifications and experience, and their opinions are entitled to little, if any, weight. Indeed, the credibility of several of these experts has been doubted by courts in other cases challenging similar laws. Second, their purported expert testimony is riddled with mischaracterizations about the treatment of gender dysphoria and its evidence base, ignoring the science supporting gender-affirming care. Lastly, their proffered testimony—even if it were entitled to any weight—does not dispute that the care banned by the Act is provided in a manner consistent with all relevant standards of care, and cannot dispute the first-hand accounts of Plaintiffs as to the enormous benefits they have experienced from receiving gender-affirming care.

I. Defendants' Defense of the Act is Supported by Witnesses Whose Fringe Views Are Not Entitled to Weight, and Ignores the Science Supporting Gender-Affirming Care.

Plaintiffs have established that gender-affirming care is safe, effective, and often medically necessary healthcare for many transgender adolescents, supported by all mainstream medical organizations in the United States—including the American Academy of Pediatrics, the American Medical Association, the Pediatric Endocrine Society, the American Psychiatric Association, and the American Psychological Association, among many others. (Olson-Kennedy Dec. ¶ 32; Moyer

[1] These include reports from two experts—Dr. Geeta Nangia and Dr. Daniel Weiss—that Defendants failed to disclose alongside the rest of their experts several weeks prior pursuant to an agreement between the parties to ensure parity in opportunity to consider the opposing parties' expert testimony.

Dec. ¶ 21.) Defendants cannot overcome this with their proffered witnesses and inaccurate scientific assertions.

A. Defendants' "Expert" Witnesses Are Unqualified and Not Credible.

Defendants' experts—Dr. Michael Laidlaw, Dr. Daniel Weiss, Dr. James Cantor, Dr. Geeta Nangia, and Dr. Sven Román—lack any meaningful clinical experience treating adolescents with gender dysphoria. Their opinions, based almost entirely on a selective review of the literature, represent fringe views outside mainstream medical practice that are speculative at best and reflect bias.

None of the Defendants' proffered experts have experience providing the type of care prohibited by the Act, and they lack credibility. Defendants' putative endocrinology experts, Dr. Laidlaw and Dr. Weiss, have no experience treating adolescents with gender dysphoria. Both are primarily adult endocrinologists, with less than five percent of their practices being patients under the age of eighteen, and neither has ever treated an adolescent with gender dysphoria. Dep. of Dr. Michael K. Laidlaw, Transcript at 43, *C.P. v. Blue Cross Blue Shield of Ill.*, No. 3:20-cv-06145 (W.D. Wash. 2022) [Laidlaw *C.P.* Dep.]; Dep. of Dr. Daniel Weiss, Transcript at 125-26, *K.C. v. Individual Members of the Med. Licensing Bd. of Ind.*, No. 1:23-cv-00595 (S.D. Ind. May 26, 2023) [Weiss *K.C.* Dep.]. Dr. Laidlaw has only once ever provided care to a transgender patient relating to their gender dysphoria, which consisted of providing a refill of estrogen more than two decades ago. Laidlaw *C.P.* Dep. at 43. Dr. Weiss stopped seeing new adult patients for treatment of gender dysphoria a decade ago. Weiss *K.C.* Dep. at 43. Defendants' expert psychologist, Dr. Cantor, has a similarly thin résumé of relevant experience—in 25 years of seeing patients, he has treated only 8 minors with gender dysphoria and has not treated a single person, *for any condition*, younger than 16. Transcript of Dep. of Dr. James M. Cantor, ECF No. 58-8 at 59-60, *K.C.*

v. Individual Members of the Med. Licensing Bd. of Ind., No. 1:23-cv-00595 (S.D. Ind. June 12, 2023) [Cantor *K.C.* Dep.].

The Defendants' putative expert psychiatrists fare no better. Dr. Román claims to have "met with approximately 35 children who have been diagnosed as suffering from gender dysphoria" but does not claim to have treated any adolescents for gender dysphoria, *see* Expert Declaration of Dr. Sven Román, Doc. 77, Ex. K ¶ 2 (Román Dec.). Dr. Nangia claims to have treated over 500 minors "who have met criteria at some point in their lives for a 'gender dysphoria' diagnosis," Expert Declaration of Dr. Geeta Nangia, Doc. 77, Ex. J ¶ 48 (Nangia Dec.), but "appears to derive [this] claim . . . based on patient case histories that she thinks could have hypothetically supported a gender dysphoria diagnosis," Expert Rebuttal Dec. of Aron Janssen, M.D., ECF No. 143 ¶ 12, *L.W. v. Skrmetti*, No. 3:23-cv-00376 (M.D. Tenn. June 1, 2023), and concedes that she has *never* actually diagnosed a child with gender dysphoria. (Nangia Dec. ¶ 48.) She claims to have "difficulty appreciating th[e] distinction" between children who are "tomboys" and "tomgirls" and children with gender dysphoria, further calling into serious question her apparent total guess as to whether she has ever treated any children with gender dysphoria. (Nangia Dec. ¶ 24.)

None of these supposed experts' credentials are bolstered by their research or academic experiences. None of Dr. Laidlaw's publications pertaining to gender dysphoria are based on original primary research, and none are peer-reviewed. *See* Laidlaw *C.P.* Dep. at 42. Dr. Cantor, who specializes in atypical sexual attractions such as pedophilia, has not performed or published any original research on the mental-health outcomes of persons with gender dysphoria. Cantor *K.C.* Dep. at 44-48. Dr. Weiss has never performed or published any original research about gender dysphoria, its treatment, or gender identity more broadly. Weiss *K.C.* Dep. At 33-34. And neither Dr. Nangia nor Dr. Román claim to have performed or published

any such original research. (*See* Nangia Dec.; Román Dec.)

In other words, the primary expertise that Defendants' experts bring to bear on this case is their ability to read (selected) scientific literature authored by others. This is not enough. *See State v. Clifford*, 2005 MT 219, ¶ 42, 328 Mont. 300, 310, 121 P.3d 489, 497 (finding that an evidence law professor "who has, historically, criticized handwriting analysis evidence" based on "many years of study" nevertheless "is not an expert in the field of handwriting analysis"); *see also, e.g.*, *Dura Auto. Sys. of Ind., Inc. v. CTS Corp.*, 285 F.3d 609, 614 (7th Cir. 2002) ("A scientist, however well credentialed he may be, is not permitted to be the mouthpiece of a scientist in a different specialty. That would not be responsible science."); *McConnie-Navarro v. Centro de Fertilidad del Caribe, Inc.*, No. 01-1977 (JAG), 2007 WL 7652299, at *13 (D.P.R. May 31, 2007) ("Courts are suspicious of purported expertise premised solely or primarily on a literature review.") (collecting cases). And as discussed *infra*, even their reading of the literature is deeply flawed.

The testimony of Defendants' "experts" is also infected by improper bias. Dr. Laidlaw has described "transgenderism" as a "very troubling life,"[2] and has stated: "It is an ultimate, long-term goal of mine to make sure that the Endocrine Society is embarrassed, publicly humiliated, and sued mercilessly . . . ."[3] Dr. Cantor—who derives roughly 80% of his income from serving as an expert witness in cases like this one, *see* Cantor *K.C.* Dep. at 30-31—complained in a recent Twitter post that "[t]he only ones who crave affirmation more than trans teens are

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[2] *See* Michael K. Laidlaw, *Gender Dysphoria and Children: An Endocrinologist's Evaluation of* I am Jazz, Pub. Discourse (Apr. 5, 2018), *available at* https://www.thepublicdiscourse.com/2018/04/21220.

[3] Email from Michael Laidlaw (Oct. 28, 2019 2:48:47 PM) (on file with Plaintiffs' counsel); Laura Jedeed, Feature, *The Parent Trap*, Lux Mag., *available at* https://lux-magazine.com/article/genspect (quoting the pertinent email).

their doctors." *Id.* at 165. Dr. Román and Dr. Nangia have both described gender dysphoria as "an epidemic in which social contacts play a major role," spread through the internet, social media, and smart phones—theories that are baseless and widely discredited—and compared gender dysphoria to "eating disorders and self-harm behavior."[4] Dr. Weiss made up the phrase "weight affirming care" to caricature gender-affirming care as being akin to providing weight loss treatment to people with eating disorders, and characterizes virtually every leading medical association in the United States as an organization that has "been overtaken by group think and social contagion." Weiss *K.C.* Dep. at 91-92, 100-02. He is also a senior fellow at Do No Harm, an ideological organization that rails against "the radical ideology of 'anti-racism' in healthcare"[5] and opposes what it refers to as "the dangerous ideology of "'gender-affirming care.'"[6]

Courts have explicitly rejected testimony offered by experts who, like Defendants' witnesses here, are serving as "deeply biased advocate[s], not as . . . expert[s] sharing relevant evidence-based information and opinions." *See Dekker v. Weida*, No. 22-cv-325, 2023 WL 4102243, at *2 n.8 (N.D. Fla. June 21, 2023). Indeed, Dr. Cantor's testimony has previously been assigned diminished weight in court in light of the fact that he has "no experience treating gender dysphoria in youth." *E.g.*, *Koe v. Noggle*, No. 23-cv-2904, 2023 WL 5339281, at *21 n.28 (N.D. Ga. Aug. 20, 2023). At a hearing in *Dekker v. Weida*, another case involving gender-affirming care, the judge found Dr. Laidlaw to be "far off from the accepted view" in the medical profession. Prelim. Injunction Hr'g. Tr. at 88,

[4] Sven Román, *Psychiatrist: Gender Dysphoria Spreads Like an Epidemic Online*, KIRJO (Sept. 21, 2019), *available at* https://www.ihmistenkirjo.net/blog/psychiatrist-gender-dysphoria-spreads-like-an-epidemic-online?s=03; Nangia Dec. ¶¶ 28, 36.
[5] *About Us*, Do No Harm, *available* at https://donoharmmedicine.org/about (last visited Sept. 3, 2023).
[6] *Protecting Minors of Gender Ideology*, Do No Harm, *available at* https://donoharmmedicine.org/gender-ideology (last visited Sept. 3, 2021).

Dekker v. Weida, No. 4:22-cv-00325 (N.D. Fla.). The *Dekker* district court also noted that Dr. Nangia "does not address her experience treating transgender children and adolescents." Order Denying Without Prejudice the Motion for Rule 35 Examinations, ECF No. 80, *Dekker v. Marstiller*, No. 4:22-cv-325 (N.D. Fla. Jan. 17, 2023). And, as noted previously and below, courts have soundly rejected many of the opinions that Defendants' experts offer.

B. Defendants' Concerns About the Accepted Medical Treatments for Adolescents with Gender Dysphoria Are Ill-Founded.

Since Defendants' experts lack appropriate qualifications and are not credible, this Court should afford their opinions no weight. But a few overarching points that emerge from these declarations and exhibits warrant responses.

i. Gender-Affirming Medical Care Is Safe and Effective.

Defendants and their experts repeatedly attempt to cast doubt on the safety and efficacy of the healthcare prohibited by the Act, *see* Doc. 77 at 10-13, 14-19, but in doing so they ignore reality and science alike. Providing this care to treat adolescent gender dysphoria where medically indicated is safe, effective, and the evidence-based best practice. (*See* Olson-Kennedy Rebuttal Dec. ¶¶ 63-68; Moyer Rebuttal Dec. ¶¶ 9-12.) As with any medical interventions, potential risks are weighed against benefits, as well as the risks of doing nothing. (*See* Olson-Kennedy Rebuttal Dec. ¶ 43.)

Under applicable standards of care, gender-affirming medical care is provided only after a patient undergoes a comprehensive assessment, and only after the patient provides informed consent. (Moyer Dec. ¶ 22; Olson-Kennedy Dec. ¶¶ 51, 62, 66.) Defendants and their experts contend that adolescents and their parents are incapable of providing informed consent to receiving gender-affirming care. *See, e.g.*, Doc. 77 at 14-15, 19-21. But these contentions lack merit, and flow instead from Defendants' continued insistence on treating transgender adolescents

differently. There is a substantial body of evidence indicating that adolescents do have the capacity to make informed decisions in the context of medical care and provide assent, and further, parents and guardians routinely consent to treatments for their minor children in other areas of medicine, including treatments that may result in irreversible changes—including infertility—including chemotherapy and other cancer-related treatments like surgery and radiation. (Moyer Rebuttal Dec. ¶¶ 13-16; Olson-Kennedy Rebuttal Dec. ¶ 120.) And there is no evidence that adolescent Montanans with gender dysphoria are receiving puberty blockers or hormone therapy where not medically indicated, or that they are being inappropriately diagnosed.

Defendants' arguments relating to FDA approval and "off-label" use mistake the nature of the practice of medicine. The use of "off-label" medications is extremely common across all fields in medicine, and particularly in pediatrics—due to various limitations on the ability to conduct clinical research in the pediatric population, most therapies prescribed to children are on an off-label or unlicensed basis. (Olson-Kennedy Rebuttal Dec. ¶¶ 57-59.) Some common medications used "off-label" in pediatrics include antibiotics, antihistamines, and antidepressants—none of these have been banned. (*Id.* ¶ 57.) Defendants' singling out of gender-affirming care is discriminatory, plain and simple.

Finally, Defendants make much ado of purported adverse effects associated with the medical treatments in question. *See, e.g.*, Doc. 77 at 14-18. Again, their arguments are misleading and discriminatory. All medical treatments come with some risk of various adverse effects. (Olson-Kennedy Rebuttal Dec. ¶ 69). With respect to the care covered by the Act, Defendants vastly overstate the adverse effects, and these effects are comparable when used to treat other conditions in cisgender adolescents, yet again the Act only bars care for transgender adolescents. (*Id.* ¶¶ 69-82.) Defendants focus on fertility risks—but puberty blockers alone do

not inherently impair fertility, hormone therapy is not "sterilizing," and fertility preservation remains available to those for whom fertility is of particular concern. (*Id.* ¶¶ 71-72, 105.) Moreover, other medications that impair fertility are not banned when medically necessary in adolescents.

ii. Gender-Affirming Care for Adolescents Is Well-Supported, and Defendants' Supposed Concerns About the Evidence Supporting This Care Can Only Be Explained by Unconstitutional Discrimination.

Defendants suggest that gender-affirming care is not supported by adequate evidence, but they would hold this care to an evidentiary standard so high that it can only be explained by unconstitutional discrimination. The evidence supporting gender-affirming medical care is comparable to the evidence supporting other forms of medical care. (Olson-Kennedy Rebuttal Dec. ¶¶ 36-55.) The absence of randomized controlled trials does not undermine the clinical guidelines for the treatment of gender dysphoria in adolescents. It is generally not ethically or practically possible to run such a trial in this field. (Olson-Kennedy Rebuttal Dec. ¶¶ 39-52; Moyer Rebuttal Dec. ¶ 7.) Indeed, systematic reviews show that *most* medical interventions are supported by the *same quality* of evidence as gender-affirming medical care. (Olson-Kennedy Rebuttal Dec. ¶ 39; Moyer Rebuttal Dec. ¶¶ 8-9.)[7] In general, the quality of the research for gender-affirming medical care is consistent with that for other complex conditions: Defendants' experts' impossible standards, which their own proposed alternative treatments fail to meet, *see infra* Pt. I.B.v, would require the State to ban most medical interventions and all

[7] *See also* Padhraig S. Fleming, Despina Koletsi, John P.A. Ioannidis & Nikolaos Pandis, *High Quality of the Evidence for Medical and Other Health-Related Interventions Was Uncommon in Cochrane Systematic Reviews*, 78 J. Clinical Epidemiology 34 (2016) (finding that out of 608 identified systematic reviews incorporating GRADE criteria, "only 13.5% (n = 82) reported a high quality and 30.8% (n = 187) a moderate quality of evidence for the first listed primary outcome, whereas 31.7% (n = 193) had low level and 24% (n = 146) had very low level of evidence.").

complex interventions.

Again, this care is overwhelmingly supported by every major medical association in the United States. Dr. Cantor points to a handful of reviews from European countries, but with one exception, these are not peer-reviewed, and Sweden's review found broad improvements across a variety of mental health outcomes. (Moyer Rebuttal Dec. ¶ 10.) Defendants' designated experts ignore systematic reviews that do show benefits, which *have* been peer reviewed—reviews that show gender-affirming medical care is associated with reduced gender dysphoria and better mental health, interpersonal relationships, and overall quality of life. (*Id.* ¶ 9.)

iii. Gender-Affirming Care for Adolescents Is Not Experimental, and Contrary to Defendants' Claims, No Country Has Banned This Care.

Gender-affirming medical care is thus far from experimental, and Defendants' references to other countries' practices, Doc. 77 at 21-24, furnishes no support for the Act. Defendants misrepresent these countries' approaches—they have not banned care: "Some or all of these [countries] insist on appropriate preconditions and allow care only in approved facilities—just as the Endocrine Society and WPATH standards insist on appropriate preconditions, and just as care in the United States is ordinarily provided through capable facilities." *Dekker*, 2023 WL 4102243, at *17. There is no evidence that *any* country has done what Montana has done: ban gender-affirming care for minors entirely.

Defendants rely often on the lower court decision in the United Kingdom case *Bell v. Tavistock*, including directly relying on some of the medical evidence before that court. Doc. 77 at 14-15, 19-22. But that decision was overturned by the Court of Appeals precisely because the lower court inappropriately relied on the very evidence the state points to. *Bell v. Tavistock*, [2021] EWCA Civ 1363, ¶¶ 63-

64 (rejecting the lower court's decision to credit the propositions "that treatment of gender dysphoria with puberty blockers was 'experimental' and that the vast majority of patients taking puberty blockers . . . are on a pathway to much greater medical interventions"). The appellate court ultimately held that it was for adolescents, their parents, and their clinicians to decide on treatment. *See id.* at ¶¶ 76, 92. Defendants' reliance on the lower court decision in *Tavistock* is misplaced.

iv. Defendants' Designated Experts' Claims About Desistence Are False or Highly Misleading.

Defendants also expend several pages discussing "desistence," which they define as the "discontinuation of gender dysphoria." Doc. 77 at 7, 9-10, 13-14, 29. But these claims are all either false or highly misleading. The studies Defendants and their experts rely on to argue that there are high desistence rates pertain to *pre-pubertal* youth and not adolescents, and/or do not distinguish between gender nonconformity and gender dysphoria. (Olson-Kennedy Rebuttal Dec. ¶¶ 10-13; Moyer Rebuttal Dec. ¶¶ 17-21.) Studies of desistence among pre-pubertal children are wholly irrelevant because *no medical interventions are recommended before puberty*. (Olson-Kennedy Rebuttal Dec. ¶ 14; Moyer Rebuttal Dec. ¶ 17.) In fact, evidence shows very low desistence rates among adolescents. (Olson-Kennedy Rebuttal Dec. ¶ 14; Moyer Rebuttal Dec. ¶ 18.) Dr. Cantor acknowledges in his writing elsewhere that "the majority of kids who continue to feel trans after puberty rarely cease." (Moyer Rebuttal Dec. ¶ 20.) Many of the studies relied on by Defendants included many young people who were not transgender to begin with, but rather were cisgender young people who exhibited gender-nonconforming traits. (Olson-Kennedy Rebuttal Dec. ¶¶ 11-13.) It is not at all surprising that some people who were not transgender to begin with might not identify as transgender in adulthood. And among those who obtain care, regret rates are very low—lower even than other forms of medical care, which are not

banned simply because some small number of people later regret receiving them. (Moyer Dec. ¶ 27 & n.25.) A handful of declarations about detransitioners outside Montana, *see* Doc. 77 Exs. BB-EE, are not evidence of widespread regret. Further, regret or discontinuation of treatment can be for a variety of reasons beyond regretting transition itself. (*See* Moyer Dec. ¶ 27.)

Defendants brazenly cast gender dysphoria as a "newfangled social contagion" that is sweeping minors through social contacts and social media. (*E.g.*, Doc. 77 at 1, 5, 7-9; Nangia Dec. ¶ 20.) These claims have been resoundingly rejected as unsupported, unscientific, and seeped in bias when advanced in cases addressing statutes similar to the Act. *See Kadel v. Folwell*, 620 F. Supp. 3d 339, 365-67 (M.D.N.C. 2022) (rejecting evidence about "social contagion" as nothing more than a "hypothesis" and concluding that a state expert's "conspiratorial intimations and outright accusations" about a lobby of activists that has improperly infected the whole of the medical community "sound[s] in political hyperbole"), *appeal pending*, No. 22-1721 (4th Cir.); *see also Doe v. Ladapo*, No. 23-cv-114, 2023 WL 3833848, at *14 (N.D. Fla. June 6, 2023) ("[I]t is fanciful to believe that all the many medical associations who have endorsed gender-affirming care . . . have so readily sold their patients down the river."). And the scientific basis for this hypothesis—a lone study, corrected by the journal that published it, based on reports from parents recruited from online communities of parents skeptical of their child's gender dysphoria—cannot support the sweeping claims Defendants make. (Olson-Kennedy Rebuttal Dec. ¶¶ 17-22; Moyer Rebuttal Dec. ¶ 22.)[8]

[8] "Perhaps the most significant problem with the study was that results were based entirely on parent reports, with no contact or association with any transgender adolescents or clinicians, and those parents were recruited largely from websites dedicated specifically for those who hold strong oppositional beliefs about their child's gender identity, including 'transgendertrend' and 'Youth Trans Critical Professionals.' In 2019, after post-publication review, the journal concluded that there were problems with the goals, methodology, and conclusions of the study,

A mere increase of adolescents seeking treatment for gender dysphoria is not the same as an increase in the overall number of people who are transgender or have gender dysphoria. There are a number of variables that may affect these figures, including diagnostic criteria, and more adolescents seeking care is unsurprising given greater awareness among youth and parents about what treatments are available for gender dysphoria and the decreasing (albeit still significant) stigma associated with being transgender. (*See* Olson-Kennedy Rebuttal Dec. ¶ 23-25.)

v. There Is *No* Evidence Supporting Defendants' Proposed Alternative Treatment of Psychotherapy Alone, Much Less High-Quality Evidence.

Notwithstanding their focus on the evidence supporting gender-affirming medical care, Defendants weakly suggest alternative treatment approaches that have absolutely *no* evidentiary support. Doc. 77 at 9-10, 31. They offer no evidence that therapy alone without gender-affirming medical care is effective to treat adolescent gender dysphoria, and no such evidence exists. (Moyer Rebuttal Dec. ¶ 32.) They conflate therapy alongside gender-affirming medical care with therapy alone. Of course, psychotherapy can be an important intervention for transgender adolescents "to help with other causes of mental distress." (*Id.* ¶ 32-33.) But what Defendants propose is psychotherapy *to treat gender dysphoria itself*, while banning gender-affirming medical care, and there is *no* evidence to support this proposal. (*Id.*)

In fact, the long history of treatment for gender dysphoria has demonstrated that "psychiatric intervention cannot alter people's gender, nor does it lead to a diminishing of the distress that arises from gender incongruence." (Olson-Kennedy

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issued an apology, and republished the study with several corrections, one of which clarified that the original study 'does not validate the phenomenon' of ROGD." (Moyer Rebuttal Dec. ¶ 22.)

Rebuttal Dec. ¶ 118.) Defendants' dangerous and unscientific assertions about alternative treatments for gender dysphoria do not hold water.

II. It Is Undisputed That the Care Prohibited by the Act Conforms to the Applicable Medical Standards of Care.

Defendants do not dispute the fact that the clinical guidelines set out by the World Professional Association for Transgender Health ("WPATH") and the similar standards established by the Endocrine Society—which include pubertal suppression and gender-affirming hormones—are the standards of care utilized by practitioners in Montana to treat adolescents with gender dysphoria. (*See, e.g.*, Hodax Dec. ¶¶ 11-13; Mistretta Dec. ¶ 6.) *See also, e.g.*, *Ladapo*, 2023 WL 3833848, at *3 (crediting "the abundant testimony in this record that these standards [those established by WPATH and the Endocrine Society] are widely followed by well-trained clinicians"). The prevailing practice in the United States is to adhere to these protocols, including by providing careful mental-health assessments, addressing comorbid psychiatric conditions, and following rigorous informed-consent processes before initiating any medical interventions for gender-dysphoric adolescents. As explained by Drs. Johanna Olson-Kennedy and Danielle Moyer—who, collectively, have treated thousands of patients with gender dysphoria, published extensively on this topic, and conducted leading research in this field—these practices not only are well-established, but are thoroughly supported by research and clinical experience. (*See* Olson-Kennedy Dec. ¶¶ 31-32, 40-49, 52-61; Moyer Dec. ¶¶ 21-26.)

III. It Is Undisputed That, Like Others, the Minor Plaintiffs Have Greatly Benefited from Receiving Gender-Affirming Care and Would Be Severely Harmed by Being Forced to Cease This Care.

Evidence-based research supports the provision of gender-affirming care to gender-dysphoric adolescents. But the wealth of evidence supporting the provision

of this care generally should not obscure the more obvious point—the care has greatly benefited the Plaintiffs. *See* Pls' Motion for Preliminary Injunction at 8-13.

Defendants' experts lack requisite qualifications, experience, and credibility. Perhaps most importantly, however, they cannot contest the experiences of the minor Plaintiffs and other young transgender Montanans for whom gender-affirming care has been transformative and even life-saving. As discussed below, these Montanans would be severely and irreparably harmed if the Act goes into effect and the necessary care upon which they rely is stripped away from them.

ARGUMENT

The Court should grant Plaintiffs' motion for a preliminary injunction as they satisfy all four elements of the sliding scale standard. *See All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011). Defendants ignore the appropriate sliding scale approach, Doc. 77 at 26-27, but Plaintiffs satisfy even Defendants' more stringent standard. As a threshold matter, Defendants wrongly assert that "Plaintiffs bear the burden to prove unconstitutionality beyond a reasonable doubt," Doc. 77 at 27, even though the Montana Supreme Court has clarified recently that "[i]n the context of a constitutional challenge, an applicant for preliminary injunction need not demonstrate that the statute is unconstitutional beyond a reasonable doubt, but 'must establish a prima facie case of a violation of its rights under' the constitution." *Weems v. State ex rel. Fox (Weems I)*, 2019 MT 98, ¶18, 395 Mont. 350, 359, 440 P.3d 4, 10. Plaintiffs readily establish such a prima facie case, and indeed where Plaintiffs have shown that the Act infringes upon multiple constitutional rights, it is Defendants who bear the burden of proving that the Act survives strict scrutiny—a burden they cannot satisfy.[9]

[9] Defendants appear to argue against the propriety of a facial challenge, but that argument does nothing more than assert that a facial challenge fails "by logical extension" of their other

I. Plaintiffs Will Suffer Irreparable Injury.

Absent a preliminary injunction, Plaintiffs will suffer irreparable injury because of the Act. Plaintiffs will suffer irreparable harm from the loss of their constitutional rights and because transgender youth like the minor Plaintiffs here are at risk of facing the "severe, ongoing psychological distress and the high risk of . . . suicide" related to gender dysphoria. *Edmo v. Corizon, Inc.*, 935 F.3d 757, 797–98 (9th Cir. 2019); *Mont. Cannabis Indus. Ass'n, v. State*, 2012 MT 201, ¶ 15, 366 Mont. 224, 229, 286 P.3d 1161, 1165; *see also Weems I*, 2019 MT 98, ¶ 25. And depriving them of gender-affirming care will cause permanent physical changes from the puberty associated with their assigned sex, which cannot be reversed through a final judgment.

As detailed previously, several other courts have found that the denial of access to gender-affirming care causes irreparable harm. *See, e.g.*, *Ladapo*, 2023 WL 3833848, at *16; *Brandt*, 551 F. Supp. 3d at 892; *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1150 (M.D. Ala. 2022), *vacated on other grounds sub nom. Eknes-Tucker v. Governor*, No. 22-cv-184-LCB, 2023 WL 5344981 (11th Cir.

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arguments defending the constitutionality of the Act. Doc. 77 at 32-33. What Defendants are really arguing seems to be a variation on a severability argument—but the question of whether some provisions of the law are salvageable does not affect the inquiry as to whether the challenged provisions of the Act are facially unconstitutional. To the extent Defendants want to argue about whether some elements of the Act are severable and could thus remain, they would have to meet a separate test that they do not attempt to address: that the remaining portion would be "complete in itself and capable of being executed in accordance with the apparent legislative intent." *Williams v. Bd. of Cnty.*, 2013 MT 243, ¶ 64, 371 Mont. 356, 376, 308 P.3d 88, 101.

Defendants also indirectly suggest that preliminary injunctive relief should be limited to the Plaintiffs. *See* Doc. 77 at 26. Nothing less than a statewide injunction barring enforcement of the Act could "provide complete relief to the plaintiffs," *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979), because the minor Plaintiffs and their families cannot obtain care in Montana if providers are unable to treat them and pharmacists are unable to fill their prescriptions; Jane and John Doe's daughter would have to reveal her identity in order to obtain care; and the provider Plaintiffs cannot continue to provide appropriate and medically necessary care to all their patients—including referring them to other providers and healthcare professionals where needed—if relief is limited in the way Defendants seem to suggest it should be.

Aug. 21, 2023); *Doe 1 v. Thornbury*, No. 23-cv-230-DJH, 2023 WL 4230481, at *6 (W.D. Ky. June 28, 2023); and *K.C. v. Individual Members of the Med. Licensing Bd. of Ind.*, No. 23-cv-00595, 2023 WL 4054086, at *13 (S.D. Ind. June 16, 2023).

Defendants have trotted out unqualified experts to make reckless and unscientific claims about gender-affirming care, whereas Plaintiffs and their experts have clearly demonstrated that this care is amply supported by evidence in line with other forms of health care, is medically necessary for many experiencing gender dysphoria, and conforms to all relevant standards of care—including ordinary and rigorous principles of informed consent. *See supra* Pt. I.B. Receiving gender-affirming medical care during adolescence can lead to substantial mental-health improvements, and forcing adolescents to wait until they turn 18 to receive care can have a severe negative impact on mental health while exacerbating lifelong dysphoria. (Olson-Kennedy Dec. ¶¶ 37-38, 46, 61; Moyer Dec. ¶¶ 28-29.) This care is particularly important because there are no alternative treatments to manage the serious effects of gender dysphoria in adolescence. Again, while Defendants' experts critique the data supporting existing treatment protocols, the alternative treatment modalities they recommend are supported by *no* evidence of safety or efficacy. *See supra* Pt. I.B.v.

Defendants' callous statement that this "Court cannot find irreparable harm simply based upon the unhappiness of adolescents," Doc. 77 at 44, and others like it are a gross misstatement of the case. Plaintiffs have communicated in great depth and with great vulnerability the severe harms that would result from the Act taking effect. The asserted harms that Defendants quote as though to dismiss them are in fact very real. *See* Doc. 77 at 43. The minor Plaintiffs *will* be stripped of their ability to receive medically necessary care that is critical to their health and well-being. (Scarlet van Garderen Dec. ¶¶ 13–14; Phoebe Cross Dec. ¶¶ 15, 20–21.) The

parent Plaintiffs *will* have to contemplate drastic measures to allow their children to continue care, including leaving Montana if feasible, or else face the devastating consequences of being forced to terminate this care. (Jessica van Garderen Dec. ¶¶ 13–14; Paul Cross Dec. ¶ 18; Jane Doe Dec. ¶¶ 33–34.) And the provider Plaintiffs *will* no longer be able to provide the appropriate care and guidance for their patients in Montana. (Hodax Dec. ¶¶ 16–18; Mistretta Dec. ¶¶ 12–14.) Plaintiffs will be irreparably and severely harmed by the Act taking effect, with potentially life-threatening consequences.[10]

II. The Balance of Hardships Tips Sharply in Plaintiffs' Favor, and the Injunction Would Serve the Public Interest.

The balance of hardships tips sharply in Plaintiffs' favor. In contrast to the severe and irreparable ongoing constitutional injuries that Plaintiffs would face under the Act, the State will suffer no harm if enjoined from enforcing the Act. Defendants incorrectly claim that granting an injunction "would subject even more Montana children to irreversible and permanent psychological, emotional, and physical consequences." Doc. 77 at 49. The record, prior briefing, and Plaintiffs' experts show that the opposite is true.

Additionally, injunctive relief would serve the public interest by preventing the violation of several of Plaintiffs' constitutional rights, as detailed below. *See Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) ("[I]t is always in the public interest to prevent the violation of a party's constitutional rights."); *see also Brandt v. Rutledge*, 2023 WL 4073727, at *38 (E.D. Ark. June 20, 2023).

[10] Defendants' submission of declarations from various individuals outside of Montana, none transgender adolescents, does nothing to alter the irreparable injury analysis. *See* Doc. 77, Exs. BB-EE. The question before this Court is whether Plaintiffs and those similarly situated will suffer irreparable injury as a result of the Act going into effect—they clearly will.

III. Plaintiffs Are Likely to Succeed on the Merits of Their Claims and Have at Minimum Shown Serious Questions Going to the Merits of Plaintiffs' Claims.

Plaintiffs are likely to succeed on the merits of their claims and have shown serious questions going to the merits of their claims, which is all that is required to warrant a preliminary injunction where the balance of hardships tips sharply in favor of Plaintiffs. *See* S.B. 191, 2023 Leg., 68th Sess. (Mont. 2023) ("SB 191") (amending § 27–19–201, MCA); *All. for the Wild Rockies*, 632 F.3d at 1135. The Act is subject to strict scrutiny under several provisions of the Montana Constitution and cannot survive any standard of judicial review.

A. The Act Is Subject to Strict Scrutiny.

Under the Montana Constitution, "[s]trict scrutiny applies if a suspect class or fundamental right is affected" by the law in question. *Snetsinger*, ¶ 17 (citation omitted). The Act discriminates against a suspect class—transgender Montanans—and burdens several fundamental rights, and is thus subject to strict scrutiny. *See* Pls. Br. in Support of Motion for Prelim. Injunction at 23-28.

i. The Act Violates Plaintiffs' Right to Equal Protection, Discriminating Against a Suspect Class.

The Act classifies on the basis of sex and transgender status. Under the Act, whether a person can receive certain medical treatments turns on their assigned sex at birth, whether they are transgender, and whether the care tends to reinforce or disrupt stereotypes associated with their sex assigned at birth.

Defendants first argue that the Act does not warrant heightened scrutiny because its "prohibitions apply equally to male and female children," Doc. 77 at 33, citing two outlier federal court decisions in cases challenging healthcare bans similar to the Act. Those decisions do not analyze claims under the Montana Constitution, whose equal protection clause "provides for even more individual

protection than does the federal equal protection clause." *Snetsinger v. Mont. Univ. Sys.*, 2004 MT 390, ¶ 58, 325 Mont. 148, 166, 104 P.3d 445, 457 (internal citation and quotation marks omitted). But even their analyses under the federal Constitution lack merit. As *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), makes clear, equal application of discriminatory treatment (e.g., injuring both transgender men and transgender women) does not change the character of the discrimination. *Id.* at 1742 (2020). Furthermore, their sex discrimination analyses cite the United States Supreme Court's 1971 decision in *Reed v. Reed* but ignore the Supreme Court's more recent declarations that "all gender-based classifications today warrant heightened scrutiny." *United States v. Virginia*, 518 U.S. 515, 555 (1996) (quotation marks omitted); *see also Sessions v. Morales-Santana*, 582 U.S. 47, 57 (2017). Defendants' citations to *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228, 2245 (2022), and *Geduldig v. Aiello*, 417 U.S. 484, 496 (1974), for the proposition that a statute "is not a sex-based classification[]" "solely because it mentions sex" are equally off the mark because *Dobbs* is limited by its own terms to abortion, 142 S. Ct. at 2277-78, and *Geduldig* did not involve a statute that was facially discriminatory, 417 U.S. at 496-97.[11]

Healthcare bans like the Act facially classify on the basis of sex by imposing differential treatment based on an individual's sex designated at birth. *See Virginia*, 518 U.S. at 555. Indeed, as much as Defendants now try to frame the Act as drawing distinctions based on a particular medical condition, the relevant

[11] In this context too, the Montana Supreme Court has construed the MHRA even more broadly than Title VII. Although the Supreme Court held in *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), that pregnancy-related distinctions do not constitute sex discrimination—a decision quickly overturned by the Pregnancy Discrimination Act—the Montana Supreme Court in *Bankers Life & Cas. Co. v. Peterson* (1993), 263 Mont. 156, 866 P.2d 241 expressly rejected *Gilbert*'s reasoning and held that pregnancy discrimination is included as part of sex discrimination under MHRA because "distinctions based on pregnancy are sex-linked classifications." *Peterson*, 263 Mont. at 160, 866 P.2d at 243.

provisions of the Act do not even reference gender dysphoria, and instead classify along explicitly sex and gender-based lines, proscribing treatments only when provided "to address a female minor's perception that her gender or sex is not female or a male minor's perception that his gender or sex is not male." Act, § 4(1)(c). As *Bostock* instructs, "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*, 2023 WL 4102243, at *11 (citing *Bostock*, 140 S. Ct. at 1737) (emphasis added). Under statutes like the Act, "the minor's [assigned] sex at birth determines whether or not the minor can receive certain types of medical care under the law." *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022). "A minor born as a male may be prescribed testosterone . . . but a minor born as a female is not permitted to seek the same medical treatment." *Id.*; *see also Ladapo*, 2023 WL 3833848, at *8; *K.C.*, WL 4054086, at *8. Transgender status is "palpably sex-based" because "the defining criteria of [this] class is plainly and simply sex[.]" *Snetsinger*, ¶¶ 82-83 (Nelson, J., concurring).

Defendants' attempt in a footnote to distinguish *Bostock* as "only protect[ing] transgender identification in the employment discrimination context under Title VII," *see* Doc. 77 at 34 n.117, does nothing to diminish the core logic underlying *Bostock*'s conclusion—that "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex," 140 S. Ct. at 1741. Furthermore, Montana's counterpart to Title VII—the Montana Human Rights Act (MHRA)—extends beyond the employment context, *see* §§ 49.2.301 *et seq.*, MCA, "implements the non-discrimination rights enumerated in Article II, Section 4 of the Montana Constitution," *see Edwards v. Cascade Cnty. Sheriff's Dep't*, 2009 MT 451, ¶ 73, 354 Mont. 307, 223 P.3d 893, and proscribes "[d]iscrimination based on transgender status" through its

"prohibition on sex discrimination." *Maloney v. Yellowstone County*, Nos. 1570–2019 & 1572–2019 (Mont. Dep't of Lab. & Industry Aug. 14, 2020).

Additionally, the Act discriminates based on a person's failure to conform to sex stereotypes or expectations associated with a particular sex designated at birth, and by penalizing a person identified as male at birth for traits or actions that it tolerates in people identified as female at birth, and vice versa, *see Bostock*, 140 S. Ct. at 1741-42; *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891 (E.D. Ark. 2021) (statutes like the Act "allow[] the same treatment for cisgender minors as long as the desired results conform with the stereotype of their biological sex"), *aff'd*, 47 F.4th 661 (8th Cir. 2022).

The Act also discriminates based on transgender status. Defendants only contention to the contrary is that transgender minors are not similarly situated to other minors seeking the same treatments because gender dysphoria is psychological rather than physical, and that some of the other indications for these treatments are otherwise distinguishable from gender dysphoria. Doc. 77 at 34-35. But the Act does not draw lines around any of these purported distinctions—it squarely draws lines around only treatments offered to transgender adolescents, and bans only that those treatments. Act, § 4(1)(c). Again, the Act on its own terms does not even refer to gender dysphoria; it more starkly targets those whose gender identity is inconsistent with their sex assigned at birth. Defendants' contentions do not affect the relevant fact: that the Act by design "prohibits medical care only transgender people undergo, i.e., medical or surgical procedures related to gender transition," and thus discriminates based on transgender status. *Brandt*, 2023 WL 4073727, at *31, *38. At most, distinctions between gender dysphoria and other conditions would go to why—in Defendants' view—the Act might be *justified*, not whether the discrimination in fact *exists*. And the Act's prohibition of Medicaid coverage similarly violates equal protection by excluding a class of otherwise-

eligible people from coverage for medically necessary treatment based on their transgender status. *See Jeannette R. v. Ellery*, No. BDV-94-811, 1995 Mont. Dist. LEXIS 795, at *27 (Mont. Dist. Ct. May 22, 1995).

Transgender Montanans constitute a suspect class for equal protection purposes. Defendants incorrectly sidestep the Montana Supreme Court's test for identifying a suspect class and turn to a United States Supreme Court case for the proposition that the test "requires showing that transgenderism is 'an immutable characteristic determined solely by accident of birth.'" Doc. 77 at 35 (quoting *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973)). But gender identity is not subject to voluntary change, Moyer Dec. ¶ 17, a point that Defendants' experts agree with even as they also claim dysphoria may desist for non-volitional reasons for some.[12] And in any event, this Court need not engage with the merits of this proposition or whether it governs interpretation of the Montana Constitution because Defendants misread even *Frontiero*. What the United States Supreme Court actually found "differentiates" suspect and non-suspect classification "is that the . . . characteristic frequently bears no relation to ability to perform or contribute to society." 411 U.S. at 686. A person's transgender status bears no relation to their ability to contribute to society, and gender identity is a core defining trait—fundamental to a person's identity—that a person cannot be required to abandon.

Regardless, under the relevant Montana Supreme Court's test, transgender Montanans constitute a suspect class because they are "subjected to such a history of purposeful unequal treatment" and suffer a level of "political powerlessness" due to longstanding and persistent discrimination sufficient to warrant "extraordinary protection" under the law. *In re S.L.M.*, 287 Mont. 23, 33, 951 P.2d

[12] *See* James Cantor, *A Bill of Transsexual Rights*, JamesCantor.org, *available at* http://www.jamescantor.org/bill-of-rights.html ("[O]ne does not choose to be dysphoric about the sex they were born into.").

1365, 1371 (1997); *see also* Pls. Br. in Support of Motion for Prelim. Injunction at 24-26. Defendants do not contest this. Doc. 77 at 35. Together, these factors warrant strict scrutiny.

Numerous federal courts have concluded that heightened scrutiny applies to an equal protection claim challenging similar bans on gender affirming care in adolescents. *See, e.g.*, *Brandt*, 47 F.4th at 670; *K.C.*, 2023 WL 4054086, at *7-9; *Ladapo*, 2023 WL 3833848, at *8–9. And Montana's equal protection clause "provides for even more individual protection than does the federal equal protection clause." *Snetsinger*, ¶ 58 (internal citation and quotation marks omitted). The Act is thus subject to strict scrutiny under the Montana Constitution's guarantee of equal protection.

ii. The Act Severely Burdens Plaintiffs' Fundamental Rights.

The Act is also subject to strict scrutiny because it burdens several fundamental rights. *See Stand Up Mont. v. Missoula Cnty. Pub. Schs.*, 2022 MT 153, ¶ 10, 409 Mont. 330, 337, 514 P.3d 1062, 1067 (strict scrutiny applies when a statute affects a fundamental right). In substituting the State's ideological judgment for the reasoned judgment of transgender adolescents, their parents, and their medical providers, the Act violates several fundamental rights.

It infringes upon "the fundamental right of a parent to make decisions regarding the care of their children, including, among other things, the upbringing, education, health care, and mental health of their children." *Stand Up Mont.*, ¶ 28 (internal quotations omitted); *see* Mont. Const. art. II, § 17; § 40-6-701(1), MCA. Defendants seemingly concede that strict scrutiny applies and merely propose that the State has a "compelling interest" in preventing" "irreparable and potentially catastrophic physical and psychological injury." Doc. 77 at 36. But Defendants offer no credible evidence that such injury would result from continuing to allow transgender Montanans to access gender-affirming care—the opposite is true.

Defendants' conclusory argument that this Act is an "exempt[ion]" from the Legislature's general mission to bolster parents' rights to direct their children's medical care, Doc. 77 at 36, merely highlights the Legislature's discriminatory treatment toward transgender people manifested by the Act.

The Act infringes upon the fundamental right to privacy by restricting the "right to choose or refuse medical treatment." *Armstrong v. State*, 1999 MT 261, ¶ 52, 296 Mont. 361, 373, 376, 989 P.2d 364, 373, 375. Defendants argue rational basis applies because "the right of choice in making personal health care decisions and in exercising personal autonomy is not without limits." Doc. 77 at 38 (quoting *Armstrong*, ¶ 59). But they confuse the question of whether strict scrutiny applies with the question of whether strict scrutiny is satisfied. The immediately following language in *Armstrong* makes clear that these limits refer to "certain instances" in which a state may be able to *satisfy* strict scrutiny by way of clear and convincing evidence of "a medically-acknowledged, *bona fide* health risk." *Armstrong*, ¶¶ 59, 62. The Act triggers strict scrutiny, striking at the heart of the right to privacy and evincing the burden on "personal autonomy and privacy that accompanies the government usurping . . . the patient's own informed health care decisions made in partnership with his or her chosen health care provider." *Id.* ¶ 58.

Defendants cannot meet their burden here. The medical community overwhelmingly agrees that gender affirming care is safe, and there is no basis for finding that this care entails more risk when provided to treat gender dysphoria in transgender adolescents than when provided for other reasons to cisgender adolescents. *See Weems II*, ¶ 51 (State failed to demonstrate a medically acknowledged, bona fide health risk where it "failed to present any evidence that demonstrates abortions performed by APRNs include more risk than those provided by physicians or PAs"). And Defendants' circular argument that the right to privacy is not violated because the right extends only to "*lawful* medical

procedure[s]," Doc. 77 at 39, would render the right utterly meaningless by allowing the State to ban any form of healthcare it chooses and then argue its behavior is constitutional because that care is no longer lawful. That cannot be the meaning of the Montana Constitution, which offers "one of the most stringent protections of its citizens' right to privacy in the United States." *Armstrong*, ¶ 34.

The Act similarly infringes upon the fundamental right to seek health by extinguishing "the right to seek and obtain medical care from a chosen health care provider and to make personal judgments affecting one's own health and bodily integrity without government interference," *Armstrong*, ¶ 72; *see* Mont. Const. art. II, § 3; *Mont. Cannabis Indus. Ass'n*, ¶ 23 ("In pursuing one's own health, an individual has a fundamental right to obtain and reject medical treatment."). Defendants contend this right is not implicated because "in pursuing health, an individual does not have a fundamental affirmative right of access to a particular drug." Doc. 77 at 40 (quoting *Mont. Cannabis Indus. Ass'n*, ¶ 24). But that does nothing to save the Act, which restricts not merely access to a particular drug or treatment option but instead bans *all* treatments for gender dysphoria that are indicated by the relevant standards of care. For transgender youth experiencing gender dysphoria, the Act wholesale closes off their "fundamental right to obtain . . . medical treatment." *Mont. Cannabis Indus. Ass'n*, ¶ 24. Furthermore, in contrast to the authorities cited by Defendants where a drug was generally banned, the Act selectively bans medications and procedures for transgender adolescents that remain freely available for cisgender patients, exposing that the State has no concern with the medications or procedures themselves.

And Defendants' bare assertion that the Act's "prohibition of funding for the relevant treatments and procedures is undoubtedly valid" is supported only by a citation to a case involving the federal Constitution's Due Process Clause. Doc. 77 at 32 (citing *Rust v. Sullivan*, 500 U.S. 173 (1991)). It ignores the Montana

Constitution's unique protections, including its enumerated protection of the right to seek health care and the concomitant right to not have funding for such care arbitrarily stripped away. *See Butte Cmty. Union v. Lewis*, 219 Mont. 426, 430, 712 P.2d 1309, 1311 (1986) (holding that a right is "fundamental" under Montana's Constitution if it is either found in the Declaration of Rights or is a right "without which other constitutionally guaranteed rights would have little meaning"). It also ignores the fact that here, the Act withdraws coverage selectively for one class of people, even as it remains available to others.

The Act infringes upon the fundamental right to dignity by denying transgender people care that would allow them to live in alignment with their gender identity, and thereby threatens and demeans the humanity and identity of transgender people. *See Walker v. State*, 2003 MT 134, ¶ 81, 316 Mont. 103, 121, 68 P.3d 872, 884 ("Treatment which degrades or demeans persons, that is, treatment which deliberately reduces the value of persons, and which fails to acknowledge their worth as persons, directly violates their dignity." (citation omitted)). Defendants spend time discussing *Walker*'s facts, Doc. 77 at 41, without rebutting the substance of Plaintiffs' claim. Constitutional protections can apply to a wide range of factual circumstances, and the *Walker* court did not limit its ruling to the facts before it. The court held more broadly that "[t]he plain meaning of the dignity clause commands that the intrinsic worth and the basic humanity of persons may not be violated" and indeed discussed access to medical care as among the basic human needs that implicate the right to dignity. *See Walker*, ¶ 80-82. Coercing the minor Plaintiffs to de-transition and live in dissonance with their own gender identity profoundly strips them of their basic humanity.

The Act also infringes upon the fundamental right to freedom of speech and expression by barring healthcare professionals from speaking—and their patients and their parents from hearing—about medically accepted treatments for gender

dysphoria. *See* Act, § 4(4).[13] Defendants cite cases holding that incidental burdens on speech are permissible alongside the State's ordinary regulation of the practice of medicine, Doc. 77 at 42, but they cannot justify a content and viewpoint-based regulation of speech that runs counter to the evidence-based consensus of medical professionals. *See* Mont. Const. art. II, § 7; *State v. Lamoureux*, 2021 MT 94, ¶ 21, 404 Mont. 61, 485 P.3d 192, 200 (regulation is content-based and presumptively invalid if, on its face, it draws distinction based on "the topic discussed or the idea or message expressed"), *cert. denied*, 142 S. Ct. 860 (2022). Defendants' citation to *Garcetti v. Ceballos*, 547 U.S. 410 (2006), lends no support to their position because this case does not involve the speech of government employees.

The Act deprives minors, their parents, and their health care providers from working together to seek what every major medical association has recognized is safe, effective, and necessary care, which gravely endangers transgender adolescents and tramples on their fundamental rights guaranteed under the Montana Constitution. The Act is subject to, and fails, strict scrutiny.

B. The Act Fails Heightened Scrutiny, and Indeed Cannot Survive Any Level of Scrutiny.

i. The Act Fails Strict Scrutiny Because It Is Not Narrowly Tailored to Serve a Compelling Government Interest.

Defendants have failed to establish a compelling government interest. The Act's only stated justification "is to enhance the protection of minors and their families . . . from any form of pressure to receive harmful, experimental puberty blockers and cross-sex hormones and to undergo irreversible, life-altering surgical procedures prior to attaining the age of majority." Act, § 2. This justification is not

[13] While Defendants claim that no Plaintiff "assert[s] harm stemming from SB 99's prohibition of 'gender affirming' surgeries on minors," Doc. 77 at 33, Dr. Hodax for example has asserted that "[t]he Act would also interfere with my ability to support referrals for other gender-affirming medical care that my patients may need," including where surgery is at issue. (Hodax Dec. ¶ 17.)

supported by the legislative record, nor would it justify a categorical ban. And as discussed *supra*, Defendants' arguments based on its proffered expert declarations, Doc. 77 at 27-32, do nothing to cure this defect. Gender-affirming care is medically necessary and effective treatment that is well-supported by research and experience, and far from being "experimental," the medical care prohibited by the Act has been robustly documented and studied and is the accepted standard of care by all major medical organizations in the United States. *See supra* Pt. I. Its prohibition will have dire consequences for transgender adolescents. "Rather than protecting children . . . the prohibited medical care improves the mental health and well-being of patients and . . . , by prohibiting it, the State undermined the interests it claims to be advancing." *See, e.g.*, *Brandt*, 2023 WL 4073727, at *35.

Even if the Act served a compelling state interest (which it does not), it is not narrowly tailored. It institutes a blanket ban on gender-affirming health care for adolescents, even when such care is medically necessary, and with no provision for circumstances where such care may be permissible. The fact that the Act does not ban psychotherapy does not somehow make it tailored, as Defendants attempt to argue, *see* Doc. 77 at 31, because psychotherapy is not sufficient to remedy the harms of gender dysphoria. Nor does characterizing the Act as promoting "watchful waiting" alter the fact that it is a categorical ban on *all* transgender adolescents. This Court need not even resolve the credibility of, or disputes among, the designated experts to conclude that the Act likely fails strict scrutiny—even the State's experts' misleading suggestions regarding desistence rates acknowledge that some portion of transgender adolescents do not desist, and therefore by categorically banning care that both parties agree is medically necessary for *some* transgender adolescents (and, indeed the vast majority of adolescents continue with gender-affirming care, (Olson-Kennedy Rebuttal Dec. ¶ 14.)), the Act's means are exceedingly overbroad. The Act also fails middle-tier review, as explained in prior

briefing, because its purported need does not outweigh the value of the rights it impairs. *See* Pls. Br. in Support of Motion for Prelim. Injunction at 30-31.

ii. The Act Fails Rational Basis Review.

While the Court should apply strict scrutiny, the Act fails even rational basis review as it serves no legitimate purpose but rather is purely motivated by animus towards transgender people.[14] *See Romer v. Evans*, 517 U.S. 620, 632, 634 (1996). Even assuming the Act's purpose is to protect the health and well-being of minors (it is not) it fails to rationally relate to that interest because it denies transgender adolescents life-saving care and allows the same treatments for cisgender minors with no explanation for why the care is only safe for that group. The Act thus cannot withstand any level of scrutiny.

CONCLUSION

FOR THESE REASONS, Plaintiffs Scarlet van Garderen, Jessica van Garderen, Ewout van Garderen, Phoebe Cross, Molly Cross, Paul Cross, Jane Doe, John Doe, Dr. Juanita Hodax, and Dr. Katherine Mistretta respectfully request the entry of an order:

(a) preliminarily enjoining Defendants, as well as their agents, employees, representatives, and successors, from enforcing the Act, directly or indirectly; and

(b) granting any other relief the Court deems just.

[14] The legislative record is replete with animus toward transgender people and gross mischaracterizations of the care prohibited by the Act, and suggests that members of the Legislature were motivated by nothing other than their personal, moral, or religious disapproval of gender transition. *See* Pls. Brief in Support of Motion for Prelim. Injunction at 5-7. This is not a legitimate governmental interest. *See Ladapo*, 2023 WL 3833848, at *10 (concluding that plaintiffs were likely to succeed on the merits in showing that Florida's ban, motivated in substantial part by the illegitimate purposes of disapproving transgender status and discouraging individuals from pursuing their honest gender identities, did not satisfy intermediate scrutiny).

Dated: September 15, 2023 Respectfully submitted,

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