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IN THE FOURTH JUDICIAL DISTRICT COURT
MISSOULA COUNTY

PHOEBE CROSS, a minor by and through his guardians Molly Cross and Paul Cross, et al.	**Case No. DV-23-541**
Plaintiffs,	**Judge: Hon. Jason Marks**
v.	**PLAINTIFFS' BRIEF IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**
STATE OF MONTANA et al.,	
Defendants.	

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INTRODUCTION

Senate Bill 99 ("SB 99") categorically denies certain medical treatments to transgender adolescents, preventing providers from offering care that they, their patients, and their patients' parents agree is medically appropriate—even though that care is supported by the leading medical organizations in the United States. As the Montana Supreme Court explained when affirming the preliminary injunction in this case, the Legislature can intrude on Montanans' right to privacy and personal autonomy and interfere with their informed healthcare decisions only in the narrowest of circumstances. Absent "a medically[] acknowledged, *bona fide* health risk, clearly and convincingly demonstrated, the legislature has no interest, much less a compelling one, to justify its interference with an individual's fundamental privacy right to obtain a particular lawful medical procedure." *Cross ex rel. Cross v. State*, 2024 MT 303, ¶ 21 (alteration in original) (quoting *Armstrong v. State*, 1999 MT 261, ¶ 62, 296 Mont. 361, 989 P.2d 364). Even if that initial hurdle could be cleared, the State has the further burden of satisfying strict scrutiny, which requires them to show that the challenged law is narrowly tailored to serve a compelling government interest. *Id.* ¶ 22. The Montana Constitution's equal-protection guarantee likewise requires application of strict scrutiny in this case—an exacting standard of review that "is seldom satisfied." *State ex rel. Bartmess v. Bd. of Trs.*, 223 Mont. 269, 275, 726 P.2d 801, 804 (1986).

Taking these foundational precepts from the abstract to the concrete, a simple proposition underlies this case and compels summary judgment: The State can invade the privacy of transgender adolescents and their parents and interfere with their ability to receive gender-affirming medical care *only* if it clearly and convincingly demonstrates "a medically acknowledged, bona fide health risk" and, even then, *only* if SB 99 is "the least onerous path that can be taken to achieve the

state objective." *Cross*, ¶ 28 (quoting *Weems v. State ex rel. Knudsen*, 2023 MT 82, ¶ 44, 412 Mont. 132, 529 P.3d 798).

In the sixteen months since the Court preliminarily enjoined enforcement of SB 99, the State has failed to proffer evidence sufficient to satisfy this high burden. It has failed to adduce evidence of a medically acknowledged, bona fide health risk, and the Legislature's sole articulated justification for SB 99 was (and remains) wholly unsubstantiated. And as for the other rationales put forward by the State in this litigation, even accepting its claims about gender-affirming medical care as true, SB 99 is the antithesis of a narrowly tailored law: It is "a complete ban, prohibiting individualized care tailored to the needs of each patient based on the exercise of professional medical judgment and informed consent." *Id.* ¶ 37. The law is both fatally overinclusive *and* underinclusive, and less-restrictive means of achieving the State's ostensible goals are readily available.

Each of these shortcomings independently establishes that SB 99 cannot satisfy the exacting requirements of strict scrutiny. Absent a genuine dispute of material fact, summary judgment in favor of Plaintiffs is warranted and SB 99 should be permanently enjoined.

BACKGROUND

I. Undisputed Material Facts

Diagnosis and Harms of Gender Dysphoria. Gender dysphoria is a recognized condition involving a marked and sustained incongruence between one's gender identity and sex assigned at birth. A.200, 327–28.[1] It is diagnosed based on multiple criteria set forth in the Diagnostic and Statistical Manual, which reflects the consensus among experts in the field of psychiatry. A.199, 327, 361. A diagnosis of

[1] Record citations ("A.###") refer to the pagination of Plaintiffs' separately filed appendix. Plaintiffs incorporate by reference all materials they previously filed in support of a preliminary injunction, some of which are reproduced in the appendix for ease of reference.

gender dysphoria requires, among other things, clinically significant distress or impairment in social or other important areas of functioning. A.200, 328.

There is no genuine dispute that gender dysphoria can cause serious harms when left untreated. Experts on both sides—including the State's expert witnesses[2]—agree that, without treatment, gender dysphoria can lead to "very adverse long-term mental health consequences, including suicide." A.375; *see also* A.200–01. Indeed, before SB 99's enactment, the State solicited an opinion on the consequences of an abrupt termination of gender-affirming medical care for minors. A.441–43, 477–78. Its own chosen medical professionals, who assist in administering the State's Medicaid program, warned that the "biggest risk" was "worsening of depression and an increase in suicidality. This is a significant problem and should not be ignored." A.447–49, 474; *see also* A.480 ("An increase in depression, anxiety, and suicidal ideation should be expected."); A.035.

Nor is there a genuine dispute that gender dysphoria does not simply "desist" for all individuals—including, in particular, for all adolescents with gender dysphoria. Indeed, the State's own expert agrees that "there's a good bit of literature that indicates that adolescent gender dysphoria continues into adulthood." A.362; *see also* A.482 ("[W]hen gender variance with the desire to be the other sex is present in adolescent, this desire usually does persist through adulthood.").

Treatment of Gender Dysphoria. There is no genuine dispute that there are clinical practice guidelines issued by the Endocrine Society and the World Professional Association for Transgender Health for the treatment of gender dysphoria in adolescents (the "Guidelines"), which include the provision of puberty

[2] The State has disclosed six witnesses purporting to offer expert testimony: Quentin Van Meter, an endocrinologist; Geeta Nangia, a psychiatrist; Sven Roman, a Swedish psychiatrist; Farr Curlin, a hospice and palliative-care physician; James Lindsay, an author; and Jamie Reed, a former case manager at a Missouri clinic.

blockers and hormone therapy—treatments collectively referred to as gender-affirming medical care. A.058–59, 201–02. There is likewise no dispute that the Guidelines are endorsed by the major medical organizations in the United States, including the American Medical Association ("AMA"), the American Psychiatric Association, the American Psychological Association, and the American Academy of Pediatrics, among others. A.059, 426; *see also* A.468–69 (AMA letter opposing SB 99). Notably, the Guidelines are also endorsed by professional medical organizations in Montana: The Montana chapters of both the AMA and the American Academy of Pediatrics filed an amicus brief in the Montana Supreme Court alongside national medical organizations. *See also* A.470 (Montana medical organization letter opposing SB 99). All of these organizations recognize that gender-affirming medical care should remain a treatment option available to adolescents with gender dysphoria where indicated.

Under the Guidelines, whether gender-affirming medical care is appropriate for any given adolescent depends on an individualized, case-by-case determination made by the adolescent's medical providers in consultation with the adolescent and their parents. As a threshold matter, there is no dispute that gender-affirming medical care is only recommended as a treatment option for adolescents—that is, individuals who have started puberty. A.060, 203, 341. There are no medical interventions recommended for prepubertal children with gender dysphoria. The Guidelines also recommend that, before initiating any gender-affirming medical interventions for an adolescent, a comprehensive psychological assessment first be performed by a qualified provider who has training and experience treating adolescents with gender dysphoria to determine if gender-affirming medical care is indeed appropriate. A.202 (noting that provider also assesses family's capacity to make informed decisions as well as any additional mental health concerns and makes plan to address such concerns when needed).

As with medical treatment for minors generally, the Guidelines provide for informed consent from parents or legal guardians prior to initiating gender-affirming medical care and specify information that should be provided about the potential risks and benefits of treatment. A.284–88. Providers of gender-affirming medical care in Montana, including Plaintiffs Juanita Hodax and Katherine Mistretta, apply the Guidelines in their practices. A.026, 033.

The State's expert witnesses have no personal knowledge of how gender-affirming medical care is provided in Montana. *See, e.g.*, A.392–93, 433–34. Nor has the State produced any evidence that adolescents in Montana are "pressured" into gender-affirming medical care by healthcare providers—who are the only parties regulated by SB 99—and their own witnesses were unaware of any such practice. *See, e.g.*, A.445–46, 455, 485–88. The State's attempt to substantiate that assertion with inapposite citations to the legislative record failed before the Montana Supreme Court.

It is undisputed that at least some adolescents—including Plaintiff Phoebe Cross, minor Joanne Doe, and former Plaintiff Scarlet van Garderen—have benefitted from gender-affirming medical care. A.001–24. Experts on both sides agree that the rate of regret for gender-affirming medical care for adolescents is low. A.205, 384.

Other Medical Care for Minors. It is undisputed that risk is an inevitable component of medical care and that many treatments carry significant risks that patients, their families, and their doctors weigh against potential benefits. A.162. It is further undisputed that it is commonplace for treatments used across the medical profession to have evidentiary bases that would be categorized as "very low quality" according to healthcare grading criteria. A.354, 368–72, 374.

It is also undisputed that Montana does not ban other medical treatments based on potential risks or inadequate evidence of efficacy. To the contrary, the same

Legislature that enacted SB 99 also amended Montana's right-to-try statute to guarantee the right of adults and minors to use even investigational drugs that have not been approved by the U.S. Food and Drug Administration ("FDA") for *any* indication, could pose all manner of risks, and have *no* evidence of efficacy. *See* SB 422, 2023 Leg., 68th Sess. (Mont. 2023).[3] By contrast, puberty blockers, estrogen, and testosterone—medications used in gender-affirming medical care—have been approved by the FDA for other indications. A.336–37. It is undisputed that, once a drug is approved by the FDA for any indication, it may be prescribed "off label" for any other purposes, and that off-label use of medications by doctors is common—including and especially for pediatric patients. A.265–66, 351, 379, 385–86, 401

Finally, it is undisputed that *all* of the potential risks the State ascribes to gender-affirming medical care—including cardiovascular-health concerns, infertility, and regret—are posed by other treatments that doctors may provide to minors free from legislative interference. A.075–76, 348.

II. Procedural Background

Plaintiffs filed suit in May 2023, raising claims under multiple provisions of the Montana Constitution. On September 27, 2023, the Court issued an order concluding that Plaintiffs were likely to succeed on the merits of their equal-protection and right-to-privacy claims and preliminarily enjoined enforcement of SB 99. *See generally* Order Granting Pls.' Mot. for Prelim. Inj. ("PI Order"), Dkt. No. 131.

On Plaintiffs' equal-protection claim, having found that the classes at issue are similarly situated and that SB 99 classifies on the basis of sex, the Court applied strict scrutiny given that "Montana's Equal Protection Clause requires greater

[3] Specifically, under the right-to-try statute, a drug need only have had a Phase I clinical trial, which merely assesses toxicity; it does *not* test efficacy. A.355.

protection than its federal counterpart" and also because "SB 99 infringes on Plaintiffs' fundamental rights." *Id.* at 23–28. Applying strict scrutiny, the Court determined that "[a] review of the legislative record does not support a factual finding that minors in Montana are being faced with pressure related to receiving harmful medical care"—the stated purpose of SB 99. *Id.* at 29–30. The Court further rejected other purportedly compelling interests for the law, observing that "risk associated with medical care is not unique to the treatments proscribed by SB 99," that concerns about safety are unavailing given that the proscribed "treatments are the accepted standard of care for treating gender dysphoria," and that another bill "passed in the same legislative session" as SB 99 expressly *permits* "parents to give consent for their minor children to engage in experimental medical treatments, regardless of efficacy or risk." *Id.* at 30–33. Having "f[ound] that SB 99 does not serve its purported compelling interest of protecting minors and shielding them from pressure," the Court "decline[d] to engage in an analysis to determine whether SB 99 is narrowly tailored." *Id.* at 34.

The Court also considered Plaintiffs' right-to-privacy claim and concluded that the State had failed to satisfy its burden of "show[ing] that gender-affirming care poses a medically acknowledged, bona fide health risk, leaving it without a compelling interest and without justification to rely on its police powers." *Id.* at 40.

After determining that Plaintiffs were likely to succeed on the merits of their equal-protection and right-to-privacy claims and satisfied the other elements for immediate injunctive relief, the Court preliminarily enjoined SB 99. *Id.* at 45–47.

The State appealed the Court's preliminary-injunction order, and the Montana Supreme Court affirmed. At the outset, the Supreme Court confirmed that Plaintiffs have standing to challenge SB 99. Specifically, Plaintiff Phoebe Cross, a transgender minor, "has standing under SB 99 § 4(1)," which would serve to deny him access to gender-affirming medical care on which he relies for his physical and mental

wellbeing. *Cross*, ¶ 16. This alone satisfies Montana's justiciability requirement, since, "[i]n a multi-plaintiff case such as here, the standing of any one plaintiff is sufficient for a claim to proceed and, upon finding that one plaintiff has standing, 'the standing of the other parties [does] not merit further inquiry.'" *Id.* (second alteration in original) (quoting *Barrett v. State*, 2024 MT 86, ¶ 19, 416 Mont. 226, 547 P.3d 630). Plaintiffs Juanita Hodax and Katherine Mistretta, both healthcare providers, also have standing to challenge SB 99 under two theories: first, based on "the threatened loss of their ability to practice medicine or face other penalties," which "is a concrete injury that entitles them to pursue their claims"; and second, because "healthcare providers have standing to challenge statutes as violative of their patients' rights to privacy under the Montana Constitution." *Id.*[4]

Moving to the merits, the Supreme Court focused on Plaintiffs' right-to-privacy claim, describing the limited circumstances in which the Legislature can interfere with Montanans' informed medical decisions and describing this Court's process for determining whether a challenged law is narrowly tailored to a medically acknowledged, bona fide health risk. *Id.* ¶¶ 35–36. The Supreme Court concluded that this Court "made no error of law when it applied the *Armstrong* standard to the evidence," *id.* ¶ 38, and agreed that Plaintiffs satisfied the other preliminary-injunction requirements, *id.* ¶ 57.

LEGAL STANDARD

"A motion for summary judgment must be granted when 'there is no genuine issue as to any material fact and . . . the movant is entitled to judgment as a matter of law.'" *Weems*, ¶ 32 (quoting Mont. R. Civ. P. 56(c)(3)); *see also Tin Cup Cnty.*

[4] For these reasons, Plaintiffs continue to have standing to challenge SB 99 on all claims and secure summary judgment. Plaintiffs Paul and Molly Cross and Jane and John Doe, the parents of transgender minors, also have standing to assert (and thus move for summary judgment on) their parental-rights claims.

Water &/or Sewer Dist. v. Garden City Plumbing & Heating, Inc., 2008 MT 434, ¶ 21, 347 Mont. 468, 200 P.3d 60 ("Summary judgment is appropriate when 'the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact[.]'" (quoting Mont. R. Civ. P. 56(c)(3))).

"Once the moving party has met its burden, the non-moving party must present substantial evidence essential to one or more elements of the case to raise a genuine issue of material fact. Conclusory statements are insufficient to raise a genuine issue of material fact." *Styren Farms, Inc. v. Roos*, 2011 MT 299, ¶ 10, 363 Mont. 41, 265 P.3d 1230 (citation omitted); *see also Tin Cup*, ¶ 54 (nonmoving party has "affirmative duty to respond by affidavit or other testimony containing material facts that raise genuine issues").

ARGUMENT

I. Strict scrutiny applies to Plaintiffs' claims.

Montana courts apply strict scrutiny "where the legislation at issue infringes upon a fundamental right or discriminates against a suspect class." *Powell v. State Comp. Ins. Fund*, 2000 MT 321, ¶ 17, 302 Mont. 518, 15 P.3d 877. Here, each of Plaintiffs' claims implicates either a fundamental right or a suspect class, and strict scrutiny is therefore required.[5]

[5] Following the Court's preliminary-injunction order and the Montana Supreme Court's opinion affirming it, Plaintiffs focus on their right-to-privacy and equal-protection claims. But Plaintiffs note that strict scrutiny applies equally to their other constitutional claims as well, including claims based on fundamental parental rights, *see Stand Up Mont. v. Missoula Cnty. Pub. Schs.*, 2022 MT 153, ¶ 28, 409 Mont. 330, 514 P.3d 1062 (Montana Constitution's Due Process Clause protects "the fundamental right of a parent to make decisions regarding the care of their children, including . . . health care[] and mental health" (cleaned up)); the right to seek health, *see Armstrong*, ¶ 72 (Montana Constitution "guarantees each person the inalienable right to seek safety, health and happiness in all lawful ways," including, "in the context of this case, 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"); the right to dignity, *see id.* (Montana Constitution's right to dignity is fundamental, "demand[ing] that people

Right to Privacy. "The right to privacy is fundamental; its protection 'exceed[s] even that provided by the federal constitution'" and courts thus "apply strict scrutiny when . . . the right to privacy[] is affected." *Cross*, ¶ 22 (first alteration in original) (quoting *Armstrong*, ¶ 34). As the Montana Supreme Court held, the right to privacy is affected by SB 99 because it "proscribes lawful medications and procedures administered by competent and licensed health care providers" and Montana's "privacy right empowers an individual 'to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from the interference of the government.'" *Id.* ¶¶ 28, 32 (quoting *Armstrong*, ¶ 39).

Equal Protection. "When analyzing an equal protection challenge," Montana courts "must first identify the classes involved and determine whether they are similarly situated." *Snetsinger v. Mont. Univ. Sys.*, 2004 MT 390, ¶ 16, 325 Mont. 148, 104 P.3d 445 (quoting *Henry v. State Comp. Ins. Fund*, 1999 MT 126, ¶ 27, 294 Mont. 449, 982 P.2d 456). "Once the relevant classifications have been identified, [courts] next determine the appropriate level of scrutiny," with "[s]trict scrutiny appl[ying] if a suspect class or fundamental right is affected." *Id.* ¶ 17.

As this Court previously found, "SB 99 classifies based directly on transgender status" and, "[i]f the language classifying minors based on their gender perception is removed, the two groups" at issue—"(1) minors who identify as transgender in Montana; and (2) all other minors in Montana"—"are identical in all

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have for themselves the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives and the intrinsic value of life in general, answering to their own consciences and convictions"); and the right to free speech and expression, *see State v. Lamoureux*, 2021 MT 94, ¶ 21, 404 Mont. 61, 485 P.3d 192 (content-based restrictions on speech are "presumptively invalid" and can be upheld only if "narrowly tailored to control conduct without reaching a substantial amount of protected speech" (cleaned up)); *State ex rel. Missoulian v. Mont. Twenty-First Jud. Dist. Ct.*, 281 Mont. 285, 301–02, 933 P.2d 829, 839–40 (1997) (free-speech rights include right to receive information).

other respects" and thus similarly situated. PI Order 20–23. The Court further concluded, and Justice McKinnon later agreed, that "transgender discrimination is, by nature, sex discrimination" because "[i]t is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex." *Cross*, ¶ 63 (McKinnon, J., concurring) (second alteration in original) (quoting *Bostock v. Clayton County*, 590 U.S. 644, 660, 140 S. Ct. 1731, 1741 (2020)); *accord, e.g.*, *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 669–70 (8th Cir. 2022) ("Because the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the [challenged] law, [it] discriminates on the basis of sex."). Because the Montana Constitution expressly prohibits discrimination on the basis of sex, strict scrutiny is required for sex-based classifications. *See Cross*, ¶ 64 (McKinnon, J., concurring) ("[S]trict scrutiny is the appropriate standard of review . . . because Article II, Section 4 is unequivocal in its intolerance for discrimination, which includes discrimination based on sex.").

Additionally, strict scrutiny is appropriate because transgender status itself constitutes a suspect class. *See id.* ¶ 65. There is no question that transgender individuals have been "subjected to such a history of purposeful unequal treatment" and "relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process." *In re S.L.M.*, 287 Mont. 23, 33, 951 P.2d 1365, 1371 (1997) (quoting *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 28, 93 S. Ct. 1278, 1294 (1973)); *accord Cross*, ¶ 65 (McKinnon, J., concurring). Transgender Montanans therefore constitute a suspect class, necessitating strict scrutiny for classifications based on transgender status. *See Snetsinger*, ¶ 17.

II. The State has failed to satisfy its high burden of clearly and convincingly demonstrating a medically acknowledged, bona fide health risk.

Before applying strict scrutiny, Plaintiffs' right-to-privacy claim presents a dispositive, threshold consideration: whether SB 99 implicates "a medically[] acknowledged, *bona fide* health risk." *Cross*, ¶ 21 (alteration in original) (quoting *Armstrong*, ¶ 62).

As *Armstrong* explained and the Montana Supreme Court reaffirmed in this case, only "under the very narrowly defined circumstances" when a medically acknowledged, bona fide health risk is "clearly and convincingly demonstrated" can a law like SB 99 stand; otherwise, "the legislature has *no* interest, much less a compelling one, to justify its interference with an individual's fundamental privacy right to obtain a particular lawful medical procedure from a health care provider that has been determined by the medical community to be competent to provide that service and who has been licensed to do so." *Armstrong*, ¶¶ 61–62 (emphasis added). In other words, if a medically acknowledged, bona fide health risk is not clearly and convincingly demonstrated, then the Legislature *cannot* prohibit medical treatment—regardless of how narrowly the law is tailored to address the purported risk the treatment poses. This initial hurdle is a high one; consistent with the presumption that patients are free to chart their own medical courses in consultation with their doctors, the *Armstrong* Court repeatedly described any qualification on this right to privacy as "narrow" and "limited." *Id.* ¶¶ 59, 61, 75.[6]

[6] Though the Montana Supreme Court has not established a bright-line test for identifying a medically acknowledged, bona fide health risk, the recognized narrowness of the exception necessarily implies that only a risk that is sufficiently grave and beyond the medical norm—and without any benefit that balances the severity of the risk—can justify legislative interference with the ordinary processes of consultation and informed consent. Underscoring the narrowness of the circumstances in which a sufficiently grave health risk would justify legislative prohibition, no Montana court has yet identified such a treatment, whereas "lobotomy, adversive reinforcement conditioning, [and] other unusual or hazardous treatment procedures" are permitted so long as the patient gives "express and informed consent after consultation." Section 53-21-148, MCA. Indeed,

Here, the State has failed as a matter of law to satisfy its substantial burden of clearly and convincingly demonstrating that the proscribed treatments pose a medically acknowledged, bona fide health risk sufficient to justify SB 99's interference with Montanans' personal healthcare decisions.

The State has failed to demonstrate that the medical community has acknowledged that the treatments at issue pose a health risk warranting their prohibition. To the contrary, Plaintiffs have shown—and the State does not and cannot dispute—that the treatments banned by SB 99 are deemed appropriate for adolescent gender dysphoria by major medical organizations, including the AMA, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association. A.059. On the other side of the ledger, the State has adduced mere instances of *disagreement* with the treatment protocols supported by these major medical groups. And while the State points to statements of some government health agencies in Europe, none imposes bans—and, instead, gender-affirming care medical is provided to adolescents in those countries. *See infra* pp. 27–28.[7]

At best, the State's asserted facts, if accepted as true, show that there are differing opinions within the medical profession regarding the care prohibited by

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Montana law generally regulates medical procedures only in terms of *who* can administer them, *see, e.g.*, § 37-26-301, MCA (limiting treatments that can be prescribed by naturopathic physicians)—not by banning treatments altogether, *see Weems*, ¶¶ 37–38 (explaining that Montana's right to privacy, which generally provides a right to seek care from qualified healthcare professionals, does not preclude State's regulation and licensure of medical professionals).

[7] Notably, the State primarily relies on foreign medical opinion to justify SB 99—and, in so doing, misstates how gender-affirming medical care is regulated in other countries—but it has *not* shown that any bona fide health risks warranting legislative interference are medically acknowledged in the United States, let alone in Montana. *Cf. Holtshouser v. United States*, No. CV 11-114-BLG-RFC, 2013 WL 1332416, at *2 (D. Mont. Apr. 1, 2013) (explaining that, under Montana medical-malpractice law, practitioners are generally "held to the standard of care of a 'reasonably competent general practitioner acting in the same or similar community in the United States in the same or similar circumstances'" (quoting *Chapel v. Allison*, 241 Mont. 83, 92, 785 P.2d 204, 210 (1990))), *aff'd*, 595 F. App'x 687 (9th Cir. 2014).

SB 99. But the fact that *some* doctors disapprove of a particular treatment does not establish a medically acknowledged, bona fide health risk such that legislative intrusion into Montanans' personal medical decisions is warranted. Given that diverse views about treatments are omnipresent in medicine—especially as to the treatment of mental health, which even a half-century ago a court recognized as "a field of medicine renowned for its responsible differences of opinion," *United States v. Klein*, 325 F.2d 283, 286 (2d Cir. 1963)—such a standard would swallow the rule and render a nullity the Montana Constitution's express protection of the right to seek health.

Not only has the State failed to demonstrate a *medically acknowledged* health risk, it has not demonstrated *any* bona fide health risk justifying interference with the right to privacy and personal autonomy. Merely pointing to potential risks associated with a given treatment is not sufficient to establish a "bona fide health risk" as that term is used by the Montana Supreme Court. After all, virtually all medical treatments present at least some level of risk—which is why consultation between patients and their doctors is "[a]n integral component of the practice of medicine." *Conant v. Walters*, 309 F.3d 629, 636 (9th Cir. 2002).[8] The ubiquity and individualized nature of medical risks and benefits support the Montana Constitution's mandate that a "patient's own informed health care decisions [be] made in partnership with his or her chosen health care provider" and disapprove "the infringement of personal autonomy and privacy that accompanies" laws that "dictate how and by whom a specific medical procedure is to be performed." *Armstrong*, ¶ 58.

[8] To give just one illustration, the FDA has repeatedly warned about the risks of "overdose, "severe liver damage," "nausea, vomiting, abdominal pain, confusion and jaundice" that can accompany acetaminophen—Tylenol. *Don't Overuse Acetaminophen*, FDA, https://www.fda.gov/consumers/consumer-updates/dont-overuse-acetaminophen (Feb. 1, 2024).

It is undisputed that risk is inherent in medicine and, consequently, that weighing risks and benefits on an individual basis is a critical component of health care. It is further undisputed that the treatments banned by SB 99 have benefited at least some minors—including the very patients who initiated this lawsuit. The State has adduced no evidence refuting that gender-affirming medical care has benefited Plaintiff Phoebe Cross, minor Joanne Doe, and former Plaintiff Scarlet van Garderen. Adopting the State's position that the mere existence of some risks alone satisfies the limited exception for bona fide health risks—regardless of any medical upside for patients—would, again, swallow the rule entirely.

The absence of a genuine health risk here is underscored by the fact that SB 99's prohibition applies *only* when medications are used for gender-affirming care and not when the same medications are used to treat precocious puberty, hypogonadism, and other conditions—even though it is undisputed that they present many of the same potential risks when used in these other contexts. *See infra* pp. 22–24; *Cross*, ¶ 32 (observing that Legislature did not "make the treatments unlawful for all minors" and "[i]nstead[] restricted a broad swath of medical treatments only when sought for a particular purpose"). Likewise, similar health risks exist for numerous other treatments that are permitted for minors, including treatments that the State expressly permits in SB 99's enumerated exceptions for "disorder[s] of sex development." *Cf. Weems*, ¶¶ 29–30 (rejecting argument that advanced practice registered nurses were not qualified to administer abortion care where "[m]anaging miscarriages—which the State does not dispute is within [their] scope of practice—entails essentially the identical procedure and protocol as early abortion care").[9]

[9] *Weems* is particularly instructive. There, on an appeal of summary judgment for the plaintiffs, the Montana Supreme Court addressed whether the State had demonstrated that abortions performed by advanced practice registered nurses ("APRNs") presented "a medically acknowledged bona fide public health and safety risk sufficient to invoke the State's regulatory

This conclusion is strengthened by the fact that the same Legislature that enacted SB 99 also amended the state's right-to-try statute to significantly expand Montanans' access to "experimental medications" not approved for any use by the FDA. A.465; *see also supra* pp. 5–6. As this Court previously observed, "assuming *arguendo* that the treatments proscribed by SB 99 are experimental" and unsafe, "under [the right-to-try law], minors should be allowed to continue engaging in that care if they choose to do so in concert with their healthcare provider and guardian and informed consent is obtained." PI Order 33. SB 99 thus creates a scenario where parents can "give consent for their minor children to engage in experimental medical treatments, regardless of efficacy or risk, that cannot be blocked by the State *unless* the minor is transgender and seeking medical treatment for gender dysphoria in line with the recognized standard of care," *id.* (emphasis added)—a result that demonstrates that any purported health risk justifying SB 99 fails as a matter of law.[10]

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authority to restrict access to abortion care guaranteed by Montana's fundamental constitutional right to privacy." *Weems*, ¶¶ 1–2. The Court explored the expert testimony propounded by the plaintiffs and the State and, even though the State's experts pointed to potential health risks, concluded that "the State has failed to meet its burden of demonstrating that [APRNs] providing abortion care present a medically acknowledged, bona fide health risk" because "the State has failed to present any evidence that demonstrates abortions performed by APRNs include more risk than those provided by physicians or [physician assistants]." *Id.* ¶ 51.

[10] Indeed, as the Court previously concluded, this inconsistency between SB 99 and Montana's right-to-try statute compels the conclusion "that the purported purpose given for SB 99 is disingenuous. It seems more likely that [] SB 99's purpose is to ban an outcome deemed undesirable by the Montana Legislature veiled as protection for minors. The legislative record is replete with animus toward transgender persons, mischaracterizations of the treatments proscribed by SB 99, and statements from individual legislators suggesting personal, moral, or religious disapproval of gender transition." PI Order 33–34. For this reason, although strict scrutiny is the proper standard to review SB 99, *see supra* pp. 9–11, the law would fail even the lowest tier of scrutiny: rational-basis review. "Under the rational basis test, the law or policy must be rationally related to a legitimate government interest," *Snetsinger*, ¶ 19, and animus towards transgender Montanans cannot possibly serve as a legitimate interest, *see, e.g.*, *Romer v. Evans*, 517 U.S. 620, 634–35, 116 S. Ct. 1620, 1628–29 (1996) (discriminatory law failed rational-basis review where it was "so far removed from [its] particular justifications that [it was] impossible to credit them").

Significantly, it is the State's burden to *clearly and convincingly* demonstrate a medically acknowledged, bona fide health risk—not merely to show that some doctors disagree with the use of these treatments and that the treatments carry potential risks, both of which would be true of virtually *all* medical care and thus render the Montana Supreme Court's threshold consideration superfluous. Having failed to establish this necessary predicate, the State cannot defend SB 99 against Plaintiffs' right-to-privacy claim, and summary judgment is appropriate.

III. SB 99 is not narrowly tailored to serve a compelling government interest.

SB 99 is unconstitutional for the additional and separate reason that the State has failed its burden of showing that the law is narrowly tailored to address any purported concerns with the proscribed treatments. SB 99 therefore cannot satisfy the exacting requirements of strict scrutiny—meaning that, with respect to Plaintiffs' right-to-privacy claim in particular, the law is unconstitutional *even if* the State could clearly and convincingly demonstrate a medically acknowledged, bona fide health risk (which, as discussed above, it cannot).

"The strict scrutiny standard requires that the State demonstrate the challenged law is narrowly tailored to serve a compelling government interest and only that interest." *Cross*, ¶ 22. The state must show that it has taken the "least onerous path that can be taken to achieve the state objective" such that it is "closely tailored to effectuate *only* that compelling state interest." *Wadsworth v. State*, 275 Mont. 287, 302, 911 P.2d 1165, 1174 (1996) (emphasis added).

And yet animus is ultimately the "more likely" purpose for SB 99, as the State's "purported justifications for the [law] ma[ke] no sense in light of how [it] treat[s] other groups similarly situated in relevant respects." *Bd. of Trs. v. Garrett*, 531 U.S. 356, 366 n.4, 121 S. Ct. 955, 963 n.4 (2001).

Even if the Court proceeds to this stage of the analysis, SB 99 fails as a matter of law because it is not narrowly tailored to address any articulated interest—least of all the sole interest identified at the time of the law's enactment.

A. SB 99 cannot withstand strict scrutiny with respect to the Legislature's sole asserted interest: "pressure."

Under strict scrutiny, the compelling government interest "must be genuine, not hypothesized or invented *post hoc* in response to litigation." *United States v. Virginia*, 518 U.S. 515, 533, 116 S. Ct. 2264, 2275 (1996). "Because post-hoc rationalizations provide an insufficient basis to find a compelling governmental interest, the court must look to the compelling interest asserted by [the State] at the time of" SB 99's enactment. *Native Am. Council of Tribes v. Weber*, 897 F. Supp. 2d 828, 849 (D.S.D. 2012), *aff'd*, 750 F.3d 742 (8th Cir. 2014); *see also*, *e.g.*, *Fox v. Washington*, 949 F.3d 270, 283 (6th Cir. 2020) ("[B]ecause the government's asserted interest must be genuine, not hypothesized or invented *post hoc* in response to litigation, [the defendant is] limited to raising the justifications it cited at the time it made the [challenged] decision[.]" (cleaned up)).

Here, the Legislature articulated its stated purpose as follows: "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." SB 99 § 2, 2023 Leg., 68th Sess. (Mont. 2023). This stated purpose—protecting minors and their families from "pressure" to receive gender-affirming care—is the sole interest the Legislature put forth to justify SB 99.

The State, however, has adduced *no* evidence—across any of its witnesses, expert reports, or submissions—of any Montana minors or their families being "pressured" to receive gender-affirming medical care. In fact, none of the State's witnesses (lay, expert, or hybrid) purports to have any knowledge of the practices of

any Montana medical providers who provide gender-affirming care, much less the medical providers who are Plaintiffs in this litigation. A.349, 360, 392–93, 400, 462–63. "Necessarily, *demonstrating* a compelling interest entails something more than simply saying it is so," *Wadsworth*, 275 Mont. at 303, 911 P.2d at 1174, and "speculation is insufficient to satisfy strict scrutiny," *Fulton v. City of Philadelphia*, 593 U.S. 522, 542, 141 S. Ct. 1868, 1882 (2021); *see also, e.g.*, *Latta v. Otter*, 771 F.3d 456, 469 (9th Cir. 2014) (rejecting unsupported legislative predictions about child welfare under heightened scrutiny).[11] Because the State is limited to the interest asserted by the Legislature when it enacted SB 99, and because it has failed to adduce any genuine evidence substantiating this interest, it has failed as a matter of law to demonstrate a compelling interest sufficient to satisfy strict scrutiny.

Even if the State could somehow substantiate the existence of pressure to receive gender-affirming medical care, less-restrictive alternatives to SB 99's categorical ban are readily apparent. *See infra* pp. 20–28 (discussing narrow tailoring). For example, to the extent that any medical provider has pressured minors to receive treatment, Montana's generally applicable means of regulating the practice of medicine—such as investigations of medical complaints and medical-malpractice actions—are less-onerous alternatives to address that issue. A.455–56, 460–61. A wholesale, categorical ban on treatment is thus an overbroad and unnecessary intrusion into Montanans' fundamental rights given the safeguards that *already exist* to address improper medical practices. *See Mont. Democratic Party v. Jacobsen*, 2024 MT 66, ¶ 102, 416 Mont. 44, 545 P.3d 1074 (rejecting need to

[11] Indeed, the Montana Supreme Court reaffirmed this principle just last year: In rejecting concerns about election integrity as an interest sufficient to justify infringing on the right to vote, the Court noted that, "[s]ignificantly, the Secretary [of State] failed to introduce any evidence of fraud related to ballot collection in Montana." *Mont. Democratic Party v. Jacobsen*, 2024 MT 66, ¶¶ 102–03, 416 Mont. 44, 545 P.3d 1074, *petition for cert. filed*, No. 24-220 (U.S. Aug. 26, 2024). Here, similarly, the State has failed to create even a genuine dispute that undue pressure presents a problem that actually needs a legislative solution.

burden right to vote where "nefarious activity" that sought to be discouraged "is already illegal" under Montana law), *petition for cert. filed*, No. 24-220 (U.S. Aug. 26, 2024).

Moreover, to the extent additional government action is needed, yet another less-restrictive path is available to combat any pressure that might exist: a more narrowly drawn law *directly* prohibiting anyone from pressuring patients to obtain gender-affirming medical care, such as by outlawing coercion or interference with a minor's healthcare decisions or requiring providers to assess for any such pressure prior to initiating gender-affirming medical care. *See id.* ¶ 102 (explaining that Legislature could "narrowly tailor[] the law to its compelling interest" by "enact[ing] a narrower law that prohibits only nefarious activity rather than the overly broad law it enacted which also proscribed [] lawful activity"); *Frisby v. Schultz*, 487 U.S. 474, 485–86, 108 S. Ct. 2495, 2503 (1988) (narrow tailoring is satisfied "only if each activity within the proscription's scope is an appropriately targeted evil").[12]

In short, the only interest articulated by the Legislature at the time it enacted SB 99 fails the strict-scrutiny analysis.

B. SB 99 is not narrowly tailored to serve any compelling government interest.

Even if the State could manufacture additional justifications, SB 99 is not "the least onerous path that can be taken to achieve" any of the State's purported objectives. *Wadsworth*, 275 Mont. at 302, 911 P.2d at 1174.

In addition to the Legislature's articulated concern about "pressure" to receive gender-affirming medical care, the State has, through its briefing and its designated

[12] Additionally, even assuming the asserted interest in protecting minors from "pressure" is a sufficient government interest, SB 99 is plainly *under*inclusive by prohibiting these medical interventions when, and only when, they are provided to "address the minor's perception that her gender or sex" is something other than the minor's sex assigned at birth. SB 99 § 2. SB 99's exceptions expressly *allow* such interventions for those with "disorder[s] of sex development" regardless of whether there is pressure to receive them. *Id.* § 4(c).

experts, advanced various other post-hoc justifications for SB 99, such as medical risks, the quality of the evidence underlying the Guidelines, that gender-affirming medical care is prescribed "off label," and a purported concern with misdiagnosis and consequent regret. But none of these justifications—even if the State's assertions are taken as true for purposes of summary judgment—explains why SB 99 bans certain treatments when, *and only when*, they are provided to "address [a] minor's perception that [their] gender or sex" is something other than the minor's sex assigned at birth. SB 99 § 2. A categorical ban on certain medical treatment—but *only* when used to affirm the gender of transgender adolescents—is at once strikingly overinclusive (prohibiting care even in circumstances where the State's own experts agree its concerns do not apply) and underinclusive (restricting gender-affirming care for reasons that apply to many other medical treatments that are not prohibited). *See Planned Parenthood of Mont. v. State*, 2024 MT 178, ¶ 32, 417 Mont. 457, 554 P.3d 153 ("A statute is not narrowly tailored if it is either underinclusive or overinclusive in scope." (quoting *IMDb.com Inc. v. Becerra*, 962 F.3d 1111, 1125 (9th Cir. 2020))). Nor is SB 99 the least-restrictive means of achieving any of the asserted governments interests. SB 99 therefore fails strict scrutiny.

1. SB 99 is underinclusive and overinclusive with respect to any potential government interest.

SB 99's categorical ban is both underinclusive and overinclusive with respect to the concerns purportedly justifying it. The law is severely underinclusive because the undisputed facts show that similar concerns exist when the medications at issue are used to treat other conditions, and likewise exist with other medications provided to minors that are not banned by SB 99. The law is also overinclusive because none of the State's asserted interests explains why gender-affirming medical care for adolescents is banned in all cases. By categorically banning *all* gender-affirming medical care for transgender adolescents, SB 99 is antithetical to any conception of

narrow tailoring. Far from addressing any risks the State's experts purport to identify or any concerns about efficacy that the State purports to possess, SB 99 is concerned only with what the statute says: ensuring that Montana minors are never provided treatment to address their "perception that [their] gender or sex" is something other than their sex assigned at birth. SB 99 § 2.

Medical Risks. The State, through its briefing and designated experts, points to various medical risks associated with gender-affirming medical care.[13] As discussed above, it is undisputed that *every* medical intervention presents potentially adverse effects. *Supra* pp. 14–15; *see also, e.g.*, A.162. SB 99, however, does *not* ban all medications that carry risks, or all treatments that pose any specific risks. Instead, it bans specific medications only when used to "address [a] minor's perception [about their] gender or sex"—and expressly permits their use in other circumstances that nonetheless present the same or similar health risks, along with other medications that carry similar risks. SB 99 is thus fatally underinclusive with respect to these risks.

For example, if Montana were concerned with the potential cardiovascular implications of estrogen, then that would not explain why it bans estrogen therapy only for gender-affirming medical care and not for other purposes. After all, it is undisputed that the cardiovascular risk of estrogen therapy is not limited to treatment of gender dysphoria. A.268–69, 380–81, 383, 427–28. In order for the State to justify the law based on such risks, it would have needed to ban the medication for minors outright. *See Brandt ex rel. Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891 (E.D. Ark.

[13] As a threshold matter, at least some of the purported "adverse effects" claimed by the State's experts are—as they acknowledge—the medications' intended effects. For example, one of the State's experts points to the "virilization" effects of testosterone, such as "lowering of voice tambor [sic]" and "broadening of shoulders hands and feet." A.337. But he acknowledges that these are, in fact, the intended effects of these medications when used to treat gender dysphoria. A.432. Far from being "harms" in need of remediation, these effects are instead *features* of gender-affirming medical care—and thus no legitimate basis for SB 99.

2021) (concluding that "the State would [need to] prohibit these procedures for all patients under 18 regardless of gender identity" to justify law based on purported health risks), *aff'd*, 47 F.4th 661 (8th Cir. 2022). But the State did not do so. Similarly, the State's experts point to potential fertility implications, but it is undisputed that many other medical treatments that can be provided to minors (and are not banned by SB 99 or any other law) likewise could impair fertility. A.158–59, 268–69, 380–81.

Moreover, the potential risk to fertility also demonstrates SB 99's *over*inclusion—to wit, its prohibition of gender-affirming medical care even in circumstances where both sides agree that the risk does not exist. It is undisputed that puberty blockers alone do not impair fertility, A.164, 342, 352–53, 413, 431—and yet SB 99 still bans that treatment. Additionally, it is undisputed that adolescents can undertake fertility-preservation measures, A.383, but SB 99 bars gender-affirming medical care even when such measures are taken. Similarly, though the State purports to be concerned with the irreversibility of gender-affirming medical care, it is undisputed that puberty blockers alone are not irreversible (or at the very least, not in all cases). A.161, 342, 352. Again, however, SB 99 bans them in *all* cases—and yet does *not* ban all other irreversible medical interventions for minors.

Though some of the State's experts purport to be concerned with the ability of minors and their families to provide informed assent and consent to gender-affirming medical care, it is undisputed that the process of parental informed consent (and minor assent) is sufficient in other medical contexts for minors that carry similar risks. A.376–79.

Finally, further undercutting *any* asserted interest in protecting against purportedly risky medical treatments is Montana's right-to-try statute, which was amended by the same Legislature that enacted SB 99 and expressly permits "investigational" treatments—including for minors—that, unlike the medications

banned by SB 99, are not even approved for use by the FDA for any purpose and carry no risk analysis beyond assessment of toxicity. A.465; *see also supra* pp. 5–6, 16.

Evidence Quality and Off-Label Use. Some of the State's designated experts criticize the Guidelines for gender-affirming medical care and the quality of evidence underlying them as being of "low" quality. Setting aside that "low"-quality evidence in this context does not equate to a lay understanding of "low" quality—rather, it relates to a specific grading system used in health care and largely refers to an absence of randomized controlled trials (as opposed to studies of other types like observational studies), A.234–35, 258, 354, 435[14]—the State's designated experts acknowledge that it is common across medicine for guidelines to be based on "low"- or "very low"-quality evidence, particularly in pediatrics. A.259–60, 354, 373–74, 435. In fact, one of the State's experts acknowledges that she frequently utilizes guidelines *in her own practice* that are supported by the same quality of evidence, including treatments she offers to minor patients. A.368–69, 373–74. SB 99 does not, however, ban *all* medical treatments supported by "low"-quality evidence; indeed, the State's experts would not support such a ban. A.374. Nor does SB 99 ban all treatments not supported by randomized controlled trials. Instead, it bans only the specific medications at issue, and only when provided to treat gender dysphoria, for failing to meet a selective evidence standard that *most* medical treatments would fail to meet.

Similarly, to the extent the State asserts an interest in curtailing medical interventions that are prescribed "off label" (meaning that they are not FDA-approved for a specific use, though they are FDA-approved for some other use), it

[14] Both sides agree, incidentally, that randomized controlled trials (generally the only kind of studies considered to be "high"-quality evidence) are generally either ethically or practically infeasible for gender-affirming medical care. A.233–34, 337–38, 355, 471–72.

is undisputed that off-label use is extremely common, particularly in pediatrics. A.265–66, 351, 379, 385–86, 401. In fact, some of the State's designated experts acknowledge that they prescribe medications off label in their own practices, or that they see no issue with doing so in other medical contexts. A.351, 379, 385, 401, 425. Off-label use does not equate to "experimental" care, and the State's experts have adduced no evidence to the contrary. A.076–77.

Indeed, not only does SB 99 *not* generally ban off-label prescriptions or care deemed to be "experimental" (by whatever arbitrary metric), Montana's right-to-try statute *protects* the ability of patients (including minors) to undertake treatments that are not approved for general use by the FDA and that are explicitly deemed "investigational." A.356, 471–72; *see also supra* pp. 5–6, 16. As this Court earlier acknowledged, the right-to-try statute undermines any asserted interest in protecting minors from treatments deemed "experimental" or used for a purpose not approved by the FDA. PI Order 33.

Misdiagnosis and Regret. Lastly, the State has asserted a concern—raised both in its Montana Supreme Court briefing and by its designated experts—regarding a supposed susceptibility to misdiagnosis among adolescents assigned female at birth, leading to a purportedly higher possibility of regret associated with gender-affirming medical care for those individuals. SB 99, however, is overinclusive with respect to this purported concern, as the State's own experts acknowledge that the studies they point to do *not* suggest that this concern applies equally to adolescents assigned male at birth—and thus it could not justify SB 99's categorical ban. A.365–66. Even if this concern were legitimate—which is far from demonstrated, given that experts on both sides agree that the regret rate is low for gender-affirming medical care, A.244–46, 364, 384, 408–10, and that "there's a good bit of literature that indicates that adolescent gender dysphoria continues into adulthood," A.362–63—SB 99 is also *under*inclusive as to any concerns with

misdiagnosis and regret, as it does nothing to prevent regret in other medical contexts. And, as discussed more fully below, *infra* pp. 26–28, less-restrictive alternatives to address the possibility of regret are readily available.

* * *

Whichever post-hoc concern the State might raise in defense of SB 99, the law is both fatally underinclusive and overinclusive. Notably, similar lack of tailoring motivated the Montana Supreme Court's conclusion in *Weems* that the abortion law at issue there failed strict scrutiny: Because "the same risk of complications" arising from abortions "exists in miscarriage care, which the State has not argued presents a threat to public health and safety when performed by" advanced practice registered nurses ("APRNs"), any argument that APRN-performed abortions present a bona fide health risk "logically must fail." *Weems*, ¶ 47. Here, likewise, because the undisputed facts show that any of the State's purported concerns about gender-affirming medical care exist for other, nonprohibited medical treatments, SB 99 defies any conception of narrow tailoring.

2. Less-restrictive means exist to address any health risks associated with gender-affirming medical care.

Indeed, even taking the State's purported concerns at face value and setting aside SB 99's over- and underinclusiveness, it has adduced *no* evidence that explains why less-restrictive alternatives to a categorical ban would not address each purported concern.

Take, for instance, the State's claims concerning misdiagnosis and regret. As noted above, experts on both sides agree that regret for gender-affirming medical care is rare. A.384; *see also supra* p. 5. But even if this were not the case, the State has not demonstrated why misdiagnosis and regret could not be addressed through any number of policies narrower than categorical prohibition, like mandating safeguards in assessment and diagnosis of gender dysphoria or instituting more rigid

requirements for care. If, for example, the State were concerned with psychiatric comorbidities interfering with diagnosis, a law mandating that care be provided consistent with the Guidelines (which require that mental-health concerns that might interfere with diagnostic clarity be addressed) would serve this purported interest. Or, if the State were concerned that doctors are not being sufficiently thorough in their assessments, it could mandate additional requirements for the assessment process before treatment. As for the State's assertions regarding medical risks associated with hormone therapy, those concerns too could be addressed using targeted laws like monitoring requirements or, with regards to the potential impairment of fertility, requiring that fertility-preservation measures be offered to patients.

Indeed, that the State's asserted concerns can be addressed through less-restrictive means is not merely hypothetical. In Nebraska, for instance, state law allows for gender-affirming medical care for minors only when certain minimum conditions are met, including that the "individual has a long-lasting and intense pattern of gender nonconformity or gender dysphoria which began or worsened at the start of puberty," a "minimum number of gender-identity-focused therapeutic hours" are completed, and "informed patient consent" is obtained. Neb. Rev. Stat. § 71-7305(1)(a)–(b). Similarly, West Virginia law allows gender-affirming medical care for minors when, among other requirements, "[t]he minor has been diagnosed as suffering from severe gender dysphoria by no fewer than two medical or mental health providers" and "[t]he minor, the minor's parents, legal guardians, or person or other persons charged with medical decision-making for the minor, and the minor's primary physician agree in writing with the treatment with pubertal modulating and hormonal therapy." W. Va. Code § 30-3-20(b), (c)(5).

Even the State's own evidence underscores this point. Though it has relied on the statements of various European health agencies, its designated experts

acknowledge that *none* of those countries bans care as SB 99 does, and these data points thus serve only to highlight alternatives that are less restrictive than Montana's blunt prohibition. For example, the State points to Sweden, but its expert—a Swedish psychiatrist—acknowledges that gender-affirming medical care is not banned in Sweden and that care is available to minors in accordance with guidelines currently in effect. A.404–06. Neither is care banned in Finland or Norway. A.407. And though the State has made much of the "Cass report" commissioned by England's National Health Service and the policy instituted in the United Kingdom, neither explains why a categorical ban is necessary. Indeed, as the State's experts concede, the Cass report does not support banning care and in fact acknowledges that care is appropriate for some minors. A.386–87, 436. The State's experts also acknowledge that the U.K. policy currently in effect is not a categorical ban—it allows hormones to be prescribed at age sixteen and allows puberty blockers in the context of clinical trials. A.152, 386–87. If anything, "[t]hese countries' approaches to gender-affirming medical care highlight that [the State's] chosen 'means'—a sweeping ban on such care—fails to properly account for the 'close means-end fit' heightened scrutiny requires." *Poe ex rel. Poe v. Labrador*, 709 F. Supp. 3d 1169, 1194 (D. Idaho 2023) (quoting *Sessions v. Morales-Santana*, 582 U.S. 47, 68, 137 S. Ct. 1678, 1696 (2017)), *appeal docketed*, No. 24-142 (9th Cir. Jan. 9, 2024).

In short, the exacting requirement of narrow tailoring requires that SB 99 be "the least onerous path that can be taken to achieve [any] objective" asserted by the State in its defense. *Cross*, ¶ 28 (quoting *Weems*, ¶ 44). Because less-restrictive means to address any concerns raised by the State are readily available, both in theory and in practice, SB 99's heavy-handed prohibition is far from the least-onerous path that can be taken—and the law is therefore unconstitutional.

CONCLUSION

FOR THESE REASONS, Plaintiffs respectfully request the entry of an order

(a) granting summary judgment in their favor;

(b) permanently enjoining Defendants, as well as their agents, employees, representatives, and successors, from enforcing SB 99, directly or indirectly; and

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

Dated: January 15, 2025

Respectfully submitted,

By: /s/ Alex Rate
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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 3(G) of the Court's Local Rules of Practice and the Court's order of January 14, 2025, *see* Dkt. No. 184, the undersigned certifies that this brief was prepared using a proportionally spaced typeface of 14 points and does not exceed thirty (30) pages in length, excluding the brief's title page, table of contents, table of authorities, certificate of compliance, and certificate of service.

Dated: January 15, 2025 By: /s/ Alex Rate
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Service Method: Other Means by Consent

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Electronically signed by Krystel Pickens on behalf of Alexander H. Rate
Dated: 01-15-2025