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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT** [ORAL ARGUMENT REQUESTED]

INTRODUCTION

Plaintiffs present the facts through a magic shop kaleidoscope, distorting evidence and testimony into a dazzling display of contradiction and ambiguity. But the reality is harrowing. Elle Palmer, like many young Montanans, believed in the snake oil medical providers and mental health specialists pushed. All of her problems, they would tell her, were because of her gender dysphoria. That by using chemicals—under the euphuism "gender affirming care" (but more correctly

medicalized gender transition ("MGT")—to alter her biological being, she would soon be cured of her problems. These promises put Elle on a conveyor belt of gender ideology, moving from one irreversible treatment to the next. Years later, Elle, like so many young people, has come to regret her short-sighted, immature decisions—now resigned to live with the permanent consequences of these treatments. But this need not and should not continue.

Montana responded to the harms like those Elle suffered with SB 99. Plaintiffs now attempt to invalidate this duly enacted law, but those efforts fail. The Legislature passed SB 99 to enhance minors' protections against the shocking harms of puberty blockers, cross-sex hormones, and surgeries. SB 99 furthers the plain and common-sense objective that medical providers should not push unproven, irreversible treatments on vulnerable children and their families stemming from an ideological rather than evidence-based agenda.

LEGAL STANDARD

Summary judgment is not proper when "by affidavits or as otherwise provided in this rule" the opposing party "set[s] out specific facts showing a genuine issue for trial." Mont. R. Civ. P. 56(e)(2).

ARGUMENT

I. DISPUTES OF MATERIAL FACT PRECLUDE SUMMARY JUDGMENT FOR PLAINTIFFS.

"[T]he concept of gender dysphoria as a medical condition is relatively new and the use of drug treatments that change or modify a child's sex characteristics is even more recent." *L.W. v. Skrmetti*, 83 F.4th 460, 472 (6th Cir. 2023). Plaintiffs cannot escape that this is an underdeveloped and understudied area of healthcare. The facts are all underscored by significant doubt concerning the safety, efficacy, and ethics of MGT. Plaintiffs cannot even make a basic showing "that this treatment

reduces completed suicide" because "completed suicide … is rare."[1] That MGT saves lives should seemingly be a low bar to prove, yet Plaintiffs cannot.

For the purposes of their Motion, Plaintiffs paint genuinely disputed facts as "mere disagreements" or some other backdoor way to achieve a veneer of factual consensus. Not so. For ease, the State will identify each alleged undisputed material fact and present evidence to show that the fact is genuinely disputed.

"Junk science" is the federal government's apt descriptor for the "standards of care" proffered by the World Professional Association for Transgender Health ("WPATH"). "The blatant harm done to children by chemical and surgical mutilation cloaks itself in medical necessity, spurred by guidance from [WPATH], which lacks scientific integrity." (Exec. Order No. 14187, 90 FR 8771, § 3(a) (Feb. 3, 2025), attached as **Exhibit A**). This recent Executive Order directs all federal agencies to rescind or amend all policies that rely on WPATH's standards or guidance. Because "junk science" contaminated this field, the Executive Order also requires the Secretary of Health and Human Services ("HHS") to publish a review of existing literature and best practices regarding treating children with gender dysphoria. (*Id*., § 3(a)(i)-(ii)). It is expected 90 days after the Executive Order's issuance. (*Id.*) This forthcoming review will provide much needed clarity on this issue. Suffice to say, WPATH's "standards" are no longer authoritative or persuasive at the federal level.

Since 2021, 26 states, including Montana, have passed laws prohibiting or restricting MGT for minors.[2] Of the 26, only two states' laws remain blocked: Arkansas and Montana.[3] The Arkansas law received another chance with a grant of

[1] Chase Strangio, Deputy Director for Transgender Justice and staff attorney for the ACLU, in response to Justice Samuel Alito at oral argument in *United States v. Skrmetti*. (Transcript at 88:16-20.) Available at: supremecourt.gov/oral_arguments/audio/2024/23-477.
[2] Amy Harmon, *These 26 States Have Restricted Gender-Transition Treatments for Minors Since 2021*, The New York Times (Dec. 4, 2024), https://tinyurl.com/mudey79n.
[3] *Id*.

an en banc hearing in the Eighth Circuit.[4] When the Court decides *United States v. Skrmetti*,[5] Montana could be the only state where "junk science" prevails.

Even worse, continued deference to WPATH's standards of care here is not just at odds with courts across the country, but also increasingly so with the western world. Finland, Sweden, England, Scotland, Wales, Denmark, and Norway have either banned MGT before the age of majority or severely restricted access to it.[6] Australia, Italy, Germany, France, and Belgium have all entered into a period of reevaluating their MGT models.[7] Australia did this most recently.[8] Perhaps the most surprising about-face was the Netherlands, the origin country of the Dutch protocol—WPATH's foundational treatment regime. The birthplace of MGT now has significant skepticism of its efficacy.[9] And the dominos continue to fall, like with the Cass Review's Final Review ("Cass Review"), which, relying on data from 113,269 children and adolescents from 18 countries, exposed MGT as lacking reliable evidentiary basis.[10] If MGT were as safe and effective as Plaintiffs insist, and if it were so well established so as to purportedly justify a court substituting its

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[4] *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 925 (E.D. Ark. 2023) (permanently enjoining the gender-affirming care ban because it violated the Equal Protection Clause of the Fourteenth Amendment). *But see Brandt v. Griffin*, Or. Granting En Banc Hearing, No. 23-2681 (8th Cir. 2023), attached as **Exhibit B**.

[5] *United States v. Skrmetti*, 144 S. Ct. 2679 (2024) (granting the petition for writ of certiorari); *see also* https://www.supremecourt.gov/qp/23-00477qp.pdf (Whether Tennessee Senate Bill 1 (SB 1) … violates the Equal Protection Clause of the Fourteenth Amendment).

[6] *SEGM promotes safe, compassionate, ethical and evidence-informed healthcare for children, adolescents, and young adults with gender dysphoria.,* SEGM (Dec. 30, 2024), https://segm.org/ (referring to country list and citations located about halfway down page).

[7] *Id*.

[8] On January 28, 2025, Queensland, Australia (one of Australia's six states), eliminated access to gender-affirming care to new patients under 18 years old. (https://tinyurl.com/t3x5ce7c). Three days later, on January 31, 2025, the Australian government announced it is reviewing the guidelines for gender-affirming care. (https://tinyurl.com/t3x5ce7c).

[9] *The 2023 Dutch Debate Over Youth Transitions*, SEGM (Nov. 19, 2023), https://tinyurl.com/4vnj47y7; *Dutch Protocol in transgender care is unsustainable*, DutchNews.nl (May 9, 2024), https://tinyurl.com/353rxy36.

[10] Cass, Hillary (2024) The Cass Report. Independent Review of Gender Identity Services for Children and Young People: Final Report, at 4, attached as **Exhibit C**.

judgment for that of Montana's duly elected representatives, one would reasonably expect the weight of reliable evidence not to continue amassing in favor of the exact opposite conclusions. Plaintiffs' lead expert also would probably not face a medical negligence lawsuit on this very issue,[11] and she likely would not have hidden the results of a taxpayer-funded study.[12] Yet medical providers still push this "junk science"—fueled by shameless greed, radical cult-like ideology,[13] and unwarranted deference to special interest groups lobbying for this medical barbarism to continue unimpeded.

Plaintiffs fight on in apparent denial, seeking summary judgment by simply labeling facts as "undisputed" despite the prolific contrary evidence. Below, the State explains how Plaintiffs' proffered facts are disputed, immaterial, or both:

1. "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—agree that, without treatment, gender dysphoria can lead to 'very adverse long-term mental health consequences, including suicide.'" (Doc. 186 at 3) (quoting Doc. 188 at A.375).

The State disputes this assertion because it assumes "left untreated" and "without treatment" mean not using puberty blockers, cross-sex hormones, and surgical interventions, thus rejecting the efficacy and benefit of solely psychological treatment. This assertion distracts from the material factual dispute of *how* gender dysphoria should be treated and the potential outcomes from treatment (or lack thereof).

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[11] *Breen v. Olson Kennedy*, (Dec. 5, 2024), attached as **Exhibit D.**

[12] Azeen Ghorayshi, *U.S. Study on Puberty Blockers Goes Unpublished Because of Politics, Doctor Says*, N.Y. TIMES (Oct. 23, 2024), https://tinyurl.com/5n7k9k57 ("[Dr. Johanna Olson-Kennedy] said that the drugs did not improve mental health in children with gender distress and that the finding might be weaponized by opponents of the care.")

[13] (*See* Doc. 191, at ¶¶ 14, 52, 53, and 57, and *generally*).

The State also disputes this assertion's reliance on cherry-picked and incomplete quotes from Dr. Nangia's testimony. The actual point Dr. Nangia made—which Plaintiffs ignore—is that many harms associated with gender dysphoria arise from untreated comorbidities, not just gender dysphoria. (Depo. of Geeta Nangia, 175:20-176-19 (Oct. 19, 2024), relevant excerpts attached as **Exhibit E**; Supplemental Declaration of Geeta Nangia, M.D., ¶¶ 47–51 (Feb. 17, 2025), attached as **Exhibit F**). "[W]hen these comorbid conditions are treated in a holistic fashion and normal development and maturation is allowed to occur, gender dysphoria has resolved over time in all the children I've seen,[14] and in the vast majority of adolescents in my patient population." (Ex. F at ¶ 49). Thus, the question is what is the proper treatment: psychological or medical? "Mental health is worse in the group of people with gender dysphoria, but there is no evidence that it is improved by [MGT], nor is there scientific support that [MGT] reduces the risk of suicide." Supplemental Declaration of Sven Román, M.D., ¶ 3 (Feb. 14, 2025), attached as **Exhibit G** (a point the ACLU has admitted in other cases[15]). How to properly treat gender dysphoria remains very much disputed.

2. "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." (Doc. 186 at 3) (citing Doc. 188 at 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

[14] Dr. Nangia has evaluated and treated around 550 children and adolescents since 2002. (Doc. 193, ¶ 17).

[15] Chase Strangio, the Deputy Director for Transgender Justice and staff attorney for the ACLU, conceded to Justice Samuel Alito in oral argument for *United States v. Skrmetti* that "there is no evidence in some -- in the studies that this treatment reduces completed suicide. And the reason for that is completed suicide, thankfully and admittedly, is rare[.]" (Transcript at 88:16-20.) Available at: supremecourt.gov/oral_arguments/audio/2024/23-477.

suicidality. This is a significant problem and should not be ignored.'" (*Id*.) (quoting Doc. 188 at A.447–49, 474).

Plaintiffs' alleged fact distorts SB 99 and the Mountain Pacific memorandum, again cherry-picking quotes to support an immaterial assertion. SB 99 does not require "abrupt termination"—its prohibitions explicitly do not apply to the treatment of the iatrogenic problems, *i.e.*, problems created by the treatment itself. SB 99 § 4(1)(c)(ii) ("[the prohibitions] do not apply for other purposes, including: treatment for any … disorder … that has been caused or exacerbated by medical treatment listed in subsection (1)(a) or (1)(b)."). Any determination of how to taper off the medications should be done on a "case-by-case basis." (Ex. G at ¶ 4). Dr. Van Meter recommends up to a "six-month gradual withdrawal" period. Supplemental Declaration of Quentin Van Meter, M.D., F.C.P. ¶ 2 (Feb. 6, 2025), attached as **Exhibit H**) SB 99 contains no prohibition on such treatment.

The context of cherry-picked Mountain Pacific memorandum quote highlights the uncertainty in this regard. (Doc. 188 at A.473-475). The document states, "abruptly stopping hormonal transitional therapy in adolescents is not well researched." (*Id*. at A.475). "The ideal schedule for tapering of hormonal therapy is unknown." (*Id*.) This is because there is "insufficient data in how an abrupt cessation would affect a transgender patient." (*Id*. at A.473). The context demonstrates the uncertainty. Yet Plaintiffs represent this as undisputed facts. Hardly. On the contrary, it *is* undisputed that the risk of completed suicide is "rare," according to the ACLU.[16]

3. "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

[16] *Id.*

that indicates that adolescent gender dysphoria continues into adulthood.'" (Doc. 186 at 3) (quoting Doc. 188 at A.362).

Plaintiffs again selectively quote a State's expert to reach the inaccurate conclusion that MGT should be available for all minors. (*But see* Ex. E at 122:2-23). "[M]y agreement with the statement was accompanied by a statement that my clinical experience is not in alignment with the literature on this matter." (Ex. F at ¶ 52) (citing Ex. E at 141:20-25-142:1-3). The Diagnostic and Statistical Manual, Fifth Edition, ("DSM-V") supports Dr. Nangia's clinical experience, reporting staggeringly high desistance rates of gender dysphoria: up to 98% of natal males, and up to 88% of natal females.[17] Even WPATH and the Endocrine Society agree desistence is very common. (Doc. 85 at 11; Doc. 86 at 3879); (*see also* Doc. 190 at 7). With desistance rates so high, Plaintiffs' broad assertion creates an inescapable blast radius, functionally demanding all minors with gender dysphoria receive treatment because a tiny minority might not desist in adulthood. This reasoning is backwards for the basic reason that it is impossible to predict desistence. Instead of waiting to treat minors who do not desist, Plaintiffs want to treat all minors—a great majority who will desist—before they have a chance to grow out of their condition.

The high desistance rate demonstrates that immediate MGT is not the proper standard of care. (Doc. 77 at 7, 10, 13-14; Ex.G at ¶ 5). "The current evidence base suggests that children who present with gender incongruence at a young age are most likely to desist before puberty, although for a small number the incongruence will persist." (Ex. C at 41).

This assertion also fails to establish that, for those few children whose gender dysphoria persists into adulthood (when SB 99 no longer applies), puberty blockers, cross-sex hormones, surgical intervention, and the associated likelihood of lifelong

[17] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 455 (5th ed. 2013), relevant excerpts attached as **Exhibit** I.

medicalization would be preferable to appropriate psychological treatment. That Plaintiffs paint this fact as undisputed is beyond logic and reality.

4. "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 blockers and hormone therapy—treatments collectively referred to as gender-affirming medical care." (Doc. 186 at 3-4) (citing Doc. 187 at A.058–59, 201–02).

WPATH's and the Endocrine Society's "guidelines" are neither medical standards nor accepted standards of care. These guidelines are the spawn of an incestuous relationship between two organizations sharing membership and research, cross-referencing and relying on the other when questioned, and creating an ouroboros of reasoning masquerading as independent conclusions. (Ex. F at ¶¶ 34–36) As the Cass Review found:

> **9.21** These two guidelines are also closely interlinked, with WPATH adopting Endocrine Society recommendations, and acting as a co-sponsor and providing input to drafts of the Endocrine Society guideline. WPATH 8 cited many of the other national and regional guidelines to support some of its recommendations, despite these guidelines having been considerably influenced by WPATH 7.
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> **9.22** The circularity of this approach may explain why there has been an apparent consensus on key areas of practice despite the evidence being poor.

(Ex. C at 130). In other words, the Endocrine Society guidelines are the same "junk science" WPATH pushes. (*See* Doc. 193 at ¶ 64; Rebuttal Report of Farr A. Curlin, ¶¶ 13–15 (July 15, 2024), attached as **Exhibit J**). Plaintiffs proffer this fact as undisputed as an underhanded attempt to legitimize these guidelines. The State genuinely disputes this conclusion.

5. "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." (Doc. 186 at 4) (citing Doc. 187 at A.059; Doc. 188 at A.426).

Again, Plaintiffs present this fact so to create the veneer of legitimacy for those guidelines. But they simply are not. It's a pig no matter how much lipstick is used. Plaintiffs cannot conjure agreement where none exists. That these medical groups endorse "the Guidelines" only damages their credibility. Because of its endorsement, Plaintiffs are pursuing tort claims against the American Academy of Pediatrics ("AAP").[18] More lawsuits are likely to follow as more evidence shows the weakness of these organizations' endorsement of junk science. An endorsement of "junk science" is nothing to boast about.

6. "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." (Doc. 186 at 4) (citing Doc. 187 at A.060, 203; Doc. 188 at A.341). "There are no medical interventions recommended for prepubertal children with gender dysphoria." (*Id*.)

According to WPATH, their standards are "based on the best available science and expert professional consensus." (Doc. 103 at S5). So when WPATH released Version 8 of their Standards of Care ("SOC-8") in 2022, they were expected to maintain specific age minimums for their treatments.[19] According to the British Medical Journal, "[t]he deletion of the age recommendations seemed to have

[18] *Ayala v. AAP*, ¶¶ 26, 71-77 (Oct. 23, 2023), attached as **Exhibit K.** (according to the lawsuit, the plaintiff was hastily pushed into taking cross-sex hormones during her first appointment by a Dr. Jason Rafferty, who was the lead author for AAP's "gender-affirmative care" policy statement.)

[19] Block J. *U.S. transgender health guidelines leave age of treatment initiation open to clinical judgment* BMJ 2022; 378 :o2303 doi:10.1136/bmj.o2303

happened at a late stage and after increased attention in social media on gender related surgery among adolescents."[20] Two years later, it was discovered that the change was not prompted by science, but political pressure. (Ex. F at ¶ 43). On June 25, 2024, The New York Times reported that "[e]mail excerpts from members of [WPATH] recount how staff for Adm. Rachel Levine, assistant secretary for health at [HHS] … urged them to drop the proposed limits from the group's guidelines and apparently succeeded." [21] Plaintiffs may claim there is an objective starting point, but there is not. WPATH removed age considerations because of politics—not for the well-being of minor patients. Again, whatever the standards are, they come from the intersection of "junk science" and politics—not objective science and research.

7. "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." (Doc. 186 at 4) (citing Doc. 187 at A.202). "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. (*Id*. at 5) (citing Doc. 187 at A.284-88). "Providers of gender-affirming medical care in Montana, including Plaintiffs Juanita Hodax and Katherine Mistretta, apply the Guidelines in their practices." (*Id*. at 5) (citing Doc. 187 at A.026, 033).

"The Guidelines" are "junk science." So is the recommendation of one comprehensive psychological assessment. Based on her clinical experience, Dr.

[20] *Id*.

[21] Azeen Ghorayshi, *Biden officials pushed to remove age limits for trans surgery, documents show*, N. Y. TIMES (Jun. 25, 2024), available at https://tinyurl.com/3xmn66yh; *see also* Megan Brock, *EXCLUSIVE: Here's How A Small Band Of Pediatricians Pushed Medical Org Into Nixing Age Minimums For Sex Changes*, (Nov. 20, 2024), available at https://tinyurl.com/h5wda6vn.

Nangia has found that "such co-occurring health concerns and issues accompanying gender dysphoria take time to identify, and one comprehensive assessment is not sufficient to do so for practically any condition in mental health." (Doc. 193 at ¶ 39(d)).

Many providers' apparent complete disregard for such an assessment compounds the problems. *See, e.g.* (Doc. 194 at ¶ 8) (Elle Palmer, a Montanan, began a testosterone regimen "[w]ithout any kind of psychological evaluation or other history[.]"); (Supplemental Decl. of Elle Palmer, ¶ 4 (Feb. 8, 2025), attached as **Exhibit L**) ("Planned Parenthood [of Montana] did not do a psychological evaluation before prescribing me testosterone or at any other point."); (Doc. 104 at ¶ 6) ("[P]sychological assistance was primarily only available to write patients' letter of support for medical transition treatments instead of ongoing therapy."); (Doc. 105 at ¶ 13) ("Nor did they do a psychological evaluation even though they acknowledged that I had trauma."); (Doc. 108 at ¶ 12) ("The therapist did not do a psychologist evaluation or testing."); (Doc. 195 at ¶ 6) ("The therapist did not do a full mental health assessment."). Medical negligence litigation across the nation only underscores this issue. *See, e.g.*, (Ex. D at ¶ 5) ("Dr. Olson-Kennedy performed no mental health assessment."); (Ex. K at ¶ 110) (no mental health evaluation done); (*Cole v. Kaiser*, ¶ 41 (Feb. 22, 2023), attached as **Exhibit M**) ("rushed into this experimental transition treatment … without any adequate evaluation of her psychological history."); (*Lovdahi v. Kaiser*, ¶ 6 (June 14, 2023), attached as **Exhibit N**) ("They should have performed an extensive psychological evaluation[.]"); (*Mosely v. Emerson*, ¶ 55 (July 17, 2023), attached as **Exhibit O**) ("she conducted no assessment … of Prisha's gender dysphoria and co-existing mental concerns."); (*Aldaco v. Perry*, ¶ 60 (July 21, 2023), attached as **Exhibit P**) ("no Crane Clinic practitioner gave Soren a psychological assessment").

The informed consent guidelines also amount to "junk science." WPATH plainly states "minors are *not* considered capable of granting informed consent to medical interventions." (Doc. 196, ¶ 37) (emphasis added). "WPATH SOC 8 states that 'decision-making regarding gender affirming medical treatments that have life-long consequences requires thoughtful, future-oriented thinking by the adolescent." (*Id*., ¶ 43) (citing SOC-8 at S63). "[N[either WPATH nor any other source referenced by plaintiffs' experts establishes that minors, whether pre-pubertal or adolescent, are *able* to meaningfully comprehend and reasonably evaluate the risk and lifelong implications of MGT." (*Id*.)

Dr. Mistretta provided the State the 2015 Fenway Health guidelines, a document she "refer[s] to" and "use[s] their informed consent … language…because it's very comprehensive." (Depo. of Katherine Mistretta, 60-63 (June 7, 2024), relevant excerpts attached as **Exhibit Q).** Those guidelines' informed consent relies on information provided in the rest of the packet, including that "*Candidates for hormone therapy must be 18 years old and able to make and give informed consent for therapy*." (Fenway Health Depo. Exhibit 8 at 7, attached as **Exhibit R).** (emphasis in original). "The protocols have been informed by the *WPATH Standards of Care, Version 7 (2011)* …[and] attempt to reflect current, knowledge and research on transgender health while acknowledging that the data and research are limited, often scientifically imperfect, and continuously evolving." *Id.* at 5. The informed consent document Dr. Mistretta uses in her practice *is part of a packet that says minors cannot make and give informed consent* for MGT. She disregards what contradicts her position while simultaneously adopting that which fits her needs. That is "junk science."

Perhaps this explains why the several providers make no effort to obtain true informed consent, either here in Montana or anywhere else. *See*, *e.g*, (Ex. L at ¶ 7) ("[T]he nurse stopped [my mother] and said, "you don't need to go back there." […]

"As a result, my parents were not in the room when the doctor was explaining the effects of testosterone to me."); (Doc. 104 at ¶ 5) ("I personally witnessed children experience shocking injuries from puberty blockers and cross-sex hormones, which often were prescribed to them without complete informed parental consent."); (Doc. 107 at ¶ 5) ("We were not told that these treatments could cause harm to our child's developing bones or that there were no clinical studies establishing them to be safe and effective as a 'treatment' for gender dysphoria in children."); (Doc. 108 at ¶ 15) ("I was provided only cursory information about side effects of testosterone."); (Doc. 195 at ¶ 11) ("I was told about some of these things before beginning testosterone, but at age 16 I had no concept of what it would mean to me."). The lawsuits tell the same stories about abuse of informed consent. *See, e.g.*, (Ex. D at ¶ 5) ("[A]t her very first visit, after mere minutes, Dr. Olson-Kennedy diagnosed Clementine with gender dysphoria and recommended surgical implantation of puberty blockers."); (Ex. K at ¶ 79) ("Ultimately, these tactics work, as by the end of that meeting, her mother caved to their pressure and coercion and consented to Isabelle being put on a 'low-dose' of testosterone."); (Ex. M at ¶ 6) ("There were no in-depth meetings with the parents to discuss the short and long-term harms and hoped-for benefits."); (Ex. N at ¶ 11) (They "did not disclose the significant health risks associated with a biological female taking off-label puberty blockers and high doses of powerful male hormone drugs having many effects other than those desired."); (Ex. O at ¶ 77) (The doctor "failed to explain the scientific basis—and lack thereof—for the testosterone injections and failed to accurately describe any benefits and failed to disclose to Prisha the permanent, detrimental consequences from taking testosterone."); (Ex. P at ¶ 11) (the doctor "failed to give Soren the necessary information to enable Soren to give informed consent").

While Plaintiffs raise a meager two examples supposedly supporting their position, so many countervailing examples (including from a Montanan treated in

Montana) show just how flawed "the Guidelines" are regarding informed consent and basic psychological evaluation requirements, how often medical providers pick and choose or entirely disregard the guidelines, and just how the guidelines' failures are harmful to children.

8. "The State's expert witnesses have no personal knowledge of how gender- affirming medical care is provided in Montana." (Doc. 186 at 5) (citing Doc. 188 at A.392–93, 433–34).

This assertion is immaterial—Plaintiffs rely on the same "standards of care" they insist are appropriate across the country, and they fail to establish how a lack of such personal knowledge of MGT treatments in Montana is of any consequence to an expert's opinions. Regardless, the State's witness, Elle Palmer, knows how MGT is provided in Montana—she received it here. (Doc. 194); (Ex. L). "I was born and raised in Montana." (Doc. 194 at ¶ 3). "I began receiving testosterone treatments for the purpose of gender transition at age 16 at the Planned Parenthood of Great Falls, Montana." (Ex. L at ¶ 2). Elle Palmer adds:

> 5. Planned Parenthood did not do a psychological evaluation before prescribing me testosterone or at any other point. They only went through a checklist of basic questions about my trans experience. I told them my history of being hospitalized due to my poor mental health, being diagnosed with bipolar disorder, depression, and eating disorders and my trying to commit suicide several times and self-harm, however, none of these were red flags to the Planned Parenthood doctor or staff and no one asked any follow-up questions.
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> 6. The doctor who saw me had to consult with other doctors at Planned Parenthood. He asked me what dose of testosterone I wanted. I told him I wanted the maximum adult dose, which the doctor ultimately prescribed.
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> 7. When they called me back to be seen by the doctor, my mother started to come with me. However, the nurse stopped her and said "you don't need to go back there." My mother responded that I was 16, a minor. The nurse then said that it was up to me as to whether my parents could accompany me to see the doctor. Because they made it my choice, I said

> no. As a result, my parents were not in the room when the doctor was explaining the effects of testosterone to me, nor when he was asking me to tell the story of realizing that I was trans, signs of gender distress in childhood and similar questions. Had my parents been present, they would have provided a more accurate and complete picture than I did as a teenager willing to say whatever was necessary to get the prescription using scripts I had found on the internet.

(*Id*., ¶¶ 5-7). Even in Montana at a supposed "leading provider and advocate of high-quality, affordable sexual and reproductive health care,"[22] the same failures occur.

9. "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." (Doc. 186 at 5) (citing Doc. 188 at A.445–46, 455, 485–88).

This assertion defies reality. The mere fact a medical provider, someone in a position of authority and knowledge, entrusts children to make decisions with lifelong consequences, is a power imbalance that reeks of such pressure. Pressure comes in many forms. For example, Elle Palmer's mother was locked out of the room so Elle, alone and susceptible to pressure, essentially prescribed herself testosterone. And when trying to explain her concerns with the treatment, medical providers brushed Elle's mother aside. *This happened in Montana*.

> 9. I witnessed that my mother was pressured into consenting to the testosterone. My mother was a nurse. She was very concerned about the health risks and did not believe it was the appropriate thing to do. She was very reluctant to give consent. My mother was not entirely opposed to treatments if my gender dysphoria had started in early childhood, however, she tried to explain that I had always been a "girly girl" and never said I was a boy, that there were no signs of childhood distress with my sex and that it came on suddenly at age 15. However, no one at Planned Parenthood appeared interested in this information.
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> 10. My mom asked questions and expressed lots of concerns about the physical impacts, particularly the health risks and the negative impact

[22] *About Us*, Planned Parenthood. Available at: https://tinyurl.com/3ej3curr.

> on fertility. My mother later shared with me that my mother felt hopeless, frustrated, sad and angry. A number of the professionals endorsing medical transition, including those at Planned Parenthood, told my mother things like "*wouldn't you rather have a live transitioned son than a dead [daughter]*?" The doctors told my mother that based on the answers I gave to being trans there was no reason to believe that I would regret it. Despite her concerns, she ultimately consented because this is what the medical professionals were telling her to do and because I wanted it so badly.

(*Id*., ¶¶ 9-10). Elle's story mirrors that of the many who have come out against MGT—exposing it as the emotional blackmail it is. *See*, *e.g*., (Doc. 104 at ¶ 14) ("I was present during visits where Center doctors obtained consent by telling the parent of a child assigned female at birth, 'You can either have a living son or a dead daughter,' or parents of a child assigned male at birth, 'You can either have a living daughter or dead son.'"); (Doc. 107 at ¶ 4) ("We were advised that children like M. had high rates of suicide and self-harm and that puberty blockers would help."); (Doc. 108 at ¶ 14) ("The therapist told my mother in front of me 'Do you want a dead daughter or living son?'"); (Doc. 195 at ¶ 8) ("Various medical professionals told my mom, "'Do you want a dead daughter or live son?'"); (Ex. D at ¶ 41) ("Dr. Olson-Kennedy went even further and lied again that if they did not agree to cross-sex hormone therapy, Clementine would commit suicide. She bluntly asked them if they would rather have a living son or a dead daughter."); (Ex. M at ¶ 6) ("Chloe's parents were also asked: 'would you rather have a dead daughter, or a live son?'"); (Ex. N at ¶ 67) ("they coerced Kayla and her parents to undergo this treatment regimen by indicating that 'it is better to have a live son than a dead daughter.'"); (Ex. P at ¶ 30) (the doctor "pressed so hard on the issue that Soren felt as though the only way to cease the discussion was to agree with him and tell him that she did identify as transgender.").

10. "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." (Doc. 186 at 5) (citing Doc. 187 at A.001–24). "Experts on both sides agree that the rate of regret for gender-affirming medical care for adolescents is low." (Doc. 186 at 5) (citing Doc. 187 at A.205; Doc. 188 at A.384).

Even if some adolescents claim benefit in the immediate to short-term, this falls far short of establishing long-term benefit, and Plaintiffs establish no objective timeframe for the allegedly low rate of regret. The State therefore disputes that this broad assertion is of any consequence to the issues in dispute.

Regardless, many more adolescents have suffered grievous harm, and many continue to suffer the consequences of a childhood decision that medical providers, choosing to medicalize a psychological condition, "affirmed." "Regret by people with gender dysphoria is usually realized within 10 years[.]" (Ex. G at ¶ 5). Even if the minor Plaintiffs now believe they benefit from this treatment, no one can say what they will think as they age. Even something that might feel good or right in the beginning can lead to harm. "From the stories of countless adults who have de-transitioned, we know that there is substantial risk of regret and an inability to return to the pre-transition state." (Ex. F at ¶ 17). "The most recent estimate based on this new trend is 30% and even that may underestimate the true numbers[.]" (Ex. H at ¶ 4). Whatever the actual rate is, there is no consensus on what the regret rate is. According to the Cass Review, "[e]stimates of the percentage of individuals who embark on a medical pathway and subsequently have regrets or detransition are hard to determine from [Gender Dysphoria] clinic data alone." (Ex. C at 188). The Report identified several reasons for this, including that those who detransition may not return to the MGT clinic and are "lost to follow-up"; that the "time to detransition ranges from 5-10 years," so current follow up study intervals are too short to capture it; and "the inflection point for the increase in presentations to gender services …

was 2014, so even studies with longer follow-up intervals will not capture the outcomes[.]" (*Id*.)

Plaintiffs also ignore Dr. Nangia's clarification of this point. While she agrees that research claims the regret rate is low, (Doc. 188 at A.384), "the literature in gender-affirming medicine thus far has significant bias." (Ex. E at 247:15-22); *see also* (Ex. F at ¶ 58). The Cass Review concluded the same. (Ex. C at 131).

Regret from MGT should not be considered in isolation, as it coincides with permanent physical dysfunction, disfigurement, and disability. *See e.g*., (Doc. 194 at ¶ 19) (According to Elle Palmer, "[s]ince detranstioning, only some of my breasts have come back and my hairline has returned somewhat, and my body hair has decreased. I still have an Adam's apple and my voice remains deep, changes that will be permanent[.]"); (Doc. 105 at ¶¶ 14, 19) ("my extremities [] get cold and discolored … I also developed a burning sensation in [the] back of my neck, tinnitus (ringing) in my ears, musculoskeletal issues, skin discolorations, [] bone spurs, and insomnia." "I hate that I underwent the surgery. I can never breast feed if I have children."); Doc. 106 at ¶¶ 12-13) ("S.S.'s pain became so intense that she began taking Fentanyl." "S.S. was found dead on August 6, 2021, with Fentanyl and alcohol in her system. She was 28.") (Doc. 107 at ¶ 9) ("I had a bone density scan done for M. It revealed that M. has an 11 percent loss of bone density in one hip, 14 percent in the other, and a 7 percent loss in her lumbar region."); (Doc. 108 at ¶¶ 24-25) (describing joint pain, cardiovascular effects, painful vaginal atrophy, scalp hair loss, facial hair growth, and a lower voice; "I don't know whether the testosterone affected my fertility."); (Doc. 195 at ¶¶ 17-18) ("I am still dealing with joint pain, poor vaginal health, sexual dysfunction, and heart issues … Now I have to wait and see if I can even have children or if my body could handle pregnancy."). The medical negligence suits describe similar horrific consequences. *See*, *e.g.*, (Ex. D at ¶ 8) (describing masculinized body and consequences of double mastectomy); (Ex. K at

¶ 7) (describing profound disfigurement and disability); (Ex. M at ¶¶ 61–65) (describing emotional, psychological, and physical consequences of the care that prompted a double mastectomy); (Ex. N at ¶ 45) (double mastectomy at the age of 13); (Ex. O at ¶ 7) (describing disfigurement and ongoing pain, including consequences of double mastectomy); (Ex. P at ¶ 61) (describing severe consequences of the double mastectomy). And there are many more. Laura Smalts is a detransitioner who went through a double mastectomy and total hysterectomy before realizing she made a mistake.[23] In a Senate hearing on SB 99, she stated that she represented thousands who had contacted her about transition regret.[24] Regret from MGT is both permanent and pervasive.

11. "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." (Doc. 186 at 5) (citing Doc. 187 at A.162).

The material dispute here is not whether "medical care" and "treatments" carry risks as a general matter—it is whether MGT carries such high risks of grievous harm that, coupled with its basis in "junk science" and dubious purported benefits, minors should be protected from it.

"Plaintiffs argue that such risks occur with other medications, and based on this, state that puberty blockers and cross sex hormones should not be banned in the treatment of transgender youth." (Ex. F at ¶ 13).

> I, however, am not aware of circumstances during which medications are used non-emergently that 1) stand to alter the trajectory of physical (endocrine, skeletal, metabolic, neurologic, reproductive) development in conditions that cannot be verified by laboratory findings or physical exams, 2) in conditions that have shown to possibly change or resolve over time, that 3) do not have an evidence base showing documented benefit, that 4) lack evidence to show positive outcomes, that 5) lack

[23] Senate Judiciary Committee hearing on January 27, 2023, at 09:27:25. (Hearing video available at https://tinyurl.com/33nr5fs5)
[24] *Id*.

> sufficient study into associated risks, and 6) that have potential for lifelong irreversible consequences, many of which cannot be appreciated by minors.

(*Id*.) Dr. Curlin agrees: "[w]hile medical procedures that impose substantial risk of serious harm are ethical in some settings, plaintiffs' experts do not remotely establish that the necessary conditions justifying such procedures exist in the case of [gender dysphoria] and [medicalized gender treatment], especially for minors." (Doc. 196 at ¶ 71). And as Dr. Van Meter states, "[t]he purported benefit of 'saving lives by resolving mental anguish' has been clearly eliminated by systemic reviews, and most recently by the data from the longitudinal NIH study. If there is no reduction is mental health morbidity, then there is no justification for the significant risks of blocking puberty and administering high dose sex steroids." (Ex. H at ¶ 5). Risks may be part of medical care, but the risks associated with gender-affirming care do not justify whatever claimed benefit Plaintiffs assert.

12. "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." (Doc. 186 at 5) (citing Doc. 188 at A.354, 368–72, 374).

There is no agreement that this is "commonplace," and Plaintiffs ignore the full context of statements by Dr. Curlin and Dr. Nangia. Dr. Curlin testified that medical care backed up by "very low quality" evidence is "a feature of *some* pediatric practice[.]" (Doc. 188 at A.354) (emphasis added). Dr. Nangia stated, "I don't know that I'd say it's common, but it does happen." (*Id*. at A.369). But this is a red herring and dodges the important problem here: *why* rely on "very low quality" evidentiary bases for an unproven treatment that is likely irreversible and so often regretted.

The Cass Review dedicated an entire section to this issue. (*See* Ex. C at 54-57). According to the GRADE (Grading of Recommendations, Assessment,

Development, and Evaluations) System, there are four levels of certainty about results. (*Id*. at 56). "Very low" means "[t]he true effect is probably markedly different from the estimated effect." (*Id*.) "Low" means "[t]he true effect might be markedly different from the estimated effect." (*Id*.) In other words, MGT being based on "very low quality" evidence is not a good thing. The true effect of the treatments (*e.g.*, permanent physical dysfunction, disfigurement, and disability) has been markedly different from the estimated effect—that is, happier children. *See* Appendix 2 of the Cass Review (Ex. C) (giving the results of the University of York's review of the very low quality of the evidence on "gender-affirming care.") Further, two recent Canadian studies performed a systematic review and meta-analysis on puberty blockers and, separately, cross-sex hormones use in gender-affirming care. These results mirrored those of the Cass Review, determining that "[t]here remains considerable uncertainty regarding the effects of puberty blockers in individuals experiencing [gender dysphoria]."[25] They concluded the same for cross-sex hormones, adding that they "cannot exclude the possibility of benefit or harm."[26] The evidence clearly contradicts Plaintiffs' claims here.

13. "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

[25] Miroshnychenko A, et al. *Puberty blockers for gender dysphoria in youth: A systematic review and meta-analysis*. Arch Dis Child. 2025 Jan 30:archdischild-2024-327909. doi: 10.1136/archdischild-2024-327909. Epub ahead of print. PMID: 39855724.

[26] Miroshnychenko A, et al. *Gender affirming hormone therapy for individuals with gender dysphoria aged <26 years: a systematic review and meta-analysis*. Arch Dis Child. 2025 Feb 6:archdischild-2024-327921. doi: 10.1136/archdischild-2024-327921. Epub ahead of print. PMID: 39855725.

efficacy." (Doc. 186 at 5-6) (citing SB 422, 2023 Leg., 68th Sess. (Mont. 2023)). "By contrast, puberty blockers, estrogen, and testosterone—medications used in gender-affirming medical care—have been approved by the FDA for other indications." (*Id*. at 6) (citing Doc. 188 at A.336–37).

This assertion is patently false. On several occasions, the Legislature has proposed prohibitions on medical treatments based on potential risks: HB 391 (2013), HB 171 (2021), and HB 721 (2023). HB 391 was an act requiring parental consent before an abortion for a minor because the Legislature found that minors lack the ability to make fully informed choices and "the medical, emotional, and psychological consequences of abortion are sometimes serious and can be lasting[.]" (HB 391 at § (1)(a)-(b), attached as **Exhibit S**). HB 171 required informed consent and placed restrictions on an abortion-inducing drug called mifepristone because the Legislature found that it "presents significant medical risks, including but not limited to uterine hemorrhage, viral infections, abdominal pain, cramping, vomiting, headache, fatigue, and pelvic inflammatory disease." (HB 171 at 1, attached as **Exhibit T**). Finally, HB 721 banned dismemberment abortions on living fetuses because "as the second trimester progresses," "the maternal health risks of undergoing an abortion are greater than the risks of carrying a pregnancy to term."(HB 721 at 2, attached as **Exhibit U**).

Plaintiffs point to SB 422 (2023) for support but undermine their own argument in doing so. *See below*, ARGUMENT, II, A. As Plaintiffs state, SB 422 amended Montana's right-to-try statute so Montanans could use "investigational drugs that have *not been approved … for any indication*." (Doc. 186 at 5–6) (emphasis added). But then Plaintiffs turn around and say that MGT drugs "*have been approved* by the FDA *for other indications*." (*Id*. at 6) (emphasis added). Because those treatments have been approved for "other indications," SB 422 is inapplicable here.

14. "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." (Doc. 186 at 5) (citing Doc. 188 at A.265–66, 351, 379, 385–86, 401).

"While the lack of FDA approval of a drug for a particular use (a.k.a. "off label use") is not, itself, an indicator of the danger or impropriety of that off label use, the lack of FDA approval or applications for the same do indicate that the FDA has not determined or been requested to determine that the particular use of the drug in question is safe, appropriate, and effective based on a review of relevant evidence, including clinical studies." Supplemental Declaration of Farr Curlin, M.D., ¶ 5 (Feb. 6, 2025), attached as **Exhibit V**) "In any event, off-label use of a drug must still be medically reasonable, and…["gender-affirming care"] among minors is not medically reasonable." (*Id.*); (*see also* Ex. H at ¶ 8). If a drug has not been FDA approved for a certain use, the FDA has not determined that drug to be safe, appropriate, or effective for that off-label use.

15. "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." (Doc. 186 at 6) (citing Doc. 187 at A.075–76; Doc. 188 at A.348).

The State rejects Plaintiffs' allegations for what they are: an incorrect painting of what MGT is and what it is not. Plaintiffs oddly cite to Dr. Curlin's religious faith rather than substantive comments to this point. (Doc. 188 at A.348). And Plaintiffs provide no example of any other treatment with the same risks as MGT requiring a warning of just how unknown the outcomes are. For example, according to the informed consent document for puberty blockers provided by Plaintiffs, "[t]he long term safety of using these medicines in transgender and gender diverse youth is not

completely understood. There may be long-term risks that are not yet known." (SB99-PLAINTIFFS_0001192, attached as **Exhibit W)**. "If someone starts puberty blockers in the earliest stages of puberty, and then goes on to gender affirming hormones, they will not develop sperm or eggs. The means they will not be able to have biological children." (*Id*.) "Taking puberty blockers may reduce the need for future gender affirming surgeries[,]" (*Id*.) The informed consent form for testosterone explains just how unknown those risks are, too: "I understand that, although testosterone is a common gender affirming treatment for adults, using this treatment in adolescents is a newer development. The long-term effects are not fully known, though recent studies[27] have been reassuring about testosterone's safety in youth and young adults." (SB99-PLAINTIFFS_0001188, attached as **Exhibit X**). "The long-term effects of testosterone on someone's fertility (ability to have a biologic child) are not known." (*Id*.) "The long term effects on chronic disease risk … is still being researched[.]" (*Id*.) Estrogen's informed consent document reads similarly: "I understand that, although estrogen is a common gender affirming treatment for adults, using this treatment in adolescents is a newer development. The long-term effects are not fully known, though recent studies have been reassuring about the safety of estrogen in youth and young adults." (SB99-PLAINTIFFS_0001190, attached as **Exhibit Y**). "It is not known if taking estrogen increases the risk of breast cancer." (*Id*.) "Sperm may not mature, leading to reduced fertility (ability to have a biologic child). The ability to make sperm normally may or may not come back even after stopping taking estrogen." (*Id*.) "The long term effects of estrogen on chronic disease risk … is still being researched." (*Id*.)

Several phrases stand out from Plaintiffs' informed consent documents: "not completely understood," "not yet known," "newer development," "not fully known,"

[27] Likely the same "very low quality" studies where "[t]he true effect is probably markedly different from the estimated effect." [Ex. C at 56.)

and "still being researched." This falls far short of the well-established, evidence-based, safe, effective, and medically necessary and appropriate treatment that Plaintiffs hold "gender-affirming care" out to be.

* * * * *

The existence of genuinely disputed material facts requires the Court to deny Plaintiffs' Motion. The State genuinely disputes facts Plaintiffs assert as undisputed material facts. These genuine factual disputes are the demise of Plaintiffs' Motion. But Plaintiffs' claims also fail as a matter of law.

II. PLAINTIFFS' CLAIMS FAIL AS A MATTER OF LAW.

Plaintiffs pursued only their privacy and equal protection claims, reducing their other claims to a footnote. (Doc. 186 at 9, n.5). They have effectively abandoned those other claims. *See In re Allstate Life Ins. Litig.*, No. CV-09-08162-PCT-GMS, 2013 U.S. Dist. LEXIS 200391, at *17 (D. Ariz. Nov. 4, 2013) ("A footnote is the wrong place for substantive arguments on the merits of a motion."); *United States v. Strong*, 489 F.3d 1055, 1060 n.4 (9th Cir. 2007) ("The Court need not consider substantive arguments summarily raised in footnotes."). And Plaintiffs cannot, in their expected Reply Brief, resuscitate their orphaned claims because "[t]he purpose of a reply brief is to respond to the arguments raised in a response brief." *Willis v. Oppegaard*, No. DA 23-0742, 2024 Mont. LEXIS 202, at *2 (Mar. 21, 2024); *see* also Mont. R. App. P 12(3). The Montana Supreme Court continually holds it "will not address the merits of an issue presented for the first time in a reply brief." *Id.* (quoting *State v. Makarchuk*, 2009 MT 82, ¶ 19, 349 Mont. 507, 204 P.3d 1213); *see also Pengra v. State*, 2000 MT 291, ¶ 13, 302 Mont. 276, 14 P.3d 499 (same). The State relies on Plaintiffs' abnegation of its other claims and will argue only about the privacy and equal protection claims Plaintiffs substantively advance, both of which fail as a matter of law.

A. Plaintiffs cannot overcome the presumption of constitutionality.

The Montana Supreme Court has repeatedly held that statutes "are presumed to be constitutional, and the party challenging a statute's constitutionality bears the burden of proving it unconstitutional beyond a reasonable doubt." *Barrett v. State*, 2024 MT 86, ¶ 13, 416 Mont. 226, 547 P.3d 530. "Every possible presumption must be indulged in favor of the constitutionality of a legislative act." *Powell v. State Comp. Ins. Fund*, 2000 MT 321, ¶ 13, 302 Mont. 518, 15 P.3d 877. "We regard that presumed constitutionality as a high burden to overcome." *Planned Parenthood v. State*, 2024 MT 178, ¶ 16, 417 Mont. 457, 554 P.3d 153 (citing *Hernandez v. Bd. of Cnty. Comm'rs*, 2008 MT 251, ¶ 15, 345 Mont. 1, 189 P.3d 638)). "[I]f any doubt exists, it must be resolved in favor of the statute." *Powell*, ¶ 13 (emphasis added).

Plaintiffs assert the Legislature enacted SB 99 with "an animus towards transgender Montanans," yet nowhere do they assert *any* evidence to support this claim. (Doc. 186 at 16, n.10). At the preliminary injunction stage, the Court likewise cited no direct evidence of a discriminatory animus. (Doc. 131 at 33–34). Although it is alleged the record is replete with discriminatory animus, Plaintiffs present no supporting evidence. This Court's job is not to search for a legislative animus when the Montana Supreme Court demands legislative enactments deserve deference. And it is problematic for a co-equal branch of government to question the motives of another branch without any evidence to that point. Such an inquiry undermines the democratic foundations of the government.

Plaintiffs try to bolster their assault by arguing Montana's right-to-try statute somehow suggests a discriminatory animus. But that is wrong. That statute provides, "A manufacturer of an investigational drug … may make the drug … available to a patient who has requested the drug" subject to certain constraints. Mont. Code Ann. § 50-12-103(1). This does not, however, cover puberty blockers or cross-sex hormones because those drugs are not "investigational." The FDA has approved

puberty blockers and cross-sex hormones—just not for MGT purposes. The right-to-try statute does not pertain to off-label use. It is strictly limited to drugs which "ha[ve] successfully completed phase 1 of a clinical trial but ha[ve] not been approved for general use by the United States food and drugs administration" and "remain[] under investigation in a United States food and drug administration-approved clinical trial." Mont. Code Ann. §§ 50-12-102(3)(a)–(b). Plaintiffs do not assert any of the drugs here fit into this category.

Also, the right-to-try is found in Chapter 12—"Treatments for Chronic or Terminal Illness." Plaintiffs never allege, and the State has no knowledge, that MGT treats chronic or terminal illness. (*See* Ex. J at ¶¶ 4–12)**.** Plaintiffs do allege MGT somehow saves lives, but they cannot show such treatment reduces suicidality—the only alleged life-threatening consequence of withholding MGT. Plaintiffs cannot prove that SB 422 shows the Legislature enacted SB 99 with a discriminatory animus. Nor could they. The Legislature had no discriminatory animus when it passed SB 99. The Court should decline Plaintiffs' attempt to throw out a duly enacted law on the weak grounds there was some (unproven) discriminatory animus.

B. Strict scrutiny is the incorrect standard of review.

Whatever the correct level of scrutiny is, it is irrelevant because the State has "wide discretion in areas," as here, "where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). "When [the State] undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation [even if] judges with more direct exposure to the problem might make wiser choices." *Marhsall v. United States*, 414 U.S. 417, 427 (1974). "[J]udicial intervention is generally unwarranted no matter how unwisely [courts] may think a political branch has acted." *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 314 (1993).

Plaintiffs' assault on deference to the democratic institutions of our society—the body most directly accountable to the people—flouts United States Supreme Court precedent that the Legislature is the best branch to navigate these uneasy waters. Courts simply cannot mediate medical debates. Nor should they. "[H]ealth and welfare laws [are] entitled to a 'strong presumption of validity.'" *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 221 (2022) (quoting *Heller v. Doe*, 509 U.S. 312, 319 (1993)). Plaintiffs indeed try as hard as possible to remove this issue from the hands of the people and place it into the Court's hands. And this is wrong.

Strict scrutiny cannot be the correct standard of review. And for good reason. Plaintiffs present only one argument that relies on Montana Supreme Court precedent to reach strict scrutiny: their *Armstrong* privacy analysis. Plaintiffs' equal protection arguments—three in total—are all Trojan Horses, transforming misconstrued legal reasoning and nonbinding opinions into binding law. All these arguments, however, reach the incorrect conclusion. Rational basis is the correct standard of review. "*It is enough that there is an evil at hand for correction*, and that it might be thought that the *particular legislative measure was a rational way to correct it*." *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 488 (1955) (emphasis added).

1. Privacy.

To justify applying *Armstrong*'s strict scrutiny standard, Plaintiffs must first overcome *Armstrong*'s exception for state laws and regulations concerning medically acknowledged, bona fide health risks. And the Court need not take a magnifying glass to *Armstrong* to find what that standard means. The plain meaning of *Armstrong*'s text is exactly what it says: "In narrowly defined instances the state, by clear and convincing evidence, may demonstrate a compelling interest in and obligation to legislate or regulate to preserve the safety, health and welfare of a

particular class of patients or the general public from medically-acknowledged, *bonafide* health risk." *State v. Armstrong*, 1999 MT 261, ¶ 59, 296 Mont. 361, 989 P.2d 364. It is the State's burden to prove as much, and the State has done so. (*See generally* Doc. 190).

Plaintiffs conjure from nothing an overly narrow and baseless interpretation of *Armstrong*'s exception. Rather than following the plain meaning of this unambiguous text, Plaintiffs, *in a footnote no less*, make up that risk must be "sufficiently grave and beyond the medical norm—and without any benefit that balances the severity of the risk" so to "justify legislative interference with the ordinary processes of consultation and informed consent." (Doc. 186 at 12, n.6). Plaintiffs aren't looking at *Armstrong* through magnifying glass; they're using a kaleidoscope.

Absolutely nowhere does *Armstrong* require a balancing of risk and benefit or a showing of gravity of the treatment or even that the treatment is beyond medical norm. *Armstrong* means what it says: if the State can, by clear and convincing evidence, show a compelling interest in and obligation to enact laws and regulations to "preserve the safety, health and welfare of a particular class of patients" from a "medically-acknowledged, *bonafide* health risk," those laws and regulations survive. Plaintiffs try (and fail) to argue that, because every medical treatment has risk, the State cannot protect its citizens on the grounds of a medically acknowledged, bona fide health risk; something more, Plaintiffs argue, must be offered, or else the right to seek health is nullified. But Plaintiffs' argument equally nullifies *Armstrong*'s exception. If every drug, even as basic as Tylenol, presents some risk and therefore cannot be regulated, *Armstrong*'s risk exception is meaningless.

This argument exposes the weakness of Plaintiffs' position: drugs are supposed to help, not hurt. As Plaintiffs point out in a footnote, Tylenol is risky when it is not used properly—in that case, being overused. (Doc. 186 at 14, n.8). In the

same way, puberty blockers and cross-sex hormones and surgery present risk *when used improperly*, such as when used (to attempt) to treat a mental illness. Plaintiffs ask this Court to permit turning health care providers into something "fundamentally incompatible with physician's role as healer." *Wash. v. Glucksberg*, 521 U.S. 702, 731 (1997). Giving insulin to a diabetic helps; giving insulin to a hypoglycemic could kill. Giving puberty blockers to a minor suffering central precocious puberty helps that child. But giving puberty blockers to a minor suffering from gender dysphoria harms that child (*e.g.* by causing hypogonadism). When doctors give otherwise healthy minors puberty blockers, cross-sex hormones, or surgery to treat gender dysphoria, they create biological abnormalities. This "blur[s] the time-honored line between healing and harming." *Id.* That is not helping; *that is harming*. And the known harms of these treatments are substantial. (Doc. 190 at 2–11; 17–23).

Judges are not medical experts well equipped to define the efficacy of treatment. Yet that is exactly what Plaintiffs want from the Court. Plaintiffs' made-up burden defies *Armstrong*'s plain meaning. The State proffered medical expert testimony—*from both sides*—to prove MGT presents a medically acknowledged, bona fide health risk. (Doc. 190 at 21–23). Plaintiffs' *Armstrong* analysis is divorced from the text. Because SB 99 falls into the *Armstrong* exception, strict scrutiny does not apply.

Alternatively, the scientific validity and medical evidence on the safety, efficacy, and ethicalness of puberty blockers, cross-sex hormones, and surgery for treating gender dysphoria is an ongoing debate. Medical ethicists' questions grow about the validity of WPATH's standard of care. (Ex. J at ¶¶ 13–15).And for good reason. WPATH's "junk science" comes not from rigorous scientific study and research but from rubberstamping its bedfellow Endocrine Society's research and vice versa. (Ex. F at ¶¶ 34–36). As these debates play out, the Court ought not

prematurely put itself in a position to determine medical community decisions before all the evidence is in. At the very least, "[t]he State also has an interest in protecting the integrity and ethics of the medical profession." *Glucksberg*, 521 U.S. at 731. If medical ethicists have doubts, the State needs to step in while the debates rage.

In the Montana Legislature, there is a pending bill which would criminalize procuring or providing "treatments on a child less than 16 years of age for the purpose of altering the appearance of the child or affirming the child's perception of the child's sex when the appearance or perception is inconsistent with the child's biological sex." SB 164, § 4 (2025). Should this bill pass, the provision of puberty blockers, cross-sex hormones, or surgery to a minor to affirm that child's perception of his sex would be illegal. It is not clear if *Armstrong* would apply anymore because its reasoning only applies to "lawful medical procedure[s]." *Armstrong*, ¶ 14.

2. Equal Protection.

Plaintiffs' equal protection argument relies on three different equal protection arguments to reach strict scrutiny. Yet each argument fails, lacking any basis in Montana law, no less common-sense.

Plaintiffs first pursue an equal protection argument following this Court's equal protection analysis in its preliminary injunction order. (Doc. 186 at 10–11). They argue that strict scrutiny is appropriate under *Hensley* because transgender minors and all other minors are identical in all respects but for the regulated behavior—here, seeking certain drugs and surgeries to address a matter of perception. *Id.* This argument is doubly wrong.

First, the classification cannot be Montanan transgender minors and all other minors because those two groups are not similarly situated. They are not "identical in all other respects" but for "the factor allegedly subject to impermissible discrimination." *Hensley*, ¶ 19. Being transgender is not the same as having gender dysphoria. The former is an intellectual decision while the latter is a medical

diagnosis. And having gender dysphoria makes that individual distinct from individuals without gender dysphoria. So minors with gender dysphoria are categorically different from all other minors. They are not similarly situated.

SB 99 has nothing to say about transgender status. Plaintiffs' imagined definitions do not dictate Montana law or bind the Legislature. SB 99 prevents medical providers giving puberty blockers, cross-sex hormones, and surgeries to male and female minors equally if they are given for the improper purpose of addressing the minor's subjective feelings of their identity. Just as much as a girl cannot get puberty blockers to delay her puberty, a boy cannot get puberty blockers to delay his (both absent a biological abnormality like an enlarged pituitary gland). No male or female minor may receive any hormone to address his or her subjective feelings. Being transgender is irrelevant to a minor's ability to get puberty blockers; if they are sought to address a matter of subjective identity, they cannot be given. SB 99 regulates MGT for all minors equally. "[This law] is best understood as a law that targets specific medical interventions for minors, not one that classifies on the basis of any suspect characteristic under the Equal Protection Clause." *Eknes-Tucker v. Gov. of Alabama*, 80 F.4th 1205, 1227 (11th Cir. 2023). SB 99 treats male and female minors equally.

And SB 99 still allows male and female minors to access, for example, estrogen and testosterone for medical purposes other than for addressing that minor's subjective identity. A male minor with biologically abnormal hormone levels may receive both testosterone and estrogen to return to biologically normal hormone levels. And a female minor can do the same. But neither a female nor male minor can receive those hormones when they are otherwise biologically normal and seek that treatment solely to address his or her subjective feelings about identity.

The primary fault in Plaintiffs' argument is that treatments, like providing a minor testosterone, are different depending on the patient—regardless of using the

same drug. Giving a male minor testosterone is not MGT. But giving a female minor testosterone is a different story. That is because male and female minors have different physiologies and biologically different reactions to the same drugs. And although the drug is the same, this does not, however, make the treatments the same. Even giving the same drug to members of the same sex does not make the treatment the same. Giving a female minor estrogen to treat a gland problem is different from giving a female adult estrogen to treat a fertility problem. According to Plaintiffs, Montana either must ban using puberty blockers, cross-sex hormones, and surgeries for all purposes, or allow them for all purposes. Plaintiffs' argument neuters the State of its legitimate authority to regulate medical practice.

Plaintiffs next argue that transgender discrimination is sex discrimination, equating sex and transgender status. (Doc. 186 at 11). This argument fails because nowhere in state or federal law does transgender status confer sex discrimination protections. Indeed, Plaintiffs try to recycle a concurring opinion—which *five* Montana Supreme Court justices declined to endorse—as binding precedent for this Court. That is wrong. Even if there were transgender discrimination here, which there is not, sex discrimination does not subsume transgender discrimination. There is no Montana caselaw to support this proposition. And federal caselaw equally lacks support. Plaintiffs' one favorable case, *Brandt ex rel. Brandt v. Rutledge*—where the Eighth Circuit granted en banc hearing of the same issue in *Brandt ex rel. Brandt v. Griffin*, No. 23-2681 (Ex. B)—faces overwhelming criticism from the Sixth, Seventh, and Eleventh Circuits, not to mention a pending United States Supreme Court case which will settle this circuit split. Taken all together, Plaintiffs have nothing to stand on. Transgender status does not confer sex discrimination protections. *See*, *e.g.*, *L.W. v. Skrmetti*, 83 F.4th 460, 489 (6th Cir. 2023); *L.W. v. Skrmetti*, 73 F.4th 408, 419, 421 (6th Cir. 2023); *Doe 1 v. Thornbury*, 75 F.4th 655, 657 (6th Cir. 2023) (per curiam); *Eknes-Tucker*, 80 F.4th at 1227, 1231; *K.C. v.*

Individual Members of the Med. Licensing Bd. of Ind., 121 F.4th 604, 621, 633–34 (7th Cir. 2024).

As a last gasp for relief, Plaintiffs improvidently posit that transgender status constitutes a suspect class. Not only do Plaintiffs fail again to present any state or federal caselaw to support this position, but "[the United States] Supreme Court has not recognized any new constitutionally protected classes in over [five] decades, and instead has declined to do so." *Ondo v. City of Cleveland*, 795 F.3d 597, 609 (6th Cir. 2015). Indeed, at various points, the United States Supreme Court had the opportunity to turn groups of disabled people (including mentally disabled people), age groups, socio-economic groups, or even special familial relationship groups into a suspect class *and declined to do so*. *See City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 441–46 (1985); *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 313 (1976); *San Antonio Ind. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 28 (1973); *Lyung v. Castillo*, 477 U.S. 635, 638 (1986). Even when it had the opportunity to make lesbian, gay, and bisexual status a suspect class, the United States Supreme Court declined. *Obergefell v. Hodges*, 576 U.S. 644 (2015). Lower federal courts have followed suit.

As for state law, Plaintiffs prove the State's argument. Again relying on a non-binding two-justice concurrence, Plaintiffs assert that transgender status is a protected class in Montana. (Doc. 186 at 11). But that **two**-justice concurrence militates against that proposition. For transgender status to be a suspect class, that two-justice concurrence would need to be a binding majority opinion. But it is not. There is no law in Montana which makes transgender status a suspect class—presumably why those justices felt compelled to write that concurrence. Indeed, Montana courts, like federal courts, continually reject creating new suspect classes. Even in Plaintiffs' cited case, *In re S.L.M.*, the Montana Supreme Court, following the United States Supreme Court, declined to create a new suspect class. *In re S.L.M.*, 287 Mont. at 33 ("We have followed the United States Supreme Court in holding

that a sentencing distinction based upon age is not a suspect classification requiring strict scrutiny."). Other courts agree. *See*, *e.g.*, *Powell*, ¶ 21; *Matter of Wood*, 236 Mont. 118, 125, 768 P.2d 1370 (1989) (declining to make new suspect class for age); *Wicklund v. State*, 1999 Mont. Dist. LEXIS 1116, *5 ("The class of minor pregnant women is not a suspect class."); *City of Helena v. Brueggeman*, 2000 ML 3771, 12 ("[T]his Court cannot conclude that automobile drivers between the age of 18 and 21 with a blood alcohol content above 0.02 constitute a suspect class."); *State v. Gillespie*, 2000 ML 3880, *7 ("It is clear that in this case the Court is not dealing with a suspect class.").

Nor does subjective gender identity equate to sex. The Montana Supreme Cout said as much when, for a sex discrimination claim, it held the party "first must establish membership in a protected class, *either male or female*." *Mont. State Univ.-N. v. Bachmeier*, 2021 MT 26, ¶ 28, 403 Mont. 136, 480 P.3d 233 (emphasis added).

Plaintiffs want to create a new suspect class.[28] The Court should decline. For the Court to create a suspect class on a whim is not only inappropriate but it implicates a myriad of laws and regulations well beyond the scope of this litigation. The Court must reject Plaintiffs' radical request. None of Plaintiffs' attempts to push this case into strict scrutiny review succeed. Rational basis is the correct level of scrutiny here. (Doc 190 at 24–27). And under that standard, Plaintiffs' claim fails.

III. PLAINTIFFS' MEDICAID CLAIM SHOULD BE DISMISSED.

In their Motion, Plaintiffs mention Medicaid once—a passing mention referring to a practice area of an expert. (Doc. 186 at 3). Never again do Plaintiffs discuss or argue SB 99's Medicaid provision. They never once substantively used

[28] Plaintiffs' argument leads to the absurd result that a man can identify as a woman so to become a member of a suspect class. As an analogy, this would be like an individual deciding to identify as a certain national origin or ethnicity to gain the suspect class status. This defies typical suspect classifications, rooted in ***immutable*** traits.

the word 'insurance.' Indeed, Plaintiffs dedicated no argument challenging SB 99's Medicaid provision. The State need not fund puberty blockers, cross-sex hormones, or surgeries for indigent minors. *See Harris v. McRae*, 448 U.S. 297, 316 (1980) (a right does not convey "a constitutional entitlement to the financial resources" so to enjoy that right). The lack of argument entitles the State to relief on this claim. Otherwise, the State and Court would have to guess what exactly Plaintiffs argue on this point. Plaintiffs have failed to show Medicaid must cover puberty blockers, cross-sex hormones, and surgeries for minors to address concerns about his or her identity. The Court should dismiss this claim.

IV. FOR THESE REASONS, GRANTING SUMMARY JUDGMENT FOR PLAINTIFFS IS IMPROPER.

Plaintiffs' burden was to show there is no genuine dispute of material fact and that they are entitled to judgment as a matter of law. They failed at both steps, and the Court should therefore deny their Motion for Summary Judgment. The disputed issues of material fact here, primarily the weight and credibility of medical expert testimony, would be best subject to the judgment of a jury. "It appears, at this summary judgment stage, this case [will] come down to a 'battle of experts' where the focus" will be on the efficacy and quality of the medical experts' opinions. *Cottonwood Environmental Law Ctr., et al., v. State*, Count II Summary Judgment Or., at 29, BDV-2023-754 (Mont. First Jud. Dist., Feb. 12, 2025). As this Court recognized, "trial is the appropriate stage for ultimate fact finding on the science presented in this matter." (Doc. 131 at 39, n.14). And "[w]e should never underestimate … the collective wisdom of the American jury to sort out complex problems." *Wood v. Old Trapper Taxi*, 286 Mont. 18, 27, 952 P.2d 1375 (1997). "Juries have an uncanny ability to evaluate the credibility of a witness, especially an expert. Problems presented in a case such as this, namely conflicting expert testimony [], are best solved by juries." *Id.* Because the parties genuinely dispute

material factual issues, the Court should deny Plaintiffs' Motion for Summary Judgment.

CONCLUSION

Plaintiffs have failed to meet their burden for achieving summary judgment by presenting genuinely disputed facts. This dooms their Motion. The weighing of medical expert testimony is best reserved for a jury trial. The Court should accordingly deny the Plaintiffs' Motion for Summary Judgment. Defendants respectfully request oral argument on parties' respective Motions.

DATED this 19th day of February 2025.

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