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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' REPLY IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**
STATE OF MONTANA et al.,	
Defendants.	

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INTRODUCTION

The Montana Supreme Court and this Court have made clear that, to prevail in this case, Defendants must overcome a very high burden. First, they must establish that the medical treatments proscribed by SB 99 constitute a "medically[] acknowledged, *bona fide* health risk," *Cross ex rel. Cross v. State*, 2024 MT 303, ¶ 21, 560 P.3d 637 (alteration in original) (quoting *Armstrong v. State*, 1999 MT 261, ¶ 62, 296 Mont. 361, 989 P.2d 364). *If*—and *only* if—that substantial burden is satisfied, Defendants must then demonstrate that SB 99 is narrowly tailored to survive strict scrutiny.

Defendants' summary-judgment filings conclusively establish that they can do neither.

Perhaps most striking about Defendants' opposition is the scarcity of Montana caselaw. At times, they seem to be litigating in the wrong forum—the U.S. Supreme Court, perhaps, or just the court of public opinion. Conspicuously missing from their brief is *any* discussion of Montanans' fundamental rights or even the Montana Supreme Court's prior opinion *in this case*. Rather than show how they might overcome the actual standards announced by the Supreme Court last December, Defendants ignore them in favor of invective and misguided arguments—all mixed metaphors, inapposite caselaw, and political grandstanding—that serve only to show why doctors, not legislators or lawyers, should make decisions about Montanans' medical care.

As the Supreme Court explained more than two decades ago, the "legal standards for medical practice and procedure cannot be based on political ideology, but, rather, must be grounded in the methods and procedures of science and in the collective professional judgment, knowledge and experience of the medical community acting through the state's medical examining and licensing authorities." *Armstrong*, ¶ 62. But rather than defer to the medical community's judgment,

Defendants attack it on purely political grounds, broadly impugning the integrity of numerous organizations of medical professionals and deeming their considered judgment "junk science" simply because it does not support their narrative.[1] Indeed, Defendants' primary approach is to attempt to elevate political talking points to the level of legal authority—but, in so doing, they have wholly disregarded the applicable standards for summary judgment generally and this case in particular.

Ultimately, Plaintiffs' attempt to turn political grandstanding into medical consensus fails. Infringing on Montanans' fundamental rights—the right to privacy in particular—necessarily requires a more robust showing than what Defendants' evidence here supplies. Despite all the diversionary tactics, trial is unnecessary because, even if their witnesses testified as presented and their assertions were accepted as true, Defendants would still fail to meet the high burden of demonstrating a medically acknowledged, bona fide health risk or satisfying narrow tailoring. Summary judgment in Plaintiffs' favor is therefore warranted.

[1] Defendants seize on President Trump's recent executive order and its use of the term "junk science" as a seemingly conclusive demonstration of official wisdom and medical consensus. But, of course, it's neither, and Defendants' repeated invocation of that term demonstrates the hollowness of their position. In any event, a nationwide temporary restraining order and preliminary injunction have been entered against enforcement of that executive order—with orders rejecting the very arguments and evidence Defendants raise here. *See generally PFLAG, Inc. v. Trump*, No. 25-337-BAH, 2025 WL 510050 (D. Md. Feb. 14, 2025) (discussing and rejecting Cass review and regret as justifications); *Washington v. Trump*, No. 2:25-cv-00244-LK, 2025 WL 659057 (W.D. Wash. Feb. 28, 2025). ("[p]laintiffs . . . submitted abundant evidence—including expert witness declarations, medical studies, and declarations attesting to personal and professional experience with gender affirming care—supporting the efficacy and safety of the" prohibited treatments and "further submitted expert testimony that the evidence supporting gender-affirming care for adolescents is as robust as the evidence supporting other pediatric treatments").

ARGUMENT

I. Because Defendants have failed to clearly and convincingly demonstrate a medically acknowledged, bona fide health risk, SB 99 violates the constitutional right to privacy.

The *Armstrong* standard presents a significant limitation on government interference with private medical decisions. Absent a medically acknowledged, bona fide health risk, "the legislature has neither a legitimate presence nor voice in the patient/health care provider relationship superior to the patient's right of personal autonomy which protects that relationship from infringement by the state." *Armstrong*, ¶ 59. The requirement that the State clearly demonstrate a medically acknowledged, bona fide health risk is a threshold consideration that applies before SB 99 even reaches strict scrutiny—not, as Defendant's frame it, a substitute. Defs.' Resp. in Opp'n. to Pls.' Mot. for Summ. J. ("Opp'n"), Dkt. No. 205, at 29. Without clear and convincing evidence of a bona fide health risk, the legislature has "*no* interest" in interfering with an individual's fundamental right to privacy in obtaining medical care, "much less a compelling one." *Armstrong*, ¶ 62 (emphasis added). Put another way, if Defendants do not satisfy *Armstrong*'s threshold, no justification would save SB 99 from being held unconstitutional. And because the State cannot meet this high burden, Plaintiffs are entitled to summary judgment on their privacy claim.

This is a high bar, and even taking all of Defendants' contentions as true, they do not clear it. Defendants' myriad arguments against gender-affirming medical care—that it is allegedly not well established, not evidence based, not effective, and without established long-term benefits, Opp'n 18, 26, 30—ultimately do not clearly and convincingly demonstrate the *risk* of treatment, which is the critical inquiry. And "ongoing debate" and testimony from individual patients and providers do not alter the medical consensus; consequently, Defendants have not demonstrated medical acknowledgment either.

A. Defendants fail to demonstrate any bona fide health risk.

Defendants acknowledge that they must, "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 case of patients' from a 'medically-acknowledged, [bona fide] health risk.'" Opp'n 30 (cleaned up). But significantly, they make no attempt to address what a bona fide health risk *is* and instead focus on the unremarkable observation that gender-affirming care is not risk-free. A bona fide health risk cannot mean *any* risk—as this Court recognized, virtually all medical treatments present some level of risk because risk is "inherent in the field of medicine." Order Granting Pls.' Mot. for Prelim. Inj. ("PI Order"), Dkt. No. 131, at 31. As a result, if "medically acknowledged, *bona fide* health risk" meant *any* risk, it would swallow the rule in defiance of the *Armstrong* Court's repeated emphasis that the State's right to intrude on privacy in healthcare decisions is "narrow" and "limited." *Armstrong*, ¶¶ 59, 61, 75. Therefore, a bona fide health risk must be a risk of sufficient gravity to justify the extraordinary act of legislative interference into personal medical decisions. Defendants discount Plaintiffs' application of *Armstrong* as "kaleidoscope[ic]," but they themselves acknowledge that "[t]he material dispute here . . . is whether [gender-affirming medical care] carries such high risk of grievous harm that" it should be banned. Opp'n 20, 30.

Rather than engage with the relative level of risk or identify a standard to apply, Defendants instead rely on ipse dixit: Their interpretation of *Armstrong* appears to be that if the State says a health risk is medically acknowledged and bona fide, then it must be. After all, they provide no rule or limiting principle other than their own say-so, baldly citing to the entirety of their own summary-judgment motion to demonstrate their satisfaction of this threshold limitation. *See* Opp'n 30. But their analysis merely confirms, *at best*, that gender-affirming medical care presents risks "*when used improperly*," which they also acknowledge is true of *all*

medical treatments. Opp'n 30–31 (emphasis added). This cannot be the standard under *Armstrong*. Nor can the rule be that treatments subject to "ongoing debate" clear the high *Armstrong* threshold, *id.* at 31; after all, virtually *all* medical treatments provoke dissenting views from some.

Although Defendants make repeated and vague references to the "risks" of gender-affirming medical care, many of the risks they identify exist for other treatments that are not banned, such as when the medications at issue are used for cisgender patients. *See, e.g.*, A.075 (risks from hormones and puberty blockers exist for both cisgender and transgender people); A.034 (risks from puberty blockers are similar for cisgender and transgender people); SA.042 (use of estrogen can increase risk of blood clots, stroke, and heart attack for both cisgender and transgender people); *see also* Pls.' Br. in Supp. of Mot. for Summ. J. ("Pls.' Br."), Dkt. No. 186, at 7–8. These risks thus cannot establish a bona fide health risk. *See Weems v. State ex rel. Knudsen*, 2023 MT 82, ¶¶ 47–48, 412 Mont. 132, 529 P.3d 798 (finding that argument that abortion procedure created bona fide health risk must logically fail when complication rates were similar to other permitted outpatient procedures). Other consequences of treatment identified by Defendants—for example, "alter[ing] the trajectory of physical . . . development," Opp'n 20 (cleaned up)—are the intended results of gender-affirming medical care and can hardly be considered "risks."

B. Defendants fail to demonstrate medical acknowledgment.

Defendants argue that "[j]udges are not medical experts well equipped to define the efficacy of treatment." Opp'n 31. Nor, for that matter, are legislators—which is why the Supreme Court has repeatedly recognized that "Montana's constitutional right to privacy 'broadly guarantees each individual the right to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from governmental interference.'" *Cross*, ¶ 22

(quoting *Planned Parenthood of Mont. v. State ex rel. Knudsen*, 2022 MT 157, ¶ 20, 409 Mont. 378, 515 P.3d 301 ("*Planned Parenthood I*")); *see also Armstrong*, ¶ 14. Deference to medical professionals is built into the *Armstrong* standard, which requires that any health risk justifying legislative intrusion be medically acknowledged. And here, Defendants have failed to carry their burden to demonstrate that the medical community has acknowledged any such risk in the context of gender-affirming medical care.

As this Court has already held and the Supreme Court affirmed, a mere showing of "conflicting evidence" does "not clearly and convincingly demonstrate that the proscribed treatments present a bona fide health risk to minors." *Cross*, ¶ 21. Instead, Montana courts have relied on the consensus of the American medical community, as represented by major medical organizations. *See Planned Parenthood of Mont. v. State*, 2024 MT 178, ¶ 38, 417 Mont. 457, 554 P.3d 153 ("*Planned Parenthood II*") (recognizing that "[t]he American Medical Association and the American Academy of Pediatrics, and other medical organizations, are opposed to parental consent laws"), *petition for cert. docketed*, No. 24-745 (U.S. Jan. 14, 2025). And here, the Supreme Court recognized that the major American medical organizations endorse and cite the WPATH standards of care as authoritative for treating gender dysphoria. *Cross*, ¶ 35.

As a matter of both law and logic, Defendants cannot demonstrate medical acknowledgment where the medical consensus is against them. It is thus unsurprising that that the only evidence Defendants present consists of mere individual disagreement with the medical consensus. But the fact that some doctors disapprove of a particular treatment cannot establish a medically acknowledged, bona fide health risk. And though Defendants turn to medical authorities from overseas, none of the countries they cite supports the sort of categorical ban implemented by SB 99. *See* Pls.' Br. 13.

Unable to demonstrate medical acknowledgment, Defendants attempt to shift the burden onto Plaintiffs by insisting that there is "ongoing debate" on the safety and efficacy of gender-affirming medical care. Opp'n 31. But ongoing debate is not clear and convincing evidence of medical consensus around a health risk so grave as to require taking personal medical decisions outside normal constitutional protections. And though Defendants try to dismiss the opinions of leading medical organizations in the United States, impinging their credibility and repeatedly calling the WPATH guidelines "junk science," *id.*, Defendants' politically motivated critiques of the American Medical Association, the American Psychological Association, and the American Academy of Pediatrics neither undermine the significance of these organizations' positions nor change the fact that they have failed to demonstrate medical consensus and acknowledgment in support of *their* position.[2]

Defendants suggest that "the Court ought not prematurely put itself in a position to determine medical community decisions before all the evidence is in," *id.* at 31–32, but this confuses the inquiry: The *Legislature* cannot prematurely prohibit medical treatment until the medical community acknowledges the existence of a bona fide health risk. In other words, it is not Plaintiffs who are acting prematurely here, but Montana's lawmakers.[3]

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[2] At every turn, Defendants fail to support any of their more specific claims about gender-affirming medical care and what they purport are its controversies with reference to undisputed facts. For example, Defendants' claim that WPATH "removed age considerations because of politics," Opp'n 11, is incorrect and vigorously disputed, *see* Declaration of Eli Coleman, PhD, *Boe v. Alabama*, No. 2:22-CV-184-LCB (M.D. Ala. July 1, 2024), Dkt. No. 629-20; SA.097–101.

[3] Defendants suggest that "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." Opp'n 29. But the *Montana* Supreme Court has held that *doctors*, not legislators, are the proper arbiters of medical treatment except in the most narrow and limited circumstances.

II. Strict scrutiny applies to Plaintiffs' claims.

In Montana, the right to privacy is "fundamental; its protection 'exceed[s] even that provided by the federal constitution.'" *Cross*, ¶ 22 (quoting *Armstrong*, ¶ 34). The Montana Supreme Court has already held that SB 99 impinges on the right to privacy. *Id.* ¶¶ 28, 32 (quoting *Armstrong*, ¶ 39). Therefore, even beyond the threshold consideration of requiring a bona fide health risk, strict scrutiny applies.

Moreover, strict scrutiny applies to Plaintiffs' equal-protection claims as well. From the start, Defendants' arguments about Plaintiffs' equal-protection claim completely fail to address the fact that SB 99 imposes a sex classification *on its face*. This Court has already found that, by SB 99's plain language, "a minor's sex plays an 'unmistakable and impermissible role' in the determination of who may receive certain treatments." PI Order 24–25. This holding is consistent with multiple courts that have found that laws like SB 99 impose differential treatment based on the sex an adolescent is assigned at birth "[b]ecause the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law." *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022); *Kadel v. Folwell*, 100 F.4th 122, 153 (4th Cir.) (en banc) ("This is textbook sex discrimination . . . . For one, we can determine whether some patients will be eliminated from candidacy for these surgeries solely from knowing their sex assigned at birth."), *petition for cert. filed*, No. 24-90 (July 29, 2024).

Apart from this facial classification that Defendants ignore, none of their arguments defeat Plaintiffs' equal-protection claim.

A. Gender dysphoria is a medical condition that requires treatment.

As the Court has already found, "[t]ransgender minors . . . [and t]heir cisgender counterparts also seek these treatments for *medical reasons* . . . and on the advice of their healthcare providers." PI Order 22. Thus, "they are similarly situated." *Id.* at 21. Recognizing its weakness, Defendants abandon their prior

attempt to draw a distinction between treating a "psychological condition" and "physical disorder[s.]" Defs.' Resp. in Opp'n to Prelim. Inj., Dkt. No. 77, at 34. In its stead, Defendants now assert that "[b]eing transgender" is an "intellectual decision" and "having gender dysphoria" is a "medical diagnosis." Opp'n 32–33. No matter how many times Defendants refer to gender dysphoria as a "subjective identity," it remains a serious medical condition that even Defendants' own experts acknowledge should not go untreated. A.375. Likewise, Defendants claim that transgender minors are not similarly situated to cisgender minors because the same medication constitutes a different treatment when provided to each group, Opp'n 33–34, but what matters is that both groups need the treatment for medical reasons—as this Court already recognized, PI Order 21–23.

B. SB 99 on its face imposes a sex classification.

Defendants try to paint over SB 99's facial sex classification by claiming that "neither a female nor male minor can receive [the proscribed hormones] when they are otherwise biologically normal and seek that treatment solely to address his or her subjective feelings about identity." Opp'n 33. This argument fails for at least two reasons.

First, SB 99 constitutes a sex-based classification on its face, so it does not matter whether it applies equally to both sexes—just as it does not matter whether a ban on marriage for interracial couples applies equally to people of different races. *See Loving v. Virginia*, 388 U.S. 1, 8–9 (1967) ("[T]he fact of equal application does not immunize the statute from the very heavy burden of justification which the Fourteenth Amendment has traditionally required of state statutes drawn according to race."). Additionally, a statute that contains classifications subject to elevated scrutiny raises equal-protection concerns *even if* applied even-handedly to both sexes. *See J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 141 (1994) (equal-protection right to jury-selection process free of sex discrimination "extends to both men and

women"); *Powers v. Ohio*, 499 U.S. 400, 410 (1991) ("The suggestion that racial classifications may survive when visited upon all persons . . . . has no place in our modern equal protection jurisprudence.").

Second, the fact remains that SB 99's plain terms prohibit the use of these medications to address a minor's gender identity only when that gender identity is inconsistent with their sex assigned at birth. Minors who conform with the State's expectations that they identify with the sex assigned to them at birth are permitted to access the medications, while those who fail to conform are denied access. This is sex discrimination.

C. Discrimination on the basis of transgender status is sex discrimination.

Defendants allege that "nowhere in state or federal law does transgender status confer sex discrimination protections," but then proceed in the same paragraph to identify at least one case that does just that. Opp'n at 34 (citing *Brandt*, 47 F.4th at 669). In addition to the U.S. Court of Appeals for the Eighth Circuit, numerous federal district courts, courts of appeals, and the U.S. Supreme Court recognize that discrimination on the basis of transgender status is a form of sex discrimination. *See, e.g.*, *Bostock v. Clayton County*, 590 U.S. 644, 669 (2020) ("[I]t is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex."); *Kadel*, 100 F.4th at 153–54; *Hecox v. Little*, 104 F.4th 1061, 1080 (9th Cir.), *petition for cert. filed*, No. 24-38 (July 15, 2024); *Fowler v. Stitt*, 104 F.4th 770, 793–94 (10th Cir. 2024), *petition for cert. filed*, No. 24-801 (Jan. 28, 2025).

Further, at least two other Montana district courts have recognized that, under the Montana Constitution, discrimination based on transgender status is a form of sex discrimination. *Kalarchik* PI Order 10 ("If the challenged state action discriminates against transgender individuals on the basis of their transgender status,

they also necessarily discriminate on the basis of sex."); *Edwards* MSJ Order 29 (adopting same reasoning as court in *Kalarchik*.)

D. Transgender status constitutes a suspect classification.

This Court has previously noted its "belie[f] that transgender persons comprise a suspect class." PI Order 25 n.7. This view is consistent with the Ninth Circuit, which has held that "discrimination based on transgender status independently qualifies as a suspect classification under the [federal] Equal Protection Clause because transgender persons meet the indicia of a 'suspect' or 'quasi-suspect classification' identified by the [U.S.] Supreme Court." *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (2015). Other federal courts across the country have reached the same conclusion.

Defendants make no showing that transgender people have not suffered a history of discrimination and prejudice. Nor have they shown that a person's identity as transgender has anything to do with the person's ability to contribute to society. Defendants have also failed to demonstrate that transgender people do not represent a discrete minority class that is politically vulnerable to discrimination. If anything, since the enactment of SB 99, transgender people have become even greater targets of discrimination and prejudice at the hands of private individuals and government officials at the state and federal level.

Defendants argue that not all transgender people experience gender dysphoria—which may be true for those who have had access to gender-affirming medical care—but that does not negate that SB 99 discriminates based on the transgender status. Indeed, not all cisgender people need hormones or puberty-delaying medication. Even if SB 99 were viewed as discriminating against the subset of transgender adolescents who need gender-affirming medical care—while allowing access to the same underlying treatment for the subset of cisgender adolescents who need it—it still discriminates based on transgender status. *See*

Kadel, 100 F.4th at 144 ("[D]iscrimination within a certain class does not mean there is no discrimination between classes" (emphasis omitted)); *see also, e.g.*, *Rice v. Cayetano*, 528 U.S. 495, 516–17 (2000) ("Simply because a class defined by ancestry does not include all members of the race does not suffice to make the classification race neutral."). Defendants' argument changes nothing about this Court's prior finding that SB 99's plain language targets transgender people for differential treatment. PI Order 21 ("Given the definition of 'transgender,' a person whose gender identity is not congruent with their sex assigned at birth, the language of SB 99 classifies based directly on transgender status.").

For these reasons, Plaintiffs have shown that SB 99 violates the Montana Constitution's equal-protection guarantee.

III. SB 99 fails because it is not narrowly tailored to any government interest.

As discussed in Plaintiffs' initial motion, SB 99's categorical ban on gender-affirming medical care is not remotely narrowly tailored to any asserted state interest. Pls.' Br. 17–18, 20–21. Furthermore, any such interest other than the legislature's articulated goal of "the protection of minors and their families . . . from any form of pressure to receive" gender-affirming medical care, SB 99 § 2, 2023 Leg., 68th Sess. (Mont. 2023), is "hypothesized or invented *post hoc* in response to litigation" and therefore impermissible, *United States v. Virginia*, 518 U.S. 515, 533 (1996).

Defendants make no explicit effort to argue that SB 99 is narrowly tailored to any state interest, nor do they respond to Plaintiffs' argument that they are limited to asserting only that specific interest articulated by the Legislature. Indeed, a review of their opposition brief reveals no references to narrowly tailoring. Rather, Defendants' argument relies solely on application of rational-basis review. The

barrage of "disputed" facts Defendants list in their opposition fail to create any argument that SB 99 is narrowly tailored.

Pressure. As explained in Plaintiffs' initial motion and opposition to Defendants' motion for summary judgment, Defendants have failed to substantiate any purported governmental interest in addressing pressure sufficient to justify a categorical ban on gender-affirming medical care. *See* Pls.' Br. in Opp'n to Mot. for Summ. J. ("Pls.' Opp'n"), Dkt. 204, at 13–15.

In their opposition, Defendants attempt to rehabilitate this deficit. First, they say it is irrelevant that their expert witnesses have no knowledge of "pressure" exerted by Montana medical providers[4] because the "mere fact" that a doctor might provide treatment to a minor "with lifelong consequences" inherently "reeks" of pressure. Opp'n 16. This is not a serious argument—as Defendants' own expert witnesses have acknowledged, medical providers routinely provide treatment with lifelong consequences to minors, which they themselves consider to be ethical. SA.004 (Dr. Curlin acknowledging that doctors "probably" provide care to minors with same "lifetime physical and social implications" and do so ethically); A.268–69, 380–81, 383, 427–28.

Next, Defendants point to Elle Palmer's supplemental declaration, which they claim evinces "pressure" by doctors to receive gender-affirming medical care. Opp'n Ex. L. But Ms. Palmer's story—even taken at face value—highlights SB 99's tailoring defects, including the availability of less-restrictive means that might have resolved whatever concerns she identified with the care she received. First, Ms.

[4] Defendants also say it is irrelevant whether their expert witnesses can substantiate "pressure" in Montana because the clinical practice guidelines apply across the country. Opp'n 15. But their own witnesses' stories explain why this is no answer—if a provider must go outside the clinical practice guidelines in order to exert "pressure" (for example, by failing to obtain informed consent, or failing to ensure that a biopsychosocial assessment has been conducted), then a less-restrictive alternative of mandating compliance with the guidelines would be wholly sufficient.

Palmer's purported experience fails to show why less restrictive means, such as directly banning "pressure," would not be a more tailored solution, rather than a categorical ban on care. Second, Defendants do not present evidence that other providers of gender-affirming medical care in Montana—including Drs. Hodax and Mistretta—"pressure" adolescents to obtain such care, again failing to justify SB 99's extraordinary sweep. Third, Ms. Palmer claims she did not receive biopsychosocial assessment, but SB 99 bans care whether or not a biopsychosocial assessment is conducted as provided for in the clinical practice guidelines. *Id.* Ex. L ¶ 5. Finally, Ms. Palmer claims providers emphasized the risk of suicide to obtain consent, but SB 99 bans care whether or not providers do so. *Id.* Ex. L ¶ 10.

Defendants also appear to see "pressure" where none has been shown to exist. Take Ms. Palmer's story about first receiving care at Planned Parenthood. Defendants claim that Ms. Palmer's mother was "locked out" of the room so that Ms. Palmer could "prescribe herself" testosterone. Opp'n 16. But a plain reading of the declaration confirms that Ms. Palmer was apparently given the choice whether to be accompanied by her parent, and she choose not to be. *Id.* Ex. L ¶ 7. And Ms. Palmer does not allege that, in the absence of her parent, the doctors pressured her to receive medical treatment—rather, it is apparently her view that if her parents *had* been present, they might have been able to correct the apparently inaccurate and incomplete history she presented to the doctor. *Id.* ("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."). Defendants do not explain how a doctor acting upon the information presented by a patient constitutes pressure. And nothing prevented Ms. Palmer's mother from expressing her skepticism and

obtaining information, as she "asked questions and expressed lots of concerns about the physical impacts." *Id.* Ex. L ¶ 10.[5]

Desistance. Apart from "pressure," Defendants' other proffered justifications for SB 99 also fail the requirements of narrow tailoring.

For instance, Defendants attempt to argue that SB 99 protects children from receiving unnecessary care because, they claim, some children's gender dysphoria will resolve without medical treatment. Defendants claim that it is impossible to predict which children will desist, so SB 99's extraordinary scope is necessary in case a given child experiences desistance.

However, this argument logically fails. First, Defendants' argument that gender dysphoria in some *children* may resolve before adolescence (i.e., before puberty) is immaterial, because *no medical interventions are offered or contemplated* before adolescence. *Cf.* Opp'n 8 (focusing on irrelevant question of whether "children who present with gender incongruence at a young age are . . . likely to desist before puberty"). Second, and more to the point, it is also undisputed that not all adolescents—that is, those who have reached puberty—will experience desistance. To the contrary, according to Defendants' own expert, "there's a good bit of literature that indicates that adolescent gender dysphoria continues into adulthood." A.362.[6] It is thus undisputed that there are adolescents whose gender

[5] As for Ms. Palmer's story of allegedly being asked by a doctor whether she had made an appointment for a hysterectomy, she seems not to remember whether she was a minor or not when this occurred. *Id.* ¶ 13 ("I began seeing my father's doctor . . . at age 17 or 18.").

[6] While one of Defendants' experts, Dr. Nangia, advocates psychotherapy alone (even though she admits "the research hasn't been done" to prove that it is adequate to treat gender dysphoria in minors, an opinion shared by Dr. Curlin), she agrees it cannot cause a change in gender identity for everyone with gender dysphoria. SA.021–22. Furthermore, although Dr. Nangia claims to have treated patients with gender dysphoria, she does not claim that her patients are representative of those seen by providers of gender-affirming medical care—who are the only ones targeted by SB 99. SA.104. Indeed, Dr. Nangia has never even had a patient request a letter of support from her (e.g., for insurance coverage) for gender-affirming medical care. SA.105–06 (further noting that she would refuse to write such letter, including for adults).

dysphoria will persist, regardless of their precise number, and yet SB 99 nonetheless bans gender-affirming medical care for all of them.

To the extent the State believes that more is needed to address its desistance concerns, it fails to show why more stringent diagnostic and assessment requirements would not be adequate. Furthermore, based on Defendants' own experts' statements—which they have now confirmed in supplemental declarations—there is at least one significant way, according to the medical literature, to gauge whether a transgender young person is likely to persist in experiencing gender dysphoria. If gender dysphoria is present during adolescence (after the onset of puberty), then there's a "good bit of literature" that indicates it is likely to persist into adulthood. A.362. Defendants' claim that "it is impossible to predict desistence" thus rings hollow. Opp'n 8. By banning care to all minors experiencing gender dysphoria, SB 99 is massively overinclusive. Notably, the State also does not ban medical treatment even where it is not possible to predict which patients may experience serious adverse effects. *See* SA.028–29, 093–96 (mood stabilizer used in minors have possibility of "fatal" reactions that are "not always possible to predict"). In this way, SB 99 manages to be simultaneously underinclusive as well.

To distract from this overreach, Defendants try to downplay the consequences of SB 99 on adolescents whose gender dysphoria persists. Opp'n 5–6. But both sides agree with the basic proposition that gender dysphoria can lead to serious harm, underscoring the stakes here for transgender youth like Phoebe Cross and Joanne Doe. The precise quantum of harm—including whether it is exacerbated by

comorbidities or whether those comorbidities can be partially mitigated by resort to other measures like psychotherapy or psychotropic medication—is immaterial.[7]

Defendants make a muddled argument that the law purportedly allows adolescents to continue to receive gender-affirming medical care for some indeterminate period of time, perhaps up to six months, to facilitate a "gradual withdrawal" of care and thus avoid some harm. Opp'n 7. But, on its face, the statute does not draw a distinction between the "abrupt" and "gradual" cessation of treatment—yet again illustrating the law's lack of narrow tailoring. And Defendants fail to persuasively explain how continuing to provide gender-affirming hormones, for instance, would constitute "treatment" for a "disorder" caused by gender-affirming medical care. Opp'n 7.[8] In any event, regardless of *how much* risk is posed by the termination of care, there is no dispute that such risk exists. And Defendants' recognition that care must be provided "on a 'case-by-case basis'" only reinforces SB 99's utter lack of tailoring, because that is equally true for the provision of gender-affirming medical care more generally. Opp'n 7.

At best, Defendants' theory seems to be that, if gender dysphoria doesn't actually require treatment, then the only harm that would result from SB 99 is the risk of withdrawal as treatment is ceased. But notwithstanding the quibbling of some dissenting voices regarding the benefits of gender-affirming medical care, it is the

[7] Plaintiffs dispute the notion that psychotherapy alone is sufficient to treat gender dysphoria, but that fact is not material for purposes of this motion, given the absence of dispute regarding facts that, themselves, would cause SB 99 to fail the application of heightened scrutiny.

[8] The State's own representatives seemingly disagree with this reading, as the very request that generated the testimony in question was for an analysis of the "clinical implications of SB 99 . . . [f]or example, those kids on hormones or puberty blockers *would no longer be able to receive those services.*" A.477–78 (emphasis added); *see also* A.478 ("Any clinical/physical issues with stopping gender affirming care for minors suddenly?").

only treatment for a serious medical condition supported by research. And Defendants cannot claim otherwise.[9]

Regret & Assessment. The fact that a few individual patients might come to regret their care does not justify a categorical ban. Heightened scrutiny requires a "close means-end fit." *Sessions v. Morales-Santana*, 582 U.S. 47, 68 (2017). When the State chooses to impose a blanket ban, its burden is to show that the chosen means—that no minor patient may obtain gender-affirming medical care—closely serves the desired goal of protecting minors. Thus, if the government contends that no one may be able to obtain care, it necessarily must demonstrate that all or virtually all minor patients would be harmed by obtaining care, not just a few isolated incidents.

Defendants' proffered evidence does not even attempt to establish that all or virtually all minor patients would be harmed by initiating gender-affirming medical care. First, take their proffered witnesses who have detransitioned. Of those, only one testifies (now, for the first time, in their supplemental declaration) that they received care in Montana. Opp'n 12. Banning care for all minors on the basis of one patient's testimony is about as far away from the required "close means-end fit" as possible.

Nor do Defendants' other proffered witnesses and references to medical malpractice actions come any closer to justifying a categorical ban; in fact, Defendants' emphasis on mental health assessments only demonstrates SB 99's lack of narrow tailoring. As described in Plaintiffs' opposition to Defendant's motion for summary judgment, and now confirmed by Defendants in their opposition, none of

[9] As discussed in Plaintiffs' opposition to Defendants' motion, Defendants' reliance on a statement made at oral argument in another case in another state confuses the issue of "completed suicide" and suicidality (the latter of which Defendants' own representatives testified would be a consequence of SB 99). Pls.' Opp'n. 10 (discussing legal relevance of the efficacy of gender-affirming medical care); A.441–43, 477–78.

Defendants' proffered witnesses who detransitioned received a mental-health evaluation or assessment as provided for in the WPATH Standards of Care. Opp'n 12. As much as Defendants emphasize this fact, they make no attempt to answer the obvious question: If all of Defendants' handful of examples of individuals who have regretted initiating care did not undergo a psychosocial assessment, why not simply mandate that providers conduct such an assessment, or that they conform to the Standards of Care (which in turn provide for the assessment)? Because that question goes unanswered by Defendants, SB 99 is not narrowly tailored to effectuate any goal of protecting patients from harm.

Defendants attempt to make up for this clear deficit by disputing the exact rate of regret, citing the supplemental declaration of Dr. Van Meter to claim that "[t]he most recent estimate . . . is 30%." Opp'n Ex. H ¶ 4. Even setting aside that Dr. Van Meter cites no source whatsoever to support this figure, and taking Dr. Van Meter's statement at face value, it powerfully illustrates SB 99's overbreadth. Montana instituted a blanket ban even where, according to its own expert witness, the great majority of patients did not regret care. And Montana does not restrict other medical treatments with similar regret rates.[10] Each point demonstrates that SB 99 is not narrowly tailored to any goal of eliminating regret.

Finally, Defendants' argument that regret might be presumed because it is unknown whether an individual will regret initiating care in the future (because "no one can say what they will think as they age") is simply illogical. Opp'n 18. For one, researchers have studied medical regret associated with gender-affirming medical care for far longer than Defendants' self-serving timeframe of ten years. *See* A.205–06 (Dr. Moyer referencing studies of low regret rates in cohorts beginning in 1972

[10] For example, studies have found that prostatectomy in some instances carries a 30% regret rate. *See, e.g.*, Jamie Lindsay et al., *Patient Satisfaction and Regret After Robot-assisted Radical Prostatectomy: A Decision Regret Analysis*, 149 J. Urology 122 (Mar. 2020).

to present). For another, Defendants do not explain why this presumption might apply to gender-affirming medical care but not to other forms of medical treatment that minors may receive and that their own experts agree may be ethically provided to minors even without the ability to see ten years into the future. *See* SA.004 (Defendants' expert Dr. Curlin stating that, in his opinion, treatments with same risks as gender-affirming care are ethically provided to minors). This differential treatment is at the heart of SB 99's underinclusiveness.

Informed Consent from Parents. Defendants assert that minors are not capable of granting informed consent to medical interventions—but it is *parents* who are providing informed consent for medical interventions. Opp'n 13. To the extent Defendants believe that minors should not be able to receive medical treatment because they cannot themselves provide informed consent, then SB 99 is dramatically underinclusive, because *all* medical care for minors should be prohibited on that ground.

Defendants' reliance on informational material from Fenway Health—a subset of which Dr. Mistretta has used as part of her process for obtaining informed consent—fails to establish anything of relevance. Opp'n Ex. Q, at 62:20–22. Fenway Health operates a community health center in Boston. Opp'n Ex. R, at 39. Defendants' citation to its informational material simply indicates that *Fenway* provides gender-affirming medical care to adults, and that adolescents seeking such care "have referral access to specialized providers in the area who may assume treatment with puberty-suppressing hormones and/or cross-sex hormones." *Id.* Ex. R, at 7 (explaining that such adolescent care is "outside the scope of medical practice at Fenway Health"). It is hardly unusual for a clinic to focus on serving particular populations—just as one medical practice may focus on adult patients, and another may focus on adolescent patients. The document does not remotely indicate that adolescents should not receive gender-affirming medical care; to the contrary,

it specifically communicates that they have such access through referrals. Furthermore, Fenway's statement that only individuals who are eighteen years or older can provide informed consent for medical care is wholly unremarkable and would be equally true for any number of medical treatments. Opp'n 13. Again, it is *parents* who are the ones providing informed consent, rather than minors.

To the extent Defendants claim that *some* providers fail to obtain "true informed consent" because their appointments were rushed or not sufficiently in-depth, for example, that plainly fails to justify SB 99's categorical ban. Opp'n 13–14 (recounting purported experiences with various providers that overwhelmingly occurred outside Montana). Defendants fail to show why medical malpractice actions—like the ones they cite—would not be sufficient to address the problem if it was true that a particular provider actually failed to obtain informed consent from parents before providing care. Likewise, a substantiated concern about the fulsomeness of informed consent from parents might justify a state law to ensure that information about risks and benefits are fully disclosed. *Cf. Planned Parenthood II*, 2024 MT 178, ¶ 35 (contrasting challenged law with mandatory reporting laws, which are example "of legislation that *does* advance the State's compelling interest in protecting minors from victimization"). But it does not justify SB 99, which bans care even in circumstances where informed consent was provided to parents. Notably, Defendants do not claim that Drs. Hodax and Mistretta fail to obtain informed consent from parents before providing gender-affirming medical care to adolescents. *Cf.* A.033. That illustrates that SB 99's application to them, and other providers like them who follow similar consenting practices, could not be justified on the basis of informed consent.

Medical Risks. Perhaps most importantly, SB 99 is fatally under- and overinclusive because it is undisputed that other medical treatments provided to minors carry the same or similar risks as gender-affirming medical care, but they are

not banned. Pls.' Br. 22–24. For example, Dr. Curlin testified in his deposition that the risks and "lifetime physical and social implications" of gender-affirming medical care are also present in other forms of medical care that providers "probably" provide to minors and, in Dr. Curlin's view, this is ethical. SA.004. Moreover, Plaintiffs' briefing did not rest on this singular example. Dr. Nangia, for example, has prescribed medications to minors in certain situations that may impair fertility. A.380–81. And Dr. Van Meter testified that puberty blockers (which he prescribes to minors for conditions other than gender dysphoria) can have serious side effects. A.428. And this is in addition to unrebutted testimony by Plaintiffs' experts. *See*, e.g., A.268–69.

Montana does not ban medical treatments for minors in other situations where they pose the same or similar risks. Defendants protest, responding by pointing to three bills—HB 391 (2013), HB 171 (2021), and HB 721 (2023), which they claim "proposed prohibitions on medical treatments based on potential risks." Opp'n 23. Each of these three laws has been enjoined by Montana courts under the very right-to-privacy claim brought by Plaintiffs here. *See generally Planned Parenthood II* (HB 391); *Planned Parenthood I* (HB 171); *Planned Parenthood of Mont. v. State ex rel. Knudsen*, 2024 MT 227, 418 Mont. 226, 557 P.3d 471 (HB 721).

More importantly, *each of these laws is more narrowly tailored than a categorical ban*, and thus their existence demonstrates that SB 99 treats gender-affirming medical care differently from other forms of medical care. Defendants explicitly acknowledge that neither HB 391 nor HB 171 sought to ban care in any form. Opp'n 23. Defendants write that HB 721 "banned dismemberment abortions," *id.*, but ignore that the statute allows those interventions in medical emergencies. Even if it were the case that HB 721 represents a single other instance of Montana instituting a ban on a particular medical treatment, Defendants do not (and cannot) argue that HB 721 presented the same under- and over-inclusiveness problems that

SB 99 presents—that is, that the regulated treatment is allowed in other circumstances carrying similar risks. Moreover, one example of another attempt to ban a medical treatment comes nowhere close to establishing that Montana has a consistently applied interest in regulating medical treatments that carry risks, particularly when SB 422, on the other side of the scale, expressly permits all treatment that is explicitly deemed "investigational," has no evidence of benefit, and may carry all manner of serious risks. *See* Pls.' Br. 6.

Quality of Evidence and Off-Label Use. Finally, SB 422 lays bare SB 99's underinclusiveness. Under SB 422, Montana expressly permits "investigational" treatments with no data supporting its safety or efficacy, while SB 99 categorically bans FDA approved treatments. Defendants' response to this is a non sequitur: They write that, because the medications at issue here *have* been approved for some indications, SB 422 is inapplicable because it allows medications that have not been approved for *any* indication. Opp'n 23. This is precisely the point. Montana allows all kinds of medical treatments with a complete absence of approval by the FDA and that have no data to support their safety or efficacy. And, at the same time, it seeks to claim an interest in regulating medications that *do* have FDA approval for some use and *do* have data to support their safety and efficacy because it takes issue with the exact circumstances of FDA approval.

Defendants attempt to justify this clear hypocrisy by quibbling with the level of quality of the data underlying gender-affirming medical care and the fact that its use is considered off-label. However, many medical treatments have evidentiary bases that would be considered "very low quality." Systematic reviews commonly find "low" or "very low" quality evidence for every medical treatment—a review of systematic reviews concluded that more than *55%* found such quality evidence. A.259. There is thus no genuine dispute that many other treatments and guidelines are supported by "low" or "very low" quality evidence. Nothing adduced by

Defendants disputes this, and they have not rebutted Plaintiffs' expert Dr. Antommaria's unrebutted testimony that, for example, none of the eighty-four recommendations in the Endocrine Society's other pediatric guidelines is supported by "high" quality evidence, and 68% of them are supported by "low" or "very low" quality evidence. A.261–62. On the other hand, Defendants offer minor objections—that only Dr. Curlin said "low" quality evidence is a feature of "some" pediatric practice while Dr. Nangia said, "I don't know that I'd say it's common, but it does happen." A.369. In the face of the evidence, Defendants' experts' "I don't know" is not sufficient to instantiate dispute. The precise frequency is not what matters; what matters is that Montana does not consistently ban care even where it is supported by a similar quality of evidence, which demonstrates SB 99's under-inclusiveness.

The same is true of the fact that off-label use is common, particularly in pediatrics. Defendants do not, in their opposition brief, appear to dispute this; rather, they double down that FDA approval signifies some kind of stamp of approval as to safety and efficacy. In doing so, Defendants effectively concede that SB 99 treats gender-affirming medical care dissimilarly from other forms of pediatric treatment, which is commonly provided off-label.

IV. Plaintiffs have not abandoned any claims.

Although Plaintiffs' motion *focuses* on their privacy and equal-protection claims, this does not mean that their other constitutional claims have been abandoned. For starters, there is no such as "*effectively* abandon[ing]" a claim, as Defendants' suggest, Opp'n 26 (emphasis added); as the Montana Supreme Court has explained, "dismissals of claims in a multiple claim lawsuit" involve the interplay of Montana Rules of Civil Procedure 15 and 41 and cannot happen by accident or implication, *see Watchtower Bible & Tract Soc'y of N.Y., Inc. v. Mont. Twentieth Jud. Dist. Ct.*, 2021 MT 13, ¶ 13, 403 Mont. 57, 479 P.3d 946. Moreover, as a general matter, claims are only abandoned if they are unsupported by any

argument or authority, *see, e.g.*, *Gausvik v. Perez*, 392 F.3d 1006, 1008 n.1 (9th Cir. 2004), and here, Plaintiffs included both in explaining that strict scrutiny applies to each of their claims (and thus all claims rise and fall with the narrow-tailoring analysis applied Plaintiffs' privacy and equal-protection claims), *see* Pls.' Br. 9–10 n.5. Moreover, even if Plaintiffs had not moved for summary judgment on *any* of their claims, that would not mean they had "abandoned" them; it would just mean that the claims would go to trial. Because any *one* of Plaintiffs' claims triggers heightened scrutiny, Plaintiffs' motion focused on the same ones that this Court focused on in issuing a preliminary injunction.

V. The entirety of SB 99's ban on gender-affirming medical care—which includes its Medicaid ban—is unconstitutional for the same reasons.

Although Plaintiffs moved for summary judgment—not partial summary judgment—Defendants perplexingly maintain that Plaintiffs did not move for summary judgment on their "Medicaid claim" and that it should be dismissed. But there is no such "Medicaid claim"; there are only Plaintiffs' *constitutional* claims, and those claims apply to all aspects of SB 99, which necessarily includes its ban on Medicaid coverage. Just as the Montana Supreme Court upheld the entirety of this Court's preliminary injunction based on a singular constitutional analysis rather than treat the law's ban on Medicaid coverage differently (as advocated by Justice Rice's partial dissent, which failed to attract any additional votes), summary judgment should be granted to Plaintiffs on all aspects of SB 99 based on the same reasons presented in their motion. *See Cross*, ¶ 39 (explaining that strict scrutiny applies to a law restricting coverage for public healthcare benefits based on recipients' exercise of fundamental right to privacy). Discriminating against transgender adolescents with respect to Medicaid coverage, for example, is unconstitutional for the exact same reasons as banning the care itself. That the Legislature has "responsibility over spending decisions" does not mean it could violate equal protection with respect to

those decisions any more than it could provide Medicaid coverage for only men and not women or, as here, only cisgender adolescents and not transgender adolescents. *See Cross*, ¶ 70 (Rice, J., partially dissenting); *Kadel*, 100 F.4th at 157 (holding that West Virginia's Medicaid exclusion on gender-affirming medical care was unconstitutional). As the Montana Supreme Court confirmed, this Court "correctly applied strict scrutiny to the entire measure" rather than "parse out the particular provisions of the statute." *Cross*, ¶ 39.

CONCLUSION

Given that Defendants have failed to establish a medically acknowledged, bona fide health risk or to satisfy the demanding requirements of strict scrutiny, SB 99 cannot pass constitutional muster. Plaintiffs respectfully request that the Court grant summary judgment in their favor and permanently enjoin SB 99.

Dated: March 7, 2025

Respectfully submitted,

By: /s/ Alex Rate
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Dated March 7, 2025

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.	)	
	)	
STATE OF MONTANA et al.,	)	
	)	
Defendants.	)	
	)	
	)	

PLAINTIFFS' SUPPLEMENTAL APPENDIX TO PLAINTIFFS' REPLY IN SUPPORT TO MOTION FOR SUMMARY JUDGMENT

Phoebe Cross, et al. v. State of Montana
Case No. DV-23-541, Hon. Jason Marks

Index to Supplemental Appendix to Plaintiffs' Reply in Support of Motion for Summary Judgement

EXHIBIT 20

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

BRIANNA BOE, et al., Plaintiffs, v. STEVE MARSHALL, et al., Defendants.	No. 2:22-cv-00184-LCB-CWB

DECLARATION OF ELI COLEMAN, PhD

I, Eli Coleman, declare as follows:

1. I am a professor *emeritus* and former director of the Eli Coleman Institute for Sexual and Gender Health (formerly the Program in Human Sexuality) in the Department of Family Medicine and Community Health at the University of Minnesota. I am a former president of the World Professional Association for Transgender Health ("WPATH") and was chair of the Guideline Steering Committee for WPATH's Standards of Care Version 8 ("SOC8"). If called upon to testify as to the facts set forth herein, I could and would testify competently thereto.

2. WPATH hired Johns Hopkins University to lead a rigorous process to identify the evidence base for treatment of gender dysphoria. That process included carrying out systematic reviews of the scientific literature relating to the treatment of gender

dysphoria, including identifying any research evaluating the efficacy and safety of the use of puberty blockers and hormone therapy in adolescents. It also included identifying any scientific literature evaluating the outcomes of use of puberty blockers and hormone therapy to treat gender dysphoria in adolescents.

3. I have reviewed portions of the State of Alabama's summary judgment briefing in this case and do not agree with the assertions made in it.

4. First, it is not true that the development of SOC8 turned on any ideological or political considerations. Development of SOC8 followed the rigorous methodology designed by Johns Hopkins University to approve recommendations through the Delphi Method, a well-established methodology to develop clinical practice guidelines.

5. In order to ensure transparency of the process, the development of the guidelines included publicly distributing a draft for review and feedback from stakeholders, medical professional organizations, and any other interested parties. WPATH received significant feedback after public release of the draft document. That included feedback from the United States Assistant Secretary for Health. It also included feedback from the American Academy of Pediatrics. Such feedback was anticipated as part of the public review process.

6. WPATH took all feedback into account in evaluating whether any additional information should be included in the SOC8 or whether any of the recommendations

should be reconsidered or re-evaluated. WPATH's review and revisions based on public feedback after the transparent review process was not ideological or political. It rested on the same measured, scientific basis as did the earlier development of the draft.

7. In addition, WPATH did not suppress publication of any of the systematic reviews developed by Johns Hopkins University. In fact, at least two of the articles that Johns Hopkins wanted to publish, were published.

8. WPATH did dispute the timing of when Johns Hopkins could publish their systematic reviews because WPATH wanted to include the information gleaned from the systematic reviews in its publication of SOC8. WPATH did not want Johns Hopkins University to publish its research prior to WPATH's opportunity to release SOC8. This was not because WPATH had any interest in suppressing Johns Hopkins' research. To the contrary, WPATH wanted to ensure that its release of SOC8 would be the first publication of the research.

9. The recommendations included in SOC8 were based on the rigorous process set up by Johns Hopkins and supported by the scientific evidence base provided to us by Johns Hopkins and upon which the members of the chapter committees voted through the Delphi process.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed in Budapest, Hungary on July 1, 2024.

DocuSigned by:
Eli Coleman
3E8172D4A5344CB...

Eli Coleman, PhD

IN THE FOURTH JUDICIAL DISTRICT COURT

MISSOULA COUNTY

PHOEBE CROSS, et al.,

Plaintiffs,

vs. Cause No. DV 23-541

STATE OF MONTANA, et al.,

Defendants.

VIDEOCONFERENCE DEPOSITION

UPON ORAL EXAMINATION OF

GEETA NANGIA

BE IT REMEMBERED, that the deposition upon oral examination of GEETA NANGIA, appearing at the instance of Plaintiffs, was taken via Zoom through the offices of Fisher Court Reporting, 442 East Mendenhall, Bozeman, Montana, on Tuesday, October 29, 2024, beginning at the hour of 9:00 a.m., MST, pursuant to the Montana Rules of Civil Procedure, before Kasey L. Fisher, Registered Professional Reporter - Notary Public.

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Also present: Alex Rate, Marthe VanSickle, Mary Grace Thurmon, Meeghan Dooley, ALCU Clinic Student

Q. Fair enough. So you obviously don't know what type of patients other physicians see.

So is it fair to say then that you can't say whether the patients that you see are representative of the patients that a gender clinic might see?

A. I can't speculate as to whether or not -- you know, what they're seeing there and whether it's different than what I'm seeing.

Q. So you don't have information to say that they're the same, correct?

A. I think all kids would present differently.

Q. Okay. In -- let's turn back to your report.

In the first sentence of paragraph 48, you describe the 550 minors --

A. Sorry. Would you give me just one second to pull that up again.

Okay.

Q. So, again, on paragraph 48 --

A. Okay. Just one second.

Q. -- you describe --

A. Sorry. One second. Let me just pull that back into where I can see it.

A. Yes.

Q. If a transgender minor wanted to access gender-affirming care, they likely wouldn't seek out a health care provider who was opposed to gender-affirming care for minors, correct?

A. I disagree with that.

Q. Why?

A. Because youth who are interested in -- nowadays, I think through social media, most youths -- hang on. I'm just going to minimize this window so I can see your face.

The majority of youths are aware of gender-affirming care these days through social media and through other outlets. They're aware of what's offered. I don't think they're ignorant to that, and I've still had patients come to see me and talk through and engage in therapy with me and engage in treatment.

So I wouldn't say that, just because they have an interest or their curiosity is piqued about gender-affirming care that that prohibits them from seeing me.

Q. Have any of your patients of any age requested a letter of support for gender-affirming care?

A. No.
Q. So you've never written a letter of support for gender-affirming care for any patient?
A. No.
Q. Would you?
A. No.
Q. Why not?
A. As I've said, I don't believe that minors can provide informed consent, and I don't believe that parents should be providing -- in lieu of minor informed consent that they should be providing parental consent with minors assent for these treatments. And I would not refer for them because I also don't believe that the data with regard to safety, efficacy and improvement in mental health outcomes is significant enough that I should advise my patients to go that direction.
Q. Would you write a letter of support for adult seeking gender-affirming care?
A. For different reasons, no.
Q. What are those reasons?
A. So I do believe that adults can provide informed consent so that if any treatment option for any condition is available to an adult, they have every right to seek that out. From an

C E R T I F I C A T E

STATE OF MONTANA)
: Ss
COUNTY OF GALLATIN)

I, Kasey L. Fisher, Registered Professional Reporter and Notary Public for the State of Montana, residing in Bozeman, do hereby certify:

That I was duly authorized to and did swear in the witness and report the deposition of GEETA NANGIA in the above-entitled cause; that the foregoing pages of this deposition constitute a true and accurate transcription of my stenotype notes of the testimony of said witness, all done to the best of my skill and ability; that the reading and signing of the deposition by the witness have been expressly reserved.

I further certify that I am not an attorney nor counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal on this the 12th day of November, 2024.

Kasey L. Fisher

KASEY L FISHER
NOTARY PUBLIC FOR THE
STATE OF MONTANA
RESIDING AT BOZEMAN
MY COMMISSION EXPIRES
FEBRUARY 06, 2027

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I, Alexander H. Rate, hereby certify that I have served true and accurate copies of the foregoing Answer/Brief - Reply Brief to the following on 03-07-2025:

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Dated: 03-07-2025