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CLERK OF THE DOUGLAS COUNTY DISTRICT COURT
CASE NUMBER: DG-2025-CV-000241
PII COMPLIANT

IN THE SEVENTH JUDICIAL DISTRICT
DOUGLAS COUNTY DISTRICT COURT
CIVIL DEPARTMENT

LILY LOE, by and through her parent and next friend Lisa Loe; LISA LOE; RYAN ROE, by and through his parent and next friend Rebecca Roe; REBECCA ROE,

Plaintiffs,

v.

STATE OF KANSAS, *ex rel* KRIS KOBACH, Attorney General,

Defendants.

Case No. _____
Div. No. 7

PETITION

Plaintiffs, Lily Loe, by and through her parent and next friend Lisa Loe; Lisa Loe; Ryan Roe, by and through his parent and next friend Rebecca Roe; and Rebecca Roe, by and through their undersigned attorneys, bring this petition against the above-named Defendants, their employees, agents, and successors in office ("Defendants"), and in support thereof state the following:

I. Preliminary Statement

1. This lawsuit, seeking declaratory and injunctive relief, challenges Kansas Senate Bill 63 ("the Act" or "SB 63"), which was enacted on February 18, 2025 over Governor Laura Kelly's veto and took effect on February 20, 2025. A copy of the Act is annexed hereto as Exhibit 1.

2. The Kansas Constitution guarantees equal protection under the law. SB 63 violates that constitutional guarantee. For minors like Plaintiffs Ryan Roe and Lily Loe, SB 63

impermissibly discriminates against them on the basis of sex and transgender status because of an unlawful state preference for gender conformity. The Kansas Constitution also protects the right to personal autonomy. For parents like Plaintiffs Rebecca Roe and Lisa Loe, SB 63 impermissibly infringes on the fundamental right to the care, custody, and control of their children by displacing their medical decision-making authority with a government mandate, even when they, their adolescent children, and medical providers are all aligned.

3. SB 63 is actively harming Kansas families, including young people like Plaintiffs Lily Loe and Ryan Roe, who have had their medical care stripped away. Lily and Ryan have been thriving since they started receiving puberty blockers and hormone therapy, but now their trusted doctors in Kansas can no longer help them, and they are at risk of unimaginable suffering from permanent physical changes inconsistent with their gender identity and untreated gender dysphoria. Forced to watch that suffering are loving parents, like Plaintiffs Lisa Loe and Rebecca Roe, who only want what is best for their children, consistent with their children's expressed needs, and who consented to now-banned medical treatment based on their own research, reflection, and consultation with trusted medical professionals at one of Kansas' most prestigious hospitals.

4. The Kansas Constitution prohibits the Kansas Legislature's use of sex and transgender status to deprive only certain Kansans of medically necessary healthcare and SB 63's interference with parents' fundamental rights.

5. Plaintiffs seek declaratory and injunctive relief, both permanently and during the pendency of this lawsuit.

II. Jurisdiction and Venue

6. This Court has jurisdiction under Kan. Stat. Ann. § 20-301.

7. Plaintiffs' requests for declaratory and injunctive relief are authorized by K.S.A. §§ 60-1701, 60-1703 (declaratory judgment and relief), 60-901, 60-902 (injunctive relief).

8. Venue in this Court is proper under K.S.A. §§ 60-602(2) and K.S.A. 60-608 because this action seeks declaratory and injunctive relief against public officers for acts done or threatened to be done in Douglas County by those officers under color of their office.

III. Parties

A. Plaintiffs

9. Plaintiff Lily Loe is a thirteen-year-old transgender girl and brings her claims by and through her mother, Plaintiff Lisa Loe. The Loe family resides in Douglas County, Kansas.

10. Plaintiff Ryan Roe is a sixteen-year-old transgender boy and brings his claims by and through his mother, Plaintiff Rebecca Roe. The Roe family resides in Johnson County, Kansas.

B. Defendants

11. Defendant Kris Kobach is the Attorney General of Kansas. He is responsible for defending Kansas laws against constitutional challenges. Kan. Stat. Ann. § 75-702. Defendant Kobach is sued in his official capacity, as are his agents and successors.

IV. Relevant Facts

A. Standards of Care for Treating Transgender Adolescents with Gender Dysphoria

12. Gender dysphoria is a recognized medical condition marked by clinically significant distress that results from incongruence between a person's gender identity and their sex assigned at birth.

13. "Sex assigned at birth" or "sex designated at birth" are more precise than the term "biological sex," because all of the physiological aspects of a person's sex are not always aligned with each other, including in individuals with differences in sex development (also known as

disorders of sex development, DSDs, or intersex conditions or variations). For these reasons, the Endocrine Society warns practitioners that the terms "biological sex" and "biological male or female" are imprecise and should be avoided.

14. Most boys are assigned male at birth based on their external genital anatomy, and most girls are assigned female at birth based on their external genital anatomy. But transgender people have a gender identity that differs from the sex they were assigned at birth.

15. "Gender identity" refers to a person's deeply felt, internal, intrinsic sense of their own gender. "Gender expression" refers to how a person enacts or expresses their gender in everyday life.

16. Everyone has a gender identity and one's understanding of it may develop over time.

17. A person's gender identity cannot be altered voluntarily or changed through medical intervention.

18. Transgender people have existed throughout history.

19. Being transgender is not itself a medical condition to be treated. But gender dysphoria is a serious medical condition, recognized in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., Text Revision. If left untreated, gender dysphoria can result in not just decreased quality of life, but also debilitating anxiety, severe depression, self-harm, suicidal ideation, and suicide attempts.

20. A person can experience gender dysphoria at any age, but among adolescents it is often associated with distress at physical changes associated with the development of secondary sexual characteristics during puberty—such as breast development, voice deepening, or growth and thickening of facial and body hair—that are inconsistent with the person's gender identity.

21. Gender affirming medical care improves mental health for adolescents who require such care by allowing a person's body to develop in accordance with the person's gender identity.

22. All of the major medical organizations in the United States have highlighted the importance of gender affirming medical care for adolescents with gender dysphoria and have issued explicit statements opposing bans on this care. These organizations include the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American College of Physicians, the American Academy of Family Physicians, the American Academy of Child & Adolescent Psychiatry, the Endocrine Society, the Pediatric Endocrine Society, the World Professional Association for Transgender Health, and the United States Professional Association for Transgender Health, among many others.

23. Gender dysphoria is a diagnosis in the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM V"). There are two separate diagnoses for gender dysphoria, one for gender dysphoria in childhood and the other for gender dysphoria in adolescence and adulthood. In order to be diagnosed with gender dysphoria in adolescence and adulthood, the incongruence between a person's gender identity and assigned sex must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

24. The World Professional Association for Transgender Health (WPATH) has issued Standards of Care for the Health of Transgender and Gender Diverse People since 1979. The current version is Standards of Care Version 8 ("SOC-8"), published in 2022. SOC-8 provides guidelines for multidisciplinary care of transgender individuals, including youth and adolescents, and describes criteria for medical treatment of gender dysphoria in adolescents and adults. Such treatment may include puberty-delaying medication, hormone treatment, and surgery where

medically indicated. Every major medical organization in the United States recognizes that these treatments can be medically necessary to treat gender dysphoria.

25. SOC-8 is based on a rigorous and methodological evidence-based approach comparable to clinical guidelines published for other conditions.

26. These treatments for gender dysphoria are typically described in medical literature and clinical practice as gender affirming medical care. SB 63 instead uses the term "gender transition services" to describe similar treatments and concepts.

27. The guidelines for gender affirming medical care outlined in SOC-8 are endorsed by numerous medical professional organizations, including the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the Pediatric Endocrine Society.

28. The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has also published a clinical practice guideline for the treatment of gender-dysphoric individuals, including pubertal suppression and sex hormone treatment. The Endocrine Society Guideline provides protocols for the medically necessary treatment of gender dysphoria similar to those outlined in the WPATH Standards of Care.

29. The quality of evidence supporting SOC-8 and the Endocrine Society Guideline are comparable to the support for guidelines that medical providers use to treat many other conditions, including in the field of pediatrics. The SOC-8 and the Endocrine Society Guideline are widely accepted. Clinicians throughout Kansas and the country follow the SOC-8 and the Endocrine Society Guideline to diagnose and treat people with gender dysphoria.

30. Gender affirming medical care is not a novel or unproven treatment. The use of puberty-delaying medication for the treatment of gender dysphoria, for example, has been the subject of medical literature since 1998, and prospective observational trials began recruiting participants in 2000. The evidence for gender affirming medical care is comparable to the evidence for many other widely accepted treatments in pediatrics.

31. Gender affirming medical care is not experimental. There are decades of studies—going back over 25 years—supporting the benefits of gender affirming medical care where medically indicated, which is why it is recommended under clinical practice guidelines for the treatment of gender dysphoria in adolescents.

32. Medical guidance to clinicians differs depending on whether the treatment is for a pre-pubertal child, an adolescent, or an adult. In all cases, the precise treatment recommended for gender dysphoria will depend upon each person's individualized needs.

33. Before puberty, gender affirming care does not include any pharmaceutical or surgical intervention. Care for pre-pubertal children may include "social transition," which means supporting a child living consistently with the child's persistently expressed gender identity, along with supportive therapy.

34. Under SOC-8 and the Endocrine Society Guideline, medical interventions may become medically necessary and appropriate when transgender youth reach puberty.

35. Endocrinologists, including pediatric endocrinologists, have extensive experience in the types of hormone management that treatment of gender dysphoria entails. In providing medical treatments to adolescents, pediatric endocrinologists and other clinicians work with qualified mental health professionals experienced in diagnosing gender dysphoria.

36. In accordance with SOC-8 and the Endocrine Society Guideline, and in the practice of clinicians in Kansas, there are generally two types of gender affirming medical treatments to treat gender dysphoria in minors: puberty-delaying treatment and hormone treatment.

Puberty-Delaying Treatment

37. There are no hormonal or medical interventions indicated for pre-prepubertal youth, i.e., those who have not started puberty.

38. For many transgender adolescents, going through puberty in accordance with their sex assigned at birth can cause extreme distress. For these individuals, puberty-delaying medication—known as gonadotropin-releasing hormone agonists ("GnRH agonists") and sometimes referred to as "puberty-blocking drugs" or "puberty blockers"—can minimize and potentially prevent the heightened gender dysphoria and permanent, unwanted physical changes that puberty would cause. For gender dysphoric adolescents who are experiencing severe distress upon the onset of puberty, this pause alleviates worsening distress that occurs as puberty progresses. These same medications are used for other conditions in non-transgender adolescents, including the treatment of central precocious puberty, and to preserve fertility during cancer treatments.

39. Treatment with puberty-delaying medication is part of the recommendation protocol to clinicians for treating gender dysphoria in adolescents.

40. Under the Endocrine Society Guideline,[1] adolescents may be eligible for puberty-delaying treatment if:

[1] *See* Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Vol. 102, Issue 11 (Nov. 1, 2017), available at https://academic.oup.com/jcem/article/102/11/3869/4157558.

"1. A qualified MHP [mental health professional] has confirmed that:

- the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
- gender dysphoria worsened with the onset of puberty,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment, and
- the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment.

2. And the adolescent:

- has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:

- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),[2]

[2] Tanner Staging is a measure of an individual's progression through puberty. *See generally* University of Cincinnati College of Medicine, *Tanner Stages*, available at https://med.uc.edu/landing-pages/reproductivephysiology/lecture-3/tanner-stages.

- has confirmed that there are no medical contraindications to GnRH agonist treatment."

41. Puberty-delaying medication has been shown to be safe and effective at treating gender dysphoria in adolescents and is associated with improved mental health outcomes that include significantly lower levels of anxiety, depression, disruptive behaviors, and suicidality and suicidal ideation, as well as improved global functioning (i.e., how well a person functions in their daily life).

42. Puberty-delaying treatment pauses a person's endogenous puberty at the stage of pubertal development that the person is in at the time their treatment begins. For transgender girls, this treatment pauses the physiological changes typical of male puberty and prevents the development of associated secondary sex characteristics like facial hair, a pronounced "Adam's apple," and a deepening voice. For transgender boys, puberty-delaying treatment prevents the development of breasts and menstruation.

43. Pausing development in early puberty stops adolescents with gender dysphoria from developing secondary sex characteristics inconsistent with their gender identity, which can be extremely distressing for them, and which may be difficult, if not impossible, to eliminate once the characteristics have fully developed.

44. The use of puberty-delaying treatment after the onset of puberty can eliminate or reduce the need for surgery later in life.

45. On its own, puberty-delaying treatment does not permanently affect fertility. Fertility is only affected for the duration of the treatment and there are no lasting effects to fertility when the treatment is discontinued.

46. Because puberty-delaying treatment followed by gender-affirming hormone therapy can affect fertility, patients and their families are counseled about the risks and benefits of treatment and provided information about fertility preservation when treatment is initiated even though puberty-delaying treatment itself does not permanently affect fertility.

47. Puberty-delaying treatment is reversible. Once puberty-delaying treatment is stopped, endogenous puberty resumes and patients undergo puberty on a timeline typical of their peers.

Gender Affirming Hormone Therapy

48. It may be medically necessary and appropriate for some adolescents later in puberty to treat their gender dysphoria with gender affirming hormone therapy (testosterone for transgender boys, and testosterone suppression and estrogen for transgender girls). Gender-affirming hormone therapy results in the development of secondary sex characteristics consistent with an individual's gender identity. If gender affirming hormone treatment is provided after puberty-delaying treatment, patients undergo puberty consistent with their gender identity on a timeline typical of their peers. These same medications (testosterone and estrogen) are used in non-transgender adolescents to treat a variety of conditions, including to affirm those non-transgender adolescents' gender embodiment goals. For example, testosterone may be used to "jump start" puberty in non-transgender boys who are "late bloomers," in part to relieve the distress associated with not developing through puberty at the same time as their male peers. Estrogen and/or testosterone suppression may also be used in non-transgender girls with polycystic ovarian syndrome who experience unwanted facial hair.

49. For adolescents and adults who do not begin medical treatment until after puberty has started or substantially progressed, gender affirming hormone therapy may be the first medical

intervention and allows an adolescent to begin a hormonal puberty consistent with their gender identity.

50. The psychological benefits of gender-affirming hormone treatment for individuals with gender dysphoria, including adolescents, include reduction of anxiety, depression, and suicidality, and improvements in life satisfaction.

51. Under the Endocrine Society Guideline,[3] transgender adolescents may be eligible for gender-affirming hormone therapy if:

"1. A qualified MHP [Mental Health Professional] has confirmed:

- the persistence of gender dysphoria,
- any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
- the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,

2. And the adolescent:

- has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),

[3] *See* Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Vol. 102, Issue 11 (Nov. 1, 2017), available at https://academic.oup.com/jcem/article/102/11/3869/4157558.

- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:

- agrees with the indication for sex hormone treatment,
- has confirmed that there are no medical contraindications to sex hormone treatment."

52. Through decades of clinical experience and research, gender affirming hormone therapy has been shown to be safe and effective at treating gender dysphoria in adolescents.

53. Treatment with gender affirming hormone therapy is demonstrated to result in improvement in symptoms of gender dysphoria, depression, and anxiety in transgender youth, as well as improved psychological functioning among transgender young adults who receive treatment for gender dysphoria.

54. Unwanted side effects from gender affirming hormone therapy are rare when treatment is provided under clinical supervision.

55. Puberty-delaying medications and gender affirming hormones are prescribed only after a comprehensive psychosocial assessment by a qualified health professional who: (i) assesses the diagnosis of gender dysphoria and any other co-occurring diagnoses, (ii) ensures the child can assent and the parents/guardians can consent to the relevant intervention after a thorough review of the risks, benefits, and alternatives of the intervention, and (iii) ensures that, if co-occurring mental health conditions are present, they do not interfere with the accuracy of the diagnosis of gender dysphoria or impair the ability of the adolescent to assent to care.

56. In the absence of intervention, distressing physical changes of puberty will progress. To not intervene, when gender affirming medical care is indicated, thus causes significant harm to the patient in the form of increasing gender dysphoria associated with the development of secondary sex characteristics that do not match the person's gender identity.

57. There are no evidence-based interventions, other than gender affirming medical care, that effectively treat adolescent gender dysphoria.

58. Psychotherapy alone does not effectively treat gender dysphoria.

59. If S.B. 63 is not enjoined, medical and mental health providers will be left with no evidence-based treatments to support their adolescent patients with gender dysphoria.

60. Given the well-documented benefits of gender-affirming medical care, and the known harms of untreated adolescent gender dysphoria, banning this care will lead to substantial deterioration of mental health for adolescents diagnosed with gender dysphoria. For many of these patients, this is likely to include worsening suicidality.

B. History and Text SB 63

61. In March 2024, the Kansas State Legislature passed Senate Bill 233, a substantially similar bill to SB 63, seeking to ban access to gender affirming medical care for transgender youth in Kansas.

62. On April 25, 2024, Governor Laura Kelly vetoed Senate Bill 233, and on April 29, 2024, the Kansas State Legislature failed to override that veto.

63. However, with a new legislative supermajority in office, Kansas Senate Republicans introduced SB 63 in the Kansas Senate on January 22, 2025 and the bill was referred to the Committee on Public Health and Welfare on January 23, 2025.

64. On January 28, 2025, the Kansas Senate conducted a public hearing on the Act, in which numerous opponents of the Act spoke out against it.

65. Nevertheless, on January 29, 2025, the Kansas Senate voted 85-31 to pass SB 63, and on January 31, 2025, the Kansas House of Representatives voted 83-35 to pass.

66. On February 5, 2025, the Act was enrolled and presented to Governor Kelly.

67. On February 11, 2025, Governor Laura Kelly vetoed SB 63 under Article 2, Section 14(a) of the Kansas Constitution. In her veto message, Governor Kelly stated in part:

> Infringing on parental rights is not appropriate, nor is it a Kansas value. As I've said before, it is not the job of politicians to stand between a parent and a child who needs medical care of any kind. This legislation will also drive families, businesses, and health care workers out of our state, stifling our economy and exacerbating our workforce shortage issue. It is disappointing that the Legislature continues to push for government interference in Kansans' private medical decisions instead of focusing on issues that improve all Kansans' lives.[4]

68. On February 18, 2025, the Kansas Legislature voted to override Governor Kelly's veto, enacting SB 63 into law.

SB 63 prohibits puberty blockers and hormone therapy only when used to treat transgender minors

69. SB 63 prohibits using puberty-delaying medication or hormone therapy only when the purpose of those treatments is to treat the distress arising from the incongruence between a minor's sex assigned at birth and their gender identity.

[4] Press Release: Governor Kelly Vetoes Divisive Legislation, Feb. 11, 2025, https://www.governor.ks.gov/Home/Components/News/News/551/56.

70. Under Section 3(a), a healthcare provider[5] "shall not knowingly perform the following surgical procedures or prescribe, dispense or administer the following medication to a female child for the purpose of treatment for distress arising from such female child's perception that such child's gender or sex is not female," including "supraphysiologic doses of testosterone and other androgens; or…puberty blockers such as GnRH agonists or other synthetic drugs that suppress the production of estrogen and progesterone to delay or suppress pubertal development in female children." S.B. 63 § 3(a)(2)-(3).

71. Under Section 3(b), a healthcare provider "shall not knowingly perform the following surgical procedures or prescribe, dispense or administer the following medication to a male child for the purpose of treatment for distress arising from such male child's perception that such child's gender or sex is not male," including "supraphysiologic doses of estrogen; or…puberty blockers such as GnRH agonists or other synthetic drugs that suppress the production of testosterone or delay or suppress pubertal development in male children." S.B. 63 § 3(b)(2)-(3).

72. Section 3(c) affirmatively allows these treatments for all other purposes, providing that "The treatments prohibited by subsections (a) and (b) shall not apply to treatment provided for other purposes, including: (1) Treatment for individuals born with a medically verifiable disorder of sex development…or; (2) treatment of any infection, injury, disease or disorder that has been caused or exacerbated by the performance of a procedure listed in subsections (a) or (b)." S.B. 63 § 3(c).

73. Section 3(d) requires existing gender affirming medical care to be systematically reduced through December 31, 2025, providing that "If a healthcare provider has initiated a course

[5] Defined in Section 1(b)(5) as "an individual who is licensed, certified, or otherwise authorized by the laws of this state to administer healthcare services in the ordinary course of practice of such individual's profession."

of treatment for a child that includes prescribing, administering or dispending of a drug prohibited by subsection (a)(2), (a)(3), (b)(2) or (b)(3) prior to the effective date of this act, the healthcare provider may continue such course of treatment if the healthcare provider: (1) Develops a plan to systematically reduce the child's use of such drug; (2) determines and documents in the child's medical record that immediately terminating the child's use of such drug would cause harm to the child; and (3) such course of treatment shall not extend beyond December 31, 2025." S.B. 63 § 3(d).

SB 63 prohibits using state funds and other resources for the prohibited treatments

74. SB 63 prohibits the use of public funds or property for the banned care.

75. For example, Section 2(a) of SB 63 provides that "A recipient of state funds shall not use such funds to provide or subsidize medication or surgery as provided in section 3, and amendments thereto, as a treatment for a child's perception of gender or sex that is inconsistent with such child's sex." S.B. 63 § 2(a).

76. Similarly, Section 2(b) provides that "An individual or entity that receives state funds to pay for or subsidize the treatment of children for psychological conditions, including gender dysphoria, shall not prescribe, dispense or administer medication or perform surgery as provided in section 3, and amendments thereto, or provide a referral to another healthcare provider for such medication or surgery for a child whose perceived gender or perceived sex is inconsistent with such child's sex." S.B. 63 § 2(b).

77. In addition, Section 2(c) provides that "The Kansas program of medical assistance and its managed care organizations shall not reimburse or provide coverage for medication or surgery as provided in Section 3, and amendments thereto, as a treatment for a child who perceived gender or perceived sex is inconsistent with such child's sex." S.B. 63 § 2(c).

78. Further, Section 2(e) provides "A state property, facility, or building shall not be used to prescribe, dispense, or administer medication or perform surgery as provided in section 3, and amendments thereto, as a treatment for a child whose perceived gender or perceived sex is inconsistent with such child's sex." S.B. 63 § 2(e).

SB 63 prohibits certain kinds of state support for social transitioning, even though by definition there is no medical or surgical component to social transition

79. SB 63 does not only restrict the use of public funds or property with respect to the banned treatments; it also prohibits certain kinds of support for social transitioning, defined as "acts **other than** medical or surgical interventions that are undertaken for the purpose of presenting as a member of the opposite sex, including the changing of an individual's preferred pronouns or manner of dress." S.B. 63 § 1(b)(10) (emphasis added).

80. For example, Section 2(d) provides "Except to the extent required by the first amendment to the United States constitution, a state property, facility or building shall not be used to promote or advocate the use of social transitioning, medication or surgery as provided in section 3, and amendments thereto, as a treatment for a child whose perceived gender or perceived sex is consistent with such child's sex." S.B. 63 § 2(d).

81. Similarly, Section 2(f) provides "A state employee whose official duties include the care of children shall not, while engaged in those official duties, promote the use of social transitioning or promote medication or surgery as provided in section 3, and amendments thereto, as a treatment for a child whose perceived gender or perceived sex is inconsistent with such child's sex." S.B. 63 § 2(f).

SB 63 imposes onerous, mandatory penalties on healthcare providers

82. SB 63 strips healthcare providers of their medical licenses if they provide treatment in violation of Section 3 and subjects them to potential tort liability.

83. Section 4(a)(1) sets forth a mandatory penalty of license revocation for healthcare providers who violate Section 3: "If a healthcare provider violates the provisions of section 3, and amendments thereto:…The healthcare provider has engaged in unprofessional conduct and, notwithstanding any provisions of law to the contrary, the license of such healthcare provider shall be revoked by the appropriate licensing entity or disciplinary review board with competent jurisdiction in this state." S.B. 63 § 4(a).

84. Section 4(b) provides that such healthcare providers "shall be held strictly liable to such child if the treatment or effects of such treatment results in any physical, psychological, emotional or physiological harms to such child in the next ten years from the date that the individual turns 18 years of age. A prevailing plaintiff may recover actual and punitive damages, injunctive relief, the cost of the suit and reasonable attorney fees." S.B. 63 § 4(b). Section 4(c) provides that "The parents of a child who has experienced a violation of section 3(a) or 3(b), and amendments thereto, shall have a private cause of action against the healthcare provider who provided such treatment for actual damages, punitive damages, injunctive relief, the cost of the suit and reasonable attorney fees." S.B. 63 § 4(c). Section 4(d) provides that "An individual who was provided treatment as a child in violation of section 3(a) or 3(b), and amendments thereto, shall have a private cause of action against the healthcare provider who provided such treatment for actual damages, punitive damages, injunctive relief, the cost the suit and reasonable attorneys," with a ten-year statute of limitations running from the child's eighteenth birthday. S.B. 63 § 4(d).

85. Section 5 of SB 63 prohibits professional liability insurance policies from providing "coverage for damages assessed against the healthcare provider who provides treatment to a child in violation of section 3(a) or (b), and amendments thereto." S.B. 63 § 5.

C. Plaintiffs

The Loe Family

86. Lisa Loe and her thirteen-year-old daughter, Lily Loe, live in Douglas County, Kansas. The Loe family has lived in Kansas for several generations, and Lisa is proud to raise Lily and her two other children in Kansas.

87. Lily is finishing eighth grade. She enjoys learning, has good grades, and is looking forward to high school. She is active and likes being outside, singing with her friends, and playing the violin.

88. When Lily was born, her sex was assigned as male. But Lily is a transgender girl, and her gender identity is female. Lily has never felt like a boy.

89. Lily always gravitated toward more girly toys, clothes, and games. From an early age, she expressed a dislike for boys' clothes and was happiest when she got to wear less gendered clothes or explicitly girly clothes. As Lily approached grade school, she started saying that she was a girl, or asking when she would get a girl's body. When Lily was about seven years old, she asked Lisa if, once she got to heaven, she could be a girl. Even though Lily's behavior challenged Lisa's faith, Lisa realized she needed to find new ways to support her child.

90. Lisa eventually took Lily to the Gender Pathways Service at Children's Mercy Hospital for professional medical guidance, and she was diagnosed with gender dysphoria in January 2019.

91. Because Lily had not started puberty when she was first seen at Children's Mercy, there were no medical interventions that she needed or that were appropriate for her. At the time, Lisa supported Lily with her love and affirming her by including by allowing her to express her female gender through things like her hairstyle, clothing, and name/pronouns.

92. Beginning in 2018, and from second grade onward, Lily has lived full-time as a girl. Lily thrived, with her personality shining through, and watching Lily brighten affirmed Lisa's decision to support her as a girl. In 2020, when Lily was nine and in fourth grade, she legally changed her name. In 2023, she changed the sex on her Kansas birth certificate to "female."

93. When Lily was twelve, in 2024, her blood tests showed that she was in the early stages of puberty, making her eligible for puberty blockers if they were deemed necessary. Lisa reviewed with Lily's doctors the risks, benefits, and alternatives, and understood that blockers would pause any further pubertal changes until Lily was older, at which point they would decide whether to let male puberty continue or to start hormone therapy for female puberty. Given the enormous distress Lisa knew that Lily would suffer if male puberty continued, and the benefit to her mental health of not having to worry about those changes, Lisa, Lily, and Lily's doctors decided that puberty blockers were the right choice for Lily.

94. Lily received her first puberty blocking shot at Children's Mercy when she was twelve years old, in 2024. As soon as Lily and Lisa got back to the car, Lily literally started dancing. She felt such enormous relief from no longer needing to worry about puberty, and had so much less fear. The puberty blocking shots let her be herself, happy, and carefree. Lily has not had any negative side effects from the shots, which last about six months. Her last shot was in November 2024, and her next shot is supposed to be in late May 2025. Lily's shots can be delayed maybe a

few weeks, but if she waits much longer, the medication will stop working and a male puberty will resume.

95. At Lily's scheduled May 2025 appointment at Children's Mercy, Lisa and Lily were planning to discuss the possibility of starting hormone replacement therapy. But after SB 63 went into effect in February 2025, Children's Mercy informed Lisa that they could no longer fill Lily's puberty blocker prescription and would not be able to discuss or start hormone therapy. Because of the law, Children's Mercy will not refer Lily to a new provider, even out of state, so Lisa has been unable to rely on the medical providers she knows and trusts to figure out next steps for her daughter's health needs.

96. As a result of SB 63, Lisa has not only had to locate an out-of-state medical provider for Lily, but has also had to move Lily's health insurance from KanCare (the State of Kansas's Medicaid program) to Lisa's employer. This is expensive, and Lisa's other children remain on KanCare. Lisa also had to move an out-of-state medical appointment for Lily from April to May because of the delay in getting Lily enrolled in new health insurance. That new clinic, though, will not provide puberty blockers on the first visit, even though it will be time for Lily's next shot. Lisa and Lily will have to travel again to that out-of-state clinic, after her shot is already overdue, for her to potentially receive treatment from those doctors.

97. Lisa is extraordinarily concerned that Lily will resume developing through male puberty before she can get additional care for her daughter. Developing male characteristics will be agony for Lily. She has been living as a girl for years, and is very private about being transgender. Most of the people in Lily's life do not know her birth sex, and because of puberty blockers, she has not developed any typical male physical traits. But without blockers, she will begin looking like a teenage boy, which will out her as transgender against her will. Lisa cannot

imagine how Lily would be able to thrive or even go to school if she were at greater risk for being outed.

The Roe Family

98. Rebecca Roe and her sixteen-year-old son, Ryan Roe, live in Johnson County with Ryan's father and siblings. Ryan is a strong, caring, and confident young man, who enjoys being active and working out. Ryan has an after-school job and is working as a camp counselor this summer. He is finishing tenth grade, and next year he will start an accelerated program that allows him to earn college credit while still in high school.

99. Ryan is a transgender boy. His sex assigned at birth was female, but his gender identity is male.

100. Ryan has expressed his male gender identity from a very young age. He repeatedly told his parents that he was a boy, and always insisted on male costumes and characters during childhood play. Beginning in fourth grade, when Ryan was about ten, he insisted on a more masculine style of dress, and a short hair cut. Even before Ryan said he was transgender, Rebecca and Ryan's father suspected he might feel more comfortable living as a boy. But the Roe family lived in a conservative area in Texas, where Ryan did not feel comfortable being himself.

101. In 2022, the Roe family moved from Texas to Kansas. The rise in anti-trans bills in 2021 in Texas left them uneasy, and in February 2022 the Texas governor decreed that families with transgender children should be investigated by Child Protective Services. That action from the Texas governor only solidified the Roe family's decision to move to Kansas for a new job opportunity. Even though Ryan had not yet said he was transgender, it was increasingly clear to Rebecca that was a possibility, and that at a minimum, Ryan's gender non-conformity would make him a target for being ostracized.

102. The Roe family moved to Kansas when Ryan was thirteen years old, during the summer before eighth grade. In his new school and more welcoming community, Ryan could be himself. During eighth grade, he told his parents that he felt like a boy and wanted to use he/him pronouns. Ryan had already started going through puberty, and could not stand the feminine aspects of his body. Even though Ryan could dress and groom in a masculine fashion, it was clear to his parents that wasn't sufficient to alleviate the distress he felt around his body.

103. Ryan began seeing a therapist in October 2022, who diagnosed him with gender dysphoria. Rebecca then set up an appointment with Children's Mercy Hospital's Gender Pathways Clinic. There was a six-month waiting list, and Ryan couldn't be seen until April 2023. After a lengthy first appointment with a multidisciplinary care team, it was clear to Ryan's doctors that he had gender dysphoria. Ryan and his parents reviewed his options with the clinic team. Because Ryan was fourteen and had already progressed through puberty, puberty blockers were not an option, but he could start testosterone to go through male puberty. After reviewing the risks, benefits, and alternatives, Ryan's parents decided to proceed with hormone therapy.

104. Ryan has thrived on testosterone. He is more comfortable in his body, and happier. Not getting a period anymore has also given Ryan enormous relief. He blossomed at school and in his social life. Ryan has been on testosterone for two years, and he continues to revel in how he looks and feels. Because he can move through the world like the 16-year-old boy that he is, Ryan is able to focus on school, his job, and his friends, and not be worried about the unrelenting distress that his typically female characteristics caused him.

105. After SB 63 passed, the Roe family spent significant time and resources looking into alternative avenues to maintain access to Ryan's medical care out of state. They have even discussed relocating to another state, even though they just moved to Kansas a few years ago and

enjoy their community. Not maintaining Ryan's care is not an option: he has been so much happier and healthier for the past two years after receiving this medical care. He feels much more stable, and like himself. It would be unimaginable and extremely distressing to Ryan to no longer live, look, and feel like the young man he is.

V. Claims for Relief

FIRST CLAIM FOR RELIEF

(Sections 1-2, Equal Protection, Sex Discrimination)

(Minor Plaintiffs)

106. Plaintiffs hereby re-allege and incorporate by reference the prior paragraphs.

107. The Act violates Section 1 of the Bill of Rights contained in the Kansas Constitution, which provides "All men are possessed of equal and inalienable rights, among which are life, liberty, and the pursuit of happiness."

108. The Act violates Section 2 of the Bill of Rights contained in the Kansas Constitution, which provides in relevant part that "All political power is inherent in the people, and all free governments are founded on their authority, and are instituted for their equal protection and benefit."

109. Sections 1 and 2 "are given much the same effect as the clauses of the Fourteenth Amendment relating to due process and equal protection of the law." *Farley v. Engelken*, 241 Kan. 663, 667 (1987). "Section 1 applies in cases...when an equal protection challenge involves individual rights." *State v. Limon*, 280 Kan. 275, 283 (2005).

110. SB 63 prohibits medical interventions based on the sex of the minor patient. The Act does not prohibit puberty blocking medication or hormone therapy for all minors, or even for the purposes of affirming a child's gender or sex, but rather only prohibits those treatments "to a

female child for the purpose of treatment for distress arising from such female child's perception that such child's gender or sex is not female," Section 3(a), or "to a male child for the purpose of treatment for distress arising from such male child's perception that such child's gender or sex is not male." Section 3(b).

111. SB 63 contains a sex-based classification that must be tested under heightened or intermediate equal protection scrutiny. *See, e.g.*, *Stephenson v. Sugar Creek Packing*, 250 Kan. 768, 775-77 (1992) (explaining that gender-based classification are subject to intermediate scrutiny, e.g. the classification "must serve important governmental objectives and must be substantially related to achievement of those objectives.") (quoting *Craig v. Boren*, 429 U.S. 190, 197 (1976)). *See also In re K.M.H.*, 285 Kan. 53, 75 (2007) (applying intermediate heightened equal protection scrutiny to statute that treated sperm donors and sperm recipients differently, even though there are biological differences between females and males with respect to conception).

112. SB 63 is not substantially related to achieving an important governmental objective.

SECOND CLAIM FOR RELIEF

(Sections 1-2, Equal Protection, Trans Status)

(Minor Plaintiffs)

113. Plaintiffs hereby re-allege and incorporate by reference the prior paragraphs.

114. The Act violates Section 1 of the Bill of Rights contained in the Kansas Constitution, which provides "All men are possessed of equal and inalienable rights, among which are life, liberty, and the pursuit of happiness."

115. The Act violates Section 2 of the Bill of Rights contained in the Kansas Constitution, which provides in relevant part that "All political power is inherent in the people,

and all free governments are founded on their authority, and are instituted for their equal protection and benefit."

116. Sections 1 and 2 "are given much the same effect as the clauses of the Fourteenth Amendment relating to due process and equal protection of the law." *Farley v. Engelken*, 241 Kan. 663, 667 (1987). "Section 1 applies in cases...when an equal protection challenge involves individual rights." *Limon*, 280 Kan. at 283.

117. SB 63 prohibits medical interventions based on the transgender status of the minor patient. The Act does not prohibit puberty blocking medication or hormone therapy for all minors, or even for the purposes of affirming a child's gender or sex, but rather only prohibits those treatments "to a female child for the purpose of treatment for distress arising from such female child's perception that such child's gender or sex is not female," Section 3(a), or "to a male child for the purpose of treatment for distress arising from such male child's perception that such child's gender or sex is not male." Section 3(b).

118. Such a classification based on transgender status is a sex-based classification. *See Bostock v. Clayton County, Ga.*, 590 U.S. 644, 668-69 (2020).

119. All sex-based classifications, even those based on biological differences, must be tested under intermediate or heightened equal protection scrutiny. *See, e.g.*, *Stephenson v. Sugar Creek Packing*, 250 Kan. 768, 775-77 (1992) (explaining that gender-based classification are subject to intermediate scrutiny, e.g. the classification "must serve important governmental objectives and must be substantially related to achievement of those objectives.") (quoting *Craig v. Boren*, 429 U.S. 190, 197 (1976)). *See also In re K.M.H.*, 285 Kan. 53, 75 (2007) (applying intermediate heightened equal protection scrutiny to statute that treated sperm donors and sperm

recipients differently, even though there are biological differences between females and males with respect to conception).

120. SB 63 is not substantially related to achieving an important governmental objective.

121. Although SB 63 must satisfy heightened equal protection review, it cannot even satisfy rational basis review. SB 63 contains a discriminatory classification. *See State v. Limon*, 280 Kan. at 286. The prohibitions in SB 63 are both overinclusive and underinclusive, providing evidence of invidious discrimination and animus toward those burdened, i.e. transgender minors. *See Limon*, 280 Kan. at 288. A preference for minors to identify with and appear as their sex assigned at birth is equivalent to disfavoring transgender minors, but "moral disapproval of a group cannot be a legitimate governmental interest." *Id.* at 295. And "when the articulated interest is the protection of minors, there still must be a connection between the State's interest and the classification and, if the burden would not be allowed if placed upon an adult, the State's interest must be unique to children." *Id.* at 296.

THIRD CLAIM FOR RELIEF

(Kansas Bill of Rights, Section 1, Fundamental Right to Parenting)

(Parent Plaintiffs)

122. Plaintiffs hereby re-allege and incorporate by reference the prior paragraphs.

123. The Act violates Section 1 of the Bill of Rights contained in the Kansas Constitution, which provides "All men are possessed of equal and inalienable rights, among which are life, liberty, and the pursuit of happiness."

124. Section 1 protects the "right to personal autonomy," including "a natural right to make decisions about parenting and procreation." *Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 644 (2019) (*Hodes I*).

125. SB 63 violates Section 1's guarantee of personal autonomy by prohibiting parents from exercising medical decision-making authority on behalf of their minor children made in accordance with their children's wishes and doctor recommendations, including the decision to treat gender dysphoria with puberty blocking medication or hormone therapy.

126. SB 63 is not narrowly tailored to further any compelling interest. *See Hodes & Nauser, MDs, P.A. v. Kobach*, 318 Kan. 940, 952 (2024) (*Hodes II*).

VI. Request for Relief

WHEREFORE, Plaintiffs request that the Court:

A. Issue a Declaratory Judgment that the Act is unconstitutional and therefore unenforceable;

B. Grant a Temporary Injunction without bond, and a Permanent Injunction restraining their agents, and their successors in office from enforcing the Act;

C. Grant such other and further relief as this Court deems just, proper, and equitable; including an award of costs and attorneys' fees to Plaintiffs.

Respectfully submitted, this 28th day of May, 2025.

By: /s/ Monica A. M. Bennett

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**Pro Hac Vice* application forthcoming