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2025 Jul 10 PM 6:15
CLERK OF THE DOUGLAS COUNTY DISTRICT COURT
CASE NUMBER: DG-2025-CV-000241
PII COMPLIANT

IN THE DISTRICT COURT OF DOUGLAS COUNTY, KANSAS
CIVIL COURT 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 of the State of Kansas,

Defendant.

Case No. DG-2025-CV-000241
Division No. 7
K.S.A. Chapter 60

DEFENDANT'S RESPONSE IN OPPOSITION TO PLAINTIFF'S MOTION FOR TEMPORARY INJUNCTION

Dated: July 10, 2025

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INTRODUCTION

The Kansas Legislature, with supermajority bipartisan support, enacted the Help Not Harm Act to protect children from experimental gender-transition interventions that lack scientific support and cause irreversible harm. Plaintiffs now ask this Court to preliminarily enjoin a law grounded in the best available evidence and designed to shield vulnerable children from procedures that permanently sterilize them, damage their bodies, and offer no proven mental health benefits. The Act does not prevent adults from undergoing these procedures, nor does it prohibit the use of such procedures for legitimate medical conditions. It simply recognizes that children cannot consent to experimental treatments that will forever alter their lives. Plaintiffs have failed to demonstrate any likelihood of success on the merits, any irreparable harm, or any basis for extraordinary injunctive relief that would expose Kansas children to dangerous and unproven medical experimentation.

BACKGROUND

I. The Help Not Harm Act protects Kansas children from experimental gender-transition interventions.

The Help Not Harm Act, enacted as Kansas Senate Bill 63 with super-majority bipartisan support, prohibits Kansas-licensed healthcare providers from "knowingly perform[ing]" certain "surgical procedures or prescrib[ing], dispens[ing] or administer[ing certain] medications 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." The Help Not Harm Act, S.B. 63 § (3)(a), 2025-2026 Leg. Reg. Sess. ("S.B. 63"). The Act prohibits the same for male children. S.B. 63 § (3)(b). The Act excludes from its prohibition treatments for children "born with a medically verifiable disorder of sex development" or "of any infection, injury, disease or disorder that has been caused or

exacerbated by the performance of a procedure listed in sub-sections (a) or (b)." S.B. 63(3)(c). The Act restricts the use of state funds for gender-transition interventions for children, designates the provision of these interventions for minors as unprofessional conduct, and provides statutory causes of action to children and parents who have been harmed by these experimental interventions. S.B. 63 §§ 2, 4.

The Act includes a sunset provision for children, like Plaintiffs, who are actively undergoing gender-transition interventions. *Id.* § 3(d). Such children may continue their course of treatment until December 31, 2025, as long as the child's "healthcare provider [d]evelops a plan to systematically reduce the child's use of such" interventions and "documents in the child's medical record that immediately terminating the child's use of such drug would cause harm to the child." *Id.* § 3(d). The Help Not Harm Act does not prevent adults from accessing these interventions to address gender-related psychological conditions. Nor does it prohibit doctors from utilizing these interventions to address other medical conditions. *See* S.B. 63.

The Act is justified by the overwhelming weight of scientific evidence, medical ethics, and the testimony of children (now adults) who underwent the experimental interventions now illegal in the State of Kansas.

II. Biological sex is an immutable characteristic that cannot be changed through hormonal or surgical interventions.

Biological sex is a binary, unchangeable characteristic determined by a person's chromosomes. Ex. A, Levine Decl. ¶¶ 22-24. Biological sex shapes a person's reproductive and physiological development. *Id.* "Sex is not"—and cannot be—"'assigned at birth' by visualizing the genitals of a newborn," *id.* ¶ 23, but is instead a characteristic that exists from conception that can be

identified through testing, including a "simple inspection" which is accurate almost all of the time, Ex. B, Lappert Decl. ¶ 28.

Although Kansas law uses the terms "sex" and "gender" interchangeably to refer to biological sex, common parlance recently has sometimes ascribed a different meaning to the term "gender." *See, e.g.*, K.S.A. 65-6710(a)(3) ("Gender, eye color and other traits are determined at fertilization."). Gender, in the newer, modified understanding of the word, is "one of the many expressions of the interior life of the person" as it relates to their sex. Ex. B, Lappert Decl. ¶ 29. Gender is thus "'the characteristics of women, men, girls and boys that are socially constructed' and that 'var[y] from society to society and can change over time.'" Ex. A, Levine Decl. ¶ 27. Gender is not a medical or scientific concept: there "is no objective, repeatable test, with known error rates, that can be used to detect [a person's] 'gender.'" Ex. B, Lappert Decl. ¶ 29. In recent years, it has become popular to define a person's gender by their "gender identity," which is a person's subjective "inner sense" of their gender. Ex. C, Cantor Decl. ¶ 56. For the purposes of this brief, the phrase "gender identity" will be used in distinction to biological sex.

Occasionally, a person's gender identity does not match his or her biological sex. People who experience this incongruence and decide to adopt a gender associated with the opposite biological sex are often referred to as "transgender." *See* Ex. B, Lappert Decl. ¶¶ 28-29. If sufficiently serious and accompanied by other markers, this can lead to a diagnosis of "gender dysphoria," defined by the Diagnostic and Statistical Manual of Mental Disorders as "a marked incongruence between one's experienced/expressed gender and assigned gender." Ex. D, Weiss Decl. ¶ 51–52.

Often, a person suffering from gender dysphoria treats their "healthy body as if it were diseased" to the extent it is not compatible with their mental self-perception. Ex. E, Curlin Decl. ¶ 50.

Such individuals at times seek out "gender-transition interventions," which are medical procedures that seek to change the person's body to more closely resemble that of the opposite sex. *See* Ex. B, Lappert Decl. ¶¶ 42-43. But "[c]ontrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become 'a complete man' or 'a complete woman,' this is not biologically attainable." Ex. A, Levine Decl. ¶ 31.

A. The interventions used in "gender transition".

The Act prohibits Kansas healthcare providers from giving to minors the three primary types of gender-transition interventions used to increase the likelihood that a transgender person can look like a person of the opposite sex: puberty blockers, hormone therapy, and "sex-change" surgeries.

Puberty Blockers: Puberty blockers are medications that suppress the onset or progression of puberty by inhibiting the release of sex hormones. *See* Ex. E, Curlin Decl. ¶ 43; Ex. D, Weiss Decl. ¶¶ 123–132. When used for the purpose of gender transition, they are administered to prepubertal or early pubertal minors to prevent the development of secondary sex characteristics, like breast growth, menstruation, and facial hair. Ex. A, Levine Decl. ¶ 41; Ex. E, Curlin Decl. ¶ 42. Unlike their use in treating precocious puberty, where blockers are given until the child reaches normal puberty age, when administered to children with gender dysphoria, they suppress puberty throughout its typical duration. *United States v. Skrmetti*, 145 S.Ct. 1816, 1841-42 (2025) (Thomas, J., concurring); *see also* Ex. C, Cantor Decl. ¶ 62.

Cross-Sex Hormones: Clinicians prescribe elevated levels of cross-sex hormones, estrogen for boys and testosterone for girls, to induce the opposite sex's secondary characteristics in a gender-confused child. *See* Ex. E, Curlin Decl. ¶ 45; *Skrmetti*, 145 S.Ct. at 1825. Girls typically receive

testosterone in an amount "6 to 100 times higher than native female testosterone levels" and boys receive estrogen "2 to 43 times above the normal range." *Skrmetti*, 145 S.Ct. at 1842 (Thomas, J., concurring); *see also* Ex. E, Curlin Decl. ¶ 40. These hormones are typically initiated after puberty blockers or later in adolescence to further alter a child's physical appearance.

Surgery: Gender-transition surgeries include procedures like chest masculinization (mastectomy for females) and genital surgeries (*e.g.*, vaginoplasty for boys or phalloplasty for girls). Ex. A, Levine Decl. ¶ 63; *see also* Ex. B, Lappert Decl. ¶ 75. For girls, this process involves removing "the uterus, ovaries, and vagina, and creation of a neophallu[s] and scrotum with scrotal prostheses" using "'a roll of skin and subcutaneous tissue' from another area of the body." *Skrmetti*, 145 S.Ct. at 1843 (Thomas, J., concurring); *see also* Ex. B, Lappert Decl. ¶ 75. Surgical interventions for boys include "removal of the testicles alone to permanently lower testosterone levels" and creating a "pseudo-vagina" by surgically opening the penis, removing "erectile tissue," and then "closing and inverting" the penis into a newly created cavity to simulate a vagina. *Id.* These surgeries alter healthy anatomy to match the child's perceived gender identity, often following hormonal treatment. *See* Ex. B, Lappert Decl. ¶¶ 46-47. While surgeries have historically been reserved for older adolescents, they are increasingly being performed on younger minors, with WPATH currently recommending mastectomy for girls as young as 15.[1] *See id.* ¶ 46.

[1] WPATH's revised "standard of care" are rooted in political ideology, not science. There is substantial evidence that WPATH "revised provisions of its clinical guidelines not on the basis of clinical evidence but for the purpose of minimizing liability risk to doctors … and maximizing insurance coverage (to be paid to its members as service providers)." Ex. E, Curlin Decl. ¶¶ 63-65; Ex. A, Levine Decl. ¶¶ 78-94. Internal WPATH documents have also revealed that "even experts on the committees that drafted the WPATH SOC-8 raised concerns in internal communications that the guidelines were not consistent with known evidence and medical standards." Ex. E, Curlin Decl. ¶ 63; Ex. A, Levine Decl. ¶¶ 78-94. Specifically, the experts expressed concerns regarding the WPATH's methodology in evaluating the efficacy of using puberty blockers to treat gender

B. Hormonal interventions have valid medical uses separate from gender transition.

The hormone interventions used in gender transitions have other, scientifically validated medical uses, which, unlike their use in gender transitions, are intended to restore proper bodily function. For instance, these hormonal treatments are prescribed to treat pubertal and sexual disorders such as "precocious puberty, hypogonadism, Turner Syndrome, Klinefelter Syndrome, Prader-Willi Syndrome, congenital adrenal hyperplasia, polycystic ovarian syndrome, endometriosis and uterine fibroids, and gynecomastia and hirsutism" to "preserve and restore healthy development of secondary sex characteristics." Ex. E, Curlin Decl. ¶ 41. Puberty blockers are "sometimes prescribed to patients undergoing chemotherapy as part of efforts to preserve fertility." *Id.* ¶ 43. "In such contexts, hormonal treatments have *medicinal* effects," but when used for the purpose of gender transition, the interventions "intentionally block[] [the] healthy development" of a child's body to further "health-diminishing effects" that "contradict and override healthy norms." *Id.* ¶¶ 41-42 (emphasis original). As discussed in Sections II-III below, by intentionally suppressing the body's healthy development, children are exposed to substantial, and often irreversible, risks, even though there is no evidence to support their use for such purposes.

C. Gender transition surgeries are aesthetic, not reconstructive.

Surgical interventions for gender transition entail removal of otherwise healthy bodily structures to satisfy a patient's subjective aesthetics of their body. Ex. B, Lappert Decl. ¶¶ 43-47. There is a fundamental distinction in plastic surgery between aesthetic and reconstructive

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dysphoria. Ex. E, Curlin Decl. ¶ 63(a)-(d); Ex. A, Levine Decl. ¶¶ 78-94. The documents also showed that WPATH removed age restrictions for interventions at the behest of AAP and the Biden administration and that WPATH hoped to shape "law and policy" through SOC8. Ex. E, Curlin Decl. ¶¶ 63-65; Ex. A, Levine Decl. ¶¶ 78-94.

surgeries. *Id.* ¶¶ 40-42. "Reconstructive surgery is the restoration of form and function for a person who has suffered a loss through genetic, in utero developmental accident, trauma, infection, or surgery for infectious events or cancer." *Id.* ¶ 41. "[A]esthetic surgery begins in the subjective life of the patient. . . . Their hope is that by modifying its appearance, they will improve their interior subjective life." *Id.* ¶ 42. Gender transition surgeries are aesthetic, as opposed to reconstructive, in nature. *Id.* ¶¶ 43-49. Unlike other cosmetic surgeries, such as breast implants and rhinoplasties, where "any functional loss caused by surgery is considered an avoidable complication since the surgery neither anticipates nor yields any functional improvement except in the subjective life of the patient," gender transition surgeries "begin[] with the known expectation that the surgery will produce a loss of [] essential human functions" and therefore "must be considered unsupportable as a matter of policy," especially for minors. *Id.* ¶¶ 45-46.

D. Gender dysphoria is a psychiatric condition from which most children desist without chemical or surgical intervention.

Gender dysphoria is a psychiatric diagnosis. Ex. A, Levine Decl. ¶ 42. It is "the only psychiatric condition to be treated by surgery, even though no endocrine or surgical intervention package corrects any identified biological abnormality." *Id.* ¶ 42. Yet "in the large majority of patients, absent a substantial intervention such as social transition or puberty blocking hormone therapy, it does not persist through puberty." *Id.* ¶¶ 152–54; *see also* Ex. C, Cantor Decl. ¶ 73. Studies show that up to 88% of children who experience gender dysphoria will desist in the absence of gender-transition intervention. Ex. C, Cantor Decl. ¶ 180; Ex. F, Reed Decl. ¶ 25. It is currently impossible to distinguish between "children who will desist from that small minority whose trans identity will persist." Ex. A, Levine Decl. ¶ 155; *see also* Ex. C, Cantor Decl. ¶¶ 77–79. The interventions' substantial side effects and limited efficacy are discussed in detail in Sections II-III, below. But given

what is currently known, there is no evidence that any form of intervention "leads to more positive outcomes … than does 'watchful waiting' or ordinary therapy." Ex. A, Levine Decl. ¶ 199.

III. Gender-transition interventions have serious and irreversible side effects.

The weak evidence of benefit is made more concerning because gender-transition interventions have serious negative health effects. Whether a medical intervention can be recommended as "safe," depends on a risk-benefit analysis. Ex. C, Cantor Decl. ¶ 163. The balance of evidence shows gender-transition interventions cause serious physical, psychological, and cognitive harm to children while having little-to-no benefit for the children's mental health.

A. Puberty blockers and cross-sex hormones cause serious side effects and many of their side effects are completely unstudied.

Plaintiffs' motion for temporary injunction fails to disclose the serious complications associated with puberty blockers and cross-sex hormones and falsely asserts that puberty blockers are "reversible." Pl. Temp. Inj. Br. at 13. The available data show that medicalized transition carries serious negative health effects for children.

Puberty blockers and cross-sex hormones can cause permanent loss of fertility. Ex. C, Cantor Decl. ¶¶ 273-77; Ex. D, Weiss Decl. ¶¶ 146-57, 175–77. Plaintiffs disingenuously claim that this effect "may be reversible," but cite no authority for that proposition. The relevant paragraphs in the declarations of Plaintiffs' experts Drs. Antommaria and Corathers do not cite any study demonstrating reversibility. *See* Antommaria ¶ 49; Corathers ¶ 55. This is because no study has examined whether loss of fertility can be reversed from these interventions. *See* Ex. C, Cantor Decl. ¶ 265.

Plaintiffs ignore the other side effects associated with chemical gender-transition interventions for minors. Testosterone administered to females increases the risk of blood clots, Ex. D, Weiss Decl. ¶¶ 178–81; heart attack, *id.* ¶ 186; and stroke, *id.* ¶ 187. Estrogen administered to males

increases the risk of breast cancer, *id*. ¶ 189; prostate cancer, *id*. ¶ 190; thyroid cancer, *id*. ¶ 193, and stroke, *id*. ¶ 197. These risks are not small: males administered estrogen are 22 times more likely to develop breast cancer and females administered testosterone are three-and-a-half times more likely to have a heart attack. *Id.* ¶¶ 186, 189. A number of studies have also suggested that chemical gender-transition interventions for minors may have permanent negative effects on brain development. Ex. C, Cantor Decl. ¶¶ 280-86.

Nor are puberty blockers "reversible." Pl. Temp. Inj. Br. at 13. Puberty blockers delay bone maturation and cause a loss of bone density that does not return when the intervention stops. Ex. D, Weiss Decl. ¶¶ 140-45. Their neurological and psychological side effects are even more concerning. Though there are no completed systematic studies of how puberty blockers affect cognition (concerning in its own right), early data shows that they may have deleterious effects on neurodevelopment. *Id*. ¶¶ 158–163; Ex. C, Cantor Decl. ¶¶ 280-86. Psychologically, delayed puberty is associated with poorer psychosocial function and lesser educational achievement. Ex. C, Cantor Decl. ¶ 287. These losses are not recovered after the child stops using puberty blockers—a child does not simply regain years of lost neurological and psychosocial development. *Id.* ¶ 314.

B. Surgical interventions cause severe and irreversible side effects.

Like hormonal interventions, surgeries modifying a patient's body to align with their perceived gender are rife with substantial and irreversible side effects. For example, mastectomies rob women of "two essential human functions, namely: sexual arousal, and breast feeding." Ex. B, Lappert Decl. ¶ 46; Ex. D, Weiss Decl. ¶¶ 226-34. Of course, genital surgery results in the total loss of one's reproductive organs, a "grievous loss that dwarfs such complications as infection, local tissue loss, urinary leakage or scarring," and, of course, infertility. Ex. B, Lappert Decl. ¶ 78; Ex. D, Weiss

Decl. ¶¶ 213–25, 235-46; Ex. G, Cole Decl. ¶ 17; Ex. H, Cohn Decl. ¶¶ 6, 11. Because these surgeries are cosmetic in nature, they "can justly be considered universally unsafe in all cases, and particularly grievous when visited upon the young." Ex. B, Lappert Decl. ¶ 78.

IV. Gender-transition interventions are experimental.

Numerous comprehensive scientific literature reviews show that the evidence supporting the efficacy and safety of gender-transition interventions for minors is dubious at best. There is almost no quality evidence supporting gender-transition interventions for minors, and the studies that have been performed show ambiguous results at best. Plaintiffs allege without support that broad-based support for these interventions exists, including to reduce suicidal ideation. But contrary to their assertions, "*zero* studies have documented medical transition to cause reduction of suicide rates in minors." Ex. C, Cantor Decl. ¶ 258 (emphasis original).

A. Systematic reviews of the available evidence reveal very weak support for the use of puberty blockers and cross-sex hormones in minors.

Systematic reviews of the evidence regarding gender-transition interventions in minors have consistently showed that the available research purportedly supporting such interventions is, at best, low quality without mental health benefits, Dr. Hillary Cass's systematic review being the most notable. H. Cass, Independent Review of Gender Identity Services for Children and Young People: Final Report, https://cass.independent-review.uk/home/publications/final-report/. The Cass Review comprises seven systematic reviews addressing medicalized and social transition of minors. Dr. Cass's review of puberty blockers found that "[n]o conclusions can be drawn about the effect on gender-related outcomes, psychological and psychosocial health, cognitive development

or fertility." Ex. C, Cantor Decl. ¶ 201.[2] The review of cross-sex hormones found that "[n]o conclusions can be drawn about the effect on gender-related outcomes, body satisfaction, psychosocial health, cognitive development or fertility." *Id.* ¶ 201.[3]

Similarly, a review commissioned by Sweden's government in 2019 concluded the "long-term effects of hormone therapy on psychosocial and somatic health are unknown, except that [puberty blockers] seem[] to delay bone maturation and gain in bone mineral density." *Id.* ¶ 191.[4] A 2020 review by the Finnish government concluded that "[i]n light of available evidence, gender reassignment of minors is *an experimental practice.*" *Id.* ¶ 328 (emphasis original).[5] An "umbrella" systematic review (a systematic review of systematic reviews) by the United States Department of Health and Human Service found that "the certainty of evidence is very low regarding the effect of [puberty blockers] on [gender dysphoria] (or gender incongruence), improvement in mental health, and safety." *Id.* ¶ 189.[6] In 2023, another systematic review concluded that,

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[2] Quoting Taylor, J., Mitchell, A., Hall, R., Heathcote, C., Langton, T., Fraser, L., & Hewitt, C. E. (2024). Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: A systematic review. *Archives of Disease in Childhood*. https://doi.org/10.1136/archdischild-2023-326669.

[3] Quoting Taylor, J., Mitchell, A., Hall, R., Langton, T., Lorna Fraser, & Hewitt, C. E. (2024). Masculinising and feminising hormone interventions for adolescents experiencing gender dysphoria or incongruence: A systematic review. *Archives of Disease in Childhood*. https://doi.org/10.1111/apa.16791.

[4] Quoting Ludvigsson, J. F., Adolfsson, J., Höistad, M., Rydelius, P.-A., Kriström, B., & Landén, M. (2023). A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatrica*. doi: 10.1111/apa.16791.

[5] Quoting Finland COHERE. (2020, June 16). *Medical treatment methods for dysphoria associated with variations in gender identity in minors—Recommendation*. [Official English Summary.] Available from https://palveluvalikoima.fi/documents/1237350/22895008/Summary_ minors _en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_ en+(1).pdf?t=1631773838474.

[6] Quoting U.S. Department of Health and Human Services. (2025). *Treatment for pediatric gender dysphoria: Review of evidence and best practices.* Available from https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf

> The evidence base for the outcomes of gender dysphoria treatment in adolescents is lacking. It is impossible from the included data to draw definitive conclusions regarding the safety of treatment… This review series has highlighted a lack of quality evidence in relation to adolescent GD [*gender dysphoria*] in general: epidemiology, comorbidity, and treatment impact is difficult to robustly assess.

Id. ¶ 207.[7] And a team from McMaster University in Canada recently published a set of systematic reviews that concluded the evidence is insufficient to "exclude the possibility of benefit or harm" from puberty blockers or cross-sex hormones. *Id.* ¶ 209.[8]

V. It is unethical to subject children to gender-transition interventions.

Medical ethics forbid interventions like gender-transition interventions for minors that have substantial and irreversible side-effects and lack supporting evidence. Ex. E, Curlin Decl. ¶¶ 16-17, 42-44, 47, 86, 94-95, 111, 125. Minors cannot consent to such interventions under any normal understanding of informed consent. *Skrmetti*, 145 S.Ct. at 1846 (Thomas, J., concurring) ("The capacity to knowingly consent to these medical interventions requires a level of comprehension about science, sex, and fertility that state legislatures could determine a child is unlikely to possess."); *see also* Ex. E, Curlin Decl. ¶¶ 16-17, 42-44, 47, 86, 94-95, 111, 125; Ex. F, Reed. Decl. ¶ 43.

Children are generally considered unable to consent to medical procedures in part because they lack "the intellectual maturity to sufficiently *comprehend* … the potentially life-long

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[7] Quoting Thompson, L., Sarovic, D., Wilson, P., Irwin, L., Visnitchi, D., Sämfjord, A., & Gillberg, C. (2023) A PRISMA systematic review of adolescent gender dysphoria literature: 3) treatment. *PLOS Global Public Health, 3,* e0001478. doi: 10.1371/journal.pgph.0001478.

[8] Quoting Miroshnychenko, A., Ibrahim, S., Roldan, Y., Kulatunga-Moruzi, C., Montante, S., Couban, R., Guyatt, G., & Brignardello-Petersen, R. (2025b). Gender affirming hormone therapy for individuals with gender dysphoria aged <26 years: A systematic review and meta-analysis. *Archives of Disease in Childhood, 110,* 437–445; and Miroshnychenko, A., Roldan, Y., Ibrahim, S., Kulatunga-Moruzi, C., Montante, S., Couban, R., Guyatt, G., & Brignardello-Petersen, R. (2025a). Puberty blockers for gender dysphoria in youth: A systematic review and meta-analysis. *Archives of Disease in Childhood, 110,* 429–436.

consequences that decision will bring." Ex. E, Curlin Decl. ¶¶ 92-95, 111 (emphasis original). This inability to comprehend the risks of a medical intervention is compounded in the context of gender-transition interventions where puberty blockers "*by design* block[] the mental, physical, and emotional maturation of puberty which may be essential for a child to come in time to comprehend decisions of this magnitude." *Id.* ¶ 95; Ex. C, Cantor Decl. ¶ 322. To complicate matters further, "a high proportion of minors experiencing [gender dysphoria] suffer from mental illnesses," rendering informed consent even more difficult. Ex. E, Curlin Decl. ¶ 103. "For all these reasons, it is doubtful that minors experiencing [gender dysphoria] have sufficient information, comprehension, or voluntariness to make possible informed consent to" gender-transition interventions, and there is no evidence-based approach for identifying the few minors that could. *Id.* ¶ 111.

VI. The experience of de-transitioners supports the Act.

The testimony of Corinna Cohn and Chloe Cole, both detransitioners who underwent medicalized gender-transition interventions as teens, provides additional evidence for the Act. Cohn began cross-sex hormones at 18 and had vaginoplasty at 19, but the interventions did not alleviate his depression or anxiety. Ex. G, Cohn Decl. ¶¶ 2–9. Cohn's depression only relented once he accepted that his "more stereotypically feminine attitudes and behaviors did not [] make [him] a woman, but rather a feminine man." *Id.* ¶ 9. Cohn now reflects that, as a teenager, he was "unprepared to understand the consequences of [his] decision to medicalize [his] transition." *Id.*

Cole, who is autistic, started puberty blockers at 12, testosterone at 13, and had a double mastectomy at 15, believing she "could actually become a boy." Ex. F, Cole Decl. ¶¶ 6, 11–16. Cole and her parents were not "present[ed] any other option[s] to treat [her] dysphoria" and were provided little information regarding the interventions' risks, poor efficacy, the possibility of desistence, or the implications of living life as a transgender individual. *Id.* ¶¶ 9, 13, 15. The interventions

came with a cost: she suffered from urinary tract infections, digestive problems, suicidal ideation (which emerged post-treatment), joint pain, and ongoing fluid leakage from the double mastectomy grafts. *Id.* ¶¶ 14, 16, 18. Eventually, the complications took their toll, and Cole decided to detransition. *Id.* ¶ 19. Only now, upon reaching adulthood, and with great regret, does Cole fully appreciate the long-term consequences of her decision: a potential loss of fertility and the inability "to breastfeed my future children." *Id.* ¶¶ 17, 24. Cole wishes it had not "been an option for [her] to be prescribed hormone treatments that caused me harm and may have affected my fertility, or to have my healthy breasts removed at the age of 15." Cole Decl. ¶ 24.

LEGAL STANDARD

Legislation that has been duly enacted through the democratic process is presumed constitutional. *Leiker v. Gafford,* 245 Kan. 325, 363- 64, 778 P.2d 823, 850 (1989). Injunctive relief "is an extraordinary and drastic remedy, one that should not be granted unless the movant, *by a clear showing,* carries the burden of persuasion." *Mazurek v. Armstrong,* 520 U.S. 968, 972, 117 S. Ct. 1865, 1867, 138 L.Ed.2d 162 (1997) (emphasis in original); *see also Winter v. Nat'l Res. Def Council, Inc.,* 555 U.S. 7, 24 (2008) ("A preliminary injunction is an extraordinary remedy never awarded as of right."). A party cannot obtain injunctive relief unless it can establish five factors:

> (1) a substantial likelihood of eventually prevailing on the merits; (2) a reasonable probability that the plaintiff will suffer irreparable injury without an injunction; (3) the lack of an adequate legal remedy, such as damages; (4) the threat of injury to the plaintiff outweighs whatever harm the injunction may cause the opposing party; and (5) the injunction will not be against the public interest.

Downtown Bar & Grill, LLC v. State, 294 Kan. 188, 191, 273 P.3d 709, 713 (2012). A plaintiff must also demonstrate it "exercise[d] reasonable diligence" to be entitled to injunctive relief. *Noble v. Butler,* 25 Kan. 645, 651 (1881).

ARGUMENT

I. Plaintiffs do not have a substantial likelihood of prevailing on the merits of their claims.

A. Plaintiffs are unlikely to succeed on their Equal Protection claims.

The minor Plaintiffs claim S.B. 63 violates the constitutional guarantee of equal protection of the laws by discriminating against them on the basis of sex and transgender status. But neither claim is valid under Kansas law. Plaintiffs' equal protection claims are likely to fail.

i. Plaintiffs face a heavy burden under the Kansas equal protection framework.

"[T]he textual grounding of equal protection guarantees contained in the Bill of Rights of the Kansas Constitution is rooted in the language of section 2." *Rivera v. Schwab*, 315 Kan. 877, 894, 512 P.3d 168, 180 (2022). Section 2 declares that "[a]ll 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." Kan. Const. Bill of Rights, § 2. Courts employ a three-part analysis to assess whether a statute violates this guarantee.

At step one, a court must determine "the nature of the legislative classifications and whether the classifications result in arguably indistinguishable classes of individuals being treated differently." *Miami Cnty. Bd. of Comm'rs v. Kanza Rail-Trails Conservancy, Inc.*, 292 Kan. 285, 315, 255 P.3d 1186, 1207 (2011). At step two, a court must select the appropriate level of scrutiny. A court must apply rational basis review unless the law "target[s] a suspect class or burden[s] a fundamental right." *Downtown Bar & Grill, LLC v. State*, 294 Kan. 188, 194, 273 P.3d 709, 715 (2012). And at step three, a court must evaluate whether the classification's link to the legislative goal withstands the applicable scrutiny. *Miami Cnty. Bd. of Comm'rs*, 292 Kan. at 316, 255 P.3d at 1208.

Furthermore, for facial challenges like this one, *see* Pet. at 29 (asserting the law is "unconstitutional and therefore unenforceable" in all applications), a plaintiff must plead and prove that "no set of circumstances exist" in which the law survives the applicable level of scrutiny. *Injured Workers of Kan. v. Franklin*, 262 Kan. 840, 850, 942 P.2d 591, 601 (1997). When the challenged law does not implicate suspect classifications, this burden is coupled with "a presumption of constitutionality," *Barrett ex rel. Barrett v. Unified Sch. Dist. No. 259*, 272 Kan. 250, 256, 32 P.3d 1156, 1162 (2001), which holds that if "there is any reasonable way to construe a statute as constitutionally valid, the court must do so." *State v. Scherzer*, 254 Kan. 926, 938, 869 P.2d 729, 737 (1994). Plaintiffs must prove *beyond a reasonable* doubt that all provisions of S.B. 63 infringe the equal protection guarantee in every application. *State v. Engles*, 270 Kan. 530, 531, 17 P.3d 355, 357 (2001); *State v. Robinson*, 303 Kan. 11, 278, 363 P.3d 875, 1050 (2015).

ii. *Skrmetti* is dispositive.

Of decisive importance in this case is the fact that the scope and application of the equal protection clause in the Kansas Constitution is the same as that of the United States Constitution. As the Kansas Supreme Court has explained, because the equal protection guarantees of the Kansas Constitution are "coextensive with the equal protection guarantees afforded under the Fourteenth Amendment," Kansas courts follow federal precedent when assessing equal protection claims. *Rivera*, 315 Kan. at 894, 512 P.3d at 180. "Kansas courts shall be guided by United States Supreme Court precedent interpreting and applying the equal protection guarantees of the Fourteenth Amendment of the federal Constitution when we are called upon to interpret and apply the coextensive equal protection guarantees of section 2 of the Kansas Constitution Bill of Rights." *Id.* With that interpretive rule in mind, this Court need look no further than the Supreme Court's

recent decision in *Skrmetti* to dispose of Plaintiffs' equal protection claim. The holding in *Skrmetti* definitively establishes that Plaintiffs have failed to plead a cognizable equal protection claim.

iii. The Act classifies on the basis of age and medical use.

"[M]ost legislation classifies for one purpose or another, with resulting disadvantage to various groups or persons." *Romer v. Evans*, 517 U.S. 620, 631 (1996). But such classifications do not trigger heightened constitutional scrutiny unless the law "burdens a fundamental right []or targets a suspect class." *Id.* Here, Plaintiffs do not claim that the Help Not Harm Act burdens a fundamental right. They instead assert it violates equal protection by discriminating on the basis of sex and transgender status. But that argument is incorrect. The Act classifies on the basis of medical use and age. It is therefore subject to rational basis review.

On one hand, the Act prohibits clinicians from "knowingly perform[ing] … [certain] surgical procedures or prescrb[ing], dispens[ing], or administer[ing] [puberty blockers and cross-sex hormones] to a [] child for the purpose of treatment for distress arising from such [] child's perception that such child's gender or sex [does] not" match their biological sex. S.B. 63 § (3)(a)-(b). On the other hand, the Act allows clinicians to provide children with these interventions for "treatment provided for other purposes." S.B. 63 § (3)(c). And the Act does not prevent clinicians from offering any of these interventions to adults, regardless of medical use. *See generally* S.B. 63. The Help Not Harm Act thus prohibits chemical and surgical gender-transition interventions for children *while allowing them* for adults and for the treatment of other conditions in minors. In doing so, the law mentions sex but only because the proscribed treatments depend on it. *See* S.B. 63(3)(a)-(b) (prohibiting vaginoplasties and "supraphysiologic doses of estrogen" for "male child[ren]" and phalloplasties and "supraphysiologic doses of testosterone" for "female child[ren]"). Indeed, boys and girls alike are prohibited from utilizing the proscribed interventions for the purpose of treating

"distress arising from" the belief that their gender does not match their biological sex. The upshot is that the Act discriminates on the basis of medical usage (gender-transition interventions) and by age (for minors). Neither classification is a suspect class, warranting heightened judicial scrutiny.

Even if transgender status were a suspect class (it is not), the Act does not discriminate on the basis of an individual being transgender. Rather, the Help Not Harm Act distinguishes between children who are given surgical and chemical interventions for a prohibited purpose (for gender-transition) and those children who would use the interventions for an approved purpose (such as for precocious puberty). *See* S.B. 63(3)(a)-(c). Children who identify as transgender fall into both categories, and thus all children can gain access to these interventions for allowable medical uses.

Skrmetti compels this conclusion. There, the Supreme Court addressed nearly identical claims asserted against a Tennessee law that was worded similarly to Kansas S.B. 63.[9] The Court

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[9] In many respects, the language used in Tennessee S.B. 1 (the law challenged in *Skrmetti*) and Kansas S.B. 63 is identical, *compare* S.B. 63 *with* Tenn. Code Ann. § 68-33-103 (emphasis added to highlight identical and similar language):

Tennessee's S.B. 1	**Kansas's S.B. 63**
• **A healthcare provider shall not knowingly perform** or offer to perform on a minor, or **administer** or offer to administer **to a minor**, a medical procedure if the performance or administration of the procedure is **for the purpose of** . . . . **Treating** purported discomfort or **distress from a discordance between the minor's sex and asserted identity**.	• **[A] healthcare provider shall not knowingly perform** the following surgical procedures or prescribe, dispense or **administer** the following medications **to a** female/male **child for the purpose of** treatment for **distress** arising **from such female/male child's perception that such child's gender or sex is not female/male**.
• **It is not a violation of subsection (a) if** a healthcare provider knowingly performs, or offers to perform, a medical procedure on or administers, or offers to administer, a medical procedure to a minor if . . . . The performance or administration of the	• **The treatments prohibited by subsections (a) and (b) shall not apply to treatment provided for other purposes, including** . . . . Treatment for individuals **born with a medically verifiable disorder of sex development** . . . **injury**, **disease** or **disorder**[.]

held that Tennessee's law prohibiting healthcare providers from administering puberty blockers, cross-sex hormones, and mutilating surgeries to treat gender dysphoria, gender identity disorder, or gender incongruence in minors—while allowing these treatments for other medical purposes—did not classify based on sex. *Skrmetti*, 145 S.Ct. at 1829-30. The Court found that the "mere reference to sex" did not trigger heightened scrutiny, particularly in medical contexts where treatments relate to biology. *Id.* at 1829. The Court also rejected claims of sex-based stereotyping, noting the law aimed to protect minors from the experimental treatments' physical and emotional harms, not enforce gender norms. *Id.* at 1832.

Skrmetti also declined to recognize transgender status as a suspect class. In her concurrence, Justice Barrett explained that transgender individuals lack the immutable traits, historical discrimination, or political powerlessness required to qualify for status as a suspect class. *Id.* at 1851-55 (Barrett, J., concurring). The Court further held that even if such a status were to exist, the law still did not target transgender individuals because it based its classification on medical use, not children's identities. *Id.* at 1832-33 (majority opinion).

So too here. The Help Not Harm Act classifies based on age and medical use—it prohibits certain interventions for children while allowing them for adults and the treatment of other conditions in minors. The Act mentions sex, but only because the proscribed treatments depend on it. Indeed, boys and girls alike are prohibited from accessing the proscribed interventions for the purpose of treating "distress arising from" the belief that their gender does not match their natal sex.

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medical procedure is to treat a minor's **congenital defect**, **precocious puberty**, **disease**, **or physical injury**[.]

The Act says nothing about transgender status. Rather, it distinguishes between children who would use the listed interventions for a prohibited purpose (to treat gender-related distress) and those children who would use the interventions for an approved purpose (such as for precocious puberty). "Thus, although only transgender individuals seek treatment for gender dysphoria, gender identity disorder, and gender incongruence—just as only biological women can become pregnant—there is a 'lack of identity' between transgender status and the excluded medical diagnoses." *Id.* Because S.B. 63 does not target a suspect class or a fundamental right, it is subject to rational basis review.

B. There is no constitutional right of parents to obtain specific medical interventions.

Plaintiffs claim that S.B. 63 violates Plaintiffs Lisa Loe and Rebecca Roe's "fundamental right to parenting." *See* Pet. ¶¶ 122–126. This claim lacks legal basis, relies on flawed reasoning, and, with respect to Ryan Roe, contradicts Kansas statute. No Kansas or federal court holding recognizes a fundamental right of a parent to choose a child's medication, let alone the right to subject a child to puberty blockers, cross-sex hormones, or sex-change procedures. Indeed, Plaintiffs' theory has been repeatedly rejected by courts.

Following federal precedent, the Supreme Court of Kansas has recognized a fundamental right to the care, custody, and control of one's child. *See, e.g., In re Adoption of Baby Girl P.*, 291 Kan. 424, 430, 242 P.3d 1168, 1173 (2010); *Int. of B.H.*, 64 Kan. App. 2d 480, 488, 550 P.3d 1274, 1283 (2024); *see also see Troxel v. Granville*, 530 U.S. 57, 66 (2000). But neither the Kansas nor the federal courts have ever extended this right to include the right to obtain particular medical interventions for one's child in the face of an otherwise valid regulation. *See Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205, 1220 (11th Cir. 2023) (surveying Supreme Court precedent). And federal

courts have repeatedly rejected a fundamental right to obtain specific medical treatment for oneself. *See L. W. by & through Williams v. Skrmetti*, 83 F.4th 460, 475 (6th Cir. 2023) (no right to obtain puberty blockers and cross-sex hormones); *Pickup v. Brown*, 740 F.3d 1208, 1222 (9th Cir. 2014) (no right to "sexual orientation change efforts" or "conversion therapy"); *Abigail All. for Better Access to Dev. Drugs v. von Eschenbach*, 495 F.3d 695, 711 (D.C. Cir. 2007) (no right to procure and use experimental drugs); *Raich v. Gonzales*, 500 F.3d 850, 864 (9th Cir. 2007) (no right to medical marijuana); *Sammon v. N.J. Bd. of Med. Examiners*, 66 F.3d 639, 645 (3d Cir. 1995) (no right to select a midwife); *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980) (no right to select non-FDA-approved cancer treatment). If people do not have a right to obtain specific medical treatment for themselves, they perforce have no right to obtain them for their children. *See Prince v. Massachusetts*, 321 U.S. 158, 168 (1944) ("The state's authority over children's activities is broader than over like actions of adults.").

Creation of a constitutional right to obtain medical treatment for one's child would potentially subject every medical regulation concerning Kansas minors to strict scrutiny. As the *Skrmetti* court observed, "[i]f parents could veto legislative and regulatory policies about drugs and surgeries permitted for children, every such regulation—there must be thousands—would come with a springing easement: It would be good law until one parent in the country opposed it." *Skrmetti*, 83 F.4th at 475. Parents could circumvent state law to obtain opioids to control their children's pain, or marijuana to alleviate their child's anxiety. But it is well established that a state's police powers encompass reasonable regulation of the medical profession. *See, e.g.*, *Gilbert v. Mathews*, 186 Kan. 672, 676–77, 352 P.2d 58, 63 (1960) ("[T]he police power of the state . . . extends not only to the protection of the public health, safety and morals, but also to the preservation and promotion of

the public welfare."); *Zahl v. Harper*, 282 F.3d 204, 211 (3d Cir. 2002) ("The state regulation of the medical profession is in the public interest; power to establish and enforce health standards 'is a vital part of a state's police power.' ").

Finally, Rebecca Roe lacks standing to claim a violation of her right to parent. Though she claims a right to "exercis[e] decision-making authority on behalf of" Ryan Roe, he has a statutory right to direct his own healthcare. Under Kan. Stat. § 38-123b, a child sixteen or older is competent to consent to "hospital, medical or surgical treatment or procedures" without their parent. *See also M.T. as next friend of M.K. v. Walmart Stores, Inc.*, 63 Kan. App. 2d 401, 403, 528 P.3d 1067, 1071 (2023), *review denied* (Aug. 25, 2023) ("Kansas law requires parental consent for medical treatment or procedures if the minor is under the age of 16."). Roe cannot plausibly claim a fundamental right to obtain care on behalf of her child when he has a statutory right to direct his own care.

C. The law satisfies rational basis review.

Because the Act does not make impermissible classifications or infringe upon parents' fundamental rights, it is subject to rational basis review. Rational basis review is a "very lenient standard," under which a court must uphold a statute if any set of facts rationally related to a legitimate government interest. *State v. Genson*, 59 Kan. App. 2d 190, 212, 481 P.3d 137, 154 (2020), *aff'd*, 316 Kan. 130, 513 P.3d 1192 (2022). The government "has no obligation to produce evidence or empirical data," and the challenger must "negative every conceivable basis" to uphold the statute. *Id.*

The Act's restrictions on certain medical interventions for minors are rationally related to Kansas's legitimate interests in protecting children and the medical profession. Kansas has a legitimate interest in "protecting children" and "particularly from all forms of cruelty, neglect, degradation, and inhumanity," *State v. Wilson*, 267 Kan. 550, 559, 987 P.2d 1060, 1067 (1999), and

"protecting the integrity and ethics of the medical profession." *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

The Help Not Harm Act's restrictions rationally advance these goals by shielding children from unproven treatments with severe, lifelong consequences. The interventions prohibited by S.B. 63, when used to treat children for "gender dysphoria, gender identity disorder, or gender incongruence 'can lead to the minor becoming irreversibly sterile, having increased risk of disease and illness, or suffering from adverse and sometimes fatal psychological consequences.'" *Skrmetti*, 145 S.Ct. at 1826; *see also* pages 8-10, above. These severe side effects are imposed on children unable to give informed consent, despite the interventions' lack of proven benefit. *See id.* at 1835-36. In circumstances of such "medical and scientific uncertainty," courts must "afford States 'wide discretion to pass legislation.'" *Id.* Given the substantial evidence that gender-transition interventions harm minors without any proof of efficacy, the Act easily clears the low bar of rational basis review. *See Hettinga v. United States*, 677 F.3d 471, 479 (D.C. Cir. 2012) (affirming grant of motion to dismiss based on finding that the law easily survived rational basis review). The Act easily satisfies rational basis review.

D. The Act survives heightened scrutiny.

Even if intermediate scrutiny were to apply (and it does not), Plaintiffs' claims would likewise fail. To satisfy intermediate scrutiny, a law must be "substantially related to an important governmental objective. This requires the justification for the statute's differential treatment to be exceedingly persuasive." *T.N.Y. ex rel. Z.H. v. E.Y.*, 51 Kan. App. 2d 956, 965, 360 P.3d 433, 440 (2015) (citation modified).

Protecting children from experimental procedures is exceedingly important exercise of the State's police powers. *Gilbert v. Mathews*, 186 Kan. 672, 676–77, 352 P.2d 58, 63 (1960) ("[T]he

source of the authority to regulate auctions is the police power of the state" which "extends not only to the protection of the public health, safety and morals, but also to the preservation and promotion of the public welfare."). And "state and federal legislatures [have] wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163, 127 S. Ct. 1610, 1636, 167 L. Ed. 2d 480 (2007); *see also Kansas v. Hendricks*, 521 U.S. 346, 360 n.3 (1997) (finding that "disagreements [among psychiatric professionals] ... do not tie the State's hands in setting the bounds of its civil commitment laws," because "it is precisely where such disagreement exists that legislatures have been afforded the widest latitude in drafting such statutes").

The Act protects children's health by prohibiting interventions which lack evidence of efficacy and cause serious and irreversible harms like infertility and loss of sexual function, as seen in Cole's ongoing complications, Ex. F, Cole Decl. ¶ 23, and Cohn's fertility loss. *See* Ex. G, Cohn Decl. ¶ 11. These interventions do not afford demonstrated psychological improvement or a decrease in suicidality. To the contrary, evidence suggests that suicidality increases after undergoing these interventions. Ex. A, Levine Decl. ¶¶ 177-221; Ex. C, Cantor Decl. ¶¶ 242-43, 258-59. Moreover, it has been shown that most children will desist if they do not undergo these experimental interventions. Ex. A, Levine Decl. ¶ 152; Ex. C, Cantor Decl. ¶ 73. These findings provide an exceedingly persuasive justification for the Act's restrictions.

Nor can there be any doubt that the Act's prohibitions are substantially related to the important objective of protecting children from these experimental interventions. "[I]t is not yet known how to distinguish those children who will desist from that small minority whose trans identity will persist." Ex. A, Levine Decl. ¶ 155. But what is known is that the vast majority of minors

will desist, Ex. C, Cantor Decl. ¶ 180—and thereby avoid a lifetime of medicalization and irreversible complications—if they are simply allowed to advance through puberty. Ex. A, Levine Decl. ¶¶ 116–18; *see also* Ex. C, Cantor Decl. ¶ 73. Under such circumstances, there was no other viable mechanism available to the Legislature protect children other than an outright prohibition on the provision of these interventions to minors.

Accordingly, Plaintiffs' claims are likely to fail even under intermediate scrutiny.

II. Plaintiffs will not suffer an irreparable injury

Plaintiffs cannot show a reasonable probability of irreparable harm because they cannot show that access to the gender-transition interventions will alleviate their distress; they still have access to the banned interventions even without an injunction; they substantially delayed in filing their suit; and the Act will not become fully effective for another five-and-a-half months.

To obtain a temporary injunction, Plaintiffs must show "a reasonable probability of suffering irreparable future injury." *Downtown Bar & Grill, LLC v. State*, 294 Kan. 188, 191, 273 P.3d 709, 713 (2012). A "reasonable probability" is lower than the applicable burden of proof at trial but requires more than "purely speculative harm." *State ex rel. Kobach v. Harper*, No. 127,390, 2025 WL 1668749, at *6 (Kan. Ct. App. June 13, 2025). A harm is not irreparable if it can be remedied with money damages. *See Persimmon Hill First Homes Ass'n v. Lonsdale*, 31 Kan. App. 2d 889, 894, 75 P.3d 278, 283 (2003).

First, Plaintiffs cannot demonstrate that they will be harmed by loss of access to the banned interventions. There is little evidence that puberty blockers and cross-sex hormones lead to better mental health outcomes. *See* pages 8-12, above. Indeed, the opposite is true: there is strong medical evidence to conclude that Loe and Roe are being actively harmed by these interventions. *See* pages 8-10, above. Rather than preventing an irreparable harm, an injunction here may very well cause it.

See, e.g., *Davis v. Detroit Downtown Dev. Auth.*, No. 17-CV-11742, 2017 WL 11318204, at *3 (E.D. Mich. June 19, 2017) ("Having considered the unrebutted evidence offered by Defendants that an injunction would cause harm to them, as well as the City of Detroit and those living and working within it, this Court concludes that this factor cuts against issuing an injunction."). Plaintiffs' evidence that these interventions are effective and safe is dwarfed by the countervailing evidence showing that the benefits are uncertain and the harms are real. *See* pages 8-12, above.

Further, Plaintiffs are not suffering irreparable harm because they have guaranteed access to those interventions for the next five months. Section 3(d) of the Act provides,

> If a healthcare provider has initiated a course of treatment for a child that includes prescribing, administering or dispensing 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). Pursuant to this sunset clause, Plaintiff Ryan Roe is still receiving testosterone from a provider in Kansas. *See* Pet. ¶¶ 104–105. He cannot reasonably claim that he will lose access to testosterone unless the Act is temporarily enjoined when he has been receiving testosterone for the last three months under the Act and will continue to do so for more than five months. Section 3(d) precludes a finding of irreparable harm at this time. *See Sato v. U.S. Bank Tr. NA*, 2014 WL 12571041, at *2 (C.D. Cal. Jan. 21, 2014) (finding plaintiff could not establish irreparable harm

because the threat of harm was not imminent where the circumstances giving rise to the potential harm was "two months away" and collecting cases).

Even if the Act halted Plaintiffs' access to gender-transition interventions for minors, they can still seek such interventions out of state. This is precisely the situation for Lily Loe who is receiving puberty blockers outside of Kansas. *See* Pet. ¶ 96. Like Roe, Loe cannot reasonably claim irreparable harm absent an injunction when she has access to puberty blockers from outside the state. *See, e.g., Smith & Nephew, Inc. v. Synthes (U.S.A.)*, 466 F.Supp.2d 978, 982 (W.D. Tenn. 2006) ("The irreparable harm requirement contemplates the inadequacy of alternate remedies available to the plaintiff."); *Curtis 1000 v. Youngblade*, 878 F. Supp. 1224, 1248 (N.D. Iowa 1995) ("Irreparable harm will not be found where alternatives already available to the plaintiff make an injunction unnecessary."). It may increase costs, but expense cannot create irreparable harm. *See Persimmon Hill*, 31 Kan. App. 2d at 894, 75 P.3d at 283.

Finally, Plaintiffs' delay in filing suit further cuts against their claim of irreparable harm. Despite claiming an imminent loss of medically necessary treatment, Plaintiffs waited three months after the law went into effect to file suit. Courts consistently hold that "delay in seeking preliminary relief cuts against finding irreparable injury." *Kan. Health Care Ass'n, Inc. v. Kan. Dep't of Soc. & Rehab. Servs.*, 31 F.3d 1536, 1543–44 (10th Cir. 1994). "A delay in seeking a preliminary injunction of even only a few months—though not necessarily fatal—militates against a finding of irreparable harm." *Wreal, LLC v. Amazon*, 840 F.3d 1244, 1248 (11th Cir. 2016). The Act has been in effect since February 20, 2025, but plaintiffs did not seek injunctive relief until May 28, 2025. This delay counsels against a finding of irreparable harm.

III. The harm to the public greatly outweighs any threat of injury to Plaintiffs.

The *de minimis* threat of injury to Plaintiffs is outweighed by the harm the public will suffer if the Act is enjoined. *See Downtown Bar & Grill, LLC*, 294 Kan. at 191, 273 P.3d at 713. Under the *parens patriae* doctrine, if a "state [is] a party to a suit involving a matter of sovereign interest, [it] 'must be deemed to represent all its citizens.'" *State of N.J. v. State of N.Y.*, 345 U.S. 369, 372 (1953). In this instance, Defendant has a "quasi-sovereign interest in [preserving] the health and well-being—both physical and economic—of its residents," by protecting children from harmful and experimental medical interventions. *See Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 607 (1982). The legislature of Kansas has determined the public interest with respect to exposing minors to these treatments, and it has done so emphatically, with supermajorities in both legislative chambers.

Enjoining the Help Not Harm Act would place Kansas children in harm's way. The law prevents them from being prescribed interventions that have been shown to be harmful and ineffective. The declarations of Defendant's experts and detransitioners highlight the lack of evidence supporting these interventions' efficacy, the irreversible harms they cause, the ethical violations in their administration to minors, and the availability of safer, evidence-based alternatives like therapy. Allowing clinicians to prescribe these interventions to minors risks widespread harm to vulnerable youth, undermines medical ethics, and burdens public resources. That is a substantial harm to the public that greatly outweighs any harm to the Plaintiffs.

IV. If the Court issues a temporary injunction, it should accord relief only among the parties to this case

Should the Court find that Roe and Loe have made the showing necessary to obtain a temporary injunction, it should enjoin SB 63 only with respect to Roe and Loe. The United States

Supreme Court recently clarified that equitable relief is generally permitted only for the named parties to a suit. *See Trump v. CASA, Inc.*, No. 24A884, 2025 WL 1773631, at *6 (U.S. June 27, 2025). Although *CASA* dealt with the power of federal courts, Kansas courts equitable authority derives from the same Anglo-American legal tradition. To the extent Plaintiffs seek an injunction, the injunction should accord relief only to them. *See Gregory v. Stetson*, 133 U. S. 579, 586 (1890) ("It is an elementary principle that a court cannot adjudicate directly upon a person's right without having him either actually or constructively before it. This principle is fundamental.").

Facial challenges of the kind brought by the Plaintiffs are "disfavored" from the outset. *Moody v. NetChoice, LLC*, 603 U.S. 707, 744 (2024). Even for permanent injunctions, "[t]he normal rule is that partial, rather than facial, invalidation is the required course, such that a statute may ... be declared invalid to the extent that it reaches too far, but otherwise left intact." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 329 (2006) (internal quotation marks omitted). In addition to requesting unusual sweeping preliminary relief, the Plaintiffs seek relief for differently situated nonparties. While the Plaintiffs are permitted to continue their gender-transition interventions through the end of the year, nonparty minors who have not begun their interventions are not. S.B. 63 § 3(d).

Narrow relief is particularly important in this case to protect the physical and mental health of children across Kansas. As described above and in the expert declarations attached to this response, the weight of scientific evidence shows that puberty blockers and cross-sex hormones are dangerous for children. More than that, the science shows that most adolescents—between 61% and 88%—who present with gender dysphoria will eventually desist. Ex. C, Cantor Decl. ¶ 73. The Kansas legislature made a decision in an area of "medical and scientific uncertainty," *Gonzales*, 550

U.S. at 163, and the Court should accord that decision deference. Doubly so in light of the voluminous scientific evidence supporting SB 63 and the ruinous consequences for Kansas children if Plaintiffs are wrong. The Court should be extremely hesitant to upset the status quo for Kansas children based on a suit by two parents and their children.

CONCLUSION

For the foregoing reasons, Plaintiffs have failed to carry their burden of demonstrating a substantial likelihood of success on the merits. Their likelihood of success was small when they filed this case; it is infinitesimally so in the wake of the Supreme Court's holding in *Skrmetti*. Plaintiffs have also failed to show irreparable harm, or that the balance of harms favors injunctive relief. The Help Not Harm Act represents a science-based legislative response to protect Kansas children from experimental gender-transition interventions that lack evidence and cause irreversible harm, while preserving access to these interventions for adults and for legitimate medical purposes. The overwhelming weight of scientific evidence supports the Act's restrictions, and Plaintiffs cannot overcome the presumption of constitutionality that attaches to democratically enacted legislation. Accordingly, Defendant respectfully requests that this Court deny Plaintiffs' motion for temporary injunctive relief.

Dated: July 10, 2025

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CERTIFICATE OF SERVICE

I certify that on July 10, 2025, the above and foregoing were electronically filed with the Clerk of the Court using the Court's Electronic Filing System, which will send notice of electronic filing to all counsel of record.

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