IN THE CIRCUIT COURT OF COLE COUNTY
STATE OF MISSOURI

EMILY NOE, individually and as next friend and on behalf of her minor child, NICHOLAS NOE, et al., Plaintiffs, v. MICHAEL L. PARSON, in his official capacity as Governor for the State of Missouri, et al., Defendants.	Case No.

PLAINTIFFS' SUGGESTIONS IN SUPPORT
OF MOTION FOR PRELIMINARY INJUNCTION

Absent a preliminary injunction, the law Plaintiffs challenge ("the Act")[1] will ban the initiation of medically necessary medical treatments and procedures provided to transgender adolescents for the purpose of treating gender dysphoria. Under Missouri Supreme Court Rule 92.02, and for the reasons discussed below, Plaintiffs respectfully request entry of a preliminary injunction against the Act from taking effect, and prohibiting Defendants from implementing or enforcing the Act, to avoid the permanent and potentially extremely serious negative health consequences for the Minor Plaintiffs and for transgender adolescents across Missouri.

[1] The Act was passed as by the Missouri General Assembly on May 10, 2023 as part of "Senate Substitute No.2 to Senate Bills Nos. 49, 236 & 164." As enacted, the Senate Substitute established § 191.1720 of the Missouri Revised Statutes, also referred to as the "Missouri Save Adolescents from Experimentation (SAFE) Act," to prohibit the provision of gender-affirming medical care to persons under 18 years of age. It also added Subsection 15 to § 208.152 of the Missouri Revised Statutes to prohibit coverage by MO HealthNet (Missouri's Medicaid program) of medically necessary gender-affirming medical care. As used herein, the terms the "Act," and "S.B. 49" all refer to these provisions collectively.

TABLE OF CONTENTS

INTRODUCTION 1

FACTUAL BACKGROUND 3

A. Medical Protocols for the Treatment of Transgender Adolescents with Gender Dysphoria 3

B. The Act 9

C. The Act Inflicts Severe and Irreparable Harms on the Plaintiffs and Others 11

i. C.J. and S.M. 11

ii. A.K. and J.K. 13

iii. Nicholas Noe and Emily Noe 14

iv. Southampton Community Healthcare 16

v. PFLAG 18

vi. GLMA 21

LEGAL STANDARDS 23

ARGUMENT 24

I. Plaintiffs are Likely to Succeed on the Merits of their Equal Protection Claim 24

A. The Act Is Subject to Heightened Scrutiny Because It Discriminates Based on Sex and Transgender Status 25

i. The Act Discriminates Based on Sex 26

ii. The Act Discriminates Based on Transgender Status 30

iii. The Act Was Enacted for the Discriminatory Purpose of Drawing Sex- and Transgender Status-Based Distinctions 32

B. The Act Cannot Survive Heightened Scrutiny 34

i. There Is No Factual Support for Any Potential Justification of the Act 35

C. Treating Gender-Affirming Care Differently from Medical Treatments with Comparable Risks, Benefits, and Scientific Support Is Unjustifiable 37

D. The Act Fails Any Level of Review 39

II. Plaintiffs are Likely to Succeed on the Merits of their Claim that the Act Violates the Fundamental Right to Parental Autonomy 47

A. The Act Infringes on a Fundamental Right, and Strict Scrutiny Applies to the Parent Plaintiffs' Due Process Claims 42

B. The Health Care Ban Cannot Survive Strict Scrutiny 45

III. A Preliminary Injunction Is Necessary 55

A. The Act will Cause Immediate, Irreparable Harm to Plaintiffs 56

B. The Balance of Equities Weigh in Plaintiffs' Favor and Issuance of a Preliminary Injunction is in the Public Interest 54

C. An Injunction of the Entire Act Is Necessary 56

D. Defendants Will Suffer No Harm from the Preliminary Injunction, So No Bond Is Required. 57

CONCLUSION 57

TABLE OF AUTHORITIES

Page(s)

Cases

Adkins v. City of New York,
143 F. Supp. 3d 134 (S.D.N.Y. 2015)....................32

Ambers-Phillips v. SSM DePaul Health Ctr.,
459 S.W.3d 901 (Mo. banc 2015)....................25, 31

Treistman ex rel. AT v. Greene,
754 F. App'x 44 (2d Cir. 2018)....................43

Awad v. Ziriax,
670 F.3d 1111 (10th Cir. 2012)....................55

Bd. of Trs. of Univ. of Ala. v. Garrett,
531 U.S. 356 (2001)....................40

Bostock v. Clayton Cnty., Ga.,
140 S. Ct. 1731 (2020)....................26, 27, 28, 29

Bowen v. City of New York,
476 U.S. 467 (1986)....................50

Boyden v. Conlin,
341 F. Supp. 3d 979 (W.D. Wis. 2018)....................29

Brandt by & through Brandt v. Rutledge,
47 F.4th 661 (8th Cir. 2022), *reh'g en banc denied*, 2022 WL 16957734 (8th Cir. Nov. 16, 2022)....................*passim*

Brandt v. Rutledge,
2023 WL 4073727 (E.D. Ark. June 20, 2023)....................*passim*

Burg v. Dampier,
346 S.W.3d 343 (Mo. Ct. App. 2011)....................56

C. P. by & through Pritchard v. Blue Cross Blue Shield of Ill.,
2022 WL 17788148 (W.D. Wash. Dec. 19, 2022)....................31

C.M.B. by Burch v. Odessa R-VII Sch. Dist. Bd. of Educ.,
No. 17-01075-CV-W-GAF, 2019WL13298894 (W.D. Mo. Mar. 21, 2019)....................27

Califano v. Yamasaki,
442 U.S. 682 (1979)....................56

City of Cleburne v. Cleburne Living Ctr.,
473 U.S. 432 (1985)....................25, 41

City of Greenwood v. Martin Marietta Materials, Inc.,
311 S.W.3d 258 (Mo. App. W.D. 2010), *as modified*....................50

Comm. for Educ. Equal. v. State,
294 S.W.3d 477 (Mo. banc 2009)....................42

Cruzan v. Harmon,
760 S.W.2d 408 (1988), *aff'd*, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990)....................44

D.M. by Bao Xiong v. Minn. State High Sch. League,
917 F.3d 994 (8th Cir. 2019)....................55

Dataphase Sys., Inc. v. C.L. Sys. Inc.,
640 F.2d 109 (8th Cir. 1981) (en banc)....................23

Dekker v. Weida,
No. 4:22CV325-RH-MAF, 2023 WL 4102243 (N.D. Fla. June 21, 2023), *appeal filed*, No. 23-12155 (11th Cir. June 27, 2023).................... *passim*

Dep't of Commerce v. New York,
139 S. Ct. 2551 (2019)....................56

State ex rel. Director of Revenue, State of Mo. v. Gabbert,
925 S.W.2d 838 (Mo. banc 1996)....................23

Dodds v. U.S. Dep't of Educ.,
845 F.3d 217 (6th Cir. 2016) (per curiam)....................28

Doe 1 v. Thornbury,
No. 3:23-cv-230-DJH-RSE, 2023 WL 4230481 (W.D. Ky. June 28, 2023).................... *passim*

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2023 WL 3833848 (N.D. Fla. June 6, 2023), *appeal filed*, No. 23-12159 (11th Cir. July 5, 2023).................... *passim*

Edmunds v. Levine,
417 F.Supp.2d 1323 (S.D. Fla. 2006)....................51

Eisenstadt v. Baird,
405 U.S. 438 (1972)....................41

Eknes-Tucker v. Marshall,
603 F. Supp. 3d 1131 (M.D. Ala. 2022), *appeal filed*, No. 22-11707 (11th Cir. May 18, 2022).................... *passim*

Evancho v. Pine-Richland Sch. Dist.,
237 F. Supp. 3d 267 (W.D. Pa. 2017) 32

F.V. v. Barron,
286 F. Supp. 3d 1131 (D. Idaho 2018) 32

Fain v. Crouch,
618 F. Supp. 3d 313 (S.D.W. Va. 2022) 31

Flack v. Wis. Dep't of Health Servs.,
328 F. Supp. 3d 931 (W.D. Wis. 2018) 31, 32, 50

Furniture Mfg. Corp. v. Joseph,
900 S.W.2d 642 (Mo. App. W.D. 1995) 24

Gallagher v. City of Clayton,
699 F.3d 1013 (8th Cir. 2012) 25

Glenn v. Brumby,
663 F.3d 1312 (11th Cir. 2011) 28

Glossip v. Mo. Dep't of Transp. & Highway Patrol Emps. Ret. Sys.,
411 S.W.3d 796 (Mo. banc 2013) 24, 25, 34

Gonzales v. Carhart,
550 U.S. 124 (2007) 34

Grimm v. Gloucester Cnty. Sch. Bd.,
972 F.3d 586 (4th Cir. 2020), *as amended* (Aug. 28, 2020) 25, 32

Hicklin v. Precynthe,
No. 4:16-CV-01357-NCC, 2018 WL 806764 (E.D. Mo. Feb. 9, 2018) 33

Hunter v. United Parcel Serv., Inc.,
697 F.3d 697 (8th Cir. 2012) 27

State ex rel. Ideker, Inc. v. Grate,
437 S.W.3d 279 (Mo. App. W.D. 2014) 57

PJ ex rel. Jensen v. Wagner,
603 F.3d 1182 (10th Cir. 2010) 43

K.C. v. Individual Members of the Med. Licensing Bd. Of Ind.,
2023 WL 4054086 (S.D. Ind. June 16, 2023) 3, 29, 49, 52

Kadel v. Folwell,
2022 WL 11166311 (M.D.N.C. Oct. 19, 2022) 31

Kadel v. Folwell,
446 F. Supp. 3d 1 (M.D.N.C. 2020) 29

Karnoski v. Trump,
926 F.3d 1180 (9th Cir. 2019) 25, 32

Karnoski v. Trump,
No. C17-1297-MJP, 2017 WL 6311305 (W.D. Wash. Dec. 11, 2017)....................51

L.W. v. Skrmetti,
2023 WL 4232308, *stayed*, No. 23-5600, 2023 WL 4410576 (6th Cir. July 8, 2023) 29, 30

Lampley v. Mo. Comm'n on Hum. Rts.,
570 S.W.3d 16 (Mo. banc 2019)....................27

M.A.B. v. Bd. of Educ. of Talbot Cnty.,
286 F. Supp. 3d 704 (D. Md. 2018)....................32

In re Marriage of Woodson,
92 S.W.3d 780 (Mo. banc 2003)....................42

Nguyen v. I.N.S.,
533 U.S. 53 (2001)....................25

Nken v. Holder,
556 U.S. 418 (2009)....................24, 54

Norsworthy v. Beard,
87 F. Supp. 3d 1104 (N.D. Cal. 2015) 32

Obama for Am. v. Husted,
697 F.3d 423 (6th Cir. 2012) 50

Osage Glass, Inc. v. Donovan,
693 S.W.2d 71 (Mo. banc 1985)....................23

Parham v. J.R.,
442 U.S. 584 (1979)....................43

Penner v. King,
695 S.W.2d 887 (Mo. banc 1985)....................45

Pers. Adm'r of Mass. v. Feeney,
442 U.S. 256 (1979)....................32

Phelps-Roper v. Cnty. of St. Charles, Mo.,
780 F. Supp. 2d 898 (E.D. Mo. 2011)....................57

Pierce v. Society of Sisters,
268 U.S. 510 (1925)....................43

Planned Parenthood S. Atl. v. Baker,
941 F.3d 687 (4th Cir. 2019)....................51

Prince v. Massachusetts,
321 U.S. 158 (1944)....................43

R.M.A. by Appleberry v. Blue Springs R-IV Sch. Dist.,
568 S.W.3d 420 (Mo. banc 2019)....................26

T.W. ex rel. R.W. v. T.H.,
393 S.W.3d 144 (Mo. App. E.D. 2013)....................43

Ray v. McCloud,
507 F. Supp. 3d 925 (S.D. Ohio 2020)....................25, 31, 32

Republican Party of Minnesota v. White,
416 F.3d 738 (8th Cir. 2005)....................43

Romer v. Evans,
517 U.S. 620 (1996)....................39

Rumble v. Fairview Health Servs.,
No. 14-cv-2037 (SRN/FLN), 2015 WL 1197415, at *2 (D. Minn. Mar. 16, 2015)....................28

Santosky v. Kramer,
455 U.S. 745 (1982)....................43

Schall v. Martin,
467 U.S. 253 (1984)....................44

State ex rel. Schoenbacher v. Kelly,
408 S.W.2d 383 (Mo. Ct. App. 1966)....................23

Sessions v. Morales-Santana,
582 U.S. 47 (2017)....................30

Smith v. Avanti,
249 F. Supp. 3d 1194 (D. Colo. 2017)....................28

Smith v. W. Elec. Co.,
643 S.W.2d 10 (Mo. App. E.D. 1982)....................50

Southampton Cmty. Healthcare v. Bailey,
No. 23SL-CC01673 (Mo. Cir. Ct. May 1, 2023)....................3, 11, 49, 51

State v. Young,
362 S.W.3d 386 (Mo. Banc 2012) 24

Toomey v. Arizona,
2019 WL 7172144 (D. Ariz. Dec. 23, 2019) 31

Tovar v. Essentia Health,
857 F.3d 771 (8th Cir. 2017) 27

Troxel v. Granville,
530 U.S. 57 (2000) 43

United States v. Virginia ("VMI"),
518 U.S. 515 (1996) .... *passim*

Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.,
429 U.S. 252 (1977) 32

Walker v. Hanke,
992 S.W.2d 925 (Mo. App. W.D. 1999) 23

Weinschenk v. State,
203 S.W.3d 201 (Mo. banc 2006) 43

Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.,
858 F.3d 1034 (7th Cir. 2017), *abrogated on other grounds as recognized by Ill. Republican Party v. Pritzker*, 973 F.3d 760 (7th Cir. 2020) 28

Constitutions, Statutes, and Rules

Missouri Constitution, Article 1, Section 2 .... 2, 24, 25, 31, 42

Missouri Supreme Court Rule 92.02 .... 23, 56

RSMo Subsection 15 to § 208.152 .... 10, 57

RSMo § 163.048 .... 11, 34

RSMo § 191.480 30

RSMo § 191.1720 57

RSMo § 191.1720.2 9

RSMo § 191.1720.2(4) 26, 28

RSMo § 191.1720.3 30

RSMo § 191.1720.4 30

RSMo § 191.1720.4(1) 26

RSMo § 191.1720.4(2) 10, 39

RSMo § 191.1720.4(3) 10

RSMo § 191.1720.5 ....9, 26, 56

RSMo § 191.1720.6 ....9, 56

RSMo § 191.1720.8 ....9, 34

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World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Conforming People* (7th Version) (2012), https://www.wpath.org/publications/soc 4

Wylie C. Hembree *et al.,* "Endocrine Treatment of Gender Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology & Metabolism,* Volume 102, Issue 11, 1 November 2017, Pages 3869-3903, https://doi.org/10.1210/jc.2017-01658 4

INTRODUCTION

After a legislative deal was struck,[2] the Missouri Legislature passed, and the Governor later signed, a series of bills restricting the rights of transgender people in the state of Missouri. One of those bills, the Act, seeks to prohibit the initiation of medically necessary, evidence-based, and potentially lifesaving healthcare when, and only when, it is used to treat transgender adolescents with gender dysphoria.

The Act was passed over the objection of medical professionals who testified in opposition, and the pleas of families who, like the Family Plaintiffs, stood to lose access to essential and often lifesaving medical care. So insistent were Missouri's legislative and executive branches on rolling back transgender rights that, in the midst of a quibble between Missouri's House and Senate chambers over exactly how far the Act should go, Governor Parson threatened to call a special legislative session if the two chambers did not resolve their dispute and send him a bill.[3] But the Act is not just cruel, it is also unconstitutional; and absent a preliminary injunction, it will go into effect August 28, 2023, barring the initiation of medically necessary gender-affirming medical care for transgender adolescents, like the Minor Plaintiffs, all across Missouri.

All relevant considerations weigh in favor of preliminary injunctive relief.

First, Plaintiffs are likely to succeed on the merits. The Act, among other things, violates

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[2] Kermit Miller, *Missouri Senate Passes Two Bills Restricting Transgender Rights*, KRCG, (Mar. 21, 023), https://krcgtv.com/news/local/missouri-senate-passes-two-bills-restricting-transgender-rights-mike-moon-holly-rehder.

[3] *See* Annelise Hanshaw, *Missouri Governor Threatens To Call Special Session To Ban Gender-Affirming Care,* MISSOURI INDEPENDENT (Apr. 27, 2023), https://missouriindependent.com/2023/04/27/missouri-governor-threatens-to-call-special-session-to-ban-gender-affirming-care/.

Article I, Section 2 of the Missouri Constitution[4] by discriminating against transgender adolescents on the basis of sex and transgender status, and by depriving parents of their fundamental right to seek appropriate medical care for their children, which is at its apex when it aligns with their adolescent children's liberty interests.

Second, the Act will cause immediate and irreparable harm to the Plaintiffs. The Minor Plaintiffs will be prevented from obtaining medically necessary and evidence-based care in coordination with their families and doctors. The Parent Plaintiffs will have their parental judgment and decision-making authority usurped by the government, and will either have to disrupt their lives at great costs to enable their children to receive critical medical care out of state, or endure watching their children suffer without the medical treatment they need.

The Provider Plaintiffs will, on the one hand, have to choose between abandoning their patients and betraying their oath and duty to provide their patients with the best medical care, or keeping their medical licenses and livelihoods, on the other. Further, the Organization Plaintiffs, whose members include the families of transgender adolescents and the medical professionals who treat them, represent other individuals whose harms are like those of the Family and Medical Provider Plaintiffs.

Third, the balance of equities and the public interest weigh heavily in favor of a preliminary injunction. The Act will cause immediate and irreparable harm if it is not enjoined, but the State will not incur any harm should the status quo—minors receiving medically necessary care and parents being able to use their own judgment, in consultation with medical professionals, to make medical decisions for their children—be maintained while this case proceeds.

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[4] As discussed below, Plaintiffs bring claims only under the Missouri Constitution, and bring no claims under the United States Constitution nor any other federal law.

Other courts have preliminarily enjoined or restrained similar bans to preserve the status quo and protect plaintiffs from irreparable harm. *See, e.g.*, *Brandt by & through Brandt v. Rutledge*, 47 F.4th 661, 672 (8th Cir. 2022) (affirming preliminary injunction against similar ban from Arkansas), *reh'g en banc denied*, 2022 WL 16957734 (8th Cir. Nov. 16, 2022); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1151 (M.D. Ala. 2022) (preliminary injunction against similar ban in Alabama), *appeal filed*, No. 22-11707 (11th Cir. May 18, 2022); *K.C. v. Individual Members of the Med. Licensing Bd. Of Ind*., 2023 WL 4054086 (S.D. Ind. June 16, 2023); *Doe v. Ladapo*, 2023 WL 3833848 (N.D. Fla. June 6, 2023), *appeal filed*, No. 23-12159 (11th Cir. July 5, 2023); *cf.* Temporary Restraining Order, *Southampton Cmty. Healthcare v. Bailey*, No. 23SL-CC01673 (Mo. Cir. Ct. May 1, 2023). This Court should do the same.

FACTUAL BACKGROUND

A. Medical Protocols for the Treatment of Transgender Adolescents with Gender Dysphoria.

"Gender identity" refers to a person's internal, innate, and immutable sense of belonging to a particular gender. Expert Affidavit of Dr. Shumer ("Shumer Aff.") ¶ 28; Expert Affidavit of Dr. Janssen ("Janssen Aff.") ¶¶ 33, 37; Expert Affidavit of Dr. Olson-Kennedy ("Olson-Kennedy Aff") ¶ 24. For most people, their gender identity aligns with the sex they were assigned at birth based on external genitalia, but others, including transgender individuals, have a gender identity that does not align with their sex assigned at birth. Shumer Aff. ¶¶ 28, 38; Janssen Aff. ¶ 32. The term "gender dysphoria" refers to the clinically significant distress related to the incongruence between one's gender identity and one's sex assigned at birth. Shumer Aff. ¶¶ 38, 39; Janssen Aff. ¶¶ 41–42; Olson-Kennedy Aff. ¶ 30.

Gender dysphoria is a serious medical condition. Shumer Aff. ¶¶ 38, 39; Janssen Aff. ¶ 42; Olson-Kennedy Aff. ¶ 30. Because, by definition, a transgender person is a person who

experiences a mismatch between sex assigned birth and an internal sense of gender, only transgender people can suffer gender dysphoria. Olson-Kennedy Aff. ¶ 30. Left untreated, gender dysphoria can lead to serious negative health outcomes including severe anxiety and depression, eating disorders, substance abuse, self-harm, and, in many instances, suicidality.[5] Shumer Aff. ¶ 43; Janssen Aff. ¶ 50; Olson-Kennedy Aff. ¶ 78. Since as early as 1966, it has been understood that a person's gender identity cannot be changed. Olson-Kennedy Aff. ¶ 28. Efforts to do so have proven to be unsuccessful and harmful. *Id.*

Gender dysphoria, however, is highly treatable, and Missouri doctors use well-established guidelines to diagnose and treat minors and adults with gender dysphoria. Shumer Aff. ¶ 43; Janssen Aff. ¶¶ 51, 53–54. When properly diagnosed and treated with gender-affirming care, those with gender dysphoria are able to live consistently with their gender identity, allowing them to survive and thrive. Shumer Aff. ¶ 44; Janssen Aff. ¶ 50. Undergoing treatment to alleviate gender dysphoria is commonly referred to as transition. Shumer Aff. ¶ 59.

Leading medical organizations, including the Endocrine Society[6] and the World Professional Association for Transgender Health ("WPATH")[7] have studied gender dysphoria and transition-related care (also known as "gender-affirming care") for more than four decades. Shumer Aff. ¶¶ 49–55; Janssen Aff. ¶¶ 51–56; Olson-Kennedy Aff. ¶ 33. As a result of their

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[5] *See* American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition 452-453 (5th ed. 2013).

[6] Wylie C. Hembree *et al.,* "Endocrine Treatment of Gender Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology & Metabolism,* Volume 102, Issue 11, 1 November 2017, Pages 3869-3903, https://doi.org/10.1210/jc.2017-01658, ("Endocrine Society Guideline").

[7] World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Conforming People* (7th Version) (2012), https://www.wpath.org/publications/soc, ("WPATH Standards of Care").

medical expertise, developed over many years of training and diligent study, some medical organizations like WPATH and the Endocrine Society have published evidence-based clinical practice guidelines for the medical treatment of transgender patients that have been endorsed and recognized as authoritative by the major professional medical health associations in the United States. Shumer Aff. ¶ 57; Janssen Aff. ¶ 50–53; Olson-Kennedy Aff. ¶¶ 33-35. These guidelines are based on the best available science and expert professional consensus and confirm that gender-affirming medical care, including puberty-delaying treatment and hormone therapy where appropriate, is safe, effective, and medically necessary.[8] Shumer Aff. ¶¶ 77–90; Janssen Aff. ¶¶ 79–85; Olson-Kennedy Aff. ¶ 33.

The precise aspects of a person's treatment plan for their gender dysphoria, as with all medical care, differ based on individualized considerations, such as whether the person is a pre-pubertal child, an adolescent, or an adult, and whether a particular treatment is indicated for that person. Shumer Aff. ¶¶ 46–48, 59; Janssen Aff. ¶¶ 67–79, 87-88; Olson-Kennedy Aff. ¶¶ 36, 41. None of the recognized clinical practice guidelines for the treatment of gender dysphoria recommend medical treatment for prepubertal children, meaning *no medical treatment is recommended until after the onset of puberty*. Shumer Aff. ¶ 60; Janssen Aff. ¶ 55; Olson-Kennedy Aff. ¶ 37. For transgender adolescents, the plan and treatment components are determined based on the individual's physical and mental health needs. Shumer Aff. ¶¶ 64–77; Janssen Aff. ¶¶ 61–79; Olson-Kennedy Aff. ¶ 41.

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[8] Rafferty J, AAP *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents,* PEDIATRICS, 2018 Volume 142 No. 4 https://pediatrics.aappublications.org/content/pediatrics/142/4/e2018 2162.full.pdf; *AACAP Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender Diverse Youth,* American Academy of Child and Adolescent Psychiatry, https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx.

The gender-affirmative model considers no gender identity outcome (transgender or cisgender) to be preferable. Olson-Kennedy Aff. ¶ 38. Under the gender-affirmative care model, support does not mean "encouraging" youth to be transgender, but rather allows children to explore their own identity. There is no evidence that the model leads a child down a path of inevitable transgender identity. Olson-Kennedy Aff. ¶ 39. In fact, studies show that gender identification does not meaningfully differ before and after social transition. *Id.*

For many transgender adolescents, going through puberty consistent with their sex assigned at birth can cause extreme distress and contribute to the development of mental health comorbidities, including depression, anxiety, and suicidality. Shumer Aff. ¶ 61; Olson-Kennedy Aff. ¶ 43. To relieve this distress and delay the permanent physical changes that would come with puberty, healthcare providers may prescribe puberty-delaying medication. Shumer Aff. ¶¶ 62–71; Janssen Aff. ¶¶ 62–63, 80–82. Medical treatments for adolescents are provided in consultation with qualified mental health professionals and with the consent of the minor's parents or guardians. Shumer Aff. ¶¶ 40–41, 43, 45; Janssen Aff. ¶¶ 61, 63–65, 68; Olson-Kennedy Aff. ¶ 67. Puberty-delaying medications pause endogenous puberty, limiting the influence of endogenous hormones on the body, and are reversible interventions. Shumer Aff. ¶ 65; Janssen Aff. ¶¶ 62-63. Such interventions afford the adolescent time to better understand their gender identity while delaying the development of secondary sex characteristics. Janssen Aff. ¶¶ 62–63; Olson-Kennedy Aff. ¶ 43.

Puberty suppression has been used safely for decades in young people with other medical conditions, including precocious puberty, and is a reversible intervention. Olson-Kennedy Aff. ¶ 44; Shumer Aff. ¶ 65. In both cases, the side effects are comparable and easily managed, and whatever risks exist are greatly outweighed by the benefits of treatment. Shumer Aff. ¶ 69.

Puberty-delaying medications are also used to treat non-transgender patients who do not have precocious puberty, but who may require pubertal suppression for other reasons, including the presence of disabilities that make them unable to tolerate puberty at the typical age, growth hormone deficiencies, or endometriosis. Shumer Aff. ¶ 70.

For some adolescents, their healthcare provider may determine it is medically necessary and appropriate to initiate puberty consistent with a patient's gender identity through gender-affirming hormone therapy (testosterone for transgender boys, and testosterone suppression and estrogen for transgender girls). Shumer Aff. ¶¶ 72–77; Janssen Aff. ¶¶ 64, 80, 83–84; Olson-Kennedy Aff. ¶¶ 54–67. Transgender adolescents who receive gender-affirming hormones after having received puberty-delaying treatment do not go through puberty in accordance with their sex assigned at birth and, instead, go through puberty that more closely matches their gender identity. Shumer Aff. ¶¶ 72–73.

Under the widely accepted clinical practice guidelines, eligibility to begin gender-affirming hormones is determined on a case-by-case basis, and is a decision made with knowing and informed consent from parents/guardians and assent from adolescent patients after an assessment of the adolescent's unique cognitive and emotional maturation. Shumer Aff. ¶ 61; Olson-Kennedy Aff. ¶ 55. The treatment decision is made after a careful review with the youth and their parents/guardians of the potential risks and benefits, which—as with puberty blockers—are based on data that strongly support the conclusion that treatment promotes wellness and helps to prevent negative mental health outcomes. Janssen Aff. ¶¶ 61–64; Shumer Aff. ¶¶ 85–90; Olson-Kennedy Aff. ¶¶ 55–65, 67. As with puberty-delaying medications, hormone therapy is also used to treat other conditions in non-transgender adolescents, and carries comparable risks in both populations. Shumer Aff. ¶ 85.

For transgender patients, gender-affirming treatment can drastically minimize dysphoria later in life and eliminate the need for surgery. Shumer Aff. ¶¶ 68–69; Olson-Kennedy Aff. ¶ 53. Adolescents who receive their initial treatment later in puberty also go through a puberty consistent with their gender identity; however, they will have already undergone durable physical changes associated with their endogenous puberty that may not be wholly reversed by hormone therapy. Shumer Aff. ¶ 73; *cf.* Olson-Kennedy Aff. ¶ 54. For some older transgender adolescents, certain types of surgery may be indicated. Janssen Aff. ¶¶ 51, 85; Olson-Kennedy Aff. ¶ 68. Due to the robust evidence of its safety and efficacy, gender-affirming medical care to treat gender dysphoria, including the use of puberty-delaying medications and hormone treatment in adolescents is the current standard of care and it is not experimental. Shumer Aff. ¶ 91; Janssen Aff. ¶ 110; Olson-Kennedy ¶ 73. There are no other evidence-based interventions to treat gender dysphoria other than gender-affirming medical care. Olson-Kennedy Aff. ¶ 74.

Accordingly, every major medical association in the country agrees that gender-affirming care, consistent with evidence-based clinical practice guidelines, such as those published by WPATH and the Endocrine Society, is safe, effective, and medically necessary treatment for gender dysphoria that improves the health and wellbeing of transgender people. Shumer Aff. ¶¶ 49–57; Janssen Aff. ¶ 53; Olson-Kennedy Aff. ¶¶ 34, 77. In fact, the protocols set forth by the WPATH Standards of Care and the Endocrine Society Guidelines are endorsed and cited as authoritative by the major professional medical and mental health associations in the United States, such as American Medical Association, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association, Pediatric Endocrine Society, and the Endocrine Society, among others. Shumer Aff. ¶ 56; Janssen Aff. ¶ 53; Olson-Kennedy Aff. ¶ 37.

B. The Act

After overnight, closed-door negotiations ended a stand-off between the two chambers of the Missouri Legislature competing over exactly how restrictive it should be,[9] the so-called "SAFE" Act was combined with several other legislative proposals restricting the rights of transgender people in Missouri and passed by the Legislature on May 10, 2023.

As enacted, the Act prohibits any medical provider from conducting the "performance of a gender transition surgery or the prescription or administrating of cross-sex hormones or puberty-blocking drugs to an individual under eighteen years of age for the purpose of gender transition." §§ 191.1720.2, .6, RSMo. The Act defines "gender transition" to mean "the process in which an individual transitions from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex, and may involve social, legal, or physical changes." *Id*. The Act states that medical providers who provide gender-affirming medical care to transgender adolescents "shall have their license revoked" by Defendant Board of Healing Arts and its members. §§ 191.1720.2, .5, .6. The Act also creates a cause of action against those providers, with a statute of limitations of "fifteen years" after the patient turns twenty-one years of age, a "rebuttable presumption" against the medical provider as to harm, and a *minimum* of $500,000 in damages, which are to be trebled. *Id*.

The Act specifically exempts from its prohibitions "[s]ervices to individuals born with a medically verifiable disorder of sex development" determined "through genetic or biochemical

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[9] *See* Alex Gaul, *After Filibuster, Transgender Care Bills Move Forward in Mo. Senate*, KMOV4, (Mar. 21, 2023), https://www.kmov.com/2023/03/21/after-filibuster-transgender-care-bills-move-forward-mo-senate/; Jack Suntrup, *Missouri House Advances Transgender Restrictions, Sets Up Showdown With Senate*, ST. LOUIS POST-DISPATCH (Apr. 12, 2023), https://www.stltoday.com/news/local/government-politics/missouri-house-advances-transgender-restrictions-sets-up-showdown-with-senate/article_ad3e107a-afa4-50ba-b2d8-9636c2342581.html.

testing;" "[t]he treatment of any infection, injury, disease, or disorder that has been caused by" the care that it prohibits; and "[a]ny procedure undertaken because the individual suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the individual in imminent danger of death or impairment of a major bodily function." § 191.1720.8.

The Act also contains a narrow "continuation of care" clause, stating that its provisions "shall not apply to the prescription or administration of cross-sex hormones or puberty-blocking drugs for any individual under eighteen years of age who was prescribed or administered such hormones or drugs prior to August 28, 2023." § 191.1720.4(2). The practical effect of this clause is that, as of August 28, 2023, the initiation of any new gender-affirming medical interventions will be completely prohibited. Because the clause allows only for the continuation of "*such hormones or drugs"* that were prescribed prior to August 28, 2023, it applies narrowly, at the level of an individual medication.

Accordingly, those who have initiated puberty-delaying medical treatment but have not moved on to gender-affirming hormones, like Plaintiffs C.J. and A.K., will be forbidden from doing so until they turn eighteen (18). Finally, as passed this session, the Act "sunsets" four years after it becomes operative, on August 28, 2027. § 191.1720.4(3). The sunset provision does nothing for the transgender adolescent Missourians for whom gender-affirming medical care is indicated during that time. And to be sure, as explained herein, the Act's proponents and sponsors demonstrated a clear hostility towards transgender people generally and gender-affirming medical care specifically throughout the entire legislative process leading up the adoption of the Act.[10]

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[10] *See Former Transgender Patients Speak Out At SAFE Act Press Conference,* MISSOURI TIMES, (Feb. 20, 2023), https://themissouritimes.com/former-transgender-patients-speak-out-at-safe-act-press-conference.

The Act also includes a prohibition on coverage of gender-affirming medical care by MO HealthNet, Missouri's Medicaid program, regardless of medical necessity. Specifically, it adds a new Subsection 15 to § 208.152 of the Missouri Revised Statutes to prohibit payments by MO HealthNet "for gender transition surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section 191.1720, for the purpose of a gender transition."

Defendant Parson signed the Act into law on June 7, 2023, simultaneously with a bill restricting the rights of transgender student athletes. § 163.048, RSMo.

C. The Act Inflicts Severe and Irreparable Harms on the Plaintiffs and Others.

By cutting off access to treatment that adolescents in Missouri rely on for their health and wellbeing, as well as limiting future access to treatment, the Act causes immediate, severe, and irreparable harm to all the Plaintiffs and others. *See* Temporary Restraining Order, *Southampton Cmty. Healthcare v. Bailey*, No. 23SL-CC01673, ¶ 33 (Mo. Cir. Ct. May 1, 2023) (finding irreparable harm in implementation of emergency rule restricting gender-affirming medical care).

i. C.J. and S.M.

C.J. is a thirteen-year-old transgender boy who loves sports—especially soccer, but he also plays racquetball and lacrosse. Affidavit of S.M. ("S.M. Aff.") ¶¶ 3–5. C.J. began to express his male gender identity in clear ways when he started kindergarten. *Id.* ¶¶ 3, 6. C.J. has been, from a young age, insistent about his gender identity. *Id.* ¶ 9.

When his hair was finally cut short, a giant smile broke out on his face. *Id.* ¶ 10. Any time C.J. and S.M. would go to the grocery store, or just walk down the street, and someone would greet C.J. with "hey bud" or call him "dude," he was overjoyed. *Id.* When C.J. started second grade, his school and classmates began referring to him with "he" and "him" pronouns, and, during third grade, he started to go by his current, legal name. *Id.* ¶¶ 11, 12. Over the years, it became clear to S.M. that this was simply who C.J. is—he has never wavered in his persistence and insistence that

he is a boy. *Id.* ¶ 13.

When C.J. was nine, S.M. sought to obtain information in preparation for the moment when C.J. might enter puberty, as that would be the first moment when C.J. and his family would have to make any decisions about pursuing gender-affirming medical care. *Id.* ¶ 14. The family reached out to the Transgender Center at Washington University (the "Center"), and had an informational appointment with Dr. Christopher Lewis, the pediatric endocrinologist, simply to discuss the options for future medical care and the potential process of obtaining it. *Id.* ¶ 15. There, C.J. and S.M. learned about the risks and benefits of gender-affirming medical care, down to the different forms of administration of particular medications. *Id.* ¶ 15. They learned that one of C.J.'s options was that, upon entering puberty, he could seek to obtain puberty–delaying medications so that he could avoid having to go through an endogenous puberty typical for someone assigned female at birth; this would allow him and his family more time to consider further medical options. *Id.* In the meantime, as C.J. was nine, all that was needed was to monitor for signs of puberty.

C.J's doctors talked them through the process, including that C.J. would need regular bone age tests and X-rays to monitor his bone density, in addition to regular testing of his hormone levels. C.J. underwent those initial tests, which confirmed that he was not yet in puberty. *Id.* ¶ 17. C.J. and S.M. continued to monitor for puberty, and in the meantime, they saw a therapist who specializes in gender-diverse clients, who confirmed C.J.'s long-standing, well-documented history of gender dysphoria. *Id.* ¶ 18.

When C.J. was ten, a typical age for a child to start puberty, he and his family noticed some of the first signs of puberty, and C.J. initiated puberty-delaying medications. He had his first blocker placed when he was ten, and his second was placed several months ago, in early 2023. *Id.* ¶ 20. C.J.'s medical plan, developed in consultation with his family and his doctors, is that he could

initiate gender-affirming hormones in the form of testosterone when he is fourteen or fifteen. *Id.* ¶ 21. But C.J. is thirteen, and he will not turn fourteen before August 28, 2023, meaning that the Act will not allow him to begin gender-affirming hormones until he turns eighteen (three to four years after he will become eligible). *Id.* ¶21. If the Act is allowed to go into effect, and C.J. is prevented from moving on to gender-affirming hormones in the form of testosterone and forced to go through an endogenous puberty, he will be devastated, and his mental health will be affected "terribly." *Id.* ¶22-23.

ii. <u>A.K. and J.K.</u>

A.K. is fourteen years old, and, although she was assigned male at birth, she came out to her family as a transgender girl in January 2022. Affidavit of J.K ("J.K. Aff.") ¶ 5. A.K. is a decisive but deliberate young person. Since coming out as transgender, she has taken every step of her transition very carefully and in her own time, after much exploration and discussion with her entire family. *Id.* ¶ 8. After coming out, A.K. and her family established a relationship with the Center, and in August 2022, A.K. began seeing a therapist who specializes in treating young people experiencing gender dysphoria, as well as their families. *Id.* ¶ 10.

A.K. has been at all times interested in pursuing a medical transition, but has done so on her own careful, deliberate timeline. She has been sure about what she wants but has felt it necessary to take time to make sure that she fully understands the process before taking each step. *Id.* ¶ 11. Consequently, in consultation with her doctors, A.K. and her parents settled on a conservative medical plan: A.K. would begin a small dose of a testosterone suppressant medication which would not fully block the effects of endogenous puberty, and continue to take things one step at a time; then, when she turns sixteen in 2024, she could consider starting gender-affirming hormones. *Id.* ¶ 13.

A.K. obtained her prescription for the anti-androgen medication on June 7, 2023, the same day that Defendant Parson signed S.B. 49. *Id.* ¶ 14. Because the Act prohibits the initiation of gender-affirming hormones after August 28, 2023, A.K. will be unable to start gender-affirming hormones consistent with her medical plan if the Act is allowed to go into effect. *Id.* ¶ 15. Ironically and nonsensically, the Act's "continuation of care" clause throws out the careful, deliberate planning that A.K. and her family have done, and threatens her access to medically necessary care only because she, in consultation with her doctors and parents, is approaching her care with a careful and deliberate approach. *Id.* ¶ 17. The Act thus places immense pressure on families like A.K.'s to either rush the process and obtain gender-affirming hormones before August 28, 2023, or risk being shut out of access to medically necessary medication with permanent consequences to her health. *Id.* ¶ 18. For A.K. and her family, "[t]his is an impossible choice, and one no family or young person should be forced to make." *Id.*

iii. <u>Nicholas Noe and Emily Noe</u>

Nicholas Noe recently turned ten years old and plays baseball, likes camp, and excels at math. He is also transgender. Affidavit of Emily Noe ("Noe Aff.") ¶¶ 3, 5. Nicholas has always preferred to wear clothes from the "boys'" section and played with typically masculine toys. *Id.* ¶ 6.

In the spring of 2020, when Nicholas was six, Emily wanted to buy swimsuits for the family for the approaching summer. Because Nicholas had always preferred "boy's" clothes, she asked him if he would prefer swim trunks and a t-shirt over a typical "girl's" bathing suit—his answer was yes, and he was so excited about it that he went with Emily to the store to pick up the order. After he got them, he did not take off the swim trunks and t-shirt for days. *Id.*

Not long after that, Nicholas told his father about the gender dysphoria that he experienced.

Id. ¶ 6. Because Nicholas was only six, his parents wanted to take things slowly and allow him time and space to figure out how he felt. The family decided they would let Nicholas decide day-by-day whether it was a "boy clothes" day or a "girl clothes" day. *Id.* ¶ 8. But that night, he put on boy's clothes, and it's been a "boy clothes" day every single day since. *Id.* Since June 2020, Nicholas has seen a therapist every other week, who has diagnosed him with gender dysphoria. *Id.* ¶10.

In the summer of 2020, the Noe family had a consultation with the Center and learned that the initial step of any potential medical care would not occur until the onset of puberty, at which point Nicholas could start puberty blockers to halt the process of puberty and give him time to further develop and solidify his gender identity without having to worry about the worsening gender dysphoria that would come from an endogenous puberty. *Id.* ¶¶ 11, 12. The Noes' medical plan, was that, for the years to follow, Nicholas could pursue his social transition and monitor for signs of puberty, when his doctors could confirm the onset of puberty and he could consider beginning puberty blockers. *Id.* ¶ 6.

Nicholas has just turned ten. *Id.* ¶16. He wants to go through a typical male puberty and grow into a man. *Id.* But he has not begun puberty yet, and it is quite unlikely that he will do so before August 28, 2023. *Id.* Thus, the Act will prohibit the Noes from initiating puberty blockers for Nicholas as puberty typically begins between the ages of 10 and 12 and he could begin to see signs of puberty at any time. *Id.* ¶ 6, 16; Shumer Aff. ¶ 59.

When the Missouri Legislature began introducing bills that target young transgender people, Emily tried to protect Nicholas from that information. *Id.* ¶ 14. However, Nicholas overheard conversations about the bills at family gatherings. *Id.* He asked his mother about them, and Emily tried to explain in ways he could understand what bills like S.B. 49 might mean for his

life. *Id.* Nicholas broke down sobbing and asked his mother if Missouri would—as some other state's policies have threatened to do—take him away from his family. *Id.* ¶ 15.

iv. **Southampton Community Healthcare**

Southampton Healthcare is a primary care medical provider that has been providing affirming medical care to the LGBTQ+ community since 1986. Affidavit of Dr. Michael Donovan, M.D. ("Donovan Aff.") ¶ 11; Affidavit of Nicole Carr, FNP-BC ("Carr Aff.") ¶ 4. Providers at Southampton Healthcare provide primary care with an LGBTQ+ focus, treatment and prevention of HIV, treatment related to sexual and reproductive health, and gender-affirming hormone care and treatment. Donovan Aff. ¶¶ 8, 11–13. Southampton Healthcare accepts private insurance and Medicaid, and also treats the uninsured. Donovan Aff. ¶¶ 12, 13.

Southampton Healthcare provides care to between 6,000-7,000 patients, close to 1,000 of whom are receiving a form of hormone care. Donovan Aff. ¶ 12. Southampton's providers treat both transgender adults and adolescents, and have provided gender-affirming medical care to adolescent patients, including puberty-delaying medications, gender-affirming hormones, and monitoring patients for the onset of puberty. Donovan Aff. ¶¶ 19–21; Carr. Aff. ¶¶ 10, 20. In their treatment of transgender patients, Southampton provides care that is consistent with the evidence-based clinical practice guidelines for the treatment of gender dysphoria published by the Endocrine Society, WPATH, and UCSF Center of Excellence for Transgender Care at the University of California - San Francisco. . Donovan Aff. ¶ 21; Carr Aff. ¶¶ 17-18. When treating patients under the age of 18, Southampton requires patients have a gender dysphoria diagnosis and that they have been properly-assessed in a manner consistent with evidence-based guidelines. Donovan Aff. ¶ 23; Carr Aff. ¶ 19. Southampton's patient population includes Medicaid recipients who will be prevented from obtaining the care that they need if S.B. 49 takes effect. Donovan Aff. ¶37; Carr

Aff. ¶ 14.

The providers treat both transgender and cisgender patients with hormone therapy. Donovan Aff. ¶¶ 18, 23; Carr Aff. ¶ 21. For example, menopausal cisgender women receive hormone therapy. Donovan Aff. ¶ 23; Carr Aff. ¶ 21. The safety profile of hormone treatment does not change based upon the population of the patient, meaning the likelihood of adverse effects is the same among cisgender and transgender patients. Donovan Aff. ¶ 23. Physicians at Southampton Healthcare know firsthand, through their academic and clinical experience, that gender-affirming medical care is safe and effective, and, when medically indicated, how it leads to substantial improvements in the health, wellbeing, and quality of life of their patients. Carr Aff. ¶¶ 24, 29-31. If the Act goes into effect, Southampton Healthcare will be forced to refuse or discontinue care for some patients. Donovan Aff. ¶ 37; Carr Aff. ¶ 24.

Southampton's medical providers know from personal experience in treating hundreds of Missourians with gender dysphoria that, given that gender dysphoria can cause such distress, denying treatment for a patient's gender dysphoria risks not only exacerbating the patient's gender dysphoria, but also increasing the risk of depression, anxiety, and suicidality. Donovan Aff. ¶ 36; Carr Aff. ¶ 28. The medical providers at Southampton Healthcare also know from personal experience that the Act, if permitted to take effect, will significantly and severely compromise the health of their patients. Donovan Aff. ¶ 24. Southampton Healthcare has already seen the mental and emotional harm of the Act, including the stress and pressure that it has inflicted on transgender adolescents and their families. Carr Aff. ¶¶ 31.

If the Act goes into effect, it will force Southampton Healthcare to deny patients medically necessary, potentially lifesaving care, violating the tenets of the medical profession by directly conflicting with the oath of those professionals: Do No Harm. Donovan Aff. ¶¶ 41, Carr Aff. ¶ 26;

Donovan Aff. ¶ 33. The Act places the medical professionals at Southampton Healthcare in the untenable position of having to decide between fulfilling their oaths by providing patients with the evidence-based medical care that they need, or avoiding risk to their license and civil liability. Donovan Aff. ¶¶ 38-41. Southampton Healthcare has grave concerns about their patients' ability to survive, much less thrive, if the Act takes effect. Donovan Aff. ¶ 36.

v. <u>PFLAG</u>

PFLAG, Inc. ("PFLAG") is a national § 501(c)(3) non-profit organization, and is the first and largest organization for lesbian, gay, bisexual, transgender, and queer people, their parents and families, and allies. Affidavit of Brian K. Bond ("Bond Aff.") ¶ 2. PFLAG has over 350 local chapters across the country and approximately 325,000 members and supporters nationwide. *Id.* ¶ 2. PFLAG's mission since its founding in 1973 has been to support LGBTQ+ young people by strengthening and supporting their families. *Id.* ¶ 4. The organization is a national, chapter-based membership organization. its five chapters in Missouri include PFLAG St. Joseph, PFLAG Springfield, PFLAG Greater St. Louis, PFLAG Poplar Bluff, and PFALG Cape Girardeau. *Id.* ¶ 7. PFLAG has been actively involved in supporting and providing resources to its members in Missouri in light of the increasing number of legislative proposals targeting transgender youth and their families in the state over the last few years. *Id.* ¶ 11.

PFLAG has members in Missouri whose children are being or will be monitored for the appropriate time to begin puberty blockers, are currently or soon will be on puberty blockers, and are currently or soon will be on hormone therapy, all as part of a medically prescribed course of care for gender dysphoria. *Id.* ¶ 12. If the Act goes into effect, current and future PFLAG members with transgender children will be denied the right to make medical decisions for their child because medically necessary care has been deemed unlawful. *Id.* ¶ 13. Those members will be prevented

from obtaining puberty blockers or hormone therapy when medically indicated for their child solely because it is treatment for gender dysphoria, and will lose any coverage that has previously been provided for that care under the MO HealthNet program, Missouri's Medicaid program. *Id.*

PFLAG is a plaintiff in this action to represent the interests of its members, shield them from harm, vindicate their rights to make medical decisions, and allow them to maintain their focus on their child's health and wellbeing. *Id.* ¶ 14. Representing their members in challenging the Act is directly connected to PFLAG's mission in that its mission includes supporting parents and families of transgender children and helping them to access the social, psychological, and medical supports that they need, as well as in that PFLAG advocates for a caring, just, and affirming world and has spoken out against bans on gender-affirming care because they directly conflict with parents' abilities to act in their children's best interest and do nothing to protect the health and wellbeing of youth. *Id.* ¶¶ 15, 16.

The Act threatens the care of not only the Minor Plaintiffs, but other transgender families all across Missouri who are *not* Plaintiffs in this action but are members of the organization PFLAG. Bond Aff. ¶ 12. For example, A.S. and her family are members of PFLAG. A.S. Aff. ¶ 3. A.S. is the mother of R.S., a fifteen-year-old transgender girl from Boone County, Missouri. A.S. Aff. ¶ 4. R.S. likes video games, and tennis, and is an excellent student, consistently receiving straight As. A.S. Aff. ¶¶4, 6–7. R.S. is in Science Olympiad and is a member of her school's Student Council. *Id.* ¶ 6.

At the age of 13, R.S. came out to her family as a transgender girl. *Id.* ¶ 7. Her family searched for options for medical care and support and found the Center, but were initially put on a waitlist. *Id.* ¶ 8. Over the next several months, R.S. came out to her friends and school, and adopted a new name, pronouns, and dress habits. *Id*. ¶ 9. Things were not always easy. When she

first came out, a local piano teacher refused to continue to teach R.S. and her sister because R.S. was transgender. *Id.* ¶ 11. When she was taken to get her hair trimmed in a more traditionally feminine style, the hair stylist told R.S.'s mother that she would not have any openings for R.S. *Id.*

R.S. had her first appointment at the Center in May 2021, and in September 2021 she was formally diagnosed with gender dysphoria. *Id.* ¶¶13-17. R.S. began to experience worsened gender dysphoria when she and her friends entered adolescence and began visibly showing signs of pubertal development. At that time, R.S. became interested in exploring gender-affirming care, in the form of puberty-delaying treatment, to slow puberty and allow her time to decide whether to pursue hormone therapy. *Id.* ¶ 15. In January 2022, R.S. was prescribed puberty-delaying medication in the form of a Supprelin implant. *Id.* ¶ 17. To preserve her fertility, an issue R.S. cares deeply about, R.S., her parents, and her medical team—including a fertility specialist at the Center—developed a plan in which R.S.'s implant would be removed in March 2023. *Id.* ¶¶19-20. Then, after the recommended three-month waiting period, the plan was for R.S. to take steps to preserve fertility and decide whether to pursue hormone replacement therapy once that process was completed. *Id*.

Three weeks later, Defendant Bailey attempted to adopt an emergency administrative rule restricting the ability of transgender people of all ages to access gender-affirming medical care (the "Rule"), and R.S., with others, filed a legal challenge to the Rule in St. Louis County Court on April 24, 2023. *Id.* ¶ 21. As a result of that litigation, the St. Louis County Court entered a temporary restraining order against enforcement of the Rule, and Defendant Bailey subsequently rescinded it on May 16, 2023. *Id.* However, R.S.'s medical plan to preserve her fertility has been progressing more slowly than expected, and, consequently, she has not yet been able to begin fertility preservation measures. *Id.* ¶ 22. Even if she were physically capable of beginning to do so

immediately, it would be impossible for her to pursue her original medical plan before August 28, 2023. There simply would not be enough time to preserve fertility, even if she also were to begin hormone replacement therapy at the last possible minute before the Act goes into effect. *Id.*

R.S. would prefer to wait until she is able to preserve her fertility before initiating hormone replacement therapy, but the impending effective date of S.B. 49's "continuation of care" clause forced her and her family onto an arbitrary timeline by which they must begin that care before August 28 or be shut out of pursuing medically necessary care until she turns eighteen. *Id.* ¶¶ 23, 24. After much conversation and with great sadness, R.S. made the decision, in consultation with her parents and doctors, to initiate hormone replacement therapy before August 28 and abandon the possibility of preserving her fertility. *Id.* ¶ 24. The Act forced R.S. and her parents to make this decision so that R.S. will not be prohibited from pursuing medically necessary care under the guidance of doctors that R.S. and her family trust. *Id.* ¶ 25.

vi. GLMA

The American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality ("GLMA") is a § 501(c)(3) national membership nonprofit founded in 1981 whose mission is to ensure health equity for lesbian, gay, bisexual, transgender, and queer individuals. Affidavit of Alex Sheldon ("Sheldon Aff.") ¶¶ 4, 6. GLMA represents the interests of tens of thousands of LGBTQ+ and allied health professionals, as well as millions of LGBTQ+ patients and families. *Id.* ¶ 9. GLMA's membership includes approximately 1,000 member medical providers and researchers who live and work all across the United States, including Missouri, and in several other countries. *Id.* General membership is open to health professionals of all disciplines and specialties, and "friend" membership is open for individuals invested in LGBTQ+ health equity who are not directly involved in health professions.

Id. ¶¶ 10, 11.

As part of its mission to ensure health care equity for the LGBTQ+ community and health care professionals, GLMA is committed to ensuring that transgender individuals receive medically necessary gender-affirming medical care. *Id.* ¶ 14. In 2018, GLMA adopted a formal policy statement, "127-18-101-21 - Transgender Healthcare," stating that GLMA views gender-affirming medical care as medically necessary treatment of gender dysphoria, and that this care should be covered by insurance plans. *Id.* ¶ 15. Similarly, in 2019, GLMA published an issue brief with the American Medical Association discussing the positive effects and outcomes of gender-affirming medical care for transgender people, and the negative health consequences from denial of access to gender-affirming medical care. *Id.* ¶ 16. GLMA holds an annual conference on LGBTQ+ health as part of its goal of promoting education and resources surrounding LGBTQ+ health issues. *Id.* ¶ 17.

If not enjoined, S.B. 49 will harm GLMA's health professional members in Missouri who provide care to young transgender people, and will in turn harm their patients as well. *Id.* ¶ 27. By prohibiting the provision of medically necessary gender-affirming medical care and banning Medicaid coverage for such care, the Act puts transgender youth in Missouri at risk of being denied the lifesaving healthcare they need, and thereby suffer potentially severe health consequences. *Id.* ¶ 19. It also forces GLMA's provider members to forsake their ethical obligation to prioritize patient care and wellbeing, placing them in the untenable position of choosing between compliance with the Act, endangering the health and wellbeing of their transgender minor patients as a result, or following their medical and professional duties. *Id.* ¶¶ 20, 21. The Act's provisions mandating the revocation or denial of licensure to providers who provide gender-affirming care to patients under 18 also harm GLMA's members. *Id.* ¶ 22. Additionally, because GLMA's mission includes

health care equity for LGBTQ+ patients and equality for LGBTQ+ health care professionals, laws like S.B. 49 frustrate their mission and erode the status of health equity in Missouri.

LEGAL STANDARDS

Missouri Supreme Court Rule ("Rule") 92.02 and § 526.030, RSMo allow for the issuance of injunctive relief where "immediate and irreparable injury, loss, or damage will result in the absence of relief." Rule 92.02(a); § 526.030, RSMo ("The remedy by writ of injunction or prohibition shall exist in all cases . . . to prevent the doing of any legal wrong whatever, whenever in the opinion of the court an adequate remedy cannot be afforded by an action for damages.").[11] A court need not, and should not, wait until some identifiable injury occurs before granting immediate temporary relief. *See*, *e.g.*, *Osage Glass, Inc. v. Donovan*, 693 S.W.2d 71, 75 (Mo. banc 1985).

The "primary purpose of a preliminary injunction is to preserve the status quo." *Walker v. Hanke*, 992 S.W.2d 925, 933 (Mo. App. W.D. 1999). Maintaining the status quo "is taken to mean not merely freezing the situation as the court now finds it but to mean figuratively the restoration of the parties to the last actual, peaceable, non-contested condition which preceded the pending controversy." *State ex rel. Schoenbacher v. Kelly*, 408 S.W.2d 383, 389 n.2 (Mo. Ct. App. 1966) (internal citations and quotation marks omitted).

Courts weigh four factors when deciding whether to issue a preliminary injunction: (1) the likelihood of success on the merits; (2) whether the injunction will prevent irreparable injury; (3) whether the injunction will harm others; and (4) whether the public interest will be served. *See State ex rel. Director of Revenue, State of Mo. v. Gabbert*, 925 S.W.2d 838, 839 (Mo. banc 1996)

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[11] All statutory citations are to Missouri Revised Statutes (2016), as updated, unless otherwise noted. All Rule references are to Missouri Supreme Court Rules, as updated, unless otherwise noted.

(relying on *Dataphase Sys., Inc. v. C.L. Sys. Inc.*, 640 F.2d 109, 114 (8th Cir. 1981) (en banc)); *see also generally* Rule 92.02. No single factor is dispositive; rather, each factor must be considered to determine whether the balance of equities weighs in favor of granting the injunction. *Furniture Mfg. Corp. v. Joseph*, 900 S.W.2d 642, 648 (Mo. App. W.D. 1995). Further, the balance-of-harms and public-interest factors "merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009).

ARGUMENT

I. Plaintiffs are Likely to Succeed on the Merits of their Equal Protection Claim.

The Missouri Constitution provides "that all persons are created equal and are entitled to equal rights and opportunity under the law." Mo. Const. Art I, § 2. While Plaintiffs **bring no claims** under the United States Constitution, the equal protection analysis conducted by Missouri courts under the Missouri Constitution is "guided by federal law" because "the Missouri Constitution's equal protection clause is coextensive with the Fourteenth Amendment." *Glossip v. Mo. Dep't of Transp. & Highway Patrol Emps. Ret. Sys.,* 411 S.W.3d 796, 805 (Mo. banc 2013); *see also State v. Young*, 362 S.W.3d 386, 396 (Mo. Banc 2012) ("Missouri's equal protection clause provides the same protections as the United States Constitution"). Therefore, Plaintiffs here rely on the decisions of Missouri courts, guided by relevant federal court decisions, interpreting the unified content of the equal protection clauses.

Transgender adolescents in Missouri are currently able to access medical care for the treatment of gender dysphoria. The Act changes that status quo by singling out transgender adolescents for a categorical prohibition on the initiation of medical treatments that are not only safe and effective for the treatment of gender dysphoria, but that also remain available to others, including non-transgender adolescents, for the treatment of other conditions. The Act therefore classifies based on sex and transgender status, triggering heightened equal protection scrutiny

under Missouri's constitution. The Act cannot survive this "exacting" test. *United States v. Virginia ("VMI")*, 518 U.S. 515, 555 (1996). Indeed, it fails even the most deferential standard of review.

A. The Act Is Subject to Heightened Scrutiny Because It Discriminates Based on Sex and Transgender Status.

The Act explicitly singles out for prohibition medical interventions related to "gender transition." Because the Act classifies based on sex and transgender status, it triggers heightened scrutiny, imposing an exacting burden on Defendants to justify their line-drawing and demonstrate that the classification substantially advances an important governmental interest.

In "[d]etermining whether a statute violates equal protection" under the Missouri Constitution, courts apply heightened scrutiny to classifications by sex and certain quasi-suspect classes. *Glossip*, 411 S.W.3d at 802; *Ambers-Phillips v. SSM DePaul Health Ctr.*, 459 S.W.3d 901 n.10 (Mo. banc 2015) (referencing quasi-suspect class for claims of gender discrimination); *see also Gallagher v. City of Clayton*, 699 F.3d 1013, 1018 (8th Cir. 2012); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985). Such classifications place on the state "the burden of demonstrating that the statute serves important government interests and is substantially related to achieving those interests." *Glossip*, 411 S.W.3d at 802.

All sex-based classifications, including those related to physical traits, trigger heightened scrutiny. *See Nguyen v. I.N.S.*, 533 U.S. 53, 73 (2001); *United States v. Virginia*, 518 U.S. 515, 534 (1996). So do classifications based on transgender status. *See*, *e.g.*, *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 607 (4th Cir. 2020), *as amended* (Aug. 28, 2020); *Karnoski v. Trump*, 926 F.3d 1180, 1200–01 (9th Cir. 2019); *Brandt v. Rutledge*, 2023 WL 4073727, at *31 (E.D. Ark. June 20, 2023); *Ray v. McCloud*, 507 F. Supp. 3d 925, 937–38 (S.D. Ohio 2020) (collecting cases).

i. <u>The Act Discriminates Based on Sex.</u>

The Act draws a classification based on sex in three distinct ways. First, the Act facially draws distinctions based on sex and speaks in explicitly gendered terms. Second, the Act discriminates based on sex stereotypes relating to a person's sex assigned at birth. Third, the Act discriminates based on sex in that it discriminates against transgender people, which is a form of sex discrimination.

First, if the legislature cannot "writ[e] out instructions" for determining whether treatment is permitted "without using the words man, woman, or sex (or some synonym)," the law classifies based on sex. *Bostock v. Clayton Cnty., Ga.*, 140 S. Ct. 1731, 1746 (2020). Here, the Act prohibits medical interventions, and Medicaid coverage thereof, when they relate to "*gender* transition," §§ 191.1720.4(1), .5 (emphasis added), which it defines as "the process in which an individual transitions from identifying with and living as a *gender* that corresponds to his or her biological *sex* to identifying with and living as a *gender* different from his or her biological *sex*," § 191.1720.2(4), RSMo (emphasis added). In other words, the Act prohibits the provision of necessary medical care when the care is provided in a manner the State deems "different from his or her biological *sex*." § 191.1720.2(4), RSMo (emphasis added). By "discriminating against transgender persons," the Act "unavoidably discriminates against persons with one sex identified at birth and another today." *Bostock*, 140 S. Ct. at 1746.

Indeed, the Act facially discriminates based on sex "[b]ecause the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law." *Brandt*, 47 F.4th 661 at 669; *see also Brandt*, 2023 WL 4073727, at *31 (holding Arkansas's similar law "discriminates on the basis of sex because a minor's sex at birth determines whether the minor can receive certain types of medical care under the law"); *Ladapo*, 2023 WL 3833848,

at *10 ("To know whether treatment . . . is legal, one must know whether the patient is transgender . . . one must know the patient's natal sex."); *cf. R.M.A. by Appleberry v. Blue Springs R-IV Sch. Dist.*, 568 S.W.3d 420 (Mo. banc 2019) (statutory sex discrimination claim survived motion to dismiss where "sex was a contributing (or motivating) factor"). For example, the Act does not prevent a minor assigned male at birth from receiving testosterone, nor does it prevent a minor assigned female at birth from receiving estrogen. *See Lampley v. Mo. Comm'n on Hum. Rts.*, 570 S.W.3d 16, 24 (Mo. banc 2019) ("it is clear an employer . . . [is] engaging in sex discrimination [where] the discrimination would not occur but for the victim's sex.") (citations omitted); *accord Bostock*, 140 S. Ct. at 1741–42 (when "an employer who fires a transgender person who was identified as a male at birth but . . . retains an otherwise identical employee who was identified as female at birth, the . . . employee's sex plays an unmistakable and impermissible role in the discharge decision."). Nevertheless, the Act prevents a minor assigned male at birth who now identifies as female from receiving estrogen, or a minor assigned female at birth who now identifies as male from receiving testosterone.

Second, the Act discriminates based on a person's failure to conform to sex stereotypes or expectations associated with a particular sex designated at birth. *See Ladapo*, 2023 WL 3833848, at *8. The Missouri Supreme Court has recognized that treatment based on "sex-based stereotypical attitudes of how a member of [one's] sex should act" can constitute "unlawful sex discrimination." *Lampley*, 570 S.W.3d at 25. And "Courts of [the Eighth] Circuit, including the Court of Appeals, have recognized a transgender person's ability" to raise a "claim of discrimination due to gender non-conformity." *C.M.B. by Burch v. Odessa R-VII Sch. Dist. Bd. of Educ.*, No. 17-01075-CV-W-GAF, 2019 WL 13298894, at *6 (W.D. Mo. Mar. 21, 2019); *see also Tovar v. Essentia Health*, 857 F.3d 771, 775 (8th Cir. 2017); *Hunter v. United Parcel Serv., Inc.*,

697 F.3d 697, 704 (8th Cir. 2012). That holding is consistent with those of other circuits that "sex stereotyping based on a person's gender non-conforming behavior"—which includes a person's "failure to act and/or identify with his or her" sex designated at birth—"is impermissible discrimination" under both federal civil rights statutes and the Equal Protection Clause. *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217, 221 (6th Cir. 2016) (per curiam) (quoting *Smith v. City of Salem, Ohio,* 378 F.3d 566, 575 (6th Cir. 2004); *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011).

"Because the term 'transgender' describes people whose gender expression differs from their assigned sex at birth, discrimination based on an individual's transgender status constitutes discrimination based on gender stereotyping." *Rumble v. Fairview Health Servs.*, No. 14-cv-2037 (SRN/FLN), 2015 WL 1197415, at *2 (D. Minn. Mar. 16, 2015); *see also Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1048 (7th Cir. 2017) ("By definition, a transgender individual does not conform to the sex-based stereotypes of the sex that he or she was assigned at birth."), *abrogated on other grounds as recognized by Ill. Republican Party v. Pritzker*, 973 F.3d 760, 762 (7th Cir. 2020); *accord Glenn*, 663 F.3d at 1316; *Smith v. Avanti*, 249 F. Supp. 3d 1194, 1201 (D. Colo. 2017) (agreeing "discrimination based on applying gender stereotypes to someone who was assigned a certain sex … at birth, constitutes discrimination based on sex"). When the government "penalizes a person identified as male at birth for traits or actions that it tolerates in" people "identified as female at birth,"—here, for example, receiving medical treatment to live in accordance with a female gender identity—the person's "sex plays an unmistakable and impermissible role." *Bostock*, 140 S. Ct. at 1741–42.

The Act explicitly enforces sex stereotypes and gender conformity by targeting medical care for exclusion if, and only if, the purpose of the medical care is to assist an individual under the age of eighteen in "identifying with and living as a gender different from his or her biological

sex." § 191.1720.2(4), RSMo. Conversely, the Act contains an explicit exception allowing for irreversible surgical interventions on infants with differences of sex development if the purpose of the surgery is to make the infant's body conform to their sex designated at birth. § 191.1720.8(1), RSMo (exempting care provided to broad categories of intersex minors "born with a medically verifiable disorder of sex development" including "biological sex characteristics that are irresolvably ambiguous").[12] By allowing and disallowing care based on sex designated at birth, the Act is an impermissible "form of sex stereotyping where an individual is required effectively to maintain [their] natal sex characteristics." *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018). The Act "tethers Plaintiffs to sex stereotypes which, as a matter of medical necessity, they seek to reject." *Kadel v. Folwell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020).

Third, as the Supreme Court explained in *Bostock*, and as further detailed below, "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex." 140 S. Ct. at 1741.

Every trial court squarely presented with the specific question of whether a law prohibiting gender-affirming medical care for transgender adolescents necessarily discriminates based on sex or transgender status has held that it does. *See, e.g.*, *L.W. v. Skrmetti*, 2023 WL 4232308, at *10-11, 19, *stayed*, No. 23-5600, 2023 WL 4410576, at *3 (6th Cir. July 8, 2023); *Doe 1 v. Thornbury*, No. 3:23-cv-230-DJH-RSE, 2023 WL 4230481, at *3-5 (W.D. Ky. June 28, 2023), *stayed,* slip op. at 2–3 (W.D. Ky. July 14, 2023); *Brandt*, 2023 WL 4073727, at *31; *K.C.*, 2023 WL 4054086, at *8; *Ladapo*, 2023 WL 3833848, at *8; *Eknes-Tucker*, 603 F. Supp. 3d at 1147; *see also Dekker v. Weida*, No. 4:22CV325-RH-MAF, 2023 WL 4102243, at *11-12 (N.D. Fla. June 21, 2023), *appeal*

[12] These surgeries have been widely criticized in the scientific literature and have far less evidence of efficacy than the procedures outlawed by the Act.

filed, No. 23-12155 (11th Cir. June 27, 2023).[13]

ii. The Act Discriminates Based on Transgender Status.

The Act expressly targets minors for differential treatment based on their transgender status. A transgender person is, by definition, someone whose sex assigned at birth is different from their gender identity. Olson-Kennedy Aff. ¶ 30. The Act explicitly bans medical treatments when, and

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13 On July 8, 2023, the Sixth Circuit in a split 2-1 decision after expedited review granted a stay of the preliminary injunction in *L.W.*, pertaining to Tennessee's ban. In so doing, the Sixth Circuit sharply deviated from the majority of federal courts. However, the Sixth Circuit acknowledged its views "are just that: initial" and they "may be wrong." *L.W.*, 2023 WL 4410576, at *8. Its decision is thus of little persuasive value, made even less still by the Eighth Circuit's decision, *Brandt,* 47 F.4th 661.

The Sixth Circuit based its decision, in large part, on the notion that a lack of FDA approval shows there is no medical consensus regarding this care. *Id.* at *4. But "[t]hat the FDA has not approved these drugs for treatment of gender dysphoria says precisely nothing about whether the drugs are safe and effective when used for that purpose." *Dekker*, 2023 WL 4102243, at *19. "Off-label use of drugs is commonplace and widely accepted across the medical profession." *Id.* Any "contrary implication is divorced from reality." *Id.* Antibiotics, antihistamines, and antidepressants, for instance, are all used "off-label" in pediatrics. Shumer Aff. ¶ 70. "Once a drug has been approved . . . the drug can be distributed not just for the approved use but for any other use as well," and "[t]here ordinarily is little reason to incur the burden and expense of seeking additional FDA approval." *Id.* What is more, the Missouri Legislature in 2014 enacted a "Right to Try" law that explicitly allows certain patients to access drugs that have not even been approved for *general* use by the FDA, *see* § 191.480, RSMo.

In addition, the Sixth Circuit's sex discrimination analysis primarily cites the U.S. Supreme Court's 1971 decision in *Reed v. Reed*, but ignores the Court's more recent declarations that "all gender-based classifications today warrant heightened scrutiny," *United States v. Virginia*, 518 U.S. 515, 555 (1996) (quotation marks omitted); *see also Sessions v. Morales-Santana*, 582 U.S. 47, 57 (2017). It also ignores that the fact that a particular court may not have recognized (to date) that classifications based on transgender status are quasi-suspect, *L.W.*, 2023 WL 4410576, at *8, does not mean they are not.

Furthermore, the district court that stayed its preliminary injunction against Kentucky's ban only did so after the Sixth Circuit's stay in *L.W. See Thornbury*, slip op. at 2–3 (W.D. Ky. July 14, 2023). In doing so, however, the district court noted that the Sixth Circuit had declined to stay the Kentucky injunction, and that the Kentucky law differed from the Tennessee law in several material ways. *Id.* The Kentucky court also reiterated its view that the Kentucky ban was clearly subject to heightened scrutiny under Sixth Circuit equal protection precedent. *Id.*

only when, they are provided to transgender minors for the purpose of "gender transition." §§ 191.1720.3–.6. By targeting "gender transition," the law necessarily classifies based on transgender status: it is transgender people who undergo "gender transition" as part of treatment for gender dysphoria, and "a person cannot suffer from gender dysphoria without identifying as transgender." *Fain v. Crouch*, 618 F. Supp. 3d 313, 325 (S.D.W. Va. 2022); *see also C. P. by & through Pritchard v. Blue Cross Blue Shield of Ill.*, 2022 WL 17788148, at *6 (W.D. Wash. Dec. 19, 2022); *Kadel v. Folwell*, 2022 WL 11166311, at *4 (M.D.N.C. Oct. 19, 2022).

In other words, the Act expressly and exclusively targets transgender young people by prohibiting medical treatments based on whether they "attempt[] to affirm the minor's perception of his or her gender or biological sex, if that perception is inconsistent with the minor's biological sex." *Eknes-Tucker*, 603 F. Supp. 3d at 1147 (explaining Alabama's ban "places a special burden on transgender minors because their gender identity does not match their birth sex"). The Act singles out medical care that only transgender people need or seek. *See Fain*, 618 F. Supp. 3d at 327; *Toomey v. Arizona*, 2019 WL 7172144, at *6 (D. Ariz. Dec. 23, 2019); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 950 (W.D. Wis. 2018).

Accordingly, because the Act singles out and discriminates against transgender people, the statute triggers heightened scrutiny. *See Ambers-Phillips v. SSM DePaul Health Ctr.*, 459 S.W.3d 901, 911 (Mo. Banc 2015) (for purposes of Article I, Section 2 of Missouri Constitution, courts apply heightened scrutiny to a statute that disadvantages a suspect class). Although the Missouri Supreme Court has yet to rule on the question of whether transgender people constitute a quasi-suspect class, a "lack of binding precedent does not require this Court to only apply rational basis review, nor does it prevent this Court from relying on well-reasoned opinions of non-binding courts to inform its opinion." *Ray*, 507 F. Supp. 3d at 938.

Courts across the country have recognized, as this Court should, that "transgender people constitute *at least* a quasi-suspect class." *Brandt,* 2023 WL 4073727, at *31; *see also Grimm*, 972 F.3d at 611-13; *Karnoski*, 926 F.3d at 1200-01; *Dekker*, 2023 WL 4102243 at *12–13; *Brandt*, 2023 WL 4073727 at *31; *Ladapo*, 2023 WL 3833848 at *9; *Ray*, 507 F. Supp. 3d at 937; *M.A.B. v. Bd. of Educ. of Talbot Cnty.*, 286 F. Supp. 3d 704, 719–20 (D. Md. 2018); *Flack*, 328 F. Supp. 3d at 952–53; *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1144-45 (D. Idaho 2018); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017); *Adkins v. City of New York*, 143 F. Supp. 3d 134 (S.D.N.Y. 2015); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015); *cf. Brandt*, 47 F.4th at 661 n.4 (finding no clear error in district court's finding that transgender people constituted quasi-suspect class).

iii. **The Act Was Enacted for the Discriminatory Purpose of Drawing Sex- and Transgender Status-Based Distinctions.**

Even if the Act did not explicitly discriminate based on transgender status and sex, it would still be subject to heightened scrutiny as a law passed "because of," not "in spite of," its effects on transgender youth. *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 279 (1979). The legislature's intent to treat transgender minors differently pervades the legislative history. And while bias is not required to show intent, throughout the legislative process, legislators made statements demonstrating a bias against transgender people. *See Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 268 (1977) ("contemporary statements by members of the decisionmaking body" are relevant to assessing legislative purpose).

Throughout the legislative history, the Act's author and sponsor made a series of astonishing comments about gender-affirming care. In one exchange, he referred to medical providers who provide that care as "conveyors of child destruction" and "evil-doers" and compared gender-affirming medical care to "malevolent deeds," "wickedness," and "medical experiments

performed in a concentration camp."[14] The Missouri Senate's YouTube account posted a video of a speech that he gave on the Senate floor in which he labeled gender-affirming medical care as "atrocities" of "experimental" "poisons" and "mutilation."[15] Despite the confident tone underlying these comments, the author of the bill admitted that when it comes to the status quo of permitting families to seek gender-affirming medical care, "I clearly don't understand it, and that's why I and several of my colleagues have taken the action that we've taken."[16]

In fact, the Act was just one part of a larger legislative effort to target and discriminate against transgender people. In addition to the absolute prohibition on the provision of gender-affirming medical care to persons under 18 years of age and the categorical exclusion of coverage of gender-affirming medical care from MO Health Net, regardless of medical necessity, the Act also bans the provision of certain gender-affirming medical care to incarcerated transgender people within Missouri's prisons. *See* § 221.120.1 RSMo.[17] This overall package was passed by the

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[14] *See* Beth O'Malley, *Videos: Some testimony before the House committee about bills to criminalize transgender health care,* ST. LOUIS POST-DISPATCH, (Feb. 14, 2023), *See* https://www.stltoday.com/news/local/government-politics/videos-some-testimony-before-the-house-committee-about-bills-to-criminalize-transgender-health-care/collection_8942f92a-a279-5501-bbaf-6ba171e505a4.html.

[15] *See Missouri Sen. Mike Moon Talks About SB 49*, MOSENCOM, (Mar. 24, 2023), https://www.youtube.com/watch?v=_3ZeDtoV7GE.

[16] *Id.*

[17] The Act seeks to do so even though a federal court has noted that Missouri's former "[p]olicy categorically restrict[ing] inmates who are diagnosed with gender dysphoria after entering the MDOC from receiving hormone treatment" did not appear to have "any rational relationship" with "a legitimate governmental interest or penological purpose." *Hicklin v. Precynthe*, No. 4:16-CV-01357-NCC, 2018 WL 806764, at *14 (E.D. Mo. Feb. 9, 2018). Indeed, the Court held that the plaintiff in that case, Ms. Jessica Hicklin, was "likely to succeed on the merits as to her Eighth Amendment claim that Defendants were deliberately indifferent by failing to provide her with hormone therapy . . . to treat her serious medical of gender dysphoria." *Id.* at *13.

legislature and later signed by the Governor simultaneously with Senate Bill 39, which banned transgender student athletes, including pre-pubescent children, from participating in scholastic athletic programs. § 163.048 RSMo. Together, these laws reveal a clear legislative scheme to roll back and restrict the rights of transgender people throughout Missouri, and demonstrate a discriminatory legislative intent.

In addition, the Act was drafted with such precision that it would impact *only* transgender people seeking gender-affirming medical care. § 191.1720.8 (outlining circumstances in which procedures would not be banned for non-transgender individuals). This context provides strong evidence that the Act was adopted with the express purpose of targeting transgender people for disparate treatment. *See Dekker*, 2023 WL 4102243, at *14 (holding Florida's ban on Medicaid coverage for gender-affirming medical care was "motivated in substantial part by the plainly illegitimate purposes of disapproving transgender status and discouraging individuals from pursuing their honest gender identities"); *Ladapo,* 2023 WL 3833848, at *10 (holding the same with regards to Florida's ban on gender-affirming medical care for persons under 18).

In sum, the Act represents "purposeful discrimination against transgender[]" people. *Dekker*, 2023 WL 4102243, at *14.

B. The Act Cannot Survive Heightened Scrutiny.

"Under intermediate or heightened scrutiny, the classification is permissible only if it is substantially related to the achievement of important governmental objectives." *Glossip*, 411 S.W.3d at 812. In evaluating whether the Act is substantially related to an important governmental interest, "[t]he Court retains an independent constitutional duty to review [legislative] factual

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To be sure, here, Plaintiffs are only challenging the prohibition on gender-affirming medical care for transgender young people under 18 and the Act's prohibition on Medicaid coverage for gender-affirming medical care.

findings when constitutional rights are at stake." *Gonzales v. Carhart*, 550 U.S. 124, 165 (2007). The "burden of justification is demanding"—not "deferential"—and it "rests entirely on the State." *VMI*, 518 U.S. at 533, 555.

As discussed below, the government cannot possibly carry its demanding burden in view of the broad medical consensus on the medical necessity for gender-affirming care and the absence of evidence-based alternatives to treat gender dysphoria—a serious medical condition. Nor is there any justification for treating gender-affirming health care differently from all other health care posing similar risks and benefits and supported by comparable evidence of efficacy.

i. <u>There Is No Factual Support for Any Potential Justification of the Act.</u>

The Act does not protect minors. Gender-affirming medical care is neither harmful nor experimental. *See Brandt*, 47 F.4th at 671; *Brandt*, 2023 WL 4073727, at *5 ("Transgender care is not experimental care."); *Dekker*, 2023 WL 4102243, at *6 (finding that, based on current medical knowledge, the Florida's determination that gender-affirming medical treatments are experimental is not reasonable).[18] The medical interventions prohibited by the Act are safe, effective, and evidence-based. They are supported by a multitude of peer-reviewed longitudinal and cross-sectional studies, as well as decades of clinical experience. *See* Shumer Aff. ¶¶ 77–90; Janssen Aff. ¶¶ 79–85; Olson-Kennedy Aff. ¶¶ 45–50, 56–65, 69–70. Indeed, "evidence suggesting these treatments are ineffective is nonexistent." *Dekker*, 2023 WL 4102243, at *15.

Those who actually treat adolescents with gender dysphoria and study the efficacy of those treatments agree that gender-affirming medical care improves the lives of those who need and

[18] The 2023 court decisions in *Brandt* and *Dekker* followed lengthy trials, both of which involved extensive expert testimony and evidence. The decisions in both cases contain extensive and detailed factual findings and conclusions of law supporting Plaintiffs' arguments and claims, and to which Plaintiffs respectfully direct the Court.

receive it. *See Brandt*, 2023 WL 4073727, *16-18, *32-34; *Dekker*, 2023 WL 4102243, at *15. It is the only treatment supported by evidence, and banning it compromises the health and wellbeing of adolescents with gender dysphoria. Simply put, "[t]here are no other evidence-based treatments besides those prohibited by [the Act] that are known to alleviate gender dysphoria." *Brandt*, 2023 WL 4073727, at *17.

That is why providing gender-affirming medical care to adolescents with gender dysphoria is consistent with professional medical standards. "The overwhelming weight of medical authority supports treatment of transgender patients with GnRH agonists and cross-sex hormones in appropriate circumstances." *Dekker*, 2023 WL 4102243, at *7. As such, the clinical practice guidelines for the treatment of gender dysphoria, published by WPATH and the Endocrine Society, are "well-established," *id.* at *6, have been "recognized as best practices by the major medical and mental health professional associations in the United States," *Brandt*, 2023 WL 4073727, at *5, and "are widely followed by clinicians." *Id.* In fact, "not a single reputable medical association has taken a contrary position." *Dekker*, 2023 WL 4102243, at *7; s*ee also Brandt*, 47 F.4th at 671 (substantial evidence supported finding that Act "prohibits medical treatment that conforms with the recognized standards of care"); *Eknes-Tucker*, 603 F. Supp. 3d at 1145; *Ladapo*, 2023 WL 3833848, at *10; Shumer Aff. ¶¶ 49-55; Janssen Aff. ¶¶ 48-53; Olson-Kennedy Aff. ¶¶ 33–35, 76.

What is more, the "risks associated with gender-affirming care for adolescents are no greater than the risks associated with many other medical treatments that are not prohibited" and "the banned treatments are effective to treat gender dysphoria and the benefits of the treatments greatly outweigh the risks." *Brandt*, 2023 WL 4073727, at *34. Moreover, "[t]he choice these plaintiffs face is binary: to use GnRH agonists and cross-sex hormones, or not. It is no answer to say the evidence on the yes side is weak when the evidence on the no side is weaker or nonexistent."

Dekker, 2023 WL 4102243, at *15.

What is clear, however, is that "[t]he harms are severe and irreparable for adolescents with gender dysphoria who need but are unable to access gender-affirming medical care." *Brandt*, 2023 WL 4073727, at *24. "[D]enial of this treatment will cause needless suffering for a substantial number of patients and will increase anxiety, depression, and the risk of suicide." *Dekker*, 2023 WL 4102243, at *8. It will also cause Minor Plaintiffs and other transgender adolescent Missourians to "go through irreversible pubertal changes inconsistent with their gender identity." *Brandt*, 2023 WL 4073727, at *24.

Simply put, gender-affirming medical care greatly improves the health and wellbeing of adolescent patients with gender dysphoria. Gender-affirming medical care does not harm transgender youth. To the contrary, it allows them to thrive.

C. Treating Gender-Affirming Care Differently from Medical Treatments with Comparable Risks, Benefits, and Scientific Support Is Unjustifiable.

The Act further fails any level of scrutiny because Missouri can provide no justification for treating gender-affirming medical care differently from other medical treatments with similar risks and benefits and comparable scientific support. *See Brandt*, 47 F.4th at 671 (substantial evidence supported that gender-affirming care has been "evaluated in the same manner as many other medical innovations").

The medications prohibited by the Act, when prescribed to transgender adolescents—pubertal suppression, testosterone, estrogen, and testosterone suppression—are used to treat other conditions in non-transgender adolescents and carry comparable risks and side effects regardless of the indication for which they are prescribed. Shumer Aff. ¶¶ 69, 85; *see also Brandt*, 2023 WL 4073727 at ¶ 192. The fact that gender-affirming care has risks does not distinguish it from other forms of medical care. Shumer Aff. ¶¶ 69, 85. "Risks attend many kinds of medical treatment,

perhaps most. Ordinarily it is the patient, in consultation with the doctor, who weighs the risks and benefits and chooses a course of treatment." *Dekker*, 2023 WL 4102243, at *16. "There is nothing unique about the risks of gender-affirming medical care for adolescents that warrants taking this medical decision out of the hands of adolescent patients, their parents, and their doctors." *Brandt*, 2023 WL 4073727, at *18. "That there are risks of the kind presented here is not a rational basis for denying patients the option to choose this treatment and to have Medicaid cover the cost." *Dekker*, 2023 WL 4102243, at *16.

To the extent that the Act attempts to address any purported risk to fertility, no such risk applies to some of the banned procedures. Puberty-delaying medications, on their own, do not affect fertility, and many patients treated with hormone therapy are able to biologically conceive children. Shumer Aff. ¶¶ 80-82; *Brandt*, 2023 WL 4073727, at ¶ 204. Where the risk could apply, it is not unique to gender-affirming care, which is not the only type of medical care provided to minor patients that can affect fertility (but it is the only care banned under the law). Shumer Aff. ¶¶ 69, 85; *Brandt*, 2023 WL 4073727, at ¶195 (listing treatments for minors other than for gender dysphoria that can affect fertility). In fact, as demonstrated below, the Act's "continuation of care" clause renders it so poorly tailored to effectuate any claimed interest in fertility preservation, that in the case of R.S., and others like her, it constitutes an immediate and direct threat *to* their ability to preserve fertility. *See* A.S. Aff. ¶¶ 19–25.

The evidence supporting the safety and efficacy of the banned care for transgender adolescents is comparable to the evidence supporting treatment for other conditions that Missouri does not ban. The Act explicitly permits the use of puberty-delaying medication to treat precocious puberty, but bans the same medication to treat gender dysphoria, even though the evidence base supporting the treatment is the same. Shumer Aff. ¶ 65; Olson-Kennedy Aff. ¶ 65. Moreover, "only

about 13.5% of accepted medical treatments across all disciplines are supported by 'high' quality evidence on the GRADE scale." *Dekker*, 2023 WL 4102243, at *15. Indeed, "[t]he evidence base supporting gender-affirming medical care for adolescents is comparable to the evidence base supporting other medical treatments for minors." *Brandt*, 2023 WL 4073727, at *17.

Finally, as noted above, prescribing puberty-delaying medication and gender-affirming hormone therapy to treat gender dysphoria in adolescents are not experimental. Nevertheless, even if they were, Missouri does not ban the use of experimental treatments solely on that basis for any other condition or group of people. "That the FDA has not approved these drugs for treatment of gender dysphoria says precisely nothing about whether the drugs are safe and effective when used for that purpose." *Dekker*, 2023 WL 4102243, at *19. "Off-label use of drugs is commonplace and widely accepted across the medical profession." *Id.*

There are no justifications for the Act, let alone any that provide an "exceedingly persuasive" explanation for why gender-affirming care should be treated differently from all other medical treatment.

D. The Act Fails Any Level of Review.

Although the Act is properly subject to heightened scrutiny, it ultimately fails any level of review. *Ladapo*, 2023 WL 3833848, at *11 ("there is no rational basis, let alone a basis that would survive heightened scrutiny, for prohibiting these treatments in appropriate circumstances"). The law's means are "so far removed from [the asserted] justifications that . . . it [is] impossible to credit them." *Romer v. Evans*, 517 U.S. 620, 635 (1996). As outlined above, rather than protect children, the Act harms them.

The Act's "continuation of care" clause, which provides for the continuation of a specific medication that has been initiated before August 28, 2023 (but bans the initiation of any additional or different gender-affirming medical care after that date), is fatally irrational.

See § 191.1720.4(2). By arbitrarily selecting which transgender adolescents may initiate gender-affirming medical care based on whether they fall on this or that side of August 28, the clause (1) implicitly acknowledges the unacceptable harm of discontinuing ongoing medically necessary care, (2) renders the Act completely ineffective at accomplishing any possible purported health interest, and (3) in many cases, constitutes an active threat to the health of transgender adolescents.

The circumstances of R.S., for example, demonstrate the Act's lack of any rational basis. R.S.'s medical plan, developed in consultation with her doctors, was to wait until she could take steps to preserve fertility before moving onto gender-affirming hormone therapy, which would have been after the operative date of the Act. A.S. Aff. ¶20. Because of the "continuation of care" clause, however, and the serious risks to her mental health if she does not continue medically necessary gender-affirming care over the course of the next four years, she must abandon her plan to preserve fertility if she wants to initiate hormones before August 28, 2023, so that she will not be shut out of pursuing that care until she turns eighteen. *Id.* ¶ 24.

The Act thus places her, and many transgender adolescents across Missouri like her, in an impossible bind: because of the imminent effective date of the Act and the "continuation of care" clause, she and her family must now choose to abandon preserving her fertility and, instead, preserve her ability to access medically necessary health care after August 28, 2023. The Act not only lacks a rational relationship between its means and its ends, but, because of the continuation of care clause, its means actually cause the very harms with which its legislative sponsors *claim* to be concerned.

Even if the Act did not contain any continuation of care clause, there is no rational basis to conclude that allowing adolescents with gender dysphoria to receive gender-affirming

medical care that they, their parents, and their doctors all agree is medically necessary "would threaten legitimate interests of [Missouri] in a way that" allowing other types of care "would not." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 448 (1985); *see also Eisenstadt v. Baird*, 405 U.S. 438, 452 (1972) (health risks of birth control pills not a rational basis for banning access for unmarried people while allowing access for married people). Even under rational basis review, the justifications for the Act "ma[k]e no sense in light of how the [statute] treat[s] other [procedures] similarly situated in relevant respects." *Bd. of Trs. of Univ. of Ala. v. Garrett*, 531 U.S. 356, 366 n.4 (2001).

Finally, an improper motive for legislation "rises not from malice or hostile animus alone" but "may result as well from insensitivity caused by simple want of careful, rational reflection or from some instinctive mechanism to guard against people who appear to be different in some respects from ourselves." *Id.* at 374 (Kennedy, J., concurring). That is yet another reason the Act fails any level of review. *See* Section I-A-iii, *supra*, at 31 ("I clearly don't understand it, and that's why I and several of my colleagues have taken the action that we've taken."); *Ladapo,* 2023 WL 3833848, at *10 ("dissuading a person from conforming to the person's gender identity rather than to the person's natal sex is not a legitimate state interest")

II. Plaintiffs are Likely to Succeed on the Merits of their Claim that the Act Violates the Fundamental Right to Parental Autonomy.

The Act triggers strict scrutiny because it burdens the fundamental rights of parents to seek appropriate medical care for their minor children. *See Brandt*, 2023 WL 4073727, at *36. As discussed, the Act cannot survive any level of constitutional scrutiny, let alone the most stringent review required for intrusions into fundamental rights. Accordingly, the Parent Plaintiffs are likely to succeed on the merits of their substantive due process claim. *Brandt*, 551 F. Supp. 3d at 892

(plaintiffs were likely to succeed on similar claims), *aff'd*, 47 F.4th 661 (8th Cir. 2022); *Eknes-Tucker*, 603 F. Supp. 3d at 1146 (holding that plaintiffs were likely to succeed on similar claims against Alabama); *Thornbury*, 2023 WL 4230481, at *5 (concluding Kentucky's ban likely interferes with parents' fundamental right to choose treatments gender dysphoria such as puberty-blockers and hormones for their children), *stayed,* slip op. at 2–3. (W.D. Ky. July 14, 2023); *Ladapo*, 2023 WL 3833848, *11 (finding that plaintiffs were substantially likely to succeed on the merits for their claim that Florida's ban violated parents' rights under the Due Process Clause).

A. The Act Infringes on a Fundamental Right, and Strict Scrutiny Applies to the Parent Plaintiffs' Due Process Claims.

Article I, Section 2 of the Missouri Constitution provides "that all persons have a natural right to life, liberty, the pursuit of happiness and the enjoyment of the gains of their own industry," and its protections are co-extensive with the Due Process Clause of the United States Constitution, which are at least the minimum of the Missouri Constitution's protections. *In re Marriage of Woodson*, 92 S.W.3d 780, 783 (Mo. banc 2003) (identical analysis of fundamental rights for purposes of Missouri Constitution as for federal substantive due process); *Comm. for Educ. Equal. v. State*, 294 S.W.3d 477, 490 (Mo. banc 2009) (noting that "Missouri courts have followed the general federal approach to defining fundamental rights" but that "Missouri's Constitution may contain additional protections"). Therefore, plaintiffs here rely on the decisions of Missouri courts, as well as relevant federal court decisions, interpreting the unified content of substantive due process protections.[19]

"Where a law impacts a 'fundamental right,'" a Missouri court "applies strict scrutiny, determining whether the law is necessary to accomplish a compelling state interest." *Comm. for*

[19] Again, and lest there be any doubt, Plaintiffs bring claims only under the Missouri Constitution and **bring no claims** under the United State Constitution.

Educ. Equal., 294 S.W.3d at 490; *see also Brandt*, 2023 WL 4073727, at *36. Under strict scrutiny, the burden is on the "state to show that the law that burdens the protected right advances a compelling state interest and is narrowly tailored to serve that interest." *Republican Party of Minnesota v. White*, 416 F.3d 738, 749 (8th Cir. 2005); *see also Weinschenk v. State,* 203 S.W.3d 201, 211 (Mo. banc 2006).

A parent has a "fundamental constitutional right to make decisions concerning the care, custody, and control of her child." *T.W. ex rel. R.W. v. T.H.*, 393 S.W.3d 144, 147 (Mo. App. E.D. 2013); *see also Troxel v. Granville*, 530 U.S. 57, 65 (2000). This includes parents' right "to direct the upbringing and education of children under their control." *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925); *see also Santosky v. Kramer*, 455 U.S. 745, 753 (1982) (noting the United States Supreme Court's "historical recognition that freedom of personal choice in matters of family life is a fundamental liberty interest protected by the Fourteenth Amendment"); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (acknowledging the existence of a "private realm of family life which the state cannot enter").

The care of one's child and their upbringing includes decisions related to medical treatment. *Brandt,* 2023 WL 4073727, at *36. In particular, it includes parents' "fundamental right to" direct "medical care for their children . . . in conjunction with their adolescent child's consent and their doctor's recommendation." *Brandt* 551 F. Supp. 3d at 892–93, *aff'd,* 47 F.4th 661 (8th Cir. 2022) *see also Parham v. J.R.*, 442 U.S. 584, 602 (1979) (parents' right to raise their child includes the ability "to recognize symptoms of illness and to seek and follow medical advice"); *Treistman ex rel. AT v. Greene*, 754 F. App'x 44, 47 (2d Cir. 2018) ("[P]arents have a right to determine the medical care their children receive and the government's interference in that right can violate due process."); *PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1197 (10th Cir. 2010) ("[A] parent's

general right to make decisions concerning the care of her child includes, to some extent, a more specific right to make decisions about the child's medical care.").

Specifically, as the court in *Brandt* held, strict scrutiny applies to parents' "fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary." *Brandt*, 551 F. Supp. 3d at 892. Other courts across the nation have agreed that such laws infringe on the fundamental right to parental autonomy. *See, e.g.*, *Eknes-Tucker*, 603 F. Supp. 3d at 1151 (Alabama ban likely infringes on parent's "fundamental right to treat their children with transitioning medications subject to medically accepted standards"); *Thornbury*, 2023 WL 4230481 at *5 (concluding Kentucky's ban likely interferes with parents' fundamental right to choose treatments); *Ladapo*, 2023 WL 3833848, *11 (plaintiffs were substantially likely to succeed on the merits for their claim that Florida's ban violated parents' rights under the Due Process Clause).

Individual transgender patients, like all Missourians, also have a fundamental right to autonomy in healthcare. *See Cruzan v. Harmon*, 760 S.W.2d 408, 416 (1988), *aff'd*, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) (observing a long-held "common law" right in Missouri to "individual autonomy relating to one's health and welfare"). Plaintiffs acknowledge that there are some instances where "the State must play its part as parens patriae," and "the juvenile's liberty interest may . . . be subordinated to the State's 'parens patriae interest in preserving and promoting the welfare of the child.'" *Schall v. Martin*, 467 U.S. 253, 265 (1984). However, the fundamental rights of the parent who has the ability and desire to seek and follow medical advice is at its apogee when it is aligned with the adolescent's fundamental right to autonomy: *i.e.*, when the parents, their minor child, and that child's doctor all agree on an appropriate course of medical treatment.

Brandt, 551 F. Supp. 3d at 892–93 (concluding plaintiffs will likely succeed in showing Arkansas's ban interferes with parents' "fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary"), *aff'd*, 47 F.4th 661 (8th Cir. 2022). And here, the Act prohibits care when a parent, child, and medical professionals are in agreement. There is no situation where a minor will access the care subject to the Act without the consent of their legal guardian, and no world where a parent may decide ***for*** their child that gender-affirming care is needed over the minor's objection. Shumer Aff. ¶ 43; Janssen Aff. ¶ 61.

While there may be factually specific circumstances where a state's parens patriae interest is relevant, no such circumstances exist here that would justify a total ban on gender-affirming care for all minors in Missouri. The right in question may not be some "limitless" right of parents to "obtain whatever drugs they want for their children, without restriction," but the treatments that Missouri seeks to ban are well-established, widely accepted medical treatments essential to the wellbeing of many transgender children. *Cf. Ladapo*, 2023 WL 3833848, at *11 ("If the state could properly prohibit the treatments at issue as unsafe, parents would have no right to override the state's decision. . . [but] there is no rational basis, let alone a basis that would survive heightened scrutiny, for prohibiting these treatments in appropriate circumstances."). But, as explained herein, Missouri also seeks to ban this care for transgender adolescents *while permitting the very same care* in circumstances where it carries comparable risks to treat other medical conditions. Shumer Aff. ¶¶ 65, 69; Olson-Kennedy Aff. ¶ 44.

B. The Health Care Ban Cannot Survive Strict Scrutiny.

As discussed above, the Act cannot survive any level of review, and fails the strict scrutiny that intrusions into fundamental rights require of Missouri. In addition to the reasons discussed above, the Act fails strict scrutiny because the means chosen by the state to address any purported

concerns about gender-affirming care are nowhere near the "least restrictive." *Penner v. King*, 695 S.W.2d 887, 890 (Mo. banc 1985).

Nothing about the Act is narrowly tailored to ***any*** interest. Rather than address any particularized concerns, the Act simply rules out ***all*** medical treatment for gender dysphoria in adolescents. While the Act does contain a "continuation of care" clause and a "sunset" provision, the Act will institute a categorical ban on the initiation of gender-affirming care (and the initiation of a new form of gender-affirming care, like the initiation of gender-affirming hormones) after August 28, 2023, and lasting until August 28, 2027. The reality of the Act is that Nicholas Noe, who began a social transition at a very young age and is thriving as a transgender boy, will have to forego *all* treatment until he turns at least fourteen, forcing him to go through an endogenous puberty typical for someone assigned female at birth. A.K., who has made a very careful and deliberate decision to not begin hormones even though she is eligible, would either have to start them before August 28, 2023, or forgo any hormone treatment until they turn eighteen, enduring severe and permanent negative health consequences in the interim.

R.S. was forced to make the incredibly difficult choice to cease fertility preservation in order to make sure that she can receive the medical care necessary to treat their gender dysphoria. And C.J., who began a social transition almost a decade ago and has consistently been treated for his gender dysphoria, will be unable to begin hormone therapy. These are just four examples of what transgender adolescents in Missouri will face if the Act takes effect. As these stories demonstrate, no two medical journeys for a transgender adolescent is the same. Nor should it be. It should be an individualized plan that is agreed to by the adolescent, their parents, and their doctors. It is not for the government to determine who can receive what treatment and when.

Missouri has made no attempt to justify this arbitrary dividing line between those who will

be allowed to continue accessing medically necessary, potentially lifesaving health care and those who will be banned from doing so and face permanent health consequences as a result. Janssen Aff. ¶ 59; Shumer Aff. ¶ 63, As explained further above, the "continuation of care" clause will, in many cases, force transgender adolescents into making permanent decisions on short timelines, constituting an active threat to their health.

The "sunset" clause will be cold comfort to the Plaintiff families and other transgender adolescents who are medically indicated to initiate new gender-affirming care while the Act is in effect, as their inability to do so during that window will have permanent and irreversible negative health consequences. Shumer Aff. ¶ 63; Olson-Kennedy Aff. ¶ 42. C.J. will not be able to change his treatment until he is seventeen. A.K. will not be able to change her treatment until she is eighteen. And Nicholas would be prohibited from starting any treatment until he is fourteen, which is well past the age in which most adolescents begin seeing signs of puberty, meaning he will not have the option to begin puberty-delaying medications.

The Act includes no legislative findings, making it impossible to discern any state interest "not hypothesized or invented *post hoc* in response to litigation." *United States v. Virginia*, 518 U.S. 515, 533 (1996).[20] In signing the bill, Defendant Parson gave only a brief statement

[20] Throughout legislative and public debates surrounding the Act, its sponsors and proponents pointed to a so-called "whistleblower's" affidavit that made allegations surrounding the care provided to transgender adolescents at a specific medical organization in Missouri.

The allegations in that affidavit have not withstood the basic scrutiny of a few months' time. An internal investigation, prompted by the affidavit, found the allegations to be unsubstantiated, and instead, concluded that the providers in question "follow appropriate policies and procedures and treat patients according to the currently accepted standard of care, as recommended by the American Academy of Pediatrics and other nationally recognized organizations." *See* Washington University Transgender Center Internal Review Summary of Conclusions, WASHINGTON UNIVERSITY OF ST. LOUIS, (Apr. 21, 2023), available at

suggesting a motivation to protect children from making permanent medical decisions.[21] Any hypothetical goal of protecting children "is pretextual because [the statute] allows the same treatments for cisgender minors that are banned for transgender minors as long as the desired results conform with the stereotype of the minor's biological sex."[22] *Brandt*, 551 F. Supp. 3d at 893. For another, the Act's "continuation of care" clause is structured so as to force families to make permanent medical decision, as is demonstrated by the Act's effect on R.S., who was forced to make the permanent medical choice to abandon her efforts to preserve fertility because of the impending effective date of the Act. A.S. Aff. ¶23.

Members of the Legislature were not motivated by any actual desire to protect children by limiting their autonomy to make decisions, together with their parents' fundamental right to decide their care. Instead, they were motivated by personal disapproval of gender transition and

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https://source.wustl.edu/wp-content/uploads/2023/04/Washington-University-Summary-ofConclusions.pdf.

After the affidavit was widely publicized, including by proponents of the Act, public reporting began to surface calling into question many of its allegations. *See* Colleen Schrappen, *Parents push back on allegations against St. Louis transgender center. 'I'm baffled.'*, ST. LOUIS POST DISPATCH (Mar. 5, 2023), available at https://www.stltoday.com/news/local/metro/parents-push-back-on-allegations-against-st-louistransgender-center-i-m-baffled/article_a94bc4d2-e68b-535f-b0c7-9fefb9e8e9f4.html; Annelise Hanshaw, *Families dispute whistleblower's allegations against St. Louis transgender center*, MISSOURI INDEPENDENT, (Mar. 1, 2023), available at https://missouriindependent.com/2023/03/01/transgender-st-louis-whistleblower/.

[21] *See Press Release*, Governor Michael Parson *Governor Parson Signs Legislation to Protect Missouri Children and Female Sports*, (June 7, 2023), https://governor.mo.gov/press-releases/archive/governor-parson-signs-legislation-protect-missouri-children-and-female.

[22] Further demonstrating a state interest in protecting children from making consequential decisions to be pretextual, at a committee hearing on the Act, the sponsor made comments defending the right of some children as young as twelve years old to marry others with their parents' consent. *See* Kelsey Vlamis, *A Missouri Lawmaker Defended Child Marriage, Saying Kids He Knows Who Got Married At Age 12 Are 'Still Married,'* BUSINESS INSIDER, (Apr. 21, 2023), https://www.businessinsider.com/mike-moon-gop-missouri-lawmaker-defends-childs-right-to-marry-2023-4.

transgender individuals. This is not a compelling governmental interest. *See Ladapo*, 2023 WL 3833848, at *10 (concluding that plaintiffs were likely to succeed on the merits in showing Florida's ban, motivated in substantial part by the illegitimate purposes of disapproving transgender status and discouraging individuals from pursuing their transitions, did not pass intermediate scrutiny).

III. A Preliminary Injunction Is Necessary.

To date, trial courts across the nation, which includes the St. Louis County Circuit Court, have unanimously enjoined or otherwise ruled against gender-affirming medical care bans that have been challenged, including courts in Arkansas, Alabama, Florida, Indiana, and Missouri. *See* Temporary Restraining Order, *Southampton Cmty. Healthcare v. Bailey*, No. 23SL-CC01673 (Mo. Cir. Ct. May 1, 2023) (granting a temporary restraining order enjoining Missouri Attorney General's emergency rule imposing severe restrictions on the provision of medical treatment for gender dysphoria to transgender adolescents and adults); *Brandt*, 2023 WL 4073727 at *1–2 (holding that Arkansas statute banning "gender transition procedures" for minors was unconstitutional after an eight-day bench trial); *Brandt* 551 F. Supp. 3d at 892–93, *aff'd,* 47 F.4th 661 ("The Court finds that the Parent Plaintiffs have a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary."); *Thornbury*, 2023 WL 4230481, at *1–2 (granting preliminary injunction against Kentucky statute banning puberty blockers and hormone therapy for transgender adolescents); *K.C.*, 2023 WL 4054086, at *1 (granting preliminary injunction against Indiana statute banning puberty blockers and hormone therapy for transgender youth); *Ladapo,* 2023 WL 3833848, at *1 (granting preliminary injunction against Florida statute and rules banning puberty blockers and hormone therapy for transgender minors); *Eknes-Tucker*, 603 F. Supp. 3d at 1137–38 (granting preliminary injunction against

Alabama statute banning puberty blockers and hormone therapy for transgender minors); *see also Dekker*, 2023 WL 4102243, at *10–11, *19 (holding that Florida's prohibition on Medicaid coverage for treatment of gender dysphoria is unconstitutional after two-week bench trial). A preliminary injunction is necessary to preserve the status quo and avoid serious, immediate, irreparable harm to the Plaintiffs.

A. The Act will Cause Immediate, Irreparable Harm to Plaintiffs.

If permitted to go into effect, the Act will inflict on Plaintiffs severe and irreparable harm for which no adequate remedy at law exists. *See, e.g., City of Greenwood v. Martin Marietta Materials, Inc.*, 311 S.W.3d 258, 266 (Mo. App. W.D. 2010), *as modified*. As discussed above, the Act violates the constitutional rights of transgender youth, their parents, and medical providers, which is itself irreparable harm. *See, e.g.*, *Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir. 2012) ("If constitutional rights are threatened or impaired, irreparable injury is presumed.").

But the irreparable harm here is far greater than just the deprivation of the Plaintiffs' constitutional rights. The Act prohibits the provision of necessary and potentially lifesaving medical care by preventing the initiation of treatment and cutting patients off from treatment, forcing families to watch their children suffer while incurring the significant expense of regular travel or relocation out-of-state to access care, and compelling medical providers to abandon their patients by threatening their medical licenses. For the patients, this will inevitably lead to recurrence or worsening of their gender dysphoria. *See* Donovan Aff. ¶ 31; Carr Aff. ¶ 29; Shumer Aff. ¶¶ 92; Janssen Aff. ¶¶ 79–81.

Courts recognize that the denial of medically necessary health care constitutes irreparable harm for which there is no other adequate legal remedy. *See Smith v. W. Elec. Co.*, 643 S.W.2d 10, 13 (Mo. App. E.D. 1982) (finding exposure to conditions deleterious to one's health is an irreparable harm "particularly . . . where the harm has not yet resulted in full-blown disease or

injury”); *Bowen v. City of New York*, 476 U.S. 467, 483-84 (1986) (finding denial of benefits caused irreparable injury by exposing plaintiffs to “severe medical setback[s]” or hospitalization); *Planned Parenthood S. Atl. v. Baker*, 941 F.3d 687, 707 (4th Cir. 2019); *Flack*, 328 F.Supp.3d at 942-46 (finding likelihood of irreparable harm to transgender Medicaid beneficiaries denied coverage for gender dysphoria treatments); *Edmunds v. Levine*, 417 F.Supp.2d 1323, 1342 (S.D. Fla. 2006) (“The denial of medical benefits, and resultant loss of essential medical services, constitutes an irreparable harm to these individuals.”); *Karnoski v. Trump*, No. C17-1297-MJP, 2017 WL 6311305, at *9 (W.D. Wash. Dec. 11, 2017) (“[M]onetary damages proposed by Defendants will not . . . cure the medical harms caused by the denial of timely health care.”).

Specifically, other courts have found the denial of access to gender-affirming medical care causes irreparable harm in the following specific ways:

- causing physical and psychological harm to patient plaintiffs, to parent plaintiffs through watching their child experience physical and emotional pain or uprooting their families, and to physician plaintiffs through “choosing between breaking the law and providing appropriate guidance and interventions. *Brandt*, 551 F. Supp. 3d at 882;
- interrupting medical care for an indefinite period of time and forcing providers to face the risk of ethical violations and civil liability. *Southampton Cmty. Healthcare v. Bailey*, No. 23SL-CC01673 (Mo. Cir. Ct. May 1, 2023);
- “If the plaintiffs do not continue appropriate treatments, the likelihood is very high that they will suffer attendant adverse mental-health consequences,” *Dekker*, 2023 WL 4102243, at *16;
- causing the “unwanted and irreversible onset and progression of puberty in [plaintiffs’] natal sex.” *Ladapo,* 2023 WL 3833848, at *16;

- harming physical and mental health because "there's evidence that puberty blockers and cross-sex hormone therapy reduces distress for some minors diagnosed with gender dysphoria." *K.C.*, 2023 WL 4054086, at *1; and
- because "without transitioning medications, [] Plaintiffs will suffer severe medical harm, including anxiety, depression, eating disorders, substance abuse, self-harm, and suicidality." *Eknes-Tucker*, 603 F. Supp. 3d at 1150.

Transgender Minors: As a result of the Act, A.K., and C.J. stand to be prohibited from moving on from puberty blockers to gender-affirming hormones in the form of estrogen and testosterone, and Nicholas Noe, whose onset of puberty is fairly imminent, stands to be prohibited from receiving any form of medical treatment while the Act is in effect. They are already experiencing varying levels of anxiety and distress at the prospect of being blocked from accessing this care. Being cut off from access to gender-affirming hormones will likely mean being forced to go through some degree of endogenous puberty that has already been paused. S.M. Aff. ¶ 23; Noe Aff. ¶ 18. Being cut off from receiving any blockers will certainly mean being forced to begin endogenous puberty. And the Act's "continuation of care" clause means that the Plaintiff families, and those like them, must scramble to abandon or reassess their medical planning done in consultation with their doctors.

For A.K., the impending operative date threatens to derail the careful, deliberate planning of her, her family, and her medical providers. A.K. is fourteen and recently started a testosterone suppressant medication. Although the evidence-based guidelines that A.K.'s medical providers follow allow her to pursue gender-affirming hormones before she turns sixteen, A.K. and her family have decided to take things conservatively and proceed one-day-at-a-time. Their current medical plan is not to begin estrogen therapy until A.K. turns sixteen in 2024. J.K. Aff. ¶¶ 11–19.

Nonsensically, the Act threatens to punish A.K. for this conservative, deliberate medical plan, and to deny her access to medically necessary care "only because she, in consultation with her doctors, wishes to take things slow and wait until the age of sixteen before initiating" care. J.K. Aff. ¶ 17. The Act "places immense pressure" on A.K. and her family and other families of transgender adolescents, "to either rush the process . . . or risk being shut out of access to medically necessary medication" with permanent negative health consequences. J.K. Aff. ¶ 18.

For C.J., whose social transition to male is almost a decade behind him, and who has been on puberty-delaying medications for three years, the Act threatens to prohibit him from pursuing gender-affirming testosterone. Despite that C.J.—a thirteen-year-old boy—has persistently and insistently expressed a male gender identity since *kindergarten*, and been known to his school, his family, his friends, and to the world as the boy he is since *second grade*, the Act would prohibit him from continuing a medical plan that he and his family started pursuing several years ago. S.M. Aff. ¶¶ 20–22. The prospect of this "would affect his mental health terribly." S.M. Aff. ¶ 23.

Finally, for Nicholas Noe, the Act is even more threatening. Because Nicholas is not yet an adolescent and has not yet entered puberty, no gender-affirming care is medically indicated for him, and he has not initiated any gender-affirming medical care. Because Nicholas will not have started puberty-delaying medications before August 28, the Act will prohibit him from initiating it, as his window to suppress the onset of puberty will be over before the Act sunsets. Shumer Aff. ¶ 59 ("most adolescents begin puberty between ages 10 and 12 years."). For Nicholas and undoubtedly many transgender young people like him across Missouri, this will have severe, permanent negative physical and mental health consequences. Olson-Kennedy Aff. ¶ 76; Noe Aff. ¶ 18.

PFLAG contains families of transgender adolescents who are currently on puberty-delaying medications (or are being monitored to start them) and others who are currently or will be on hormone therapy as part of their medical plan in consultation with their doctors. Bond Aff. ¶ 12. Adolescent members of PFLAG families are at risk of having their care interrupted or being denied new care, which will result in similar physical and mental health harm to the Minor Plaintiffs. *Id.*

Parents: If the Act is permitted to go into effect, the Parent Plaintiffs and parent members of PFLAG will have their parental decision-making usurped by the state. They will be forced to watch their children suffer immense and possibly deadly pain, or disrupt their lives and families to travel or move out of the state for treatment, despite deep financial and emotional investment in their communities. A.S. Aff. ¶ 28; S.M. Aff. ¶ 23; J.K. Aff. ¶ 18; Noe Aff. ¶¶ 23.17, 18; Bond Aff. ¶¶ 12, 13.

Providers: The Act also irreparably harms Southampton Healthcare, its medical providers, and healthcare provider members of GLMA by requiring them to make the untenable decision to either follow the law (and in so doing violate their professional obligations by sacrificing the health of her patients) or provide lifesaving, medically necessary care to her patients (and in so doing, risk the loss of their medical license and livelihood). Donovan Aff. ¶¶ 33, 41, Carr Aff. ¶ 26; Sheldon Aff. ¶ 26. By forcing them to act unethically in withholding potentially lifesaving and medically necessary care, the Act also forces them to violate the tenets of their professions, causing them great distress and misery. Donovan Aff. ¶¶ 38-41; Sheldon Aff. ¶ 26.

B. The Balance of Equities Weigh in Plaintiffs' Favor and Issuance of a Preliminary Injunction is in the Public Interest.

In weighing the preliminary injunction factors, "harm to the opposing party and the public interest [] merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 129

(2009). The balance of harms weighs heavily toward granting injunctive relief and maintaining the status quo. As discussed above, the Plaintiff families, providers, and organizations all face serious, permanent negative consequences if the Act is allowed to go into effect. Those harms far outweigh any harm to Defendants, who stand only to temporarily lose the ability to disrupt the status quo with a new law that would be in effect for a limited period of time, does not advance any legitimate state interest, and is likely to be held unconstitutional. *See D.M. by Bao Xiong v. Minn. State High Sch. League*, 917 F.3d 994, 1004 (8th Cir. 2019) (finding injunction in the public interest because of probability that Defendant's policy was unconstitutional).

The harm to Plaintiffs (and to transgender adolescents, their parents, and their healthcare providers all across Missouri, many of whom are members of PFLAG or GLMA) from allowing the Act to go into effect would be tangible, immediate, and irreparable. Whatever interest the State may have in enforcing the Act during the pendency of this case pales in comparison to Plaintiffs' certain and severe harm. Missouri has no cognizable interest in immediately enforcing the Act because the interest of the public that it represents "is served by the preservation of constitutional rights." *Bao Xiong*, 917 F.3d at 1004 (8th Cir. 2019) (quoting *Phelps-Roper v. Nixon*, 545 F.3d 685, 694 (8th Cir. 2008), *overruled on other grounds by Phelps-Roper v. City of Manchester*, 697 F.3d 678, 692 (8th Cir. 2012) (en banc)); *see also Awad v. Ziriax*, 670 F.3d 1111, 1132 (10th Cir. 2012) ("[I]t is always in the public interest to prevent the violation of a party's constitutional rights." (quoting *G & V Lounge, Inc. v. Mich. Liquor Control Comm'n,* 23 F.3d 1071, 1079 (6th Cir. 1994))).

An injunction would simply maintain the status quo while Plaintiffs pursue their claims. Parents can continue to meet their children's medical needs; transgender Missourians can continue to receive recommended, evidence-based, medically necessary treatment for their gender

dysphoria; and healthcare providers can continue to treat patients without fear of serious professional and financial consequences.

C. An Injunction of the Entire Act Is Necessary.

"[T]he scope of injunctive relief is dictated by the extent of the violation established," which here is statewide. *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). An injunction for just the named Plaintiffs is insufficient because patients are not able to receive health care without an injunction allowing third parties to provide it to them. The Act impacts a broad swath of medical providers, pharmacists, parents, and adolescents across Missouri, in addition to the individual Plaintiffs. §§ 191.1720.5, 6 (providing for professional discipline and a private right of action against medical providers who provide gender-affirming care, with a fifteen-year statute of limitations and a *minimum* damages award of $500,000). And with severely negative consequences for providers, some who may technically not be within the Act's scope will likely avoid providing some care to transgender people such that the breadth and scope of harm from the Act is immediate and statewide. *See Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2566 (2019) ("third parties will likely react in predictable ways . . . even if they do so unlawfully"). "[M]olding an appropriate injunctive decree rests largely in the sound discretion of the trial court, which is vested with a broad discretionary power to shape and fashion relief to fit the particular facts, circumstances and equities of the case before it." *Burg v. Dampier,* 346 S.W.3d 343, 357 (Mo. Ct. App. 2011) (quoting *Schluemer v. Elrod*, 916 S.W.2d 371, 379 (Mo. Ct. App. 1996)). In light of the severe and irreparable harms the Plaintiffs and other transgender adolescents across Missouri face, a facial statewide preliminary injunction is appropriate. *See Brandt*, 47 F.4th 661, 672 (affirming facial injunction against Arkansas ban).

D. Defendants Will Suffer No Harm from the Preliminary Injunction, So No Bond Is Required.

Given the rights at stake in this case and the fact that Defendants will not suffer any harm from the imposition of a preliminary injunction, the Missouri Supreme Court Rule 92.02(d) bond should be waived. *See State ex rel. Ideker, Inc. v. Grate*, 437 S.W.3d 279, 287 (Mo. App. W.D. 2014) (acknowledging the right of courts to not require bonds for injunctive relief where "it does not appear that [the non-moving party] will suffer harm as a result of this temporary restraining order"); *Phelps-Roper v. Cnty. of St. Charles, Mo.*, 780 F. Supp. 2d 898, 904 (E.D. Mo. 2011) (granting injunctive relief without a security bond where Defendant would "suffer no financial harm if found to be wrongfully enjoined"). A bond is neither appropriate nor necessary in this case.

CONCLUSION

For these reasons, Plaintiffs request the Court to grant their motion for a preliminary injunction, prevent the Act from taking effect, and enjoin and restrict Defendants from implementing or enforcing the Act, namely, §191.1720 and Subsection 15 of § 208.152 of the Missouri Revised Statutes, during the pendency of this litigation.

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Respectfully submitted,

By: */s/ J. Bennett Clark*

GILLIAN R. WILCOX, #61278
JASON ORR, #56607
ACLU of Missouri Foundation
406 West 34th Street, Ste. 420
Kansas City, MO 64111
gwilcox@aclu-mo.org
jorr@aclu-mo.org

ANTHONY E. ROTHERT, #44827
ACLU of Missouri Foundation
906 Olive Street, Suite 1130
St. Louis, Missouri 63101
Phone: (314) 652-3114
arothert@aclu-mo.org

NORA HUPPERT*
KARA INGELHART*
CAMILLA B. TAYLOR*
Lambda Legal Defense
and Education Fund, Inc.
65 E. Wacker Pl., Suite 2000
Chicago, IL 60601
(312) 663-4413
nhuppert@lambdalegal.org
kingelhart@lambdalegal.org

OMAR GONZALEZ-PAGAN*
Lambda Legal Defense
and Education Fund, Inc.
120 Wall Street, 19th Floor
New York, NY 10005
(212) 809-8585
ogonzalez-pagan@lambdalegal.org

J. BENNETT CLARK, #30907
MICHAEL E. ROWAN, #72992
MARY GRACE E. WARREN, #73147
Bryan Cave Leighton Paisner LLP
One Metropolitan Square
211 North Broadway, Suite 3600
St. Louis, MO 63102
(314) 259-2000
ben.clark@bclplaw.com
michael.rowan@bclplaw.com
marygrace.warren@bclplaw.com

JAMES D. LAWRENCE, #53411
TYLER JERRAD BLAKE BRIGGS, #73151
Bryan Cave Leighton Paisner LLP
One Kansas City Place
1200 Main Street, Suite 3800
Kansas City, Missouri 64105
(816) 374-3200
jdlawrence@bclplaw.com
tj.briggs@bclplaw.com

* Application for admission *pro hac vice* forthcoming.

Attorneys for Plaintiffs