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Absent a preliminary injunction, transgender adolescents in Arkansas currently receiving gender-affirming medical care will have that care stripped away from them on July 28, 2021, when the Health Care Ban is set to take effect. These young people, including plaintiffs Dylan Brandt, Sabrina Jennen, and Parker Saxton, will suffer significant physical and psychological harm if they have to stop the treatment that has enabled them to manage their gender dysphoria, eliminated their debilitating distress, and ultimately, allowed them to thrive. Their parents will have to witness their children suffer and will, in many cases, be forced to consider leaving the homes and communities they love in order to take care of their children. And medical providers like Dr. Hutchison and Dr. Stambough will be placed in the untenable position of leaving their patients to suffer or risking their medical licenses.

The Health Care Ban is an unprecedented and sweeping prohibition on one, and only one, type of health care—care related to gender transition for minors. Defendants claim an interest in protecting the well-being of minors, citing purported concerns about the sufficiency of the evidence supporting the banned care and the risks associated with such care. But as explained in Plaintiffs' Opening Brief and below, all of the treatments prohibited by the Health Care Ban when provided to transgender adolescents for purposes of gender transition are explicitly permitted by the statute when provided to minors with intersex conditions for purposes of

conforming the minor's body to their sex assigned at birth. ARK. CODE ANN. § 20-9-1501(6)(A)(ii), (B).

Arkansas has not banned other medical care supported by similar or less evidence and involving similar or greater risks. (*See* Plaintiffs' Opening Brief (ECF No. 12, "Pls. Op. Br.") at 34-40.) It has banned health care that is related to "gender transition." This disconnect between the law and the asserted rationales fails any level of constitutional scrutiny, let alone the heightened scrutiny required of laws that discriminate based on sex and transgender status, burden parental autonomy rights, and restrict speech. *See Romer* v. *Evans*, 517 U.S. 620, 635 (1996) (invalidating state constitutional amendment under rational basis review because "[t]he breadth of the amendment is so far removed from these particular justifications that we find it impossible to credit them").

Not only does the Health Care Ban fail to align with or advance Defendants' claimed interests, it ultimately undermines Arkansas's interest in protecting children by denying access to medically necessary care for adolescents with gender dysphoria. And despite their repeated attempts to cast the prohibited treatment as "risky," "experimental," and "dangerous," the banned care is recognized as an appropriate and effective treatment for adolescents with gender dysphoria by every major medical and mental health professional organization in the United States. (*See generally* Brief of *Amici Curiae* American Academy of Pediatrics, *et. al.* (ECF

No. 30, "Medical Brief" or "Br. of Amici AAP, *et. al.*") at 8-10 (confirming that the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the Endocrine Society, the Pediatric Endocrine Society, and several other national medical groups, along with Arkansas's pediatric and psychiatric professional groups, recognize that the treatment prohibited by the Health Care Ban is part of the accepted standards of care and the medical profession's consensus recommendation for the treatment of gender dysphoria in adolescents).)

In their response to Plaintiffs' Motion, Defendants argue that all of these medical professional organizatgaan t2.564 -2ssp.J0.004 (tif)12.2 (f)3.7 (s.6 (d)8(n)8.3 (d)-8.

affirming medical treatment is unique in the level of risk it poses to patients, necessitating a State ban on the care. But as discussed in Plaintiffs' Opening Brief and further explained below, none of these claims is defensible.

Ultimately, the existence of outlier views reflected in Defendants' expert witness declarations does not change the fact that all of the treatment banned by the

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numerous others expressing suicidal thoughts related to the prospect of losing gender-affirming care.

The preliminary injunction sought by Dylan, Sabrina, Parker, Brooke, and their parents to protect these children's ability to access medically necessary care,

who had accessed pubertal suppression during adolescence to 3405 transgender adults who wanted but were unable to access pubertal suppression during adolescence. After adjusting for confounding variables, the study found that those who accessed pubertal suppression had a statistically significant lower odds of

and others [2021] EWHC 741, at ¶¶ 68-70 (Fam); *Bell* v. *Tavistock and Portman National Health Service Foundation Trust*, [2020] EWHC (Admin) 3274, at ¶ 47.

Defendants' experts also claim that the evidence relied on in the adoption of the treatment protocols is not of adequate quality. (Regnerus Decl. ¶¶ 52-55.) As discussed in Plaintiffs' Opening Brief (at 40-41), this characterization of the evidence is false, and much of pediatric medicine—including medical care the Health Care Ban explicitly permits for non-transgender patients—relies on evidence of similar quality. (*See* Declaration of Armand H. Matheny Antommaria, MD, PhD, FAAP, HEC-C (ECF 11-12, "Antommaria Decl.") ¶¶ 29-41; *see also* Turban Decl. ¶ 40.[4])

Defendants' experts' position appears to be that since the evidence does not meet the standard they claim is necessary, patients should not be provided the care

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Throughout Defendants' submissions they repeat the false claim that a majority of youth who identify as transgender will ultimately abandon their transgender identity and come to identify with their assigned sex at birth. (Defs. Br. at 1, 7-8, 20, 55, 63, 100.) Defendants' experts claim that because most transgender-identified youth will outgrow gender dysphoria and come to identify as the sex they were assigned at birth—what they refer to as "desistance"— gender-affirming care should be prohibited. (Levine Decl. ¶¶ 56-57; Declaration of Paul W. Hruz, M.D., Ph.D (ECF No. 45-3, "Hruz Decl.") ¶ 8; Regnerus Decl. ¶ 77.) Moreover, they assert that affirming minors' gender is harmful because that will cause them to persist in their transgender identity when they otherwise would desist. (Levine Decl. ¶¶ 56-57; Hruz Decl. ¶ 8; Regnerus Decl. ¶ 77.) Neither of these claims is accurate or borne out in the literature.

First, Defendants misrepresent a body of literature that suggests that a majority of *children* who express gender non-conforming behavior or transgender identity will ultimately come to identify as their assigned sex at birth. As Dr. Turban explains, Defendants and their experts conflate the terms "children" and "adolescents," which have distinct meanings when it comes to child and adolescent psychiatry. (Turban Decl. ¶ 21 ("'child' and 'children' refers to a child who has not

yet reached the earliest stages of puberty. The term 'adolescent' refers to a minor who has begun puberty.").) All of Defendants' claims about "children" ultimately coming to identify as non-transgender are based on studies with serious methodological limitations, but even putting those methodological limitations aside, those studies relate only to *pre-pubertal children*, none of whom would be receiving any of the prohibited treatment. (*Id.*; *see also* Hutchison Decl. ¶ 8 ("There are no medical treatments indicated or provided for pre-pubertal children with gender dysphoria.").) "[O]nce a transgender youth reaches the earliest stages of puberty, it is extremely rare for them to later identify as cisgender." (Turban Decl. ¶ 22.)

Relatedly, Defendants' experts also misrepresent the "watchful waiting" treatment modality that is followed by some practitioners largely outside of the United States.[6] They claim that this approach entails not offering gender-affirming medical interventions to transgender adolescents. But the "watchful waiting" model refers only to the treatment of pre-pubertal youth and is an approach in which one does not implement any interventions to try to push a pre-pubertal child to identify as cisgender, but also does not advise a social transition until puberty. (Turban Decl.

[6] Dr. Levine cites a paper by Dr. James Cantor that criticized The American Academy of Pediatrics policy statement regarding the treatment of transgender youth. That criticism focused only on the treatment of pre-pubertal children and primarily defends the watchful waiting approach for these children. He does not criticize gender-affirming medical care for transgender adolescents. (Turban Decl. ¶ 23.)

¶¶ 31-32.) This approach is not relevant to transgender youth who have reached puberty (*i.e.*, adolescents) and in no way suggests any limitation on medical treatment for adolescents. In fact, the "watchful waiting" approach was developed by the same clinic in Amsterdam that was also the first to develop and recommend pubertal suppression for transgender adolescents. (*Id.*) In other words, this is a form of treatment that has no relevancy for the population of minors impacted by the Health Care Ban, but the Defendants nonetheless conflate the experiences of pre-pubertal children with those of adolescents in order to defend the Health Care Ban.[7]

Additionally, there is no data to support Defendants' claim that gender-affirming care for adolescents or social transition for pre-pubertal children increases the likelihood that a minor will be transgender in adulthood. As Dr. Turban explains, "recent research has shown . . . gender identification is not significantly different before and after a social transition." (Turban Decl. ¶ 24.) The fact that a significant percentage of pre-pubertal youth who undergo social transition or adolescents who initiate medical treatment ultimately continue to identify as transgender is because

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[7] Defendants submitted declarations containing anecdotal experiences of adults who regretted earlier decisions to transition, and their experts suggest that regret and "de-transitioning" is common and a reason to prevent transition among adolescents. But as Dr. Turban explains, transition regret is exceedingly rare and even in the cases where it does happen it is often "social regret" (*e.g.*, related to discrimination and rejection) rather than "true regret." (Turban Decl. ¶ 25.)

they had a “stronger discordance between their sex assigned at birth and their gender identity to begin with,” were properly evaluated, and were treated appropriately. (*Id.*) There is simply no data to support the contention that treatment makes people transgender.

Ultimately Dr. Levine’s views and recommendations about care seem to be informed by his opinion that it is inherently harmful to be transgender because of the medical interventions that may be necessary to treat gender dysphoria over the course of one’s lifetime, and his assumption that tran

Defendants' experts suggest that gender-affirming medical care should be categorically banned because doctors rush to treat minors without thoroughly evaluating their patients, screening for and addressing other mental health conditions, and adequately informing their patients and their parents of the potential risks and benefits of the treatment. (*See* Levine Decl. ¶ 36; Hruz Decl. ¶¶ 73-74, 79.) This description is inconsistent with the protocols for assessing and treating gender dysphoria and the rigorous requirements that must be met before the initiation of gender-affirming medical treatments, recited in full in Plaintiff's Opening Brief. (*See also* Brief of Amici AAP, *et. al.*, at 10-11; Adkins Decl. ¶¶ 33-35, 49; (Anthe i Am pr.2 o(theon)8

(evidenced by long-lasting and intense gender dysphoria that worsened with the onset of puberty); (2) that "any coexisting psychological, medical, or social problems" have been addressed; (3) that the patient and their family is informed of the risks with hormone treatment, "including potential loss of fertility" and options to preserve fertility, and has given informed consent; (4) that puberty has started (verified by a pediatric endocrinologist or similar clinician); and (5) that there are no medical contraindications to treatment. (Adkins Decl. ¶¶ 31-35.) For hormone therapy, the Endocrine Society Guidelines have additional requirements that the adolescent "has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment," and that they have been "informed of the (irreversible) effects and side effects of treatment," and they and their parents have given informed consent. (*Id.*)

Defendants' experts' characterization of the work of doctors who treat youth with gender dysphoria is at odds with the accepted protocols and the experience of doctors like Dr. Hutchison and Dr. Adkins. (Adkins Supp. Decl. ¶ 11; Hutchison Decl. ¶ 4.) In Dr. Adkins' clinic, each patient is met first by mental health providers who explore the patient's medical and mental health history and identity. (Adkins Supp. Decl. ¶ 11.) All patients are treated by a multi-disciplinary team that includes a social worker, psychologist, psychiatrist, and endocrinologist. (*Id.*) Patients who

are found to have other mental health diagnoses are treated by the mental health team, and medical treatment for gender dysphoria is not initiated without written confirmation from the team that those conditions are well-managed and the patient is stable. (*Id.*) There is an extensive informed consent process going through every potential side effect and risk verbally, then in writing, then verbally a second time. (*Id.*; *see also* Hutchison Decl. ¶ 4 ("The Clinic has an interdisciplinary team, including mental health providers, to ensure each child receives appropriate and necessary care. We require all of our patients to be receiving mental health counseling while they are in treatment at the Clinic."); Stambough Decl. (ECF No. 11-10) ¶ 4.)[8] As Dr. Turban also explains, the WPATH guidelines have extensive requirements for evaluating patients and require that "before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken." (Turban Decl. ¶ 39.)

Defendants offer no evidence that failure to comply with the protocols for evaluation and informed consent is happening systematically. And even if it were, there are other mechanisms available to the State to address this other than categorically banning treatment and denying patients who need access to care.

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[8] Dr. Levine's comparison between the prohibited care and the Tuskegee experiments and "Nazi and Imperial Japanese wartime experimental research on prisoners" (Levine Decl. ¶ 112) is preposterous. (Antommaria Decl. ¶ 25.)

Defendants' experts' asserted concerns about unscrupulous practices by medical providers appear to be related to their focus on so-called "social contagion" or "rapid onset gender dysphoria." (Hruz Decl. ¶¶ 29, 69; Levine Decl. ¶ 14.) They say exposure to social media influencers talking about being transgender causes youth to identify as transgender, and that groups of teenage girls influence one another to identify as transgender. (Hruz Decl. ¶ 29; Levine Decl. ¶ 15.) Dr. Hruz says many girls come out as transgender after seeing YouTube "training" or "following school 'gender training' programs." (Hruz Decl. ¶ 29.) As Dr. Turban explains, the entirety of this discussion is a fringe view without any evidentiary support. (Turban Decl. ¶¶ 41-45.) This concept emerged in an article from Dr. Leah Littman where she discussed both the concept of "social contagion" and what she called "rapid onset gender dysphoria." A formal correction to the paper was issued, and it was explained that "[r]apid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis" and "the term should not be used in any way to imply that it explains the experiences of all gender dysphoric youth." (Turban Decl. ¶ 41.) And the Littman paper that originated the term was based only on interviews of parents (and not adolescents) who reported that their child's transgender identity came on "suddenly." But as Dr. Turban explains, this is more likely explained by adolescents hiding their gender identity for fear of parental rejection, as has been the experience of many lesbian and gay people. (*Id.*) Ultimately, the increase in referrals to gender

clinics and an increase in the number of young people identifying as transgender is not explained by "social contagion" but rather by increased societal acceptance, effective medical treatment and insurance coverage, and general support. (*See* Turban Decl. ¶¶ 42-43.)[9]

But even if one were to accept Defendants' claim that there is a fad among adolescent girls to identify as transgender, individuals who do not have gender dysphoria and do not meet the requirements for treatment under the Endocrine Society Guidelines will not be provided treatment. (*See*, *e.g*., Adkins Supp. Decl. ¶ 12; *see also supra* at 15-17 (discussion regarding the extensive mental health screening required to initiate treatment under existing guidelines).) And such a phenomenon would certainly not be a basis to deny medically needed care to adolescents who actually are suffering from gender dysphoria.

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[9] Defendants also point to changing demographics at genderggrarpie-2.297 07.64 Tm(

Defendants' experts suggest that the risks and consequences of gender-affirming medical care are uniquely harmful and should be treated differently than all other areas of pediatric medicine and be banned. Though minors and their parents are afforded the opportunity to assent, in the case of the minor, and consent, in the case of the parents, to all other medically accepted treatments once they are informed of the risks and benefits, including those that have significant risks, Defendants' position is that no one should have the ability to consent to gender-affirming care for minors. They specifically focus on the irreversibility of some treatments and the potential that the treatment may result in sterilization. But many permitted treatments have significant risks, which patients and their parents can consent to if they, with the advice of their doctors, deem the benefits to outweigh the risks. (Antommaria Decl. ¶¶ 45-46.) Defendants' experts' quarrel here is due, at least in part, to their failure to appreciate the harms in denying medical treatment for gender dysphoria—severe distress that can result in self-harm and suicidality. (Adkins Decl. ¶¶ 50-55; Hutchison Decl. ¶¶ 13-17; Sabrina Jennen Decl. ¶¶ 4, 11; *see* Levine Decl. ¶ 81 (characterizing the pain of gender dysphoria as "relatively minor").)

Though Defendants' experts warn of the risk of infertility related to gender-affirming hormone therapy, all patients are informed of this risk and options for

fertility preservation, and many transgender individuals are still able to conceive children after undergoing hormone therapy.[10] (Adkins Decl. ¶ 45; Adkins Supp. Decl. ¶ 17.) More generally, many medical interventions that are necessary to preserve a person's health and well-being can impact an individual's fertility (*e.g*. certain cancer treatments), but treatment is still provided after informed consent.

is a sociologist who studies sexual relationship behavior and decision-making. (Regnerus Decl. ¶¶ 1-2, Exhibit A (curriculum vitae).) He has no experience relevant to this case. The last time he testified on a topic about which he had no experience in a case involving LGBTQ+ issues, he was discredited by the Court. *See DeBoer* v. *Snyder*, 973 F. Supp. 2d 757, 766 (E.D. Mich. 2014) (marriage equality case), *rev'd on other grounds*, 772 F.3d 388 (6th Cir. 2014), *rev'd sub nom. Obergefell* v. *Hodges*, 576 U.S. 644 (2015). The Court found Prof. Regnerus's testimony "entirely unbelievable and not worthy of serious consideration" because "[t]he evidence adduced at trial demonstrated that his 2012 'study' was hastily concocted" for the purpose of opposing marriage equality litigation approaching the Supreme Court. *Id.*

Dr. Levine's testimony has also been discredited by several courts, all in cases in which he was offering testimony about the treatment for gender dysphoria. *See Norsworthy* v. *Beard*, 87 F. Supp. 3d 1164, 1188–89 (N.D. Cal. 2015) (finding Dr. Levine's testimony "not credible because of illogical inferences, inconsistencies, and inaccuracies," and noting that his report misrepresents the standards of care and "admittedly includes references to a fabricated anecdote"); *Edmo* v. *Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1126 (D. Idaho 2018), *order clarified*, No. 1:17-CV-00151-BLW, 2019 WL 23195

Mayer, PH.D. in Support of Petitioner at 22, *Gloucester Cty. Sch. Bd.* v. *G.G. ex rel. Grimm*, 137 S. Ct. 1239 (2017) (mem.) (No. 16-273) ("[C]onditioning children into believing that a lifetime of impersonating someone of the opposite sex, achievable only from chemical and surgical interventions, is a form of child abuse.").

Ultimately, all of Defendants' experts are oriented towards ideological opposition to transgender people and recite discredited views that cannot justify an unprecedented intrusion by the State into widely accepted and life-saving medical care.[12]

In issuing a preliminary injunction, the Court assesses: (1) the threat of irreparable harm to the moving party; (2) the balance between this harm and the injury that granting the injunction will inflict on the non-moving party; (3) the probability that the moving party will succeed on the merits; and (4) the public interest. *Turtle Island Foods, SPC* v. *Thompson*, 992 F.3d 694, 699 (8th Cir. 2021). The Court's consideration of these factors is flexible, and no single factor is in itself dispositive. Plaintiffs have put forth substantial evidence showing that they are likely to suffer irreparable harm if the Health Care Ban is allowed to take effect, that

[12] The brief filed by Alabama and other states as *amici curiae* (ECF No. 49) repeats the same erroneous arguments proffered by Arkansas and offers nothing to inform the Court's analysis here.

the balance of equities tips in Plaintiffs' favor, and that they are likely to succeed on the merits. The preliminary injunction standard does not, as Defendants claim, create an additional burden that Plaintiffs must meet to obtain a preliminary injunction. (Defs. Br. at 33.) Instead, as the Eighth Circuit explained in *Rounds*, it means "a party seeking a preliminary injunction of the implementation of a state statute must demonstrate more than just a 'fair chance' that it will succeed on the merits," and the district court must "make a threshold finding that a party is likely to prevail on the merits." *Planned Parenthood Minn., N.D., S.D.* v. *Rounds*, 530 F.3d 724, 731-32 (8th Cir. 2008). Plaintiffs have(n)8.3 (2 (e198 (on ofp2 (e198 (on3 (.0(s m)4.2 (u)

(Pls. Op. Br. at 13-19.) This is sufficient to establish standing to bring Plaintiffs' claims challenging the constitutionality of the Health Care Ban's prohibition of this category of treatment and to seek an injunction prohibiting Defendants from enforcing this section of the Health Care Ban. *Webb ex rel. K.S.* v.

Southeastern Pennsylvania v. *Casey*, 505 U.S. 833, 887-88 (1992). Because the Health Care Ban contains a public enforcement mechanism, Plaintiffs have standing to challenge the law, including the private right of action.[14]

Defendants assert that Plaintiffs ask this court to "expand the holding of decisions granting third-party standing to abortion practitioners so that it covers all doc

(2004)). The Doctor Plaintiffs meet the third-

Defendants similarly repeat their argument that the Doctor Plaintiffs lack standing because four transgender minors have also brought claims. (Defs. Br. at 42.) But it is often the case that both patients and physicians together have standing to challenge the law, and the fact that some transgender patients are plaintiffs does not negate the Doctor Plaintiffs' standing. For example, in

woman's claim."). Defendants incorrectly assert that minors seeking gender-affirming care "do not face the same mootness problem faced by pregnant women." (Defs. Br. at 41 n.99). Each of the Doctor Plaintiffs' minor patients will turn 18 years old within a period of months or years, and therefore no longer be subject to the Health Care Ban. Moreover, the fact that some transgender minors affected by the Health Care Ban are plaintiffs in this case does not negate the significant hindrance for many others who desire to protect the privacy of their medical decisions and transgender status. *See Singleton*, 428 U.S. at 117 (the patients' hindrance need not be "insurmountable").

As Plaintiffs explain in their Opening Brief, by banning medical care only for "gender transition," thereby singling out for unique prohibition care designed to bring a patient's body into alignment with their gender identity rather than their sex assigned at birth, the Health Care Ban discriminates on the basis of transgender status and sex. (Pls. Op. Br. at 24-30, Opp. to Mot. to Dismiss at 16-24.) None of the interests advanced by Defendants justifies the Health Care Ban under any level of scrutiny.

Arkansas's Health Care Ban is subject to heightened scrutiny under the Equal Protection Clause because it discriminates based on transgender status and sex, including non-conformity with sex stereotypes, and because it bars treatment solely based on whether or not the State considers the treatment to be in alignment with a person's "biological sex." (*See generally* Statement of Interest of the United States (ECF No. 19) at 5-17 (arguing that the Health Care Ban is subject to heightened scrutiny because it discriminates on the basis of transgender status and sex).)

1. <u>The Health Care Ban Discriminates Based on Transgender Status.</u>

Defendants take great pains to argue that the Health Care Ban, which categorically prohibits care related to "gender transition," does not discrim 414.08.2 5

scrutiny. *See*, *e.g.*, *Phillips* v. *Martin Marietta Corp.*, 400 U.S. 542, 543-44 (1971)

undergo. The Health Care Ban does not establish a generally applicable requirement that all medical treatment for minors satisfy some state-defined test of scientific rigor or physiological verification or FDA label-use. Rather, the *only* care prohibited by the Health Care Ban is care prescribed, administered, or referred for "gender transition." *See* ARK. CODE ANN. § 20-9-1502(a)-(b).[16] Where a law targets "gender transition"—a process that only transgender people undergo—it discriminates based on transgender status. *Karnoski* v. *Trump*, 926 F.3d 1180, 1201 (9th Cir. 2019) (holding that a policy banning individuals who have undergone "gender transition" from open military service discriminates on the basis of transgender status).

Third, Defendants' argument that the Health Care Ban does not discriminate based on transgender status because no child can undergo "gender transition" strains credulity. (Defs. Br. at 52, 74 (claiming that the Health Care Ban "appl[ies] evenhandedly to all" children).) It is not unlike arguments raised in defense of unconstitutional bans on marriage for same-sex couples. Marriage bans restricted civil marriage to one man and one woman. In defense of the bans, many states argued that they did not discriminate based on sexual orientation because no one, regardless of sexual orientation, could marry a person of the same sex. *See*, *e.g.*, *Baskin* v. *Bogan*, 12 F. Supp. 3d 1144, 1160 (S.D. Ind. 2014) ("Defendants respond

[16] The Health Care Ban, 2021 ARK. ACTS 626, will be codified at ARK. CODE ANN. 20-9-1501-1504.

that the marriage laws do not discriminate against same-

minors, while allowing coverage for other medical treatments for gender dysphoria.[18] No. CV-20-00335, 2021 WL 1192842 at *9 (D. Ariz. Mar. 30, 2021). In contrast, Arkansas has banned all medical care related to "gender transition," thereby discriminating against transgender people as a class. *Karnoski,* 926 F.3d at 1201.

2. The Health Care Ban Discriminates Based on Sex.

In addition to triggering heightened scrutiny because it discriminates based on transgender status, the Health Care Ban triggers heightened scrutiny because it discriminates on the basis of sex. (*See* Pls. Op. Br. at-8.ioB4T(B)4.3 (1 Tf0 (.)65 (hn d)8(t)8.5s9

individual employee because of that individual's sex an independent violation."); *see also Waters* v. *Ricketts*, 48 F. Supp. 3d 1271, 1282 (D. Neb.) ("The 'equal application' of [marriage] laws to men and women as a class does not remove them from intermediate scrutiny."), *aff'd,* 798 F.3d 682 (8th Cir. 2015).

Where the state "intentionally penalizes a person identified as male at birth for traits or actions that it tolerates in [someone] identified as female at birth . . . sex plays an unmistakable and impermissible role." *Bostock*, 140 S. Ct. at 1741-42. Under the Health Care Ban, care is prohTc 0.004a

and may involve social, legal, or physical changes." *Id*. Accordingly, what the

2637992 (U.S. June 28, 2021); *Karnoski*, 926 F.3d at 1200. Defendants devote ten pages to arguing that transgender people have not faced a history of discrimination, do not share any defining characteristics, and do not lack political power. (Defs. Br. at 57-67.) But their arguments distort both the test for a suspect class and the historical and contemporary realities facing transgender people.

The last century of American law and history is replete with examples of intentional and ongoing discrimination against transgender people. *See G. G.* v. *Gloucester Cty. Sch. Bd.*, 853 F.3d 729, 730 (4th Cir. 2017), as amended (Apr. 18, 2017) (Davis., J., concurring) (recognizing that discrimination against transgender people is part of our country's "long and ignominious history of discriminating against our most vulnerable and powerless."). "[O]ne would be hard-pressed to identify a class of people more discriminated against historically . . . than transgender people." *Grimm*, 972 F.3d at 610 (internal quotations omitted). Defendants disagree with this conclusion but do not—and cannot— s21

Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States,* Harvard Univ. Press 2002, at 246-53 (tracing history of anti-transgender laws and policies in the United States).

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immutable; they are so fundamental to one's identity that a person should not be required to abandon them.'"); *Love* v. *Beshear*, 989 F. Supp. 2d 536, 546 (W.D. Ky. 2014) ("As to immutability, the relevant inquiry is not whether a person *could*, in fact, change a characteristic, but rather whether the characteristic is so integral to a person's identity that it would be inappropriate to require her to change it to avoid discrimination."). As courts have recognized, the question is whether the trait is one a person should have to change in order to secure one's rights as an individual—even if such a choice could be made. *See Wolf* v. *Walker*, 986 F. Supp. 2d 982, 1013 ("[R]egardless whether sexual orientation is immutable, it is fundamental to a person's identity, which is sufficient to meet this factor.") (internal quotation marks and citations omitted). As Dr. Adkins explains, "[A] person's gender identity (regardless of whether that identity matches other sex-related characteristics) is fixed, is not subject to voluntary control, [and] cannot be voluntarily changed." (Adkins Decl. ¶ 21.)[20] Being transgender is not something that one could or should

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explained in *Grimm*, "[a] transgender person's awareness of themselves as male or female is no less foundational to their essential personhood and sense of self than it is for those [who are not transgender]. History demonstrates that this self-conception is unshakeable indeed." *Grimm*, 972 F.3d at 624 (Wynn, J., concurring).

The "political powerlessness" question is not, as Defendants argue (Defs. Br. at 65), solely about representation among elected officials, but rather about whether transgender people are "in a position to adequately protect themselves from the discriminatory wishes of the majoritarian public." *Windsor* v. *U.S.*, 699 F.3d 169, 185 (2d Cir. 2012), *aff'd sub nom. United States* v. *Windsor*, 570 U.S. 744, 770 (2013). As this legislative session in Arkansas alone demonstrates, they are not. This year Arkansas considered at least 8 bills aimed at limiting rights for transgender people, four of which became law. (Compl. ¶¶ 58-63.) In 2021, lawmakers across the country introduced over 100 bills restricting rights for transgender people and at least 13 became law,[22] despite the fact that transgender people already face staggeringly high rates of discrimination in employment, health care, education, and

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the fact that some people's understanding of their gender identity changes over time or have non-binary identities does not mean that someone's gender identity can be changed by external forces. (*See*

Heightened scrutiny imposes a "demanding" standard on the government to demonstrate an "exceedingly persuasive" justification for its differential treatment. *VMI*, 518 U.S. at 533. The government "must show at least that the [challenged] classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *Id*. (internal quotation marks and citations omitted). A court must assess the law's "actual purposes and carefully consider the resulting inequality to ensure that our most fundamental institutions neither send nor reinforce messages of stigma or second-class status." *SmithKline Beecham Corp.* v. *Abbott Lab'ys*, 740 F.3d 471, 483 (9th Cir. 2014). And in so doing, the court "retains an independent constitutional duty to review factual findings where constitutional rights are at stake." *Gonzalez* v. *Carhart*, 550 U.S. 124, 1“in4,6.1 ( )(n)-8.3 (a)4.2 (t)0.5 (o)-4.5 (.)6(4,)6.1 (.3 (s e)30.004 aGv

the medical profession.[24] But the means that the government has employed—categorically banning medical treatment for gender transition in minors—do not substantially advance those objectives.

In defense of the Health Care Ban, Defendants raise a series of purported concerns about medical treatment for gender transition, but none of the concerns raised are unique to the care banned by the law and many of the concerns are based on a mischaracterization of the science. *See supra,* Section I (summarizing Defendants' mischaracterization of the scientific evidence supporting treatment guidelines for transgender minors).

First, Defendants argue that the Health Care Ban is justified because of a lack of evidence of the treatment's efficacy. (Defs. Br. at 78-82.) This argument ignores significant data about gender-affirming medical treatment. As Dr. Antommaria and Dr. Turban detail, there is a substantial body of research that has tested the efficacy and safety of treatment for transgender minors, which has formed the basis for the Endocrine Society Guidelines as well as the consensus within the American medical community about the recommended use of this care. (*See* Antommaria Decl. ¶¶ 32-36 (detailing studies); Turban Decl. ¶¶ 12-14 ; *see also* Br. of Amici AAP *et. al.* at

[24] Though Defendants separately enumerate these two governmental interests, the analysis they offer combines them, and Plaintiffs respond to the asserted justifications together.

12-15 (noting, among other things, that "multiple studies have revealed long-term positive outcomes for transgender people who have undergone puberty suppression") (internal citation omitted).) Defendants' argument also ignores the clinical experience of doctors who see the positive effects of treatment in their patients. (*See* Turban Decl. ¶ 18 (noting clinical experience from around the world showing the effectiveness of gender-affirming treatments for adolescents).) As Dr. Adkins explained of her experience treating over 400 transgender patients: "My patients who receive medically appropriate hormone therapy and who are treated consistent with their gender identity in all aspects of life experience significant improvement in their health." (Adkins Decl. ¶ 50.) Dr. Adkins' experience mirrors that of Dr. Hutchison in Arkansas who explained that for her 160 patients, gender-affirming treatments prevent them "from suffering the severe emotional and physical consequences of going through puberty that does not match their gender identity." (Hutchison Decl. ¶ 6.)

As for Defendants' assertion that the evidence showing the benefits of gender-affirming medical care is not of sufficient quality, as Dr. Antommaria explains, many treatments accepted within pediatric medicine are utilized with equal or lower quality evidence than what is available for the treatment of gender dysphoria. (*See* Antommaria Decl. ¶¶ 21, 39-40.) If Defendants' concern is about harm to minors through the administration of medication and treatment that has not been validated

by what they consider "high quality" evidence, banning *only* gender-affirming care is wildly underinclusive. *Republican Party of Minnesota* v. *White*, 536 U.S. 765, 780 (2002) (a law did not serve a government interest where it was "woefully underinclusive as to render belief in that purpose a challenge to the credulous").

And while Defendants critique the data supporting the accepted treatment paradigm for gender dysphoria in adolescents, the alternatives they propose—"watchful waiting" and psychotherapy alone—have not proven effective for adolescents by *any* scientific study. (Levine Decl. ¶ 35; Antommaria Supp. Decl.

Third, many of the claimed risks of gender-affirming care that Defendants use to justify the ban are inaccurate and apply to other non-banned treatments. Regarding Defendants' claims that gender-affirming treatment is sterilizing, Dr. Adkins explains: "Many people undergo fertility preservation before any treatment

(Antommaria Decl. ¶¶ 45-46.) And treatment protocols for gender-affirming medical care follow established principles of informed consent. (Antommaria Supp. Decl. ¶¶ 16-24.) Moreover, the Health Care Ban permits all of the banned treatments, including genital surgery, if provided to intersex minors, which carry all of the risks cautioned by Defendants they claim justify the Health Care Ban. (*See* Antommaria Decl. ¶ 49.)

Fourth, Defendants' experts erroneously suggest that most young people affected by the law will "outgrow" their transgender identity absent treatment. (Levine Decl. ¶ 8(e).) As stated above, Defendants and their experts conflate the terms "children" and "adolescents," which have distinct meanings. No medical treatment is provided under the accepted protocols until after the onset of puberty. While some practitioners, largely outside of the United States, follow the approach of "watchful waiting" for pre-pubertal *children*, there is no such approach applied to transgender adolescents because there is no evidence of a likelihood of "desistance" once individuals reach adolescence. (Turban Decl. ¶¶ 21-23, 31.)

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for minors with gender dysphoria results in predictable and dire harms. (*See* Pls. Op. Br. at 43; Turban Decl. ¶¶ 12-14.)

Though the Health Care Ban's discrimination based on transgender status and sex triggers heightened scrutiny, the law fails under any level of scrutiny. As discussed above and in Plaintiffs' Opening Brief, the stated justifications for banning gender-affirming care for minors "ma[k]e no sense in light of how" Arkansas treats other types of care. *Bd. of Trustees of Univ. of Ala.* v. *Garrett*, 531 U.S. 356, 366 n.4 (2001) (citation omitted). But beyond that, "[t]he history of [the statute's] enactment and its own text demonstrate that" the purpose of the Health Care Ban was to express Arkansas's moral and social disapproval of transgender people. *Windsor*, 570 U.S. at 770. Under any standard of review, laws that have the "peculiar property of imposing a broad and undifferentiated disability on a single named group" are "invalid." *Romer* v. *Evans*, 517 U.S. 620, 632 (1996). And that is precisely what Arkansas's Health Care Ban does to transgender minors.

The Health Care Ban is "at once too narrow and too broad." *Id.* at 633. If the object of the law, as Defendants suggest, is to ban care that does not meet certain standards of evidentiary support, has potential side-effects or risk, or is in some way "irreversible," then the law is entirely too narrow, only covering a tiny subset of care that might fall into one of those categories. *See supra*, Section I. It is likewise too

broad as it reaches all gender-affirming care regardless of whether it falls into one of those categories. Ultimately, the purpose of the law is not to protect minors by limiting care that may cause particular harms, but rather to limit care that tends to affirm one's gender identity when it differs from that individual's assigned sex at birth. Indeed, this is spelled out in the text of the law itself. ARK. C

and to seek and follow medical advice." *Parham* v. *J.R.*, 442 U.S. 584, 602 (1979).[25] Defendants' assertion that Plaintiffs seek a "significant expansion of current substantive-due-process doctrine" (Defs. Br. at 90) is simply incorrect: the fundamental right of parents to direct their children's medical care is well-established. *Kanuszewski* v. *Mich. Dep't of Health and Human Servs*, 927 F.3d 396, 419 (6th Cir. 2019) ("[P]arents' substantive due process right to make decisions concerning the care, custody, and control of their children includes the right to direct their children's medical care.") (citation and internal quotation marks omitted).

Defendants also assert that Plaintiffs claim a right to parental autonomy that H that8

in dealing with children when their physical or mental health is jeopardized.”). Defendants’ attempt to distinguish *Kanuszewski*, 927 F.3d at 419, on the basis that it held that “[t]his does not mean that parents’ control over their children is without limit” is misplaced. (Defs. Br. at 92.) *Kanuszewsks.( )Tj0.004-0.0(-)6.25 Tr54(o)8(usze)c8.2 (k*

offer no support for their argument that the Health Care Ban "comes close to perfect" tailoring to the State's interest. (Defs. Br. at 94.) This could not be further from the truth. If the Health Care Ban takes effect, all transgender adolescents with gender dysphoria in Arkansas will be categorically prohibited from receiving gender-affirming care, irrespective of the individual patients' circumstances and regardless of whether it is medically indicated, medically necessary, or in that patient's best interest. Moreover, adolescents who are currently receiving such care will be immediately required to stop treatments, with no regard as to their safety or well-being. Such a tactic—which ignores an individualized approach to care and the best interests of the adolescent—not only belies Defendants' naked assertion that they have an interest in protecting minors, but also belies Defendants' assertion that the law is narrowly tailored. And the Health Care Ban leaves untouched numerous forms of medical care that raise the same concerns proffered by Defendants and, in fact, expressly allows treatments that raise those same concerns when provided to intersex children to conform their bodies to their "biological sex." ARK. CODE ANN. § 20-9-1501(6)(B). This is not merely imperfect tailoring; it is a complete disconnect between the stated concerns and law.

In Governor Hutchinson's words, the Health Care Ban creates "new standards of legislative interference with physicians and parents as they deal with some of the

most complex and sensitive matters concerning our youths."[28] (*See* Pls. Op. Br. at 9-10.) Rather than the State making these choices, legally-competent parents should be empowered to seek and follow these well-accepted medical treatments. By prohibiting them from doing so, thus exposing their children to unnecessary harm, the Health Care Ban violates the Due Process Clause.

Plaintiffs are therefore likely to succeed on the merits of their due process claim.

Defendants attempt to avoid the First Amendment's application to the law's ban on referring individuals under the age of 18 for gender-affirming care (the "Referral Prohibition") by ignoring the plain language of the Referral Prohibition, binding case law cited in Plaintiffs' briefs, and Plaintiffs' arguments in Plaintiffs' Opening Brief and in Plaintiffs opposition to Defendants' Motion to Dismiss (at 52-57 and 38-45, respectively).

Defendants argue that the Referral Prohibition is not subject to the First Amendment because it "regulates conduct and not speech." (Defs. Br. at 95.) This is a false distinction because the "conduct" that is prohibited *is speech*. A referral is

[28] "Governor Asa Hutchinson Holds Pen and Pad Session with Local Media," April 5, 2021, at 9:16, http://www.youtube.com/watch?v=9Jt7PxWkVbE.

the act of providing information to assist a patient in seeing another health care provider for care, and it therefore is speech within the meaning of the First Amendment. *See Sorrell* v. *IMS Health Inc.*, 564 U.S. 552, 570 (2011) ("[D]issemination of information [is] speech within the meaning of the First Amendment.").

To support their argument that the Referral Prohibition does not regulate speech, Defendants turn to a discussion of "referrals" in the WPATH Guidelines. (Defs. Br. at 95.) After reading that source, Defendants say "referring" means to

"[h]ealth professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service," demonstrating that a referral constitutes more than just a ministerial transfer of documents. (ECF No. 45-19 at 26.) *See Bartnicki*, 532 U.S. at 514 ("It is true that the delivery of a tape recording might be regarded as conduct, but given that the purpose of such a delivery is to provide the recipient with the text of recorded statements, it is . . . 'speech' that the First Amendment protects . . . .").

Defendants next argue that the Referral Prohibition is valid because even if it prohibits speech, states are permitted to regulate such professional speech so long as the practice sought to be regulated is "tied to a procedure." (Defs. Br. at 96 (citing *Nat'l Inst. of Fam. & Life Advocs.* ("*NIFLA*") v. *Becerra*, 138 S. Ct. 2361, 2373, (2018).)

This argument misreads *NIFLA*'s clear holding. *NIFLA* holds that speech is only afforded less protection "in two circumstances—neither of which turn[] on the fact that professionals [are] speaking": (1) when laws "require professionals to disclose factual, noncontroversial information in their 'commercial speech'"; and (2) when the state regulates "conduct that incidentally involves speech." *NIFLA,* 138 S. Ct. at 2372. *NIFLA* simply does not hold that states are permitted to infringe the First Amendment when the speech in question is "tied to a procedure." In *NIFLA*,

hold, as Defendants suggest, that a law may forbid speech so long as a plaintiff is able to practice other procedures. As explained further in Plaintiffs' Opposition to Defendants' Motion to Dismiss, *Rust* did not concern whether the government could prohibit certain speech, but whether it could fund only certain speech. (Opp. to Mot. to Dismiss at 43.) *See also Planned Parenthood of Mid-Missouri & E. Kansas, Inc.* v. *Dempsey*, 167 F.3d 458, 461 (8th Cir. 1999) (explaining that *Rust* is about government funding of projects); *Conant* v. *Walters*, 309 F.3d 629, 638 (9th Cir. 2002) (*Rust* "did not uphold restrictions on speech itself. *Rust* upheld restrictions on federal funding for certain types of activity, including abortion counseling, referral, or advocacy"). Moreover, the Court in *Rust* found that291 TTw 0.214 0 Tdc.5 (r)3.7 (t)4 Twd(nc

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gender-affirming care relieves the distress caused by gender dysphoria. (Defs. Br. at 99-100.)

These claims by Defendants are meritless. They ignore the established consensus of medical associations in the United States on these issues. They ignore the facts discussed by Plaintiffs' experts, including those discussed at length in

parents whose children have been expressing suicidal thoughts directly related to the prospect of losing their gender-affirming care. (Hutchison Decl. ¶ 13.)

Considering all of the psychological and potential physical harm in addition to the harm to Plaintiffs' constitutional rights under the First and Fourteenth Amendments, it is undeniable that allowing this law to go into effect will cause real and lasting harm to Plaintiffs and to many young transgender people and their families throughout Arkansas. In light of the severe and irreparable harms the

posture. (*See* Defs. Br. at 99-102.) This recharacterization is not only illogical, it also disregards the law's denial of care that several of the minor Plaintiffs (and numerous other Arkansans) have already been receiving for months or years and ignores the long-standing availability in Arkansas of the exact same care that the State only now attempts to ban. A change from allowing such medically necessary care to prohibiting it does not maintain the status quo; it upends it. A preliminary injunction is necessary to maintain the current posture and prevent irreparable harm during the pendency of this case.

Even setting aside that a preliminary injunction would work only to preserve the status quo, Defendants have presented no evidence, nor did legislators ever point to a single example, of a young person in Arkansas being harmed by the lack of a ban on gender-affirming care for transgender youth. As described above, the harm to Plaintiffs from allowing the Health Care Ban to go into effect would be tangible, immediate, and irreparable. Whatever interest the State may have in enforcing the Health Care Ban during the pendency of this case pales in comparison to the certain and severe harm faced by Plaintiffs. And despite Defendants' unsupported assertions to the contrary, the "State has no interest in enforcing laws that are unconstitutional," meaning that "an injunction preventing the State from enforcing [the challenged statute] does not irreparably harm the state." *Little Rock Family Planning Servs.* v. *Rutledge*, 397 F. Supp. 3d 1213, 1322 (E.D. Ark. 2019).

Because Plaintiffs are likely to succeed in demonstrating that the Health Care Ban is unconstitutional, a preliminary injunction would best serve the public interest. *D.M. ex rel. Bao Xiong* v. *Minn. State High Sch. League*, 917 F.3d 994, 1004 (8th Cir. 2019) ("The public is served by the preservation of constitutional rights.") (citations omitted). The balance of equities favors injunctive relief to preserve the status quo until a final decision in this case.

Despite stating the correct standard to justify a facial injunction—that there is "no set of circumstances exists under which the Act would be valid," Defendants ask the Court to misapply that standard, arguing that it requires Plaintiffs to provide evidence that every transgender young person seeking gender-affirming care in Arkansas would be harmed by the Health Care Ban. (Defs. Br. at 103, citing *United States* v. *Salerno*, 481 U.S. 739, 745 (1987).) Here, there is "no set of circumstances" in which the Health Care Ban's prohibition of gender-affirming care "would be valid" because any application of the law would violate the Equal Protection rights of the affected transgender minor, their parent's fundamental right to parental autonomy, and their doctor's First Amendment rights.

Defendants are not arguing that the Health Care Ban is valid in any particular circumstance, but instead argue that Plaintiffs have failed to present evidence showing that all children who seek gender-affirming care would be irreparably

harmed by the Health Care Ban. This too is incorrect: Pla

For the reasons set forth above, Plaintiffs respectfully request that the Court grant their Motion for a Preliminary Injunction and deny Defendants' Motion to Dismiss.

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Respectfully submitted,

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