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

IN THE SEVENTH JUDICIAL DISTRICT
DOUGLAS COUNTY DISTRICT COURT
CIVIL DEPARTMENT

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

Plaintiffs,

v.

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

Defendants.

Case No. _____
Div. No. 7

BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION

Plaintiffs respectfully file this brief in support of their motion for a temporary injunction against the enforcement of SB 63, which violates their fundamental rights and equal protection under the Kansas Constitution.

I. Introduction

On February 18, 2025, the Kansas Legislature enacted—over Governor Laura Kelly's veto—Senate Bill 63, entitled the "Help Not Harm Act" ("SB 63" or the "Act"). The Act strips Kansas transgender minors and their parents of their ability to seek gender affirming medical care and allows for civil actions against healthcare providers who offer such care to minor patients, violating transgender minors' right to equal protection under the law and parents' fundamental right to the care, control, and custody of their children.

Plaintiffs respectfully request that this court enter a temporary injunction against the provisions of SB 63 that prohibit the use of puberty blockers and hormone therapy to treat gender

dysphoria in adolescents. Absent such relief, Minor Plaintiffs Lily Loe and Ryan Roe will suffer irreparable harm, including permanent changes from puberty that do not align with their gender identity. Their loving parents, Plaintiffs Lisa Loe and Rebecca Roe, will be forced to watch their children suffer needlessly because the Kansas legislature has prevented them from seeking medical care that they, their children, and their family doctors all agree is necessary and appropriate.

II. Statement of Facts

A. The Standard of Care for Treating Gender Dysphoria in Adolescents

1. Transgender People, Gender Identity, and Gender Dysphoria

Although most people have a gender identity that aligns with their sex assigned at birth, transgender people have a gender identity that differs from their birth sex. Corathers ¶ 22-23.[1] Sex is usually assigned at birth based on the observation of external physical attributes, like genitals. *Id.* ¶ 21-22. Gender identity refers to someone's inner sense of self as male, female, or something else. *Id.* ¶ 19. Being transgender is not a mental health condition to be treated or cured. *Id.* ¶ 27. Transgender people, however, may experience gender dysphoria, the medical condition marked by clinically significant distress that can arise from the incongruence between a person's gender identity and their sex assigned at birth. Corathers ¶ 25-26; Turban ¶ 12; Antommaria ¶ 32.

2. Standard of Care

When appropriately treated, gender dysphoria can be effectively managed. Corathers ¶ 37. The Endocrine Society and WPATH have each published a clinical practice guideline for the treatment of gender dysphoria in adolescents, which is supported by mainstream U.S. medical associations, including the American Academy of Pediatrics and the American Medical

[1] Plaintiffs attach the declarations of Plaintiffs Lisa Loe (Ex. 1), Lily Loe (Ex. 2), Rebecca Roe (Ex. 3), and Ryan Roe (Ex. 4), as well as expert declarations from Dr. Sarah Corathers (Ex. 5), Dr. Armand Antommaria (Ex. 6), Dr. Jack Turban (Ex. 7), and Dr. Angela Turpin (Ex. 8).

Association. Corathers ¶ 37, 75; Antommaria ¶ 37; Turban ¶ 16-17, 41. The evidence supporting those guidelines is comparable to other guidelines in pediatric medicine, i.e. they rely on a similar quality and quantity of research. Antommaria ¶ 6, 36-38.

Under those guidelines, no medical treatments are provided to pre-pubertal children with gender dysphoria. Corathers ¶ 54; Turban ¶ 31. For adolescents—i.e. young people who have started puberty—rigorous diagnostic criteria and clinical evaluations determine whether a person has gender dysphoria and would benefit from medical treatment in the form of puberty blocking medication or hormone therapy. Corathers ¶ 42, 47, 51-52; Turban ¶ 12-15. Puberty blockers temporarily pause puberty and relieve gender dysphoria symptoms by pausing further physical changes that do not match an adolescent's gender identity. Corathers ¶ 32. Hormone therapy (e.g., estrogen or testosterone) treats gender dysphoria by inducing physical changes that bring a person's body into alignment with their gender identity. *Id.* ¶ 34. These medications are all used for other purposes, including gender affirmation for non-transgender people, such as minimizing undesired facial hair in non-transgender girls with polycystic ovarian syndrome. *Id.* ¶ 71-73.

Scientific research and clinical experience demonstrate that puberty blockers and hormone therapy are safe and effective for treating gender dysphoria in adolescents. Antommaria ¶ 78; Corathers ¶ 67-70; Turban ¶ 18, 42. Though there are risks related to the use of puberty blockers and hormone therapy, no medical treatment is without risks, and the risks attendant to gender affirming medical care are the same or very similar to the risks present when those medications are used for other conditions. Antommaria ¶ 57-58; Corathers ¶ 65-66; Turban ¶ 42. Although there may be differences in the risk to fertility, gender affirming medical care does not preclude future fertility, young people are offered fertility counseling to address potential risks, and there are many other medical treatments for which parents consent and adolescent children assent that

may threaten or even foreclose future fertility. Antommaria ¶ 48-51; Corathers ¶ 57-58.

There are no evidence-based alternatives to gender affirming medical care for treating gender dysphoria. Corathers ¶ 86; Turban ¶ 25. While transgender youth may benefit from psychotherapy to support their social transition and other mental health conditions, therapy alone cannot treat gender dysphoria. Turban ¶ 26. Attempts to change someone's gender identity are harmful and unethical. Turban ¶ 27-28.

3. Gender Affirming Medical Care in Kansas

Gender affirming medical care has been available for almost a century: hormone therapy began in the 1930s after estrogen and testosterone became commercially available. Antommaria ¶ 74. Puberty blockers and hormone therapy have been used to treat adolescents since at least the 1990s, including in the United States since the early 2000s. Antommaria ¶ 33; Corathers ¶ 49. Prior to SB 63, puberty blockers and hormone therapy had been provided to minors with gender dysphoria in Kansas, including at the multidisciplinary gender clinic established at Children's Mercy Hospital in 2014. Turpin ¶ 22-26. Clinical experience of providers in the United States is consistent with research demonstrating the profound positive impact of puberty blockers and hormone therapy on transgender adolescents with gender dysphoria and the enormous negative effects when this care is delayed or denied. Corathers ¶ 48, 86; Turban ¶ 16-24; Turpin ¶ 44-53.

B. SB 63 Prohibits Puberty Blockers and Hormone Therapy for Transgender Minors

SB 63 prohibits Kansas healthcare providers from treating minors with puberty blockers or hormone therapy only to treat the incongruence between a birth sex and gender identity, i.e. "to a female child for the purpose of treatment for distress arising from such female child's perception that such child's gender or sex is not female" or "to a male child for the purpose of treatment for distress arising from such male child's perception that such child's gender or sex is not male." S.B.

63 § 3(a), (b). These treatments remain available for any other purpose. S.B. 63 § 3(c).

C. Plaintiffs

***The Loe Family*.** Lisa Loe and her 13-year old daughter Lily Loe live in Douglas County, Kansas along with Lily's two older siblings. Lily is a transgender girl in the eighth grade. Although she was assigned male at birth, Lily has always felt like a girl. Lisa Loe ¶ 4-10, 12; Lily Loe ¶ 5. Lily's life improved dramatically once she was allowed to express herself as a girl through clothing, hairstyles, and being treated as a girl in all aspects of her life. Lily Loe ¶ 6-7; Lisa Loe ¶ 16.

When Lily was in second grade, Lisa took her to be seen at Children's Mercy Hospital in Kansas City for professional medical guidance. Lisa Loe ¶ 14; Lily Loe ¶ 8. Lily was diagnosed with gender dysphoria in 2019, and because she had not yet started puberty, there were no medical interventions necessary or appropriate for her to receive then. Lisa Loe ¶ 15. Lily thrived living as a girl via social transition and had no stress around being transgender until she became increasingly anxious and hyper-vigilant about starting male puberty. Lisa Loe ¶ 18-21; Lily Loe ¶ 10.

After Lily started puberty in 2024, at age 12, and Lisa consulted with doctors about the risks and benefits of the treatment, Lily began receiving puberty blockers at Children's Mercy Hospital. Lisa Loe ¶ 22-24; Lily Loe ¶ 11-12. This treatment paused Lily's pubertal changes until she was older. *Id.* Lily felt immediate, immense relief after receiving blockers, no longer suffering from distress about growing facial hair or getting a deeper voice. *Id.*

After a year of blockers, Lily was excited about the possibility of starting estrogen so she could begin a gender-congruent puberty alongside her peers. Lisa Loe ¶ 26; Lily Loe ¶ 13. But because of SB 63, the future of Lily's care is precarious. Lily's last puberty blocker treatment was in November 2024, and after SB 63 went into effect, Lily's doctors will no longer provide her with her medication or refer her to alternative providers outside of Kansas. Lisa Loe ¶ 25-28; Lily Loe

¶ 13-14. Although Lisa—whose family has lived in Kansas for generations—has explored the possibility of relocating to a different state, the effect of uprooting her older children's lives would be devastating. Lisa Loe ¶ 33. Stopping treatment and forcing Lily to go through male puberty inconsistent with her identity and life as a girl is not an option.

The Roe Family. Rebecca Roe and her 16-year-old son Ryan Roe live in Johnson County, Kansas. Ryan is a transgender boy in tenth grade. Rebecca Roe ¶ 2-3; Ryan Roe ¶ 2-4. Starting in early childhood, Ryan would always adopt male roles in play, consistently sought to dress in boys' clothes, and told his parents at age six that he was a boy. Rebecca Roe ¶ 5-7. In 2021, after an increase in anti-transgender legislation, the Roe family left their previous home in Texas, moved to Kansas, and in his new, more accepting environment, Ryan again told his parents he felt like he was a boy, and asked to use he/him pronouns. Rebecca Roe ¶ 11, 13; Ryan Roe ¶ 6-7.

It soon became clear that social transition was insufficient to alleviate Ryan's distress about his body. Rebecca Roe ¶ 18. Ryan's parents took him to a new therapist in October 2022, who diagnosed him with gender dysphoria. Rebecca Roe ¶ 19; Ryan Roe ¶ 9. In April 2023, after a six-month wait, Ryan was seen at the clinic at Children's Mercy Hospital, where he had a multi-disciplinary evaluation and was seen by a general practitioner, a psychiatrist, a nurse, an endocrinologist, and a chaplain. Rebecca Roe ¶ 20. After confirming Ryan's gender dysphoria diagnosis, the clinic staff reviewed the risks, benefits, and alternatives to hormone therapy with Ryan's parents, who in turn considered his needs. Beginning at 14 years old, Ryan was prescribed a low dose of testosterone. Rebecca Roe ¶ 20-22; Ryan Roe ¶ 10-11. Testosterone has significantly improved Ryan's mental health and well-being. Rebecca Roe ¶ 23; Ryan Roe ¶ 11-12.

Ryan has been on testosterone for two years and continues to thrive with support from his family, therapist, and medical providers. Rebecca Roe ¶ 23-24; Ryan Roe ¶ 11-12. But SB 63

threatens his healthcare and has placed his entire family under intense stress because of the immense harm it would cause Ryan to lose the medical care he needs. Rebecca Roe ¶ 25-27; Ryan Roe ¶ 14-18.

III. Legal Standard for a Temporary Injunction

A party seeking a temporary injunction must demonstrate: "(1) The plaintiff has a substantial likelihood of eventually prevailing on the merits; (2) a reasonable probability exists that the plaintiff will suffer irreparable injury without an injunction; (3) the plaintiff lacks an adequate legal remedy, such as damages; (4) the threat of injury to the plaintiff outweighs whatever harm the injunction may cause the opposing party; and (5) the injunction will not be against the public interest." *Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 619 (2019) (*Hodes I*) (citing *Downtown Bar and Grill v. State*, 294 Kan. 188, 191 (2012)).

IV. Plaintiffs are Likely to Succeed on the Merits of Their Constitutional Claims

Plaintiffs seeking a temporary injunction "are not required to establish to a certainty that they will prevail on the merits...but only that they are substantially likely to prevail..." *Hodes & Nauser, MDs, P.A. v. Schmidt*, No. 2015CV000490, 2015 WL 13065200, at *2 (Kan. Dist. Ct. June 30, 2015) (*Hodes Temp. Inj.*). "[T]he purpose of a temporary or preliminary injunction is not to determine any controverted right, but to prevent injury to a claim right pending final determination of the controversy on its merits." *Idbeis v. Wichita Surgical Specialists, P.A.*, 285 Kan. 485, 491 (2007) (cleaned up). "Indeed, a reasonable probability of success is a much lower hurdle than meeting the applicable burden of proof at trial," *id.*, i.e. "actual success on the merits." *Steffes v. City of Lawrence*, 284 Kan. 380, 396 (2007).

A. SB 63 violates Minor Plaintiffs' equal protection rights to be free from discrimination based on their sex (Claim I) and trans status (Claim II)

SB 63 facially classifies based on sex and trans status. The law triggers heightened scrutiny

but fails under any standard of review. Section 1[2] of the Bill of Rights in the Kansas Constitution is given "much the same effect" as the "Fourteenth Amendment's guarantees of…equal protection of the law." *Farley v. Engelken*, 241 Kan. 663, 667 (1987). "Section 1 applies in cases...when an equal protection challenge involves individual rights." *State v. Limon*, 280 Kan. at 283. Equal protection includes freedom from unjustified differential treatment based on suspect classifications like sex. *See, e.g.*, *Farley*, 241 Kan. at 668-69.

1. SB 63 triggers heightened scrutiny because it classifies based on sex and transgender status

SB 63 facially classifies based on sex. SB 63 contains a sex classification because it prohibits certain medical interventions based on the sex of the minor patient. The Act does not prohibit puberty blocking medication or hormone therapy for all minors, or even for the purposes of affirming a child's gender identity, but rather only prohibits those treatments "to a female child for the purpose of treatment for distress arising from such female child's perception that such child's gender or sex is not female," S.B. 63 § 3(a), or "to a male child for the purpose of treatment for distress arising from such male child's perception that such child's gender or sex is not male." S.B. 63 § 3(b). That is, the Act facially and explicitly treats males and females differently based on their sex assigned at birth. A person whose sex is assigned as female at birth can receive estrogen to affirm her gender, but a person assigned male cannot. S.B. 63 § 3(a). Similarly, a person whose sex is assigned as male at birth can receive testosterone as a treatment to affirm his male gender identity, but a person whose sex is female cannot. S.B. 63 § 3(b).

For example, if a non-transgender adolescent boy is a "late bloomer" and suffering socially or psychologically because he is not developing along the same trajectory as his male peers, he

[2] "All men are possessed of equal and inalienable rights, among which are life, liberty, and the pursuit of happiness." K.S.A. Const. Bill of Rights § 1.

can be prescribed testosterone, even if his distress is not clinically significant and there is no medical reason for his later-than-average puberty. But a transgender adolescent boy who is suffering socially and psychologically because he is not developing male secondary sex characteristics, even if his distress is clinically significant and he has a medical need for hormone therapy to address his gender dysphoria, cannot receive testosterone. Similarly, a non-transgender girl with unwanted facial hair from polycystic ovarian syndrome can receive estrogen and testosterone blockers, but a transgender girl who has gender dysphoria because of facial hair cannot.

SB 63 facially classifies based on transgender status. SB 63 employs the definition of being transgender and is therefore a facial classification: its prohibitions hinge on the discordance between gender identity and birth sex. S.B. 63 § 3(a), (b). Only transgender minors seek medical treatment to affirm a gender or sex *different* from their sex assigned at birth, and they are categorically prohibited from doing so. That is a "per se classification" based on trans status, regardless of whether it is understood as applying based on "orientation, conduct, practices, or relationships," *Limon*, 280 Kan. at 285 (quoting *Lawrence v. Texas*, 539 U.S. 558, 574 (2003)), and "a discriminatory classification," *id.* at 286, because of the disparity between non-transgender adolescents (who can obtain treatment to affirm their gender or conform their body to their gender) and transgender adolescents (who cannot). *See also Christian Legal Society v. Martinez*, 561 U.S. 661, 689 (2010) ("Our decisions have declined to distinguish between status and conduct in this context.") (citing *Lawrence v. Texas*, 539 U.S. at 583-84 (O'Connor, J., concurring) ("While it is true that the law applies only to conduct, the conduct targeted by this law is conduct that is closely correlated with being homosexual. Under such circumstances, [the] law is targeted at more than conduct. It is instead directed toward gay persons as a class.")).

Sex and trans status classifications trigger heightened scrutiny. Sex-based

classifications must be tested under heightened or intermediate equal protection scrutiny. *See, e.g.*, *Stephenson v. Sugar Creek Packing*, 250 Kan. 768, 775-77 (1992) (explaining that gender-based classifications "must serve important governmental objectives and must be substantially related to achievement of those objectives.") (quoting *Craig v. Boren*, 429 U.S. 190, 197 (1976)). A facial sex classification is tested under heightened scrutiny even when it is purportedly based on biological differences. *See also In re K.M.H.*, 285 Kan. 53, 75 (2007) (applying intermediate heightened equal protection scrutiny to statute that treated sperm donors and sperm recipients differently, even though there are biological differences between people assigned female and male that render them differently situated with respect to conception). That is because heightened scrutiny tests whether the purported biological differences are substantially related to the government's compelling interest: to sidestep intermediate scrutiny because of a biological difference reverses the two-step analysis which begins with the classification and then proceeds to the level of scrutiny. *See, e.g.*, *Limon*, 280 Kan. at 284.

Transgender status classifications are also sex-based, triggering heightened scrutiny. *See, e.g.*, *Bostock v. Clayton County, Ga.*, 590 U.S. 644, 662 (2020). It "is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex." *Id.* at 660. Though transgender status is a "distinct concept[] from sex," discrimination based on "transgender status necessarily entails discrimination based on sex; the first cannot happen without the second." *Id.* at 669. The logic of *Bostock* that a transgender classification is necessarily a sex classification extends outside of the Title VII context to equal protection analysis under the Fourteenth Amendment. *See Fowler v. Stitt*, 104 F.4th 770, 788-94 (10th Cir. 2024) (rejecting contrary analyses from other circuits).

Transgender status classifications also independently trigger heightened scrutiny. SB 63's

prohibitions only apply to individuals who seek to affirm a gender identity different from their birth sex, i.e. transgender individuals. Merely because the Act does not use the term "transgender" does not mean it does not classify based on trans status. For example, although the statute in *Limon* contained "no per se classification of homosexuals, bisexuals, or heterosexuals in the statute," because the statute imposed a greater burden on conduct engaged in by people who were gay or bisexual, it nonetheless was "a discriminatory classification." 280 Kan. at 284-86. So too here: SB 63 imposes a greater burden on transgender individuals by categorically prohibiting medical interventions to affirm their gender identity, while permitting those same interventions for non-transgender people who seek to affirm their gender identity. That requires heightened scrutiny.

2. SB 63 fails heightened scrutiny

SB 63's sex classification cannot survive intermediate equal protection scrutiny because it is not substantially related to achieving an important government interest. *See Stephenson*, 250 Kan. at 775-77. There is no "direct relationship between the classification and the state's goal." *Farley*, 241 Kan. at 669. The government has not articulated an interest served by SB 63 and the law is dramatically over- and under-inclusive, even considering the government's potential interest in matters of regulating medical interventions, scientific rigor and evidence of efficacy, reversibility, fertility, informed consent, and regret.

Regulating medical interventions: SB 63 is not substantially related to mitigating the risks of any particular medical intervention because it prohibits *all* medical interventions to affirm gender identity in transgender adolescents while permitting *any* medical intervention to affirm gender identity in non-transgender adolescents. There are common examples of hormone treatments in pediatric endocrinology for social/emotional or gender affirming purposes in cisgender populations. Corathers ¶ 71. The risks and side effects for puberty blockers and hormone therapy are the same (or very similar) whether they are provided to transgender adolescents or

cisgender adolescents. Corathers ¶ 54, 56, 64, 70. But SB 63 prohibits those treatments entirely for youth seeking to affirm a gender identity different from their birth sex while allowing non-transgender adolescents continued access to those interventions for any reason, including to affirm their gender identity. Likewise, the Act explicitly exempts from prohibition interventions, including surgery, when provided for individuals with differences of sex development, also known as intersex variations, whose bodies do not align with "normal" binary sex characteristics "for a male or female." S.B. 63 § 3(c)(1)(A), (B). Even genital surgeries are permitted on intersex children without their consent and despite controversy, regret, infertility, and other harms documented around the practice. Antommaria ¶ 62.

Scientific rigor and evidence of efficacy: SB 63 is not substantially related to any concerns about the medical or scientific evidence demonstrating the safety and efficacy of the banned care. The evidence base for this care is comparable to the evidence for many other treatments in pediatrics. Antommaria ¶ 6. Existing research shows that this care improves the lives of transgender adolescents with gender dysphoria, and all the major U.S. medical organization highlight its importance. Turban ¶ 16-17. The majority of youth with gender dysphoria who receive this care benefit from it, as demonstrated by longitudinal and cross-sectional studies, as well as clinical experience. Turban ¶ 18; Corathers ¶ 70, 72, 84; Turpin ¶ 49. The potential benefits frequently outweigh the potential risks. Antommaria ¶ 57, 74-76; Ryan Roe ¶ 11-13, 17; Lily Loe ¶ 12-15. The efficacy of puberty blockers and hormone therapy is well-studied, with substantially long follow-up periods. Turban ¶ 18-24. And importantly, there are no evidence-based psychotherapy protocols that effectively treat gender dysphoria. Turban ¶ 25. SB 63 cannot be substantially related to concerns about scientific rigor where the prohibited treatment is well-studied, the only permissible alternative (psychotherapy alone) has no evidence of efficacy at all,

and only medical care for transgender adolescents has been singled out for prohibition.

Reversibility: SB 63 is not substantially related to any concerns about reversibility. Puberty blockers are reversible: once discontinued, endogenous puberty resumes. Corathers ¶ 30, 42, 53, 66. Nonetheless, SB 63 prohibits puberty blockers on the same terms as hormone therapy, which can have effects that are fully reversible, partly reversible, or not reversible. Corathers ¶ 47, 55. At the same time, non-transgender adolescents can continue to access any and all medical treatments, regardless of whether they are fully reversible (like puberty blockers) or permanent (like surgery). Similarly, the law explicitly allows doctors to perform irreversible medical procedures on children with intersex conditions, or DSDs, despite the poor evidence base for these surgeries as compared to the banned care. Antommaria ¶ 62.

Fertility: SB 63 is not substantially related to any concerns about fertility. Puberty blockers do not, on their own, permanently impair fertility. Antommaria ¶ 48. While hormone therapy may impair fertility, that is not universal and may be reversible. Antommaria ¶ 49; Corathers ¶ 55. At the same time, there are other treatments that may impact fertility, such as for pediatric cancers and other conditions, but none of those are prohibited. Antommaria ¶ 51, 58; Corathers ¶ 56.

Informed Consent: Nor is SB 63 substantially related to concerns about informed consent. The potential benefits and risks of the prohibited care are comparable to those of other forms of medical treatment to which parents can provide informed consent and minor adolescents can assent. Antommaria ¶ 6, 45. The Endocrine Society guidelines require providers to use rigorous informed consent processes when discussing this care. Corathers ¶ 42, 47, 57. And concerns about informed consent can be addressed by statutory requirements, a far more tailored means than a categorical ban. *See, e.g.*, K.S.A. 65-6704 (requiring certain information and counseling before providing an abortion to a minor); K.S.A. 39-7,121g (requiring written informed consent listing risks and

benefits of using banked donor human breast milk for recipients under the Kansas program of medical assistance). And while SB 63 prohibits adolescents with gender dysphoria—who have been shown to have sufficient decision-making capacity to contribute to informed decisions about their care—from receiving medical care they desire and to which their parents also consent, it allows medical providers to perform surgeries on children with intersex conditions who are too young to meaningfully participate in such decision-making at all. Antommaria ¶ 45, 62.

Regret: To the extent that the government could have a compelling interest in preventing regret, SB 63 is not substantially related to that purported concern. The rates of regret around gender affirming medical care are very, very low, both as an absolute matter and compared to other treatments. Antommaria ¶ 59; Corathers ¶ 68; Turban ¶ 36-38; Turpin ¶ 50. And the potential for regret is not unique to gender affirming medical care. Antommaria ¶ 60; Corathers ¶ 68; Turban ¶ 38. Nor is the law substantially related to any concerns about the possibility that people who identify as transgender will later identify as cisgender. There are no medical interventions for gender dysphoria prior to the onset of puberty. Corathers ¶ 52. Once transgender youth begin puberty, it is rare for them to later identify as cisgender. Turban ¶ 30, 33. Providers use biopsychosocial evaluations to ensure that those youth who receive this care have gender dysphoria and families understand this complex decision. Corathers ¶ 50; Turban ¶ 30; Turpin ¶ 29, 34.

3. SB 63 fails any standard of review

Although SB 63's sex and trans status classification must be tested under (and fails) heightened scrutiny as a sex-based classification, it cannot even satisfy rational basis review. *See Limon*, 280 Kan. at 286. Under the rational basis standard, a statute (1) "must implicate legitimate goals" and (2) "the means chosen by the legislature must bear a rational relationship to those goals." *Id*. at 288 (quoting *Mudd v. Neosho Memorial Regional Medical Center*, 275 Kan. 187, 198 (2003)). This ensures that "classifications are not drawn for the purpose of disadvantaging the group

burdened by the law." *Id.* at 288 (quoting *Romer v. Evans*, 517 U.S. 620, 632 (1996)). Courts examine "the scope of the classification" because "[o]ver-inclusiveness, where the legislation burdens a wider range of individuals than necessary given the State's interest, may be particularly invidious and unconstitutional." *Id.* By the same token, "a failure to create a classification which is sufficiently broad to effectively accommodate the State's interest, *i.e.*, the creation of an under-inclusive class, may evidence an animus toward those burdened." *Id.* (internal citations omitted). And "when the articulated interest is the protection of minors, there still must be a connection between the State's interest and the classification and, if the burden would not be allowed if placed upon an adult, the State's interest must be unique to children." *Id.* at 296.

As described above, SB 63 is both overinclusive and underinclusive, suggesting invidious discrimination and animus toward those burdened, i.e. transgender minors. *See Limon*, 280 Kan. at 288. Indeed, the statute facially prefers sex-gender congruence—that is, for minors to identify with and appear as their sex assigned at birth. That is equivalent to disfavoring transgender minors and gender nonconformity, but "moral disapproval of a group cannot be a legitimate governmental interest." *Limon*, 280 Kan. at 295. And the fact that the Act explicitly allows medical interventions on intersex children that produce the very outcomes it is ostensibly meant to prevent (such as reduced fertility and regret) undermines any purported aim of protecting children, equally demonstrating its irrationality. *See generally* Ido Katri & Maayan Sudai, *Intersex, Trans, and the Irrationality of Gender-Affirming-Care Bans*, 134 Yale L.J. 1521 (2025).

Other portions of SB 63 reveal the impermissible preference for non-transgender minors and gender conformity: the Act prohibits state property or employees from "promot[ing] or advocat[ing] the use of social transitioning," S.B. 63 § 2(d), (2(f), defined as "acts other than medical or surgical interventions that are undertaken for the purpose of presenting as a member of

the opposite sex, including the changing of an individuals' preferred pronouns or manner of dress." S.B. 63 § 1(b)(10). That is explicitly a government preference that individuals not "present[] as a member of the opposite sex," even linguistically or sartorially. There is no legitimate state interest in regulating such gender expression. The only reason for the state to discourage transgender people from dressing or using pronouns consistent with their gender identity is disapproval of being transgender, which cannot be a legitimate state interest. There is no unique interest in forcing minors to conform to the government's preferences for how young men and women live, act and identify. *Limon*, 280 Kan. at 296. SB 63 fails even rational basis review.

B. SB 63 infringes Parent Plaintiffs' fundamental right to the care, custody, and control of their minor children (Claim III)

Parents have a fundamental right to the care, custody, and control of their children, which includes the right to consent to the medical care that their children need and desire and which is recommended by a clinician. SB 63 infringes on that fundamental right by usurping the aligned judgment of parents, adolescents and doctors and replacing it with the government's preference.

Section 1 of the Kansas Bill of Rights protects the "right to personal autonomy," including "a natural right to make decisions about parenting and procreation." *Hodes I*, 309 Kan. at 644. "This right allows Kansans to make their own decisions regarding their bodies, their health, their family formation, and their family life." *Id.* at 660. A "parent who is not found to be unfit, has a fundamental right . . . to the care, custody and control of his or her child," *Sheppard v. Sheppard*, 230 Kan. 146, 154 (1981); *accord Troxel v. Granville*, 530 U.S. 57, 65 (2000), which "will be disturbed only in extraordinary circumstances." *Matter of Adoption of T.M.M.H.*, 385 P.3d 935 (Kan. Ct. App. 2016), *aff'd*, 307 Kan. 902 (2018). *See also In re Creach*, 37 Kan. App. 2d 613, 614 (2007); *State, Dep't of Soc. & Rehab. Servs. v. Paillet*, 270 Kan. 646, 650 (2001). Parents are presumed to act in the best interests of their children, "and it is only when parents are unfit … that

the state as parens patriae, with its courts and judges, steps in to find fitting custodians in loco parentium." *Sheppard v*, 230 Kan. at 149 (quoting *In re Kailer*, 123 Kan. 229, 230 (1927)). Parental rights include a "high duty to recognize symptoms of illness and to seek and follow medical advice," and the existence of "risks d[oe] not automatically transfer the power to make that decision from the parents to some agency or officer of the state." *Parham v. J.R.*, 442 U.S. 584, 602-03 (1979).

SB 63 violates Section 1 by prohibiting parents from consenting to medical treatment that they, their minor children, and their medical providers all believe to be medically necessary. Under SB 63, the government has displaced these informed, aligned decisions, in favor of a state edict. As set forth below, that infringement cannot survive strict scrutiny.

C. SB 63 is not narrowly tailored to further any compelling state interest

When the government infringes a fundamental right, it bears the burden of demonstrating the infringement can survive strict scrutiny, i.e. that it is narrowly tailored to further a compelling government interest. *See Hodes & Nauser, MDs, P.A. v. Kobach*, 318 Kan. 940, 952 (2024) (*Hodes II*). The government must prove that "(1) it has a compelling state interest; (2) the challenged action actually furthers that interest; and (3) it does so in a way that is narrowly tailored." *Id.* at 951-52. Kansas cannot meet that burden here.

1. The government has not articulated a compelling interest

A compelling interest is "not only extremely weighty, possibly urgent, but also rare—much rarer than merely legitimate interests and rarer too than important interests." *Hodes II*, 318 Kan. at 952. It must be "concrete and exhibit some level of specificity, rather than broad and open to wide interpretation and inclusion of a great array of concerns," because to determine whether a law is narrowly tailored, it is "difficult, if not impossible, to effectively regulate in the interest of something that is amorphous or capable of encompassing countless sub-interests." *Id.* at 952-53.

SB 63 contains no statement of the government's interest, and it is the government's burden

to articulate it. And while "the welfare of children is, of course, a matter of state concern," *Sheppard*, 230 Kan. at 149, that is the kind of "broadly stated aspirational interest" like "promoting the value and dignity of human life, born and unborn," that is insufficiently specific to satisfy the constitutional inquiry. *Hodes II*, 318 Kan. at 958. The government must articulate a much more specific interest: otherwise "the narrow tailoring inquiry will be left untethered." *Id.* at 952. Nor can the government rely on generalities such as the state's interest in adolescents' potential future fertility to justify specific intrusions on individual liberty. *Cf., e.g.*, *Hodes I*, 309 Kan. at 650.

2. SB 63 is not narrowly tailored to a compelling government interest

SB 63 is not narrowly tailored to further any compelling government interest because it is (a) not "necessary, or, in other words, the least restrictive alternative"; (b) it is "underinclusive, meaning it fails to regulate activities that pose substantially the same threats to the government's purportedly compelling interest as the conduct that the government prohibits"; and (c) it is "overinclusive, meaning it regulates activity that does not affect the government's asserted interest." *Hodes II*, 318 Kan. at 954-55 (cleaned up). Failure to satisfy any of these three components may demonstrate the government's failure to carry its burden. *See id.* at 960.

SB 63 is not narrowly tailored because it contains no tailoring at all. It cannot be the least restrictive alternative to further any conceivable compelling government interest even tangentially related to children's welfare. And because SB 63 cannot clear the lower hurdle of heightened scrutiny, it cannot satisfy the higher threshold of strict scrutiny. Concerns about the medical care itself could be addressed in some less restrictive way, such as regulation of the informed consent process or certification requirements for those providing the care. *See, e.g.*, K.S.A. 65-6704 (requiring certain information and counseling before providing an abortion to a minor). So too for older minors. *See* K.S.A. 38-123b (permitting minors sixteen years of age and older to consent to hospital, medical, or surgical treatment when no parent or guardian is immediately available).

"Even when the State regulates health care, demands some medical action such as an immunization, or eliminates treatment options in the interest of public health, safety, and welfare, the government still cannot intrude on a person's control of his or her own body when doing so will cause harm to the individual." *Hodes I*, 309 Kan. at 642.

3. SB 63 does not actually further a compelling state interest

Even if the "welfare of children" was sufficiently specific to constitute compelling state interests—which it is not—SB 63 does not actually further that interest because it harms, rather than helps, minors. A blanket prohibition on puberty blockers and hormone therapy only for transgender adolescents actively threatens the health and well-being of those adolescents for whom such treatment is medically indicated. Antommaria ¶ 40, 67-68, 74-75; Corathers ¶ 65, 72-84; Turban ¶ 18, 20, 24, 38, 42; Turpin ¶ 51-53; Ryan Roe Decl. ¶¶ 14-18; Lily Loe Decl. ¶¶ 14-16.

V. Reasonable Probability of Irreparable Injury & Lack of Adequate Remedy at Law

Plaintiffs seeking a temporary injunction need only demonstrate a "'reasonable probability of irreparable future injury' or harm." *Bd. of Cnty. Comm'rs of Leavenworth Cnty. v. Whitson*, 281 Kan. 678, 684 (2006); *see also Steffes*, 284 Kan. at 395 (emphasizing that parties seeking a preliminary injunction need only show a reasonable probability of irreparable harm to correct prior misinterpretations requiring closer to "virtual certainty"). Because Plaintiffs have demonstrated that "a constitutional right will be abridged, no further showing of irreparable harm is required; a deprivation of a constitutional right is in and of itself irreparable harm." *Hodes Temp. Inj.*, 2015 WL 13065200, at *5 (citing with approval federal cases holding the same). Similarly, because Plaintiffs have demonstrated a substantial likelihood of success on their constitutional claims, "they have demonstrated a reasonable probability of irreparable future harm without adequate remedy at law." *Id.* (citing with approval federal cases holding the same).

In addition to constitutional injuries, Minor Plaintiffs will suffer irreparable harm from

their inability to access medically necessary healthcare in their home state during this case. Lily Loe ¶ 14-16; Ryan Roe ¶ 14-18. Similarly, Parent Plaintiffs will be forced to watch their children suffer and incur the logistical, emotional, and financial burdens of trying to obtain medical care for their children where it remains legally available. Lisa Loe ¶ 27-32; Rebecca Roe ¶ 26-28.

VI. Threat of Injury to Plaintiffs Outweighs Harm to Defendants

Absent a temporary injunction, Minor Plaintiffs will lose access to medically necessary healthcare and suffer irreparable harm from permanent physical changes, while Parent Plaintiffs will be forced to watch them suffer and unable to make medical decisions with their adolescent children and family doctors. Meanwhile, Defendants "face little, if any, injury from issuance of an injunction, which will impose no affirmative obligations and will preserve the *status quo*." *Hodes Temp. Inj.*, 2015 WL 13065200, at *5. SB 63 has already gone into effect, but for purposes of a temporary injunction, the status quo is "the last actual, peaceable, noncontested position of the parties which preceded the pending controversy." *State v. Alston*, 256 Kan. 571, 579 (1994) (citing *Unified Sch. Dist. No. 503 v. McKinney*, 236 Kan. 224, 227 (1984)). That relative position was that parents could consent to, minors could assent to, and healthcare professionals could provide puberty blockers and hormone therapy where medically indicated to treat gender dysphoria.

VII. Injunction is in the Public Interest

A temporary injunction against SB 63 is in the public interest because the "public's interest in not suffering a potential constitutional limitation is served more by maintaining the *status quo* than by permitting a law which may be unconstitutional to go into effect." *Hodes Temp. Inj.*, 2015 WL 13065200, at *5.

Plaintiffs respectfully request that this court grant their motion for temporary injunction.

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

By: /s/ Monica A. M. Bennett

Monica Bennett, KS Bar 30497
D.C. Hiegert, KS Bar 29045
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF KANSAS
10561 Barkley St., Suite 500
Overland Park, KS 66212
Tel: (913) 303-3641
Fax: (913) 490-4119
mbennett@aclukansas.org
dhiegert@aclukansas.org

Harper Seldin, *Pro Hac Vice**
Shana Knizhnik, *Pro Hac Vice**
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad St.
New York, NY 10004
hseldin@aclu.org
sknizhnik@aclu.org

ATTORNEYS FOR PLAINTIFFS

**Pro Hac Vice* application forthcoming