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IN THE FOURTH JUDICIAL DISTRICT COURT
MISSOULA COUNTY

SCARLET VAN GARDEREN, a minor by and through her guardians Jessica van Garderen and Ewout van Garderen; JESSICA VAN GARDEREN, an individual; EWOUT VAN GARDEREN, an individual; PHOEBE CROSS, a minor by and through his guardians Molly Cross and Paul Cross; MOLLY	)	**Case No. DV 23-541** **Judge: Honorable Jason Marks**

CROSS, an individual; PAUL CROSS, an individual; JANE DOE, an individual; JOHN DOE, an individual; JUANITA HODAX, on behalf of herself and her patients; KATHERINE MISTRETTA, on behalf of herself and her patients,	)	**FIRST AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**
Plaintiffs,	)	
v.	)	
STATE OF MONTANA; GREGORY GIANFORTE, in his official capacity as Governor of the State of Montana; AUSTIN KNUDSEN, in his official capacity as Attorney General; MONTANA BOARD OF MEDICAL EXAMINERS; MONTANA BOARD OF NURSING; MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; CHARLIE BRERETON, in his official capacity as Director of DPHHS,	)	
Defendants.		

Plaintiffs[1] Scarlet van Garderen; Jessica van Garderen; Ewout van Garderen; Phoebe Cross; Molly Cross; Paul Cross; Jane Doe; John Doe; Dr. Juanita Hodax; and Dr. Katherine Mistretta (together, "Plaintiffs"), through their undersigned attorneys, complain against the State of Montana; its governor, Gregory Gianforte, in his official capacity ("Governor Gianforte"); its attorney general, Austin Knudsen, in his official capacity ("Attorney General Knudsen"); the Montana Board of Medical Examiners (the "Medical Board"); the Montana Board of Nursing (the "Nursing Board"); the Montana Department of Public Health and Human Services ("DPHHS"); and the Director of DPHHS, Charlie Brereton, in his official capacity ("Director Brereton") (collectively, "Defendants"), as set forth below.

INTRODUCTION

1. This is an action for declaratory and injunctive relief against Defendants arising out of a law that prohibits transgender minors in Montana from receiving critical, medically necessary, and potentially life-saving health care.

2. Over the objection and concern of medical professionals, advocates, transgender individuals, and their families, the 2023 Montana State Legislature (the "Legislature") adopted Montana Senate Bill 99 (the "Act"), and Governor Gianforte signed it into law.

3. The Act bars the provision of a wide range of medical treatments and procedures when, and only when, they are provided for the purpose of treating gender dysphoria. The same medical treatments and procedures are not barred

[1] Plaintiffs Jane Doe and John Doe are filing a motion for a protective order and for leave to proceed using these pseudonyms, rather than their legal names, to protect the privacy rights of their minor child regarding the non-party child's transgender status, medical diagnoses, and treatment, and for the safety of their family. The motion is filed jointly and without opposition.

when they are provided to minors for the purpose of treating other conditions, such as precocious or delayed puberty.

4. These prohibited interventions are evidence-based and medically necessary care essential to the health and well-being of transgender minors who are suffering from gender dysphoria. Gender dysphoria is a serious condition that can lead to depression, anxiety, and other serious health consequences when untreated.

5. The Act takes away critical health care from transgender minors, leaving them and their parents in dire circumstances. It represents vast government overreach and will cause untold harms to the individuals affected and the practice of medicine in Montana.

6. The Act was created to marginalize transgender people. It has no other plausible public purpose, and specifically targets transgender people for discriminatory treatment.

7. The Act flies in the face of the Montana Constitution, infringing on myriad fundamental rights guaranteed to Montanans. These include the right to equal protection of the laws, the right of parents to direct the upbringing of their children, the right to privacy, the right to seek health care, and the right to dignity.

8. The Act is unlawful and unconstitutional and should be permanently enjoined.

JURISDICTION AND VENUE

9. Original jurisdiction is conferred on this Court through Article VII, Section 4, of the Montana Constitution and § 3–5–302, MCA.

10. This Court has jurisdiction to grant declaratory relief under the Montana Uniform Declaratory Judgments Act. §§ 27–8–201, –202, MCA; M. R. Civ. P. 57.

11. This Court has jurisdiction to grant injunctive relief under § 27–19–101 *et seq.*, MCA.

12. Pursuant to § 25–2–126, MCA, venue is proper in Missoula County because suit may be brought in the county in which the claim arose. Plaintiff Dr. Hodax maintains her relevant practice in Missoula County, and Missoula is thus the appropriate venue for her claim.

PARTIES

Plaintiffs

A. The Minor Patients & Their Families

13. Plaintiffs Jessica van Garderen, Ewout van Garderen, and Scarlet van Garderen live in Belgrade, Montana. Jessica and Ewout are the parents of Scarlet, who is 17 years old. Scarlet is transgender and is currently receiving medically necessary care that would be prohibited by the Act.

14. Plaintiffs Molly Cross, Paul Cross, and Phoebe Cross live in Bozeman, Montana. Molly and Paul are the parents of Phoebe, who is 15 years old. Phoebe is transgender and is currently receiving medically necessary care that would be prohibited by the Act.

15. Plaintiffs Jane Doe and John Doe live in Montana. Jane and John are the parents of Joanne Doe, who is 15 years old. Joanne Doe, who is not a party to this case, is transgender and is currently receiving medically necessary care that would be prohibited by the Act. Jane and John Doe raise legal claims on behalf of themselves as individuals, and on behalf of their minor child, Joanne Doe.

B. The Provider Plaintiffs

16. Plaintiff Dr. Juanita Hodax ("Dr. Hodax") is a pediatric endocrinologist licensed to practice medicine in Montana and Washington, an Assistant Professor in the Department of Pediatrics at the University of Washington, and Co-Director of the Gender Clinic at Seattle Children's Hospital. Dr. Hodax provides pediatric endocrine care through Community Children's at Community Medical Center in Missoula, Montana. This care includes gender-

affirming care to transgender patients under the age of 18 that would be prohibited by the Act. She brings claims on behalf of herself and her patients.

17. Plaintiff Dr. Katherine Mistretta is a Board-Certified Family Nurse Practitioner and Advanced Practice Registered Nurse licensed by the Montana Board of Nursing. She is also a Doctor of Nursing Practice with extensive training in both nursing and family medicine. Dr. Mistretta has worked as a Family Nurse Practitioner at Bozeman Creek Family Health in Bozeman, Montana since 2013, where she assesses, diagnoses and treats acute illnesses in patients of all age groups, and provides pediatric acute and well child care. This care includes gender-affirming care to transgender patients under the age of 18 that would be prohibited by the Act. She brings her claims on behalf of herself and her patients.

Defendants

18. The State of Montana is a government entity subject to and bound by the laws of the State of Montana and its constitution. Under Article II, Section 18, of the Montana Constitution, the state is subject to suit for injuries to persons.

19. Governor Gianforte is the governor of the State of Montana. He is the state's principal executive officer and is responsible for administering Montana's laws, including the Act. Governor Gianforte is sued in his official capacity.

20. Attorney General Knudsen is the attorney general of the State of Montana. He is the state's principal law enforcement officer, and is expressly authorized to enforce provisions of the Act. Act, §§ 4(11), 5(5). Attorney General Knudsen is sued in his official capacity.

21. The Montana Board of Medical Examiners is the entity that governs medical licensing and regulation of medical practice within the State of Montana. The Board has authority to discipline healthcare professionals who violate the Act as "the appropriate licensing entity or disciplinary review board with competent jurisdiction in this state." Act, § 4(2)(a).

22. The Montana Board of Nursing is the entity that governs licensing and regulation of nursing practice within the State of Montana. The Board has authority to discipline healthcare professionals who violate the Act as "the appropriate licensing entity or disciplinary review board with competent jurisdiction in this state." Act, § 4(2)(a).

23. The Montana Department of Public Health and Human Services is the governmental entity responsible for administering the State of Montana's Medicaid Program and Healthy Montana Kids ("HMK") Children's Health Insurance Plan, and is thus responsible for implementing the Act's provision that "[t]he Montana medicaid and children's health insurance programs may not reimburse or provide coverage for the medical treatments prohibited in subsection (1)(a) or (1)(b)." Act, §§ 4(6), 8. As a governmental entity, DPHHS is subject to suit for injuries to persons under Article II, Section 18, of the Montana Constitution.

24. Director Brereton is the Director of DPHHS and is thus charged with administering the State of Montana's Medicaid Program and HMK Children's Health Insurance Plan, and, accordingly, with implementing the Act's provision constraining use of Medicaid funds. Act, §§ 4(6), 8. Director Brereton is sued in his official capacity.

ALLEGATIONS COMMON TO ALL COUNTS

Gender Dysphoria and Its Treatment

25. Gender identity refers to a person's core sense of belonging to a particular gender. Every person has a gender identity. It is not a personal decision, preference, or belief. It is durable and cannot be altered through medical intervention.

26. A person's gender identity is a fundamental aspect of human development. There is a general medical consensus that gender identity has a significant biological component.

27. A person's gender identity usually matches, or is congruent with, the sex they were designated at birth based on their external genitalia.[2]

28. Most boys are designated male at birth based on their external genital anatomy, and most girls are designated female at birth based on their external genital anatomy. People whose gender identities are congruent with the sex they were assigned at birth are referred to as "cisgender."

29. Transgender people have gender identities that are not congruent with their sex as assigned at birth.[3] For example, a transgender boy is someone who was assigned a female sex at birth but persistently, consistently, and insistently identifies as male. A transgender girl is someone who was assigned a male sex at birth but persistently, consistently, and insistently identifies as female.

30. Just as cisgender boys and girls cannot (and are not expected or asked to) simply turn off their gender identities like a switch, so too are transgender boys and girls unable to "turn off" their gender identity—because, again, it is innate.

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[2] The terms "sex assigned at birth" or "sex designated at birth" are more precise than the term "biological sex" because there are many biological sex characteristics, and they do not always align with each other. For example, some people with intersex characteristics may have a chromosomal configuration typically associated with a male sex designation but genital characteristics typically associated with a female sex designation. Terms such as "biological sex", "biological female", and "biological male" are imprecise and should be avoided. *See generally* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869, 3875 tbl.1 (2017), *available at* https://academic.oup.com/jcem/article/102/11/3869/4157558.

[3] "Transgender" is an umbrella term used to describe many identities in which the person's "gender identity, gender expression, or behavior does not conform to that typically associated with the sex to which they were assigned at birth." *Understanding Transgender People, Gender Identity and Gender Expression*, Am. Psychological Ass'n (Mar. 9, 2023), *available at* https://www.apa.org/topics/lgbtq/transgender-people-gender-identity-gender-expression. The term is used herein to refer to all people who experience a discordance between their gender identity and their sex assigned at birth.

31. For transgender people, the incongruence between their gender identity and sex assigned at birth can cause clinically significant distress and discomfort.

32. "Gender dysphoria," codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V) at 302.6 (for children) and 302.85 (for post-pubertal adolescents and adults), is the diagnostic term for the clinically significant distress experienced by some transgender people resulting from the lack of congruence between their gender identity and the sex assigned to them at birth. To be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

33. Being transgender in and of itself is not a medical condition to be cured. As the American Psychiatric Association explained in promulgating the DSM-V, "[t]he presence of gender variance is not the pathology"; rather, gender dysphoria results "from the distress caused by the body and mind not aligning and/or societal marginalization of gender-variant people."

34. Untreated, gender dysphoria can result in significant lifelong distress, clinically significant anxiety and depression, self-harming behaviors, substance misuse, and suicidality.

35. In fact, research consistently demonstrates that up to 51% of transgender young people have attempted suicide at least once, compared to 14% of adolescents without gender dysphoria.

36. Gender dysphoria can be diagnosed very early in a child's life, sometimes as early as three years of age. Children often develop a sense of their gender identity around that age as well.

37. The World Professional Association for Transgender Health ("WPATH")[4] and the Endocrine Society[5] have published widely accepted and evidence-based standards of care for the assessment, diagnosis, and treatment of gender dysphoria. These clinical practice guidelines are recognized by leading mental health and medical organizations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association.

38. The WPATH Standards of Care Version 8 set out a regimen of care designed to address and alleviate the clinically significant distress caused by the incongruence between a transgender individual's gender identity and their birth-assigned sex. The distress may be extremely debilitating and dangerous and is alleviated by helping a transgender person live in alignment with their gender identity. This treatment is sometimes referred to as "gender transition," "transition-related care," or "gender-affirming care." These clinical practice guidelines are widely accepted as best practices guidelines for the treatment of adolescents and adults diagnosed with gender dysphoria and have been recognized as authoritative by leading medical organizations, including the American Academy of Pediatrics,

[4] The World Professional Association for Transgender Health (WPATH) "is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, public policy, and respect in transgender health. Founded in 1979, the organization currently has over 3,000 health care professionals, social scientists, and legal professionals, all of whom are engaged in clinical practice, research, education, and advocacy that affects the lives of [transgender and gender diverse] people." *See* Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1, S5 (2022), *available at* https://doi.org/10.1080/26895269.2022.2100644. ("WPATH Standards of Care Version 8")

[5] The Endocrine Society is an organization representing more than 18,000 endocrinologists from across the globe, dedicated to "advancing hormone research, excellence in the clinical practice of endocrinology, broadening understanding of the critical role hormones play in health, and advocating on behalf of the global endocrinology community." *Who We Are*, Endocrine Soc'y, *available at* https://www.endocrine.org/about-us. It has existed for over one hundred years, and continues to serve as the primary professional organization for endocrine scientists and clinical practitioners promoting scientific research and advancements in medical care.

which agrees that this care is safe, effective, and—for many youth diagnosed with gender dysphoria—medically necessary.

39. Medical necessity is properly defined as:

> Health care services that a physician and/or health care professional, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
>
> a. in accordance with generally accepted standards of medical practice;
>
> b. clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and
>
> c. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

WPATH Standards of Care Version 8 at S16-S18 (2022); *see also Definitions of "Screening" and "Medical Necessity" H-320.953*, Am. Medical Ass'n, *available at* https://policysearch.ama-assn.org/policyfinder/detail/H-320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml (last modified 2016).

40. The precise treatment for gender dysphoria depends upon each person's individualized needs, and the guidelines for medical treatment differ depending on whether the treatment is for an adolescent or an adult.

41. For pre-pubertal children, interventions are directed at supporting the child with family, peers, and at school, as well as supportive individual psychotherapy for the child as needed. Some pre-pubertal children may also

explore their gender identity by adopting a different name or pronoun and/or wearing clothes and hairstyles that match their gender identity as part of what is referred to as "social transition."

42. No medical interventions beyond mental health counseling are recommended or provided to any person before the onset of puberty. In other words, gender transition does not include any pharmaceutical or surgical intervention before puberty.

43. Under the WPATH Standards of Care Version 8 and Endocrine Society Clinical Guidelines, medical interventions may become medically necessary and appropriate after a transgender young person reaches puberty. In providing medical treatments to adolescents, qualified medical providers may work in close consultation with mental health professionals experienced in diagnosing and treating gender dysphoria.

44. After the earliest sign of the beginning of puberty, the standard of care for transgender adolescents is to consider providing puberty-delaying medical treatment through medications, generically known as puberty blockers.

45. "Puberty blockers" refers broadly to the gonadotropin-releasing hormone ("GnRH") agonist treatment.

46. A puberty blocker interrupts the sequence of hormonal signals of the pituitary gland that control puberty. This means that the testicles or ovaries remain at a prepubertal stage that are incapable of production of testosterone (for a child born with testicles) or estradiol (for a child born with ovaries) that control the many bodily changes associated with puberty. Puberty will resume if puberty blockers are stopped.

47. For many transgender youth, puberty blockers are a medical necessity as they mitigate the significant anxiety and extreme distress experienced by adolescents as the physical changes of endogenous puberty begin and they start

experiencing potentially permanent physical changes in their bodies that are incongruent with their gender identity. Puberty-delaying medication allows transgender adolescents to avoid these permanent changes, therefore minimizing and potentially preventing the heightened gender dysphoria that endogenous puberty would cause.

48. This treatment is provided only when the youth's transgender status is marked and sustained over time and only after discussing the matter with the youth and their parent(s) or legal guardian(s) and obtaining informed consent.

49. Puberty-delaying medical treatment is reversible. If an adolescent discontinues the medication, puberty consistent with their assigned sex at birth will resume. Puberty-delaying medical treatment does not cause infertility.

50. Without the support of puberty blockers, the stresses and anxieties that are common among pubertal transgender youth are markedly increased, often to the point of clinically significant social isolation, depression, self-harm, suicidal ideation, and suicide.

51. Transgender youth who are denied this treatment are at a greatly increased risk of experiencing or continuing clinically significant distress, suicidal behavior, self-harm, and other serious and lifelong psychological harm as compared to their cisgender peers.

52. For some young people, it may be medically necessary and appropriate to initiate hormonal puberty consistent with the young person's gender identity through gender-affirming hormone therapy (e.g., testosterone for transgender boys, and estrogen and testosterone suppression for transgender girls).

53. Under Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A qualified mental health professional has confirmed:
    - The persistence of gender dysphoria;

- Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's environment and functioning are stable enough to start sex hormone treatment;
- 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 the adolescent:
  - Has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility);
  - Has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process;
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
  - Agrees with the indication for sex hormone treatment;
  - Has confirmed that there are no medical contraindications to sex hormone treatment.

Wylie C. Hembree et al., *Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice*

Guideline, 102 J. Clinical Endocrinology & Metabolism 3869, 3878 tbl.5 (2017), *available at* https://academic.oup.com/jcem/article/102/11/3869/4157558.

54. These guidelines represent the best practices of care based on the best available evidence, as determined by WPATH and the Endocrine Society. As with all medical care, the care provided to each transgender young person with gender dysphoria is tailored to their unique needs based on their individual experiences, proximity to specialists, and general health, as well as the clinical experience of practitioners.

55. Many individuals treated with hormone therapy can still conceive children while undergoing treatment or after discontinuing.

56. As with all medications that could impact fertility, transgender young people and their parents or guardians are counseled on the potential risks of the medical intervention, and treatment is only initiated where parents and adolescents are properly informed, the adolescent's parents consent to the care, and the adolescent assents to the care.

57. Gender-affirming hormones will be prescribed when it is a medical necessity to do so after thorough mental health and medical evaluations.

58. Transgender boys treated with puberty-delaying medication and then gender-affirming hormones will receive exogenous testosterone in order to achieve levels similar to those that cisgender boys generate endogenously. They will develop the phenotypic features typically associated with cisgender boys such as muscle mass, fat distribution, facial and body hair, and lower vocal pitch. Likewise, transgender girls treated with puberty-delaying medication and then gender-affirming hormones will receive exogenous estrogen in order to achieve similar levels of estrogen during puberty that cisgender girls generate endogenously. They will develop the same muscle mass, fat distribution, skin and female hair patterns, and breasts typically associated with cisgender girls.

59. Adolescents who first receive treatment later in puberty and are only treated with gender-affirming hormone therapy (and not puberty-delaying treatment) also go through a hormonal puberty consistent with their gender identity. However, they will have undergone physical changes associated with their endogenous puberty that may not be wholly reversed by hormone therapy or even surgery later in life.

60. Gender-affirming hormone therapy is prescribed for minors when it is deemed medically necessary to ameliorate the potentially severe symptoms of gender dysphoria and when it is medically safe and consistent with the youth's gender identity.

61. This treatment is provided only when the youth's transgender status is marked and sustained over time and only after discussing the matter with the youth and their parent(s) or legal guardian(s) and obtaining informed consent before any treatments are prescribed.

The Act and Its Effects

62. On March 29, 2023, the Legislature passed the Act and sent it to Governor Gianforte for signature.

63. On April 17, 2023, Governor Gianforte issued an amendatory veto, returning the Act to the Legislature with recommended amendments—which included revising definitions to further entrench a binary definition of sex based on reproductive capacity as well as clarifying the broad scope of the Act's prohibition on use of public funds for gender-affirming care. On April 21, 2023, the Legislature approved the proposed amendments and sent the Act back to Governor Gianforte for signature.

64. On April 28, 2023 Governor Gianforte signed the Act, which will become effective October 1, 2023.

65. The Act prohibits the provision of a wide range of health care treatments "only when knowingly provided to address a female minor's perception that her gender or sex is not female or a male minor's perception that his gender or sex is not male" and thus allows cisgender people to access the same treatments when necessary to address their medical needs. Act, § 4(1)(c). The law mandates that healthcare professionals who provide such care are subject to discipline for unprofessional conduct by the appropriate licensing entity or disciplinary review board and, furthermore, may be sued by the Attorney General or private parties. The Act also prohibits coverage of or reimbursement by Medicaid or other public funds for gender-affirming care provided to minors.

66. In passing the Act, the Legislature ignored testimony from Montana physicians, pediatricians, psychiatrists, and other healthcare professionals about the lifesaving benefits of gender-affirming care to their patients and the substantial harm that youth would suffer if they were prohibited from receiving this care. Senator Emrich, for instance, insisted that gender dysphoria was a dissociative disorder, based on information retrieved from the internet, despite testimony from a licensed Montana psychiatrist to the contrary based on the DSM-V. *See* 2/7/23 Senate Floor Session, 13:33:09, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230207/-1/46207#agenda; *see also* 1/27/23 Senate Committee Hearing, 12:44:45, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230127/-1/45413#agenda.

67. The Legislature also ignored the testimony of Montanans, both youth and adults, who shared their painful experiences of depression, anxiety, and suicidal ideation prior to receiving treatment for their gender dysphoria. Indeed, the Legislature censured Representative Zooey Zephyr after she described the life-threatening effects that the Act would have on Montanans.

68. The Legislature further disregarded the testimony of Montana parents pleading for the State not to risk their children's health and survival by stripping them of medical care that has enabled them to survive and thrive.

69. Members of the Legislature also voiced their disapproval of gender transition, including based on their personal views about sex, morality, and religion. For example, Senator Manzella stated that "you cannot change your sex" because "the Creator has reserved that for Himself." *See* 2/7/23 Senate Floor Session, 13:44:46, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230207/-1/46207#agenda.

70. Likewise, Senator Fuller, the primary sponsor of the Act, objected to providing transgender people with gender-affirming hormones because he believed that it is not "natural." *See* 2/7/23 Senate Floor Session, 13:15:30, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230207/-1/46207#agenda. He further opined that "transgender ideology" is a "spiritual dogma" and that "medicine cannot make a man into a woman or a woman into a man." *See id.* at 13:14:33. He claimed that a young person seeking gender-affirming care to treat their gender dysphoria was tantamount to someone seeking to engage in self-harm. *See id.* at 13:15:20. He had also previously characterized his legislative mission as seeking "to protect children from being spayed, neutered, and mutilated." John Fuller, *Glacier Queer Alliance director's criticism off-base¸* Daily Inter Lake News (Dec. 1, 2022), *available at* https://dailyinterlake.com/news/2022/dec/01/glacier-queer-alliance-directors-criticism-base.

71. Multiple legislators similarly described gender-affirming treatments as "mutilation" and "disfigurement." *See* 2/7/23 Senate Floor Session, 14:16:40, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230207/-1/46207#agenda; *see also* 3/20/23 House Committee

Hearing, 8:25:25, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230320/-1/47786#agenda. Senator Hertz went so far as to compare receiving gender-affirming care to getting a lobotomy. *See* 2/7/23 Senate Floor Session, 14:01:15, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230207/-1/46207#agenda.

72. Representative Seekins-Crowe acknowledged concerns that without gender-affirming care, "the risk of suicide goes way up." But she nonetheless supported the Act. She explained that when one of her children previously experienced suicidal ideation (for unstated reasons), someone once asked her: "Wouldn't [you] do anything to help save her?" Representative Seekins-Crowe responded the answer was "No. I was not going to give in to her emotional manipulation." She closed her remarks by stating, "That's my story, and I want this to be your story as well." *See* 3/23/23 House Floor Session, 14:02:30, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230323/-1/46152#info.

73. The Act's sole purpose is to intentionally burden a transgender person's ability to seek necessary care to align their body with their gender identity.

74. The Legislature failed to offer any legitimate public purpose for the Act, and none exists. The Act was passed to express antipathy toward and to harm transgender people.

75. If the Act goes into effect, health care professionals and physicians in Montana will cease providing gender-affirming care to minor patients. In addition to the risk of litigation authorized by the statute, a health care professional or physician who provides the prohibited care will be subject to suspension of their license to practice for at least a year.

76. These licensing actions may be pursued by the Montana Board of Medical Examiners and the Montana Board of Nursing.

77. The Act will result in the denial of medically necessary care to transgender people under the age of 18.

78. The Act will result in parents of transgender children being unable to obtain necessary medical treatment for their children.

79. Withholding medically necessary medical treatment from adolescents with gender dysphoria puts them at risk of extreme harm to their health and well-being.

80. Studies have shown that when adolescents are able to access puberty-delaying medication and gender-affirming hormone therapy, their distress recedes, and their mental health improves. Both clinical experience and multiple medical and scientific studies confirm that for many young people this treatment is not only safe and effective, but also prevents significant harms of untreated gender dysphoria. Indeed, transgender youth who are able to access this essential and well-established medical care often go from painful suffering to become thriving young people.

81. Conversely, for adolescents with gender dysphoria and a clinical need for hormone therapy, withholding or denying this treatment contributes to clinically significant distress and places the young person at ongoing increased risk of suicide, self-harm, and other serious and lifelong psychological harms.

82. If a healthcare provider is forced to stop puberty-delaying medication or hormone therapy due to the Act, it may cause patients to resume their endogenous puberty, and there may be reversal of some of the physical changes that have occurred during hormone therapy. Involuntary withdrawal of gender-affirming hormones will likely be associated with a marked increase in the

debilitating experience of gender dysphoria associated with significant anxiety, depression, self-harm, and suicidality.

83. This could result in extreme distress for patients who have been relying on medical treatments to prevent bodily changes from endogenous puberty. For a girl who is transgender, this could mean that she would start experiencing genital growth, body hair growth, deepening of her voice, and development of a more pronounced laryngeal prominence (Adam's apple). For a boy who is transgender, this could mean the initiation of a menstrual cycle, breast growth, and feminine fat distribution (primarily in the hips and buttocks). These changes can be extremely distressing for a transgender young person experiencing gender dysphoria that had been relieved by medical treatment.

84. Additionally, the effects of undergoing one's endogenous puberty may not be reversible even with subsequent hormone therapy and surgery in adulthood, thus exacerbating lifelong gender dysphoria in patients who have this essential and necessary treatment withheld or prematurely terminated. Secondary sex characteristics, such as stature, genital growth, voice, and breast development, can be impossible or more difficult to counteract.

85. For patients who are currently undergoing treatment with gender-affirming hormones like estrogen or testosterone, withdrawing care can result in a range of serious physiological and mental health consequences. The body takes about six weeks to ramp up endogenous hormones, so if a healthcare provider is forced to stop treatment, a patient may be without sufficient circulating hormones at all. This can result in depressed mood, hot flashes, and headaches. For patients on spironolactone—a testosterone suppressant—terminating treatment abruptly can cause a patient's blood pressure to spike, increasing a young person's risk of heart attack or stroke. The withdrawal of treatment also results in predictable and negative mental health consequences, including heightened anxiety and depression.

86. What is more, the enactment of laws like the Act gravely and directly threatens the mental health and wellbeing of transgender youth in Montana. Studies have shown that experiencing discrimination in health care settings poses a unique risk factor for heightened suicidality among transgender individuals. And the 2022 National Survey on LGBTQ Youth Mental Health found that LGBTQ youth who had experienced discrimination based on sexual orientation or gender identity had attempted suicide in the past year at nearly three times the rate as those who had not (19% vs. 7%). *See 2022 National Survey on LGBTQ Youth Mental Health*, Trevor Proj. 18 (2022), *available at* https://www.thetrevorproject.org/survey-2022/assets/static/trevor01_2022survey_final.pdf. The same survey revealed that 93% of transgender youth have worried about transgender people being denied access to gender-affirming medical care due to state or local laws, *see id.* at 14, while a different survey found that for 86% of transgender youth, the debates about bills like the Act had negatively impacted their mental health. *See* Brooke Migdon, *Over 71 Percent of LGBTQ Youth Say Restrictive State Laws Have Negatively Impacted Their Mental Health*, Hill (Jan. 19, 2023), *available at* https://thehill.com/changing-america/well-being/mental-health/3819919-over-71-percent-of-lgbtq-youth-say-restrictive-state-laws-have-negatively-impacted-their-mental-health.

87. Gender-affirming medical care can be lifesaving treatment for transgender minors experiencing gender dysphoria. The major medical and mental health associations support the provision of such care and recognize that the mental and physical health benefits to receiving this care outweigh the risks. These groups include the American Academy of Pediatrics, American Medical Association, the Endocrine Society, the Pediatric Endocrine Society, the American Psychological Association, the National Association of Pediatric Nurse Practitioners, the American Nurses Association, the American Academy of Family Physicians, the

American College of Obstetricians and Gynecologists, the National Association of Social Workers, and WPATH.

88. The failure to provide the appropriate medically necessary treatment, or the withdrawal of such medically necessary care, to a transgender youth will cause immediate, serious, and potentially life-threatening and life-long harm.

89. The Act establishes a complete ban on well-established, evidence-based, and medically necessary medical treatments for minors "only when knowingly provided to address a female minor's perception that her gender or sex is not female or a male minor's perception that his gender or sex is not male" Act, § 4(1)(c).

90. While the Act prohibits the use of well-established, medically necessary treatments for gender dysphoria in transgender adolescents because these treatments are provided for the treatment of gender dysphoria, it nonetheless permits the use of these treatments for any other purpose.

91. The puberty-delaying medication prohibited by the Act for the treatment of gender dysphoria are the same drugs that are commonly used to treat central precocious puberty, which is the premature initiation of puberty (before eight years of age in people assigned female at birth and before nine years of age in people assigned male) by the central nervous system. The Act permits puberty-delaying medical treatment for central precocious puberty because it is not provided to affirm a person's gender identity different from their sex assigned at birth.

92. The Act prohibits hormone therapy when the treatment is prescribed to transgender patients to treat gender dysphoria, but the same hormone therapy is permitted when prescribed to cisgender patients for other purposes. For example, cisgender boys with delayed puberty may be prescribed testosterone if they have not begun puberty by fourteen years of age. Without testosterone, puberty would

eventually initiate naturally for most of these patients. Testosterone, however, may be prescribed to avoid some of the social stigma that comes from undergoing puberty later than one's peers and failing to develop the secondary sex characteristics consistent with their gender at the same time as their peers. Likewise, cisgender girls with primary ovarian insufficiency, hypogonadotropic hypogonadism (delayed puberty due to lack of estrogen caused by a problem with the pituitary gland or hypothalamus), or Turner's Syndrome (a chromosomal condition that can cause a failure of ovaries to develop) may be treated with estrogen. And cisgender girls with polycystic ovarian syndrome (a condition that can cause increased testosterone and, as a result, symptoms including facial hair) may be treated with testosterone suppressants. The same treatments that are permitted for cisgender minors are thus banned if provided to transgender minors.

93. The Act prohibits chest surgery on transgender young men to treat gender dysphoria, but minors are permitted to undergo chest surgeries for other reasons. For example, cisgender adolescent boys can have surgery to treat gynecomastia—the proliferation of ductal or glandular breast tissue, as opposed to adipose tissue, in individuals assigned male at birth. And cisgender adolescent girls can have breast reconstruction surgery, including to address conditions such as breast hypoplasia: a lack of breast development in people assigned female at birth. These kinds of surgeries are commonly performed to reduce psychosocial distress. Therefore, under the Act, a transgender boy cannot receive medically necessary chest-masculinizing surgery to affirm his gender identity, but a cisgender boy can receive such care for his medical needs. Likewise, a transgender girl cannot receive medically necessary chest-feminizing surgery to affirm her gender identity, but a cisgender girl can receive such care for her medical needs.

94. The Act is so damaging to the health and well-being of transgender adolescents that some of these adolescents' families with the resources to do so

have taken steps to uproot their entire lives to move out of Montana in light of the Act. For many more, however, that devastating option is not available, so these families and youth will have no choice but to remain and endure the harms that the Act inflicts.

The Impact of the Act on Plaintiffs

A. The Minor Patients & Their Families

The van Garderen Family

95. Scarlet is 17 years old and about to finish her junior year of high school, where she is actively involved with activities including jazz band, concert band, marching band, speech and debate, and color guard. She has lived in Montana her whole life and wants to attend Montana State University after she graduates.

96. Scarlet is transgender. When she was born, she was designated as male on her birth certificate but her gender identity is female.

97. In early spring 2021, Scarlet first told a close friend that she was transgender. In May 2021, she came out to her mom. She remembers the relief of learning about other people's stories and beginning to understand that she was not the only person who felt like they were trapped in the wrong body.

98. Scarlet's parents were accepting of her identity, although they worried about how the world would accept her. Overall, they have been pleased with how supportive the people in their lives have been.

99. Throughout the fall of 2021, Scarlet gradually came out to more and more people until, by December, she was using female pronouns and her preferred name exclusively.

100. Scarlet started seeing a therapist in November 2021, and she was eventually referred to a doctor to discuss gender-affirming medical care. In

addition to the information provided by her doctors, Jessica also did a lot of research about gender-affirming care during this time.

101. In or around February 2022, Scarlet started seeing an endocrinologist and was prescribed puberty-blocking medication.

102. In July 2022, Scarlet started gender-affirming hormone therapy. Scarlet's endocrinologist prescribed estrogen to initiate puberty consistent with her gender identity. She now continues her gender-affirming hormone therapy under the care of her nurse practitioner in coordination with her naturopath, and with continued support from her therapist.

103. Scarlet legally changed her name in December 2022.

104. Before accessing gender-affirming care, Scarlet's parents had noticed that Scarlet had withdrawn and found it increasingly hard to get out of bed. Her mom noticed that, in public, Scarlet would wear a baggy hoodie all the time, even when it was warm out, as if she did not want anyone to see her. Her distress reached such an intense point that Jessica remembers times when she would open Scarlet's bedroom door and hope she was still alive. She felt a wave of relief each time she was.

105. After starting care, Scarlet felt like a weight had been lifted. Within weeks of Scarlet starting her puberty-blocking medication, Jessica was not so worried that Scarlet would hurt herself.

106. As Ewout explains, the positive change he has witnessed in Scarlet since she has been able to access gender-affirming care has been "night and day." Jessica noticed that Scarlet's distress lessened almost immediately upon learning about the possibility of gender-affirming care.

107. Now that Scarlet is receiving this care, Jessica knows that this was the right choice and they "can't go back" without the same distress and pain resurfacing.

108. Scarlet finally feels more comfortable in her body and does not believe she could live without the gender-affirming care she is now receiving.

109. Jessica and Ewout are also concerned about their daughter's mental health if her treatment is cut off. They fear she will lose the happiness and self-confidence she has experienced because of her treatment, and are worried her distress would return if her care was interrupted and her body began to undergo additional changes from endogenous puberty.

110. Scarlet's family has built ties in the community and they do not want to be pressured to leave in order to live in a place where they can access necessary medical care. Scarlet is looking forward to being a section leader in her high school band next year and does not want to leave her friends. Jessica is the color guard coach at the school. Ewout started a local handyman business last year and does not want to have to rebuild his clientele.

The Cross Family

111. Phoebe Cross is 15 years old and about to finish his first year of high school, where he is actively involved in many activities, including playing the saxophone in symphonic band, speech and debate, and art. He qualified to join his school's speech and debate team in competing at this year's National competition. He has lived in Montana his entire life.

112. Phoebe is transgender. When he was born, he was assigned the gender designation of female. He, however, has known he was not a female since preschool.

113. Throughout much of childhood Phoebe expressed his gender identity in a traditionally male manner in, for example, the activities he participated in and the clothing he chose to wear.

114. In upper elementary school, he experienced significant bullying and peer pressure, which led him to try to conform to a traditionally female manner of expressing gender. During this time, he began experiencing acute gender dysphoria.

115. When Phoebe was in 6th grade, he told his friends that he did not identify as a girl.

116. Molly and Paul noticed Phoebe's intense and worsening mental health challenges throughout Phoebe's 7th and 8th grade years. They arranged for Phoebe to receive mental health and psychiatric care to address these challenges.

117. During this time period, Phoebe's parents witnessed Phoebe's deteriorating mental health condition, expressed through suicidal ideations and attempts/gestures.

118. In the fall of Phoebe's 8th grade year he came out to his parents as transgender and began socially transitioning. Phoebe cut his hair short, returned to wearing more traditionally masculine clothing, and began wearing a chest binder. Since then, Phoebe has consistently described his persistent painful feelings related to having a female body, while desiring to feel more masculine. Molly and Paul noticed a marked improvement in Phoebe's health after he began socially transitioning.

119. Despite some improvements in Phoebe's mental health, he suffered an acute mental health crisis resulting in the need for emergency medical treatment in January 2022. Following this incident, Phoebe began asking about other ways to better align his body with a male gender, including options to prevent menstruation and the potential of starting hormone replacement therapy.

120. In May 2022, Phoebe had his first appointment with a Board-Certified Family Nurse Practitioner and Advanced Practice Registered Nurse, licensed by the Montana Board of Nursing, with expertise in gender-affirming care where they

discussed the potential of Phoebe starting hormone replacement therapy. The family was given resources to consider and scheduled follow up appointments.

121. In July 2022, Phoebe began seeing a therapist with expertise in treating gender-diverse individuals; after a number of visits, that therapist diagnosed Phoebe with gender dysphoria.

122. Molly and Paul were accepting of Phoebe's male/transgender identity. Although they were not surprised by Phoebe's diagnosis, as Phoebe had begun talking about being transgender for some time, they were not familiar with the science and care related to a gender dysphoria diagnosis.

123. As they explored options for gender-affirming care, both parents began reviewing scientific publications on gender dysphoria and its treatments, consulting resources such as the WPATH Standards of Care, and generally sought out more information on gender dysphoria.

124. With the aid of medical and mental health professionals, Phoebe has taken certain steps to bring his body into conformity with his male identity. In September 2022, Phoebe was prescribed and began taking testosterone to treat his gender dysphoria.

125. Phoebe feels that receiving gender-affirming care, including testosterone, has been a lifeline.

126. Phoebe continues to see a therapist, the Family Nurse Practitioner specializing in gender-affirming care, and a psychiatrist.

127. Phoebe wishes he would have received education about being transgender sooner so that he could have started receiving gender-affirming care earlier to prevent much of the anguish of gender dysphoria he experienced as a result of starting puberty.

128. Before accessing gender-affirming care, Phoebe suffered from severe depression and anxiety. At the onset of puberty and starting middle school, where

sports were segregated by birth-assigned sex for the first time, Phoebe's gender dysphoria soared. He lost motivation to do the things that he had once excelled at and loved.

129. He felt constant discomfort being in his body. Doing everyday menial tasks, such as bending over, was a painful reminder that his body did not align with who he knew himself to be.

130. Since receiving gender-affirming care and taking testosterone, Phoebe feels so much better just existing. He feels that his baseline is happier, and when he looks in the mirror, he feels like he is finally seeing his real self.

131. Paul and Molly have witnessed numerous positive changes in Phoebe since he has been able to access gender-affirming care, including that their child is clearly more comfortable and pleased with his appearance. His depression has significantly abated and he has not experienced any acute mental health challenges since starting testosterone. They have witnessed an immense growth in his confidence. They see that their child has hope for his future, in a way that he did not have before he received gender-affirming care.

132. Phoebe believes that taking testosterone saved his life and he would be devastated if his care was taken away. He fears that his mental health would return to the dark space that he was previously in before receiving care for his gender dysphoria.

133. Paul and Molly are also concerned about the potentially devastating impacts on Phoebe if his gender-affirming care is taken away from him. They fear that his mental health would erode and he would slip back into a state of depression, possibly even leading to self-harm.

134. The Cross family does not wish to leave Bozeman and would only do so if Phoebe's medically necessary care was taken away. Paul has been working at his dream job for the past 18 years, studying wildlife issues around the

Yellowstone ecosystem. His expertise is very specific. The family loves Montana and feels immersed in the community. They have a supportive friend network with whom they participate in many Montanan activities, including hiking, fishing, rafting, and skiing.

JANE AND JOHN DOE

135. Jane and John Doe have a 15-year-old transgender daughter, Joanne Doe, and they live in Montana. Jane Doe Dec. Joanne Doe, who is not a party to this case, is transgender and is currently receiving medically necessary care that would be prohibited by the Act. They are both physicians; Jane Doe is a board-certified licensed pediatrician in the state of Montana, although not currently practicing, and currently works as a medical educator. Throughout most of her childhood, Joanne expressed her gender identity in a traditionally female manner, including in her preferred style of clothing and play. They noticed when she was around age three that her mental health was declining—she did not want to leave home, had significant emotional outbursts, and appeared to be suffering from worsening depression and anxiety, and when she was six and a half years old, Jane and John found her self-harming.

136. They began to seek mental health counseling for Joanne, and both undertook intensive research to better understand the cause of their daughter's struggles. As she began socially transitioning, including wearing traditionally female clothing outside of the home, Jane and John noticed immediate and striking improvement. While they sought professional advice elsewhere and learned that Joanne was transgender, Joanne was unable to see any health care professionals for her gender dysphoria for a significant period of time due to a dearth of professional support in their local community.

137. When Joanne was in fourth grade, she first saw a pediatric endocrinologist at the Seattle Children's Gender Clinic. Once she had begun

puberty, in sixth grade, she—along with Jane and John Doe and her treating healthcare professionals—determined that gender-affirming care was right for her. After extensive battles with insurance and specialty pharmacies, she was eventually able to start puberty suppressant medication during seventh grade, and during eighth grade was also prescribed estrogen to initiate feminine pubertal changes consistent with her gender identity. After Joanne started on estrogen, she appeared to be ecstatic with the physical changes to her body; Jane can see how it has dramatically increased her self-esteem, and she appears visibly more comfortable in her body.

138. Jane attended or viewed all of the committee hearings for the Act, and found it abhorrent to hear legislators say a goal of this bill was protecting parental rights when in fact they were stripping her of her right to guide her child's healthcare, and also to say this bill was needed to "protect children" when, in fact, it would directly and severely harm her child. If the Act goes into effect, it would impede Jane and John Doe's parental rights to seek out medically necessary health care for their daughter, taking away their ability to make such decisions notwithstanding the fact that they spent countless hours and resources to determine the best course of care for her. Jane fears for the mental health harms Joanne will experience as a result of the Act, and her biggest fear is that if the lifesaving medication that Joanne receives were no longer accessible to her and she was forced to undergo male puberty, Joanne might commit suicide.

139. Montana is their home and they do not want to be forced out by the Act—Jane Doe's entire extended family lives in their town, and Joanne has a large network of supportive friends and is thriving in her academics, her job, and her activities. John Doe is a leader in the hospital where he works, and Jane Doe is well established in her career. The community they have built for themselves is one that they love and do not wish to leave.

B. The Provider Plaintiffs

Dr. Juanita Hodax

140. Plaintiff Dr. Juanita Hodax is a physician licensed by the Montana Board of Medical Examiners and certified by the American Board of Pediatrics in general pediatrics and pediatric endocrinology. She obtained a Bachelor of Science degree in physiology from the University of Washington and received her Doctor of Medicine degree from New York Medical College. After medical school, Dr. Hodax completed a residency and fellowship at Hasbro Children's Hospital at the Warren Alpert Medical School of Brown University. While training in pediatric endocrinology at Brown University, Dr. Hodax took an interest in gender-affirming care.

141. After completing her fellowship at Brown University, Dr. Hodax began working as a pediatric endocrinologist at Seattle Children's Hospital. In that role, she continued to develop her interest and expertise in gender-affirming care, in addition to providing general pediatric endocrine care such as diabetes management and thyroid care. Dr. Hodax provides gender-affirming care through the Gender Clinic at Seattle Children's Hospital and has served as Co-Director of that clinic since 2020. She has conducted research on the health of transgender youth, including serving as the primary investigator on grant-funded research, and is also a member of WPATH.

142. In addition to her practice at Seattle Children's Hospital, Dr. Hodax provides pediatric endocrine care through Community Children's at Community Medical Center in Missoula, Montana ("the Missoula Clinic"). Dr. Hodax has regularly traveled to Montana since 2019 in order to provide care to young Montanans through the Missoula clinic. Her current practice at the Missoula clinic is focused exclusively on gender-affirming care because of the extent to which that

care is needed in the community. Some of Dr. Hodax's patients travel from across the state of Montana in order to receive gender-affirming care at the Missoula Clinic. A number of her patients rely on reimbursement from Montana Medicaid to access gender-affirming care.

143. Dr. Hodax is bringing her claims on behalf of herself and her patients whose gender-affirming care will be prohibited by the Act.

144. Over the course of her career, Dr. Hodax has treated hundreds of minors for gender dysphoria and provided them with gender-affirming care. The Gender Clinic at Seattle Children's Hospital, for which Dr. Hodax serves as Co-Director, sees thousands of minor patients each year.

145. In cooperation and consultation with other healthcare providers at the Missoula Clinic, Dr. Hodax treats patients under the age of eighteen for gender dysphoria and provides gender-affirming care. As part of that care, Dr. Hodax prescribes medically necessary medications to treat gender dysphoria, including medications to delay puberty and hormone replacement therapy where medically appropriate.

146. A significant portion of the time that Dr. Hodax spends with families is devoted to discussing treatment options and explaining their risks and benefits, just as she discusses options and risk with other patients experiencing other medical conditions. Dr. Hodax requires parental consent before treating minors with puberty blockers or hormone replacement therapy.

147. Dr. Hodax has repeatedly witnessed dramatic benefits in her patients who are able to access gender-affirming care, including reduction in depression, anxiety, and suicidality from untreated gender dysphoria.

148. The Act would prohibit Dr. Hodax from providing medically necessary care, even though the very same medications could be prescribed to cisgender minors for reasons other than to treat gender dysphoria, such as for

precocious puberty and hypogonadism. Dr. Hodax regularly prescribes these same medications to cisgender minors for reasons other than to treat gender dysphoria. The Act would also interfere with Dr. Hodax's ability to support referrals for other gender-affirming care that her patients may need.

149. The Act would subject Dr. Hodax to professional discipline for providing the same medically necessary care that can be provided to cisgender patients for reasons other than gender dysphoria. The Act would also impose civil liability on Dr. Hodax for providing medically necessary care.

150. If the Act were to take effect, Dr. Hodax would likely cease providing medical care in Montana altogether, and give up her Montana medical license, because the nature of her medical practice in Montana would be prohibited by the Act.

151. The consequences of the Act for Dr. Hodax's patients who are unable to continue accessing gender-affirming care would be dire. These patients and their families have expressed significant anxiety about what they will do if the Act goes into effect. During appointments, some parents have requested to speak in private with Dr. Hodax, outside the presence of their children, and have cried over their fears about what will happen if their children are deprived by the Act of the medical care that they need.

Dr. Katherine Mistretta

152. Plaintiff Dr. Katherine Mistretta is a Board-Certified Family Nurse Practitioner and Advanced Practice Registered Nurse, licensed by the Montana Board of Nursing. She is also a Doctor of Nursing Practice with extensive training in both nursing and family medicine. She has obtained multiple nursing degrees over the span of nearly a decade of educational training, including a post-Graduate Doctor of Nursing Practice degree from the University of Colorado, College of Nursing, a Bachelor of Science in Nursing, a Master's in Nursing, and a Certificate

in Nursing Education from Montana State University, College of Nursing in Bozeman, Montana.

153. Dr. Mistretta has worked as a Family Nurse Practitioner at Bozeman Creek Family Health in Bozeman, Montana since 2013, where she provides a wide range of care to patients of all ages. As part of her practice, Dr. Mistretta provides gender-affirming care to transgender patients, including those under the age of 18, in accordance with the WPATH Standards of Care Version 8, and with the guidelines issued by the Endocrine Society for the diagnosis and treatment of gender dysphoria. This includes providing gender-affirming care when medically necessary to treat gender dysphoria in minors in the form of puberty blockers and hormone therapy that would be prohibited by the Act.

154. Dr. Mistretta is bringing her claims on behalf of herself and her patients whose gender-affirming care will be prohibited by the Act.

155. Over the course of her career, Dr. Mistretta has provided gender-affirming care to several hundred transgender patients, including adult patients as well as patients who were minors at the time of treatment initiation. Dr. Mistretta is also currently treating and intends to continue treating gender dysphoria in minors with gender-affirming care. Several of Dr. Mistretta's patients, including some transgender youth receiving gender-affirming care to treat their gender dysphoria, are currently insured by Montana Medicaid.

156. As one of the few providers of gender-affirming care in Montana, a massive state in which the population is spread widely, many of her patients travel long distances to obtain this care.

157. Dr. Mistretta treats all of her minor transgender patients in accordance with well-established standards of care.

158. Dr. Mistretta also regularly prescribes and administers the same medications used to treat gender dysphoria in transgender minors—testosterone,

estrogen, testosterone suppressants, and hormonal contraception—to cisgender patients as part of her general healthcare practice. This includes, for example, prescribing: hormone therapy to treat hormonal issues in cisgender women who are pre-menopausal or cisgender men who are approaching andropause; hormone suppressants to treat symptoms of polycystic ovarian syndrome, which can include unwanted facial hair and body hair, excessive sweating, and body odor in cisgender women; and testosterone for perimenopausal and menopausal cisgender women.

159. If the Act goes into effect, Dr. Mistretta will be prohibited from continuing to provide these medications to treat gender dysphoria in her minor transgender patients because the purpose of that treatment is "to address the minor's perception that [their] gender or sex is not [that assigned to them at birth]." Act, § 4(1)(c). But she will be permitted to continue providing the same treatments to her cisgender patients to address their medical needs.

160. If enforced, the Act would require Dr. Mistretta to either fully comply, as described above, and abandon the needs of her transgender patients, or risk the loss or suspension of her license, depriving her of the ability to care for any of her patients and thereby negatively impacting her livelihood. The Act would also directly conflict with Dr. Mistretta's education and training by labeling her compliance with accepted, evidence-based guidelines for treating gender dysphoria in transgender patients as "unprofessional conduct." Act, §§ 4(2)(a), 7.

161. As a healthcare provider of patients who experience gender dysphoria, Dr. Mistretta has developed close and meaningful relationships with her patients and their families. Seeking and receiving treatment for gender dysphoria is a profoundly personal and informed decision based on a person's innermost sense of self and individual needs in consultation with their family. It is also a subject that remains deeply misunderstood by the public at large, particularly among those

lacking relevant healthcare knowledge and training. Given this reality, many of Dr. Mistretta's patients require and desire complete privacy. Dr. Mistretta believes that as a healthcare provider it is her duty and obligation to advocate on behalf of her patients, especially those who are not able to do so for themselves for fear of discrimination, harassment and violence.

162. Dr. Mistretta knows, from both her training and personal experience in treating adolescents with gender dysphoria, that allowing the Act to take effect will be devastating to her patients and will significantly compromise their health and wellbeing. She is concerned that, without access to hormone therapy through a licensed healthcare provider, some transgender youth with gender dysphoria will seek alternative means of accessing the care, including buying medication from unauthorized suppliers and using medication that they obtain from friends. This obviously presents serious risks to the health and safety of the individual.

163. Dr. Mistretta has already seen the mental and emotional harm that the Act has caused her patients and their families before it has even taken effect. She has observed the undue stress and pressure it places on transgender adolescents and their families. Several of her patients and their families have told her that, if the Act takes effect, they may need to leave the state in order to obtain this life-saving medical care. She has seen how even discussing the loss of gender-affirming care can cause so much discomfort, pain, fear, and anxiety in her patients that she must seriously consider the most appropriate time and manner to initiate the discussion to minimize its negative consequences to their health and wellness.

164. Dr. Mistretta is deeply concerned for her young transgender patients because her educational, clinical, and practical experience fully confirm her knowledge that denying them access to the gender-affirming care proscribed by the Act will likely lead to an increase in their depression, anxiety, suicidal ideation, and even suicidal attempts.

CLAIMS FOR RELIEF

165. Article II, Section 15 of the Montana Constitution provides: "Rights of persons not adults. The rights of persons under 18 years of age shall include, but not be limited to, all the fundamental rights of this Article."

COUNT I

(Equal Protection of the Laws)

(All Plaintiffs Against All Defendants)

166. Plaintiffs hereby incorporate all other paragraphs of this complaint as if fully set forth in this claim.

167. Article II, Section 4 of the Montana Constitution states that: "No person shall be denied the equal protection of the laws."

168. The Act, on its face and as applied, denies patients equal protection of the laws on the basis of their gender identity, transgender status, and sex. It discriminates on the basis of gender identity, which is also a form of discrimination on the basis of sex. *Maloney v. Yellowstone County et al.*, Cause No. 1570–2019 & 1572–2019 (Department of Labor and Industry, August 14, 2020). All of these forms of discrimination are forbidden by the equal protection clause of Article II, Section 4.

169. As described above, the Act targets transgender people, and only transgender people, because it bars the provision and coverage of various forms of medically necessary care only when such care is sought by transgender people seeking to align their bodies with their gender identity.

170. The Act treats similarly situated groups differently because the same medical treatments that are prohibited when provided to transgender adolescents to help align their bodies with their gender identity may be provided to cisgender adolescents for any other purpose.

171. Under the Act, health care providers are prohibited from providing certain medically necessary care to their transgender adolescent patients that they are permitted to provide to their cisgender adolescent patients.

172. Under the Act, whether or not a person can receive certain medical treatments turns on their assigned sex at birth, whether they are transgender, and whether the care tends to reinforce or disrupt stereotypes associated with their sex assigned at birth. The sex stereotypes that motivated the Act are also evidenced by its restrictions on promoting the use of "clothing or devices, such as binders, for the purpose of concealing a minor's secondary sex characteristics." Act, §§ 3(10); 4(7).

173. These restrictions, only affecting transgender people, serve no legitimate purpose. They do nothing to protect the health or well-being of minors. To the contrary, they gravely threaten the health and well-being of transgender adolescents by denying them access to lifesaving care, and evidence an intent to discriminate against transgender people.

174. Discrimination on the basis of transgender status or on the basis of sex is subject to heightened scrutiny because (a) transgender people have suffered a long history of discrimination, which continues to this day; (b) transgender people are a discrete and insular group that lacks the political power to protect their rights effectively; (c) a person's gender identity or transgender status bears no relation to their ability to contribute to society; and (d) gender identity is a core defining trait, fundamental to a person's identity, that, as a condition of equal treatment, a person cannot be required to abandon.

175. The Act's prohibition of Montana Medicaid and HMK coverage violates equal protection by excluding a class of otherwise-eligible people from coverage for medically necessary treatment based on their transgender status.

176. The Act makes it such that transgender people who are eligible for state assistance are unable to access medically necessary treatment, while cisgender people who are eligible for state assistance are able to access such treatment.

177. Moreover, the Act, on its face and as applied, diminishes the intrinsic worth and compromises the inalienable rights of transgender individuals, in violation of Article II, Section 4.

178. The Act violates the equal protection rights of the minor plaintiffs and their parents, and the equal protection rights of the provider plaintiffs' current and future adolescent patients.

179. The Act is not narrowly tailored to further a compelling state interest or substantially related to an important government interest.

180. For these reasons, Plaintiffs are entitled to a declaratory judgment finding the Act unconstitutional and an injunction prohibiting the Act's enforcement.

COUNT II

(Interference with Fundamental Parental Rights)

(Parent Plaintiffs Against All Defendants)

181. Plaintiffs hereby incorporate all other paragraphs of this complaint as if fully set forth in this claim.

182. Article II, Section 17 of the Montana Constitution provides: "No person shall be deprived of life, liberty, or property without due process of law."

183. The Montana Supreme Court has recognized that this provision protects "the fundamental right of a parent to make decisions regarding the care of their children, including, among other things, the 'upbringing, education, health care, and mental health of their children.'" *Stand Up Mont. v. Missoula Cnty. Pub.*

Schs., 2022 MT 153, ¶ 28, 409 Mont. 330, 514 P.3d 1062. This fundamental right is also explicitly protected by Montana statutory law. § 40-6-701, MCA.

184. This fundamental right is enforceable through an explicit private right of action. § 40-6-701(3), MCA.

185. The fundamental right of parental autonomy includes the right of parents to seek medically necessary care and to follow medical advice to protect the health and well-being of their minor children.

186. Parents' fundamental right to seek and follow medical advice is at its apogee when the parents, their minor child, and that child's doctor all agree on an appropriate course of medical treatment.

187. The Act's prohibition against well-accepted medical treatments for adolescents with gender dysphoria stands directly at odds with parents' fundamental rights to make decisions concerning the care of their children.

188. The Act does nothing to protect the health or well-being of minors. To the contrary, it gravely threatens the health and well-being of adolescents with gender dysphoria by denying their parents the ability to obtain lifesaving care for them.

189. The Act violates the fundamental rights of the parent plaintiffs.

190. The Act's prohibition against the provision of medically accepted treatments for adolescents with gender dysphoria is not narrowly tailored to serve a compelling government interest.

191. For these reasons, Plaintiffs are entitled to a declaratory judgment finding the Act unlawful and an injunction prohibiting the Act's enforcement.

COUNT III

(Plaintiffs' Right to Privacy)

(All Plaintiffs Against All Defendants)

192. Plaintiffs hereby incorporate all other paragraphs of this complaint as if fully set forth in this claim.

193. Article II, Section 10, of the Montana Constitution provides that the right of individual privacy is essential to a free society and "shall not be infringed without the showing of a compelling state interest."

194. The right to privacy "broadly guarantees each individual the right to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from government interference." *Armstrong v. State*, 1999 MT 261, ¶ 14, 296 Mont. 361, 989 P.2d 364.

195. The Act, on its face and as applied, violates patients' right to privacy by drastically limiting their ability to make medical decisions in concert with their parents, barring a wide swath of health care options even where both patient and provider agree they would be appropriate and necessary.

196. Only transgender people are subjected to these infringements on their right to privacy, and the medical options foreclosed by the Act are often of critical importance to their health and well-being.

197. The Act intrudes upon the private relationship between a patient and a health care provider, essentially imposing the State's ideologically-informed opinion on the patient-provider relationship and restricting providers' ability to rely on their expertise and reasoned medical judgment in recommending and seeking the best health care options for their patients.

198. The Act violates the privacy rights of the minor plaintiffs and their parents, and the privacy rights of the provider plaintiffs' current and future adolescent patients.

199. The Act and its infringements on the right to privacy are subject to strict scrutiny. There is no compelling state interest that justifies this breach of Article II, Section 10 of the Montana Constitution. Nor are the infringements

authorized by the Act related to a substantial or important government interest. There is no justification for the State of Montana to deny to patients and their parents the right to make medical decisions without state compulsion.

200. For these reasons, Plaintiffs are entitled to a declaratory judgment finding the Act unconstitutional and an injunction prohibiting the Act's enforcement.

COUNT IV

(Plaintiffs' Right to Seek Health)

(All Plaintiffs Against All Defendants)

201. Plaintiffs hereby incorporate all other paragraphs of this complaint as if fully set forth in this claim.

202. Article II, Section 3, of the Montana Constitution contains the fundamental right to seek health, providing that Montanans have a fundamental and inalienable right to "seek[] their safety, health and happiness in all lawful ways." *Montana Cannabis Industry Ass'n v. State*, 2012 MT 201, ¶¶ 22-24, 366 Mont. 224, 286 P.3d 1161.

203. This right encompasses "the right to seek and obtain medical care from a chosen health care provider and to make personal judgments affecting one's own health and bodily integrity without government interference." *Armstrong*, ¶ 72.

204. As discussed above, the Act, on its face and as applied, violates patients' right to make medical decisions in concert with their parents free from government interference.

205. The Act thus flies in the face of the Montana Constitution's multi-layered protections for medical autonomy, which is protected through both the right to privacy—discussed above—and the right to seek health contained in Article II, Section 3.

206. Additionally, the Act's prohibition of Medicaid and HMK coverage violates patients' fundamental rights because the right to seek health would have little meaning without the financial resources to access the medically necessary care one seeks.

207. The Act runs counter to the stated purpose of Montana Medicaid, which is "providing necessary medical services to eligible persons who have need for medical assistance." § 53-6-101(1), MCA.

208. The Act, on its face and as applied, violates patients' fundamental right to seek health and their corresponding right to finance their health care, and is therefore subject to strict scrutiny.

209. There is no justification for the State of Montana to deny patients their fundamental right to seek health.

210. The Act violates the health rights of the minor plaintiffs and their parents, and the health rights of the provider plaintiffs' current and future adolescent patients.

211. The Act is not narrowly tailored to further a compelling state interest or substantially related to an important government interest.

212. For these reasons, Plaintiffs are entitled to a declaratory judgment finding the Act unconstitutional and an injunction prohibiting the Act's enforcement.

COUNT V

(Plaintiffs' Right to Dignity)

(All Plaintiffs Against All Defendants)

213. Plaintiffs hereby incorporate all other paragraphs of this complaint as if fully set forth in this claim.

214. Article II, Section 4, of the Montana Constitution provides that "[t]he dignity of the human being is inviolable."

215. The Montana Supreme Court has recognized that this right to dignity is a fundamental right and "demands that people have for themselves the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives and the intrinsic value of life in general, answering to their own consciences and convictions." *Armstrong*, ¶ 72.

216. The express fundamental right to dignity is a unique and highly significant component of the Montana Constitution, and has been interpreted by this State's courts to bolster the individual rights of the citizens of Montana.

217. "Moreover, '[t]reatment which degrades or demeans persons, that is, treatment which deliberately reduces the value of persons, and which fails to acknowledge their worth as persons, directly violates their dignity.'" *Walker v. State*, 2003 MT 134, ¶ 81, 316 Mont. 103, 68 P.3d 872 (quoting Matthew O. Clifford & Thomas P. Huff, *Some Thoughts on the Meaning and Scope of the Montana Constitution's "Dignity" Clause with Possible Applications*, 61 Mont. L. Rev. 301, 307 (2000)).

218. The Act, on its face and as applied, violates patients' right to dignity by threatening and demeaning the humanity and identity of transgender individuals.

219. A person's ability to live their life as their true self, consistent with their core identity, and—specifically to the point here—to align their body with their gender identity, is at the heart of the notion of dignity.

220. By drastically limiting the ability of transgender people to seek potentially life-saving care that would allow them to live in alignment with their gender identity, the Act infringes on their fundamental right to dignity.

221. Moreover, the Act's recasting of a transgender person's gender identity as a mere "perception" is itself demeaning to their dignity.

222. The right to dignity also augments the claims above regarding discrimination and medical autonomy, as it has been read together with other fundamental rights to bolster the strength of protections afforded by the Montana Constitution to the citizens of the State.

223. Infringements on the right to dignity—a fundamental right—draw strict scrutiny.

224. The Act violates the dignity rights of the minor plaintiffs and their parents, and the dignity rights of the provider plaintiffs' current and future adolescent patients.

225. The Act is not narrowly tailored to further a compelling state interest or substantially related to an important government interest.

226. For these reasons, Plaintiffs are entitled to a declaratory judgment finding the Act unconstitutional and an injunction prohibiting the Act's enforcement.

COUNT VI

(Freedom of Speech & Expression)

(All Plaintiffs Against All Defendants)

227. Plaintiffs hereby incorporate all other paragraphs of this complaint as if fully set forth in this claim.

228. Article II, Section 7 of the Montana Constitution provides: "No law shall be passed impairing the freedom of speech or expression. Every person shall be free to speak or publish whatever he will on any subject, being responsible for all abuse of that liberty."

229. The bundle of rights protected by this constitutional provision includes the right to receive information, as an indispensable component of the free exchange of ideas. *See State ex rel. Missoulian v. Montana Twenty-First Judicial Dist. Court, Ravalli County* (1997), 281 Mont. 285, 301, 933 P.2d 829, 839.

230. The Act provides that "[a]ny individual or entity that receives state funds to pay for or subsidize the treatment of minors for psychological conditions, including gender dysphoria, may not use state funds to promote or advocate the medical treatments prohibited in subsection (1)(a) or (1)(b)." Act, § 4(4).

231. These provisions of the Act impermissibly burden the right to freedom of speech and expression protected by the Montana Constitution, restricting the rights not only of those who would—relying on the robust medical guidance detailed above—promote various practices prohibited by the Act, but also the rights of Plaintiffs' to receive such information.

232. The speech restricted by the Act is fully protected—healthcare practitioners have a right and indeed a duty to promote evidence-based and medically accepted treatments that they believe are in the best interest of their patients, including patients experiencing gender dysphoria, and patients have a right to hear their doctors' medical recommendations.

233. The Act is subject to strict scrutiny because it is neither viewpoint nor content neutral.

234. The Act discriminates on the basis of viewpoint by penalizing speech only when that speech is related to care that would affirm a gender identity when that gender identity is different from a person's assigned sex at birth. The law does not restrict speech related to care that would affirm a gender identity that matches a person's assigned sex at birth.

235. The Act discriminates on the basis of content because it penalizes speech related to transgender patients, gender transition, and treatment for gender dysphoria, thus penalizing speech based on its content.

236. The Act violates the free speech and expression rights of the provider plaintiffs, and the related rights to receive information of the minor plaintiffs and their parents.

237. The Act is not narrowly tailored to further any compelling state interest or substantially related to any important government interest.

238. For these reasons, Plaintiffs are entitled to a declaratory judgment finding the Act unconstitutional and an injunction prohibiting the Act's enforcement.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

A. Declare the Act unlawful and unconstitutional on its face and as applied for the reasons set forth above;

B. Permanently enjoin Defendants, as well as their agents, employees, representatives, and successors, from enforcing the Act, directly or indirectly;

C. Award Plaintiffs the reasonable attorney's fees and costs incurred in bringing this action; and

D. Grant any other relief the Court deems just.

Dated: July 17, 2023

Respectfully submitted,

By: /s/ Akilah Deernose
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