IN THE MISSOURI SUPREME COURT

No. SC100933

E.N., individually and as next friend and on behalf of her minor child N.N., et al.,

Appellants,

v.

Mike Kehoe, in his official capacity as Governor for the State of Missouri, et al.,

Respondents,

On Appeal from the Circuit Court of Cole County
Case No. 23AC-CC04530
Honorable R. Craig Carter

APPELLANTS' OPENING BRIEF

GILLIAN R. WILCOX, #61278
JASON ORR, #56607
ACLU of Missouri Foundation
406 West 34th Street, Ste. 420
Kansas City, Missouri 64111
Phone: (816) 470-9938
gwilcox @aclu-mo.org
jorr @aclu-mo.org

KRISTIN M. MULVEY, #76060
JONATHAN D. SCHMID, #74360
ACLU of Missouri Foundation
906 Olive Street, Suite 1130
St. Louis, Missouri 63101
Phone: (314) 652-3114
kmulvey @aclu-mo.org
jschmid @aclu-mo.org

NORA HUPPERT*
Lambda Legal Defense
and Education Fund, Inc.
3656 North Halsted Street
Chicago, Illinois 60613
(312) 663-4413
nhuppert @lambdalegal.org

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

* Admitted *pro hac vice*

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

J. BENNETT CLARK, #30907
MICHAEL E. ROWAN, #72992
TORI ANDREW, #76929
Bryan Cave Leighton Paisner LLP
One Metropolitan Square
211 North Broadway, Suite 3600
St. Louis, Missouri 63102
(314) 259-2000
ben.clark @bclplaw.com
michael.rowan @bclplaw.com
tori.andrew @bclplaw.com

Attorneys for Appellants

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Rules

Other Authorities

JURISDICTIONAL STATEMENT

On May 10, 2023, the Missouri General Assembly passed "Senate Substitute No. 2 to Senate Bills Nos. 49, 236 & 164." As enacted, the Senate Substitute established § 191.1720—the "Missouri Save Adolescents from Experimentation (SAFE) Act"—prohibiting the provision of certain medications and procedures for the purpose of gender transition to persons under 18 (hereafter, the "Care Ban"). It also added Subsection 15 to § 208.152 to prohibit coverage by MO HealthNet of medically necessary gender-affirming medical care for both transgender adolescents and adults (hereafter the "Medicaid Ban"). Together, the Care Ban and the Medicaid Ban are referred to herein as "the Act."[1]

Each count in Appellants' Petition challenges the validity of the Care Ban and the Medicaid Ban. This case therefore involves the validity of a Missouri statute and falls within the exclusive appellate jurisdiction of this Court. *See* Mo. Const. art. V, § 3.

[1] Unless otherwise noted, all statutory citations are to Missouri Revised Statutes (2016), as updated, and all Rule references are to Missouri Supreme Court Rules, as updated.

INTRODUCTION

Decades of clinical experience and rigorous study have demonstrated medical treatment for a transgender person's gender dysphoria (known as "gender-affirming medical care," hereafter "GAMC") is safe and effective. This is true for adults and adolescents. Yet, through the Act, Missouri bans all medical interventions "for the purpose of a gender transition" for any transgender person under age 18 (the Care Ban) and prohibits Medicaid from covering such interventions for any transgender person, regardless of age (the Medicaid Ban). The Act thus takes aim at one class of people who need treatment to align their bodies with their gender identity.

The Act interferes with rights of transgender Missourians that are guaranteed by the Missouri Constitution—rights that every Missourian shares and that are meant to be more expansive and protective than those guaranteed by the U.S. Constitution. The Act interferes, *inter alia*, with the right of parents to make decisions about medical care for their children; the rights of transgender Missourians, young and old, to autonomy in making healthcare decisions and to both equal rights and equal opportunity under the law; and the right of medical providers to exercise their profession. As such, Appellants sued to vindicate their rights, as well as those of their patients and members.

After a two-week trial, the trial court entered a judgment and order permeated by legal and factual errors and which reflects little independent judgment, having adopted largely verbatim Respondents' proposed findings and conclusions.

Given the gravity of what is at stake—the health and wellbeing of hundreds of Missourians—and the multitude of legal and factual errors that permeate its decision, this Court should reverse the trial court's decision.

STATEMENT OF FACTS[2]

I. Background and Procedural History

Appellants brought several claims under the following provisions of the Missouri Constitution: the Equal Protection Clause (Article I, § 2), for discrimination against transgender adolescents and adults because of sex, transgender status, and animus towards transgender individuals; the Natural Rights and Due Process Clauses (Article I, §§ 2 and 10), for infringing upon parents' fundamental right to make decisions concerning the care and upbringing of their children, along with transgender adolescents' and adults' liberty interests and right to autonomy in healthcare; the "Gains of Industry" Clause (Article I, § 2), for depriving healthcare providers of their right to the enjoyment of the gains of their own industry; and the Special Law Limitation (Article III, § 40), as the Act is a special law that does not apply equally to all members of a given class. D2; App 240.

The trial court held a two-week bench trial and heard testimony from over thirty witnesses, including thirteen experts.

Each side moved to exclude the testimony of the other's experts, with one exception. D84, 86, 88, 90, 92, 94, 98, 104, 107, 110, 114, 116. The trial court did not rule on these motions and appeared to accept the testimony of each expert at trial. At the pretrial

[2] The trial and the preliminary injunction hearing transcripts are cited herein as "Trial Tr." and as "PI Tr.," respectively.

conference, Respondents moved to incorporate all the PI testimony and admitted PI exhibits into the trial record, a categorical approach Appellants opposed. The trial court ruled that it would "allow[] evidence from the initial hearing in this case to be admitted in the present trial, with the caveat that the parties will be granted time for additional trial objections before ruling on admissibility." D1. Appellants agreed to the admission of the PI transcript as part of the trial record. Some PI exhibits were re-offered at trial and ruled on; as to others, Appellants objected during and after the trial. D180. The trial court did not admit any of these objected-to PI exhibits during the trial or after. *See*, *e.g.*, Trial Tr. 1699:15-17 (excluding Ex. 1028, which was Defs.' PI Ex. R, accepted only as demonstrative at trial).[3] Respondents did not object to Appellants' PI exhibits, and, in fact, moved to have *all* exhibits admitted. Thus, the transcript and all of Appellants' PI exhibits, but none of Respondents' exhibits to which Appellants objected, were incorporated into the trial record by operation of the trial court's September 20, 2024 Order. *See State v. Drinkard*, 750 S.W.2d 630, 635 (Mo. App. S.D. 1988).[4]

A final judgment was entered on November 25, 2024. Appellants timely appealed.

[3] Throughout this brief, all trial exhibits are referred to as "Ex. [number]" and PI exhibits are referred to as either "Plts.' PI Ex. [number]" or "Defs.' PI Ex. [number]." Plaintiffs' trial exhibits started at number 1 and Defendants' started at number 1000.

[4] The only PI exhibits incorporated into the trial record are Appellants' PI Exhibits 1-17 and 19-22, for which there was no objection, and Respondents' PI Exhibits B, C, D, and E, which were admitted separately at trial as Trial Exhibits 1201, 1230, 1231, 1232, and 1233.

II. Expert Testimony at Trial

At trial, six expert witnesses testified for Appellants: Dr. Aron Janssen, a child and adolescent psychiatrist; Dr. Danielle Moyer, a psychologist; Dr. Daniel Shumer, a pediatric endocrinologist; Dr. Johanna Olson-Kennedy, a pediatrician and adolescent medicine doctor; Dr. Armand H. Matheny Antommaria, a pediatric hospitalist and bioethicist; and Dr. E. Kale Edmiston, a neuroscientist and professor of psychiatry. Exs. 66, 69, 72, 75, 78, 81; *see also* Trial Tr. 100:5-12, 231:18-23, 301:10-23, 491:12-25, 492:1-2, 710:3-6, 711:5-10, 823:9-12, 824:2-8. Appellants' experts have extensive experience treating, assessing, diagnosing, and/or studying transgender youth and/or adults in clinical settings.

Respondents' expert witnesses were: Dr. Stephen Levine, an adult psychiatrist; Dr. James Cantor, an adult psychologist specializing in the study of pedophilia; Dr. John Michael Bailey, a psychology professor who has never held a license to treat patients; Sara Stockton, a therapist; Dr. Daniel Weiss, an adult endocrinologist; Dr. Farr Curlin, a hospice and palliative care physician; and Dr. Patrick Lappert, a retired plastic surgeon. PI Tr. 395:18-21; Trial Tr. 1766:7-22, 1772:16-18, 1902:11-14, 1903:21-22, 1908:18-25, 1909:17-1910:2, 1910:6-14, 2040:6-2041:2, 2145:1-4, 2389:13-14, 2418:9-2419:18, 2488:20-23; *see also* Ex. 151, at 1. Only Dr. Levine and Ms. Stockton purported to have any experience treating gender dysphoria in adolescents, and both have supported minors obtaining GAMC in the past. Trial Tr. 2465:23-2466:1, 2158:23-11, 2212:11-16, 2160:17-25, 2156:2-12, 2158:16-22. None of Respondents' other experts have any experience assessing or treating minors with gender dysphoria.

III. Gender Identity and Gender Dysphoria

"Gender identity" refers to a person's deeply felt, inherent sense of belonging to a particular gender. Trial Tr. 101:25-102:2. One's "sex assigned at birth" refers to the designation that doctors make at birth, usually based on external genitalia. Trial Tr. 102:3-14. The term "transgender" refers to those whose gender identity differs from their sex assigned at birth. Trial Tr. 372:6-11.

Being transgender is not itself a disorder or condition to be cured. PI Tr. 54:21-22. However, many transgender people suffer from gender dysphoria, a diagnosis under the American Psychiatric Association's DSM-5-TR that refers to the clinically significant distress resulting from a marked incongruence between one's experienced or expressed gender and their sex assigned at birth. Ex. 13; Trial Tr. 102:5-21. Gender dysphoria is a serious condition that, if left untreated, is highly associated with conditions such as depression, anxiety, and suicidality. Trial Tr. 131:11-16.

IV. Medical Treatment for Gender Dysphoria

A. The Clinical Guidelines

There are well-established, widely accepted guidelines for the treatment of gender dysphoria. Trial Tr. 37:10-12. Since 1979, the World Professional Association for Transgender Health ("WPATH") has continuously published clinical guidelines for the treatment of gender dysphoria, now in its eighth version, *Standards of Care for the Health of Transgender and Gender Diverse People*, *Version 8* ("SOC8"). PI Tr. 65:14-66:13; Ex. 5. The Endocrine Society has also published practice guidelines. Trial Tr. 115:15-116:16, 628:22-23, 2097:14-15; Ex. 306. These guidelines are consistent with one another, Trial

Tr. 123:19-22, and have been cited authoritatively by the major medical organizations in the United States. Trial Tr. 116:20-24.

B. Assessments

Under the guidelines, medical treatment of transgender adults and adolescents with gender dysphoria begins with a biopsychosocial assessment, after which patients may receive medical interventions. Trial Tr. 239:19-240:8; Ex. 5, at S5, S48; Ex. 306, at 3876-77.[5] In all cases, it is recommended that professionals performing assessments be licensed and receive appropriate training. Trial Tr. 108:10-14, 126:20-127:7. The biopsychosocial assessment of adolescents comprises four main elements, which correspond to specific requirements: gender identity development history; psychosocial history and supports (including family support); diagnostic assessment of possible co-occurring mental health concerns; and capacity for decision-making and consent. Trial Tr. 238:23-239:2, 238:23-239:2; Ex. 5, at S51; Ex. 306, at 3876-77.

C. Puberty Blockers

Puberty blockers are considered medically necessary to treat gender dysphoria in some adolescents. Trial Tr. 311:13-18. Puberty blockers prevent the progression of pubertal development. Trial Tr. 334:13-25. The onset of secondary sex characteristics can cause an intensification of gender dysphoria, and treatment with puberty blockers reduces the risk of worsening gender dysphoria and mental health deterioration. Trial Tr. 258:25-259:5, 70:19-71:9.

[5] No medical interventions are provided to pre-pubertal children to treat gender dysphoria. Trial Tr. 117:20-24, 219:14-16, 249:25-250:3, 311:21-24, 350:7-9, 497:18-22.

The effects of puberty blockers are reversible. Trial Tr. 337:20-338:13. A patient will typically begin taking them at the onset of puberty and continue taking them until mid-adolescence. Trial Tr. 316:19-22, 338:8-10. During this time, the question of whether to continue medical treatment is continually evaluated.

While bone density is monitored as part of the ongoing evaluation, there is no evidence that puberty blockers have a negative or lasting effect on it. Trial Tr. 337:3-16. Puberty blockers themselves have no effect on fertility, although fertility is discussed with patients because gender-affirming hormone treatment ("GAHT") following puberty blockers can affect patients' fertility. Trial Tr. 246:6-18. There is no evidence that puberty blockers have a negative effect on brain development. Trial Tr. 337:17-19, 670:11-13.

D. GAHT

GAHT is considered medically necessary to treat gender dysphoria in some adolescents and adults. Trial Tr. 344:17-20; *see also* Ex. 5, at S100. Some effects of GAHT are reversible (e.g., changes in body fat composition, decreases in facial and body hair), while others are irreversible (e.g., deepening of the voice, breast tissue development). Trial Tr. 354:21-356:25. For adolescents, practitioners aim to begin GAHT within the normal age range for a person going through puberty, so the patient develops sex-specific physical changes that are congruent with their gender identity. Trial Tr. 348:2-348:22, 349:17-20, 352:24-353:15. While there can be effects of GAHT on a person's fertility, adolescents have options to preserve fertility, if desired, and many pursuing GAHT are able to have children in the future. Trial Tr. 737:14-19, 335:11-23, 414:16-415:4; *see also* Trial Tr. 2329:24-25, 2330:7-10.

Side effects of GAHT are discussed at length with patients (and for adolescents, with parents or guardians) before it is prescribed, and potential side effects continue to be monitored and discussed throughout the course of treatment. Trial Tr. 345:13-348:1, 357:1-3. The testimony at trial supports this finding. Trial Tr. 1013:14-1014:25, 1071:6-9, 1107:8-10, 1225:6-1229:17, 1272:11-23, 1376:4-24, 1377:15-19, 1378:3-1380:3, 1385:4-1386:4, 1452:3-7, 1455:12-24, 1470:16-1471:2, 1499:18-1500:2, 1532:5-12, 1534:12-1535:3, 1539:2-1539:21, 2295:17-2296:6; *see also* Exs. 349, 352, 353, 356.

GAHT is a safe, effective, and evidence-based treatment for patients with gender dysphoria. Trial Tr. 330:10-15.

E. Surgery

Surgical interventions are medically necessary for some transgender individuals. Trial Tr. 332:3-8; Ex. 5, at S5. The risks of such procedures are well-documented in the literature and are no different when used to treat gender dysphoria than other health conditions. Ex. 5, at S128. "Generally, surgical interventions are … reserved for adults; however, masculinizing chest surgery can be a surgery that's helpful for … older adolescents with significant chest dysphoria." Trial Tr. 332:3-8; PI Tr. 70:2-7. "[I]t's extraordinarily rare that minors have any other forms of surgery." Trial Tr. 571:21-23. However, the insertion of a puberty blocker implant is an outpatient surgical procedure. Trial Tr. 572:8-13.

F. The Evidence Base for GAMC

GAMC dates back nearly a century. Trial Tr. 525:10-12, 525:13-18. GAHT began in the 1930s. Trial Tr. 506:22-25. Puberty blockers have been used since at least the late 1990s. Trial Tr. 508:2-3.

Many studies have demonstrated that puberty blockers are effective at treating gender dysphoria by preventing the development of secondary sex characteristics incongruent with an adolescent's gender identity and thereby preventing deterioration or worsening of gender dysphoria and related distress. Trial Tr. 329:16-330:20, 538:6-17; *see also, e.g.*, Exs. 135, at 2282; 129, at 2213; 190, at 801.[6] The scientific literature also establishes that treatment with puberty blockers is safe. Trial Tr. 329:16-330:20, 538:6-17.

The scientific literature demonstrating the efficacy of GAHT is similarly well-established. Trial Tr. 330:8-15, 456:2-7. Numerous longitudinal studies document improvement in gender dysphoria and associated distress resulting from GAHT. *Id.*; *see, e.g.*, Exs. 125, 186.[7]

Further, GAHT has been shown to have other positive health outcomes when used to treat gender dysphoria. Trial Tr. 545:21-546:12, 551:18-552:19, 554:7-21, 555:19-556:24, 557:16-558:5, 558:19-559:23, 561:10-23; *see also, e.g.*, Exs. 125, at 240; 142, at

[6] Exhibits 129, 135, and 190 were admitted by the trial court as demonstratives. Throughout the brief, Appellants note which exhibits were admitted for demonstrative purposes only. All other cited exhibits were admitted for substantive purposes.

[7] Exhibit 186 was admitted as a demonstrative.

643; 111, at 3; 112, at 302; 124, at 1109.[8] GAHT is safe and has a low risk of side effects. Trial Tr. 549:19-550:3, 594:10-17; *see also, e.g.*, Ex. 193, at 1.

The scientific literature also shows that surgery is an effective treatment for gender dysphoria. Trial Tr. 332:5-8, 571:15-579:1; *see also* Ex. 5, at S128. This includes gender-affirming chest surgery for older adolescents. Trial Tr. 332:5-8, 571:25-572:1; *see also, e.g.*, Exs. 232; 5, at S66. Patient satisfaction with gender-affirming surgery is high, and regret rates are low. Exs. 232, at 434; 5, at S128-30.

V. Appellants' Fact Witnesses

Three of the parents of minor transgender Missourians ("Parent Appellants") and one of the minor transgender adolescents ("Minor Appellants") testified: E.N.*[9] testified about her eleven-year-old transgender son, N.N.*; S.M. testified about her fourteen-year-old transgender son, C.J.; J.K. testified about his fifteen-year-old transgender daughter, A.K.; and A.K. also testified (collectively, "Family Appellants"). Additionally, five of Appellants' non-party fact witnesses testified about their own or their child's experiences receiving GAMC in Missouri.

Family Appellants each described a careful, deliberate process of understanding the experience of gender dysphoria, exploring medical options for treatment, and forming a treatment plan under the close, careful guidance of their Missouri medical practitioners. Trial Tr. 1154:19-1182:21, 1217:6-1241:10, 1264:8-1277:9, 1296:24-1311:19. Each

[8] Exhibits 111, 112, 124, and 142 were admitted as demonstratives.

[9] * Indicates the name is a pseudonym.

Minor Appellant underwent extensive counseling and received a biopsychosocial assessment prior to initiating any medical treatment. Trial Tr. 1205:20-21, 1206:18-20, 1223:6-12, 1302:6-1303:8, 1328:15-16; Exs. 360, 372. Further, the testimony of each Family Appellant, as well as some of the fact witnesses, demonstrated that Respondents' witness Jamie Reed accessed their private medical information and widely disseminated it without consent, which was distressing to them. Trial Tr. 1181:11-13, 1244:4-13, 1310:12-16, 1474:24-1475:4, 1498:19-25, 1549:17-1550:4.

Appellants Dr. Michael Donovan and Nurse Nicole Carr of Southampton Community Healthcare (collectively, "Provider Appellants") testified about their medical practice and treatment of patients with gender dysphoria, including Medicaid beneficiaries. Both Dr. Donovan and Nurse Carr are members of GLMA. Trial Tr. 989:10-21, 1111:1. Southampton's patient population includes adults and minors diagnosed with and receiving treatment for gender dysphoria, including individuals on Medicaid. Trial Tr. 992:5-16, 993:1-3, 1111:18-1112:4, 1113:15-1114:2, 1115:18-25, 1116:15-18, 1114:5-9. Dr. Donovan estimates he has treated around 300 transgender patients. Trial Tr. 993:19-994:2.

Provider Appellants utilize the clinical guidelines. Trial Tr. 1003:8-13, 1117:2-4. When diagnosing and treating patients with gender dysphoria, they conduct a biopsychosocial assessment, including an assessment of capacity to consent and, if moving forward with treatment, they obtain informed consent and/or assent. Trial Tr. 1003:14-1005:6, 1004:21-1005:6, 1013:14-17, 1117:10-1118:5, 1118:25-1119:16, 1013:18-24, 1014:11-25.

Appellant PFLAG, Inc. is a national membership nonprofit organization for LGBTQ+ people and their parents, families, and allies, comprising approximately 350,000 members and supporters and over 350 local chapters throughout the United States, including seven in Missouri. Trial Tr. 1333:8-12, 1333:16, 1336:16-21, 1337:21-25; Ex. 92, at 1. Approximately 280 of its members reside in Missouri, including families of transgender youth who currently receive or will need access to GAMC, as well as minors and adults who receive GAMC through Medicaid. Trial Tr. 1336:13-15, 1136:22-1137:1. These members include the Family Appellants; Amy Salladay, the parent of a transgender Missouri adolescent; and A.Q., who submitted an affidavit stating that their transgender foster child received health coverage through Medicaid. Trial Tr. at 1137:2-18, 1338:1-3.

Appellant GLMA: Health Professionals Advancing LGBTQ+ Equality ("GLMA") is a national membership nonprofit organization whose mission is to ensure health equity for LGBTQ+ people and equality for LGBTQ+ health professionals in their work and learning environments. Trial Tr. 952:2-13, 961:1-6. GLMA's membership includes approximately 1,000 member physicians, nurses, and other health professionals. Trial Tr. 956:9-21. GLMA's Missouri members include individual Provider Appellants, as well as Dr. Sam Tochtrop, a primary care physician who practices gender-affirming medicine in Missouri. Trial Tr. 957:22-25, 981:22-982:5.

Appellants also presented testimony from two transgender adults who received GAMC as minors in Missouri (John Doe* and Elliot M.), as well as a parent of each (Kim H. and Suzanne M.). Amy Salladay, the parent of a transgender Missouri minor, and Logan Casey, a transgender man many years into his medical transition, also testified. Each of

these witnesses expressed deep satisfaction with the care they received, much of which was in Missouri. Trial Tr. 83:4-23, 1542:25-1543:8, 1543:25-1, 1382:18-20, 1392:5-6, 1470:12-1471:5, 1474:10-13, 1496:4-21.

VI. Respondents' Expert Witnesses' Bias

Many of Respondents' experts exhibited bias and/or credibility issues. Dr. Cantor has stated pedophiles should be included within the LGBTQ+ umbrella and has expressed concern over losing his "career" as an expert witness when confronted with such views. Trial Tr. 1876:12-14, 1877:12-23, 1881:2-14; Exs. 500, 501. Before becoming a "career" expert witness, Dr. Cantor believed that "youth should be permitted to begin to transition … medically" at "age 12 … because that is what the (current) evidence supports." Trial Tr. 1882:8-1883:3; Ex. 399. Over eighty percent of his income comes from expert witness fees. Trial Tr. 1875:21-1876:4. Dr. Bailey admitted that his views involve great skepticism of the self-reported experiences of transgender people, just like that of Jerry Sandusky's sexual assault victims. Trial Tr. 1980:25-1982:5, 1980:5-24. Ms. Stockton admitted to making exaggerated claims about LGBTQ+ people, including that "LGBTQ websites" educate children on "santeria" or other rituals. Trial Tr. 2240:25-2243:12. Dr. Lappert has stated that GAMC is a "lie," a "moral violation," a "huge evil," and "diabolical"—statements he stood by at trial. Trial Tr. 2611:9-2612:9.

VII. The Lack of Record Support for the State's Criticisms of GAMC

Adult Care. Respondents presented virtually no evidence regarding GAMC for adults. Respondents' experts' criticisms of GAMC were exclusively about care for minors,

and many, in fact, support GAMC for adults. Trial Tr. 1838:24-1839:5, 1951:18-1952:10, 1982:6-13, 2086:13-2087:3, 2097:23-2098:2, 2099:3-9, 2107:19-25, 2400:24-2401:2.

Quality of Evidence. Respondents' witnesses criticized the quality of evidence underlying the guidelines for GAMC for minors, which is classified under the GRADE system as "low" or "very low." Trial Tr. 1795:17-22. This is a red herring. Clinical guidelines across medicine are very commonly supported by "low" or "very low" quality evidence under GRADE. Trial Tr. 732:25-733:3, 734:5-7. The Endocrine Society's guidelines on obesity and adrenal hyperplasia and the American Heart Association's guidelines on CPR in children are all supported by "low" or "very low" quality evidence. Trial Tr. 733:13-734:4. The classification of "low" or "very low" under GRADE principally refers to a lack of randomized controlled trials, which are both ethically and practically inappropriate to conduct for GAMC. Trial Tr. 735:18-736:10. Relatedly, while some of Respondents' experts testified about "systematic reviews" finding a lack of "high" quality evidence, it was undisputed that this is also exceedingly common across areas of medicine—only about ten to fourteen percent find "high" quality evidence for their primary outcome. Trial Tr. 733:9-12, 739:19-740:11; *see also* PI Tr. 423:14-18, 424:23-425:25. There is no ethical or medical basis for singling out GAMC.

Crucially, Respondents presented no evidence supporting the notion that gender dysphoria can be treated effectively by psychotherapy alone. Trial Tr. 588:14-19, 750:13-22, 1796:8-10, 2468:10-15; PI Tr. 81:14-21, 666:12-16.

Detransition/desistance. Some people who initiate GAMC may choose to discontinue such treatment (*i.e.*, detransition). Trial Tr. 150:2-24, 266:19-12, 583:17-

584:3. Most commonly, cessation of treatment is due to external factors, such as harassment, discrimination, and societal and familial pressure. Trial Tr. 150:22-151:13. Far less commonly, a person may cease treatment due to reidentification with their birth-assigned sex. Trial Tr. 150:22-24, 151:14-21, 266:19-267:17, 584:4-6, 584:13-16; *see also* Ex. 130, at 7.

Separate from the concept of "detransition" is the concept of "desistance." Trial Tr. 272:3-273:14, 583:7-16. Desistance refers to the concept that a small number of pre-pubertal children who experience gender dysphoria in childhood may not go on to experience gender dysphoria in adolescence. *Id.* On the other hand, ***if gender dysphoria persists into adolescence, it is very unlikely to ever desist***. Trial Tr. 272:25-273:2, 417:16-25, 582:11-14, 584:3-4. Even Respondents' experts acknowledged this. Trial Tr. 1883:1-7, 1964:22-1965:3; Ex. 399.

Some of Respondents' experts pointed to studies purporting to show high rates of desistance, Trial Tr. 2441:1-9, but these studies pre-date the modern diagnostic criteria for gender dysphoria, and many of the participants did not meet even the older, broader diagnostic criteria for the former diagnosis of "gender identity disorder." Trial Tr. 2474:12-2475:14, 1957:3-1959:2. Thus, these studies largely involved participants who never expressed a desire or insistence of being the opposite gender and would not, today, receive a diagnosis of gender dysphoria at all. *Id.*

Other countries. The record reflects that no country's guidelines have prohibited GAMC for minors. Trial Tr. 586:23-587:5, 1850:9-23. In Sweden, Finland, and the United Kingdom (UK), GAMC is provided to adolescents with gender dysphoria when indicated

under their guidelines, as Respondents' own experts acknowledged. Trial Tr. 586:23-587:5; PI Tr. 412:24-413:8, 678:16-24. In Finland, GAHT is provided to minors if the adolescent's gender identity is persistent and causes severe dysphoria. PI Tr. 678:16-24. The UK has restricted puberty blockers to a research protocol but continues to provide GAHT starting at the age of sixteen. Trial Tr. 749:4-9, 1073:12-18. In Sweden, GAMC for minors is permitted "in cases that fit" the model of care practiced in Dutch clinics. Trial Tr. 1850:21. No restrictions are in place in Australia, New Zealand, Northern Ireland, Germany, Spain, Denmark, the Netherlands, Canada, "and many other countries." Trial Tr. 587:11-15. And the record does not show that any countries have restricted coverage of GAMC for adults.

Off-label use. The use of puberty blockers and GAHT for the treatment of gender dysphoria is an off-label use, meaning that the medications themselves are approved by the FDA, but not for this particular use. However, this does not mean they are unsafe or ineffective. Trial Tr. 321:8-12. Nor does it mean their use is experimental. Trial Tr. 321:13. Off-label use of medication is common in all areas of medicine, especially in pediatrics. Trial Tr. 319:21-25.

POINTS RELIED ON

Point I: The trial court erred in finding Appellants lacked standing to challenge the Medicaid Ban because it misapplied the law in that Provider Appellants have individual and third-party standing on behalf of their transgender patients on Medicaid, and Appellants PFLAG and GLMA have associational standing.

- *St. Louis Ass'n of Realtors v. City of Ferguson*, 354 S.W.3d 620 (Mo. banc 2011)
- *Planned Parenthood of Kan. v. Nixon*, 220 S.W.3d 732 (Mo. banc 2007)
- *Genevieve Sch. Dist. R II v. Bd. of Aldermen of Ste. Genevieve*, 66 S.W.3d 6 (Mo. banc 2002)

Point II: The trial court erred in finding Appellants failed to properly plead their constitutional challenge to the Medicaid Ban because Appellants pled a claim against the Medicaid Ban in that the facts alleged meet the elements necessary for such a challenge.

- *Matthews v. Harley-Davidson*, 685 S.W.3d 360 (Mo. banc 2024)
- *Wash. Univ. v. Royal Crown Bottling Co. of St. Louis*, 801 S.W.2d 458 (Mo. App. E.D. 1990)

Point III: The trial court erred in finding Appellants failed to argue and prove their constitutional challenge to the Medicaid Ban because it misapplied the law and disregarded undisputed evidence, in that, as discussed, Appellants demonstrated standing to raise this claim, the Medicaid Ban violates the Missouri Constitution, and the record lacks evidence to justify banning GMAC coverage for adults.

- Mo. Const. art. I, §§ 2, 10

Point IV: The trial court erred in denying Parent Appellants' due process claim because it misapplied the law by failing to apply strict scrutiny in that Parent Appellants have a fundamental right to direct the medical care of their children and the Act violates that right.

- *Troxel v. Granville*, 530 U.S. 57 (2000)
- *Parham v. J.R.*, 442 U.S. 584 (1979)

- *PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182 (10th Cir. 2010)
- *Brandt v. Rutledge*, 551 F.Supp.3d 882 (E.D. Ark. 2021), *aff'd*, 47 F.4th 661 (8th Cir. 2022)
- Mo. Const. art. I, § 2

Point V: The trial court erred in denying Appellants' due process claim related to the fundamental right to autonomy in making healthcare decisions because the court misapplied the law in that it failed to apply heightened scrutiny and erroneously held that there is no protection for an individual's fundamental right to autonomy in making healthcare decisions.

- *Cruzan v. Harmon*, 760 S.W.2d 408, 416 (Mo. banc 1988), *aff'd*, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990)
- *Cross ex rel. Cross v. State*, 560 P.3d 637 (Mont. 2024)
- *Moe v. Yost*, 2025 WL 844497 (Ohio App. 10 Dist., 2025)
- Mo. Const. art. I, §§ 2, 10

Point VI: The trial court erred in denying Appellants' claim that the Act violates the Equal Protection Clause because the trial court should have applied heightened scrutiny and, even if it did not, the Act does not satisfy rational basis review, in that the Act classifies and purposely discriminates based on sex and transgender status.

- *Bostock v. Clayton Cnty.*, 590 U.S. 644 (2020)
- *United States v. Virginia*, 518 U.S. 515 (1996)
- *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256 (1979)
- *Glossip v. Mo. Dep't of Transp. & Highway Patrol Emps. Ret. Sys.*, 411 S.W.3d 796 (Mo. banc 2013)
- Mo. Const. art. I, § 2

Point VII: The trial court erred in denying Appellants' claims based on its erroneous factual findings because those factual findings are not supported by the record and any conclusions based on them are against the weight of the evidence in that by adopting almost verbatim Respondents' proposed findings,

the trial court relied on evidence it either excluded during the trial and/or that is not in the record thereby making factual findings that have no support in the record, much less carry any weight, and including factual findings that contradicted the trial court's evidentiary rulings.

- *United States v. Virginia*, 518 U.S. 515 (1996)
- *Ivie v. Smith*, 439 S.W.3d 189 (Mo. banc 2014)
- *Brandt v. Rutledge*, 677 F.Supp.3d 877 (E.D. Ark. 2023)
- § 490.220 RSMo

Point VIII: The trial court erred in admitting and relying on testimony of Drs. Curlin and Lappert because neither satisfies the evidentiary requirements for expert testimony in that both lack any relevant experience or expertise in the areas to which they testified, are biased and prejudiced, and their testimony is unreliable and irrelevant.

- *Moore v. Monsanto Co.*, 699 S.W.3d 516 (Mo. App. E.D. 2024)
- § 490.065 RSMo

Point IX: The trial court erred in denying facial and as-applied relief because it misapplied the law, in that it erroneously required Appellants to demonstrate the Act has no constitutional applications to prevail on a facial challenge and failed to evaluate the as-applied claims on their merits.

- *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442 (2008)
- *Doe v. City of Albuquerque*, 667 F.3d 1111 (10th Cir. 2012)
- *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320 (2006)

Point X: The trial court erred in finding that the Act does not violate the "Gains of Industry" Clause because the trial court misapplied the law in that such clause is not limited to "workplace slavery" or laws that require the provision of services without pay.

- *Fisher v. State Highway Comm'n of Mo.*, 948 S.W.2d 607 (Mo. banc 1997)
- Mo. Const. art. I, § 2

ARGUMENT

Point I: The trial court erred in finding Appellants lacked standing to challenge the Medicaid Ban because it misapplied the law in that Provider Appellants have individual and third-party standing on behalf of their transgender patients on Medicaid, and Appellants PFLAG and GLMA have associational standing.

I. Standard of Review and Preservation of Error

"Standing is a question of law, which is reviewed *de novo*." *St. Louis Ass'n of Realtors v. City of Ferguson*, 354 S.W.3d 620, 622 (Mo. banc 2011). "The jurisdiction of the trial court is a question of law." *Lett v. City of St. Louis*, 24 S.W.3d 157, 161 (Mo. App. E.D. 2000). "To properly raise a constitutional question, plaintiffs are required to: (1) raise the constitutional question at the first available opportunity; (2) designate specifically the constitutional provision claimed to have been violated, such as by explicit reference to the article and section or by quotation of the provision itself; (3) state the facts showing the violation; and (4) preserve the constitutional question throughout for appellate review." *Callier v. Dir. of Revenue*, *State*, 780 S.W.2d 639, 641 (Mo. banc 1989).

No post-trial motions were required, and the issue is preserved.

II. Argument

Appellants, through Southampton, Dr. Donovan, Nurse Carr, PFLAG, and GLMA, have standing to bring their claims challenging the Medicaid Ban because (i) Southampton, Dr. Donovan, and Nurse Carr have both individual and third-party standing; and (ii) PFLAG and GLMA have associational standing. The trial court's order finding Appellants lack standing was in error.

A. Provider Appellants have individual and third-party standing to challenge the Medicaid Ban.

1. Individual Standing

The Medicaid Ban impinges on the ability of Provider Appellants to comply with their ethical duties and provide necessary medical care to their patients. "Reduced to its essence, standing roughly means that the parties seeking relief must have some personal interest at stake in the dispute, even if that interest is attenuated, slight or remote." *Ste. Genevieve Sch. Dist. R II v. Bd. of Aldermen of Ste. Genevieve*, 66 S.W.3d 6, 10 (Mo. banc 2002). To have standing, a plaintiff must allege "a pecuniary or personal interest directly in issue or jeopardy which is subject to some consequential relief, either immediate or prospective." *Vowell v. Kander*, 451 S.W.3d 267, 271 (Mo. App. W.D. 2014). "There is no litmus test for determining whether a legally protectable interest exists; it is determined on a case-by-case basis." *Mo. All. for Retired Ams. v. Dep't of Lab. & Indus. Rels.*, 277 S.W.3d 670, 676 (Mo. banc 2009).

The medical providers have a pecuniary and personal interest directly at issue and thus seek injunctive relief in this case. *See State v. Loe*, 692 S.W.3d 215, 226 (Tex. 2024). At issue is the providers' ability to provide medical care to their patients and comply with their ethical duties, which demand that they do no harm and treat all patients equally.

Although the trial court did not use the term "standing" directly, it found that Appellants "failed to submit" evidence that they are harmed by the Medicaid Ban and that the medical providers "could not say" whether they had any patients receiving Medicaid coverage for gender dysphoria and denied their claims. D185 p. 48; App 1. This implies a

lack of standing and is incorrect. Provider Appellants testified that they provide GAMC to patients on Medicaid, Trial Tr. 994:16-996:10, 1116:15-1117:1, and that, but for the Act, they would continue to provide GAMC to all their patients, including those on Medicaid. Trial Tr. 1019:5-16, 1126:8-1128:13. The trial court makes much of the fact that the Provider Appellants purportedly could not say whether any of the transgender *minor* patients they specifically referenced received coverage through Medicaid, but ignores the clear, direct testimony that many of their adult transgender patients, whom they treat for gender dysphoria and to whom the Medicaid Ban applies, were covered under Medicaid. *Id.* And it ignores the record evidence establishing that at least one of Southampton's patients who obtained care as a minor received their coverage through Medicaid. Trial Tr. 1116:15-24.

Provider Appellants testified that GAMC is necessary, and that their patients "suffer needless harm" when unable to receive it. Trial Tr. 1016:10-15, 1017:2-1018:14, 1126:23-1130:1. As they testified, the Act, including the Medicaid Ban, forces medical providers into the untenable position of deciding between fulfilling their ethical and professional oaths to provide patients with individualized, evidence-based medical care, or risking their licenses and facing disciplinary actions. Trial Tr. 1018:23-1019:4. Provider Appellants have individual standing.

2. Third-Party Standing

Provider Appellants also have third-party standing to challenge the Medicaid Ban on behalf of their transgender patients on Medicaid. To have third-party standing, a litigant must show: "(1) a concrete injury, (2) a close relation to the third party, and (3) some

hindrance to the third party's ability to protect its own interests." *State ex rel. Delmar Gardens N. Operating, LLC v. Gaertner*, 239 S.W.3d 608, 610 (Mo. banc 2007). This Court has recognized that physicians and their employers have standing to assert claims on behalf of their patients. *See Planned Parenthood of Kan. v. Nixon*, 220 S.W.3d 732, 738 (Mo. banc 2007).

Provider Appellants testified that each would, but for the Act, continue to provide minors and adults with safe, effective, and medically necessary GAMC, for which they would be reimbursed under Medicaid but for the Act. Trial Tr. 1019:5-16, 1126:8-1128:13; *see also Singleton v. Wulff*, 428 U.S. 106, 112-13 (1976). Further, the right of doctors to bring claims on behalf of their patients, particularly where the procedure at issue is one in which the physician is intimately involved, has been repeatedly recognized in analogous medical contexts. *See Singleton*, 428 U.S. at 115; *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Nixon*, 220 S.W.3d at 738. Finally, Provider Appellants' patients face substantial obstacles in asserting their own rights, including the desire to protect the "privacy of [their] decision" to seek GAMC—a particularly relevant concern considering the high levels of discrimination their patients face. *Singleton*, 428 U.S. at 117; *see also, e.g.*, Trial Tr. 998:15-999:13, 1015:1-25, 1112:23-1113:14, 1117:7-1118:22, 1126:23-1128:13.

Other courts have recognized providers' third-party standing to bring claims on behalf of their transgender patients. *See San Francisco A.I.D.S. Found. v. Trump*, 2025 WL 1621636, at *12-13 (N.D. Cal. June 9, 2025); *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.*, 485 F.Supp.3d 1, 34-35 (D.D.C. 2020); *City & Cnty. of San*

Francisco v. Azar, 411 F.Supp.3d 1001, 1011 (N.D. Cal. 2019); *Cross ex rel. Cross v. State*, 560 P.3d 637, 645 (Mont. 2024).

B. PFLAG and GLMA have associational standing.

An organization has associational standing if "(a) its members would otherwise have standing to bring suit …; (b) the interests [they] seek[] to protect are germane to the organization's purpose; and (c) neither the claim[s] asserted nor the relief requested requires the participation of individual members in the lawsuit." *Mo. Outdoor Advert. Ass'n v. Mo. State Highways & Transp. Comm'n*, 826 S.W.2d 342, 344 (Mo. banc 1992).

PFLAG and GLMA have associational standing. *See, e.g.*, *Muth v. Voe*, 691 S.W.3d 93, 122-23 (Tex. App. 2024) (holding PFLAG met the criteria for associational standing in case involving GAMC for minors). Their members on Medicaid are prevented from accessing GAMC under the Medicaid Ban, and their medical professional members have patients on Medicaid who are prevented from obtaining GAMC by the Medicaid Ban. The subject-matter of this case—protecting access to GAMC in Missouri, including for those on Medicaid—is also germane to their missions. Trial Tr. 952:2-954:16, 1333:22-24, 1357:3-7. Additionally, the participation of any individual member is not needed, and it is "presumed that the relief to be gained from the litigation 'will inure to the benefit of those members of the association actually injured.'" *St. Louis Ass'n of Realtors*, 354 S.W.3d at 624 (quoting *Warth v. Seldin*, 422 U.S. 490, 515 (1975)).[10]

[10] GLMA has derivative standing to assert claims on behalf of the transgender patients of its healthcare provider members. *See Pa. Psychiatric Soc'y v. Green Spring Health Servs., Inc.*, 280 F.3d 278, 293 (3d Cir. 2002).

St. Louis Association of Realtors affirmed *Warth*'s conclusion that the first element of associational standing is satisfied if the organization establishes that "its members, or any one of them, are suffering immediate or threatened injury as a result of the challenged action." *Warth*, 422 U.S. at 511. PFLAG's corporate representative testified about a foster parent to a transgender minor who received health coverage through Medicaid, including GAMC. Trial Tr. 1337:13-20. The foster parent and their family are members of PFLAG. *Id.* As noted, E.N., J.K., S.M., and Amy Salladay, along with their families, are also members of PFLAG.

The trial transcript also includes direct testimony from two members of GLMA, Dr. Donovan and Nurse Carr. Trial Tr. 994:16-996:10. GLMA's representative, Alex Sheldon, testified about another GLMA member, Dr. Tochtrop, who is also a provider of GAMC to transgender Missourians on Medicaid. Trial Tr. 981:22-982:5.

Accordingly, PFLAG and GLMA have associational standing to challenge the Act, including the Medicaid Ban.

Point II: The trial court erred in finding Appellants failed to properly plead their constitutional challenge to the Medicaid Ban because Appellants pled a claim against the Medicaid Ban in that the facts alleged meet the elements necessary for such a challenge.

I. Standard of Review and Preservation of Error

A decision, typically on a motion to dismiss, finding that a party failed to state a claim is "solely a test of the adequacy of the petition" and is reviewed *de novo*. *Matthews v. Harley-Davidson*, 685 S.W.3d 360, 366 (Mo. banc 2024) (cleaned up). On appeal, "[t]he Court does not weigh the factual allegations to determine whether they are credible or

persuasive." *Bromwell v. Nixon*, 361 S.W.3d 393, 398 (Mo. banc 2012). "Instead, this Court reviews the petition to determine if the facts alleged meet the elements of a recognized cause of action, or of a cause that might be adopted in that case." *Id.* (quotation omitted).

And, although Missouri is a fact-pleading state, "[t]he facts that must be pleaded are the ultimate facts, not evidentiary facts." *Matthews*, 685 S.W.3d at 366 ("Ultimate facts are those the [fact finder] must find to return [judgment] for the plaintiff."). Respondents did not file a motion to dismiss for failure to state a claim or a motion for a more definite statement within the time permitted. *See State ex rel. Div. of Fam. Servs. v. Bullock*, 904 S.W.2d 510, 512 (Mo. App. S.D. 1995). If the trial court reviewed the pleading *sua sponte*—which is unlikely, given that this portion of the order was copied verbatim from Respondents' proposed order, *compare* D182 p. 39-42 (App 75), *with* D185 p. 45-48 (App 1)—"the [c]ourt must afford a plaintiff a fair opportunity to address the issue before deciding it." *Dickerson v. Desimone, Inc.*, 400 F. App'x 636, 638 (3d Cir. 2010); *see also Davken, Inc. v. City of Daytona Beach Shores*, 159 F. App'x 970, 973 (11th Cir. 2005).

"To preserve a constitutional question for review in this Court, it must be raised at the earliest possible opportunity; the relevant sections of the Constitution must be specified; the point must be preserved in the motion for new trial, if any; and, it must be adequately covered in the briefs." *In re H.L.L.*, 179 S.W.3d 894, 897 (Mo. banc 2005). No post-trial motion was required to preserve this error for appeal.

II. Argument

To find Appellants failed to adequately plead a challenge to the Medicaid Ban, it must appear on the face of the petition that the "plaintiffs can prove no set of facts in support of their claim which would entitle them to relief." *Y.G. v. Jewish Hosp. of St. Louis*, 795 S.W.2d 488, 494 (Mo. App. E.D. 1990). The language of the petition is "to be given a liberal construction, according the averments their reasonable and fair intendment …. So considered a petition should be held sufficient if its averments invoke substantial principles of law which entitle plaintiff to relief." *Wash. Univ. v. Royal Crown Bottling Co. of St. Louis*, 801 S.W.2d 458, 462-63 (Mo. App. E.D. 1990) (quotation omitted).

The Petition is replete with specific allegations concerning Appellants' challenge to the constitutionality of the Medicaid Ban. Appellants made their challenge plain: "[Appellants] bring this challenge to the constitutionality of §§ 191.1720, 208.152.15 [the Medicaid Ban] of the Missouri Revised Statutes …." D2 ¶ 6; App 240. The Petition creates three defined terms to succinctly refer to the combined provisions challenged herein—i.e., § 191.1720 (the Care Ban) *and* § 208.152.15 (the Medicaid Ban)—collectively referring to them as "the Act," "the Ban," and "S.B. 49." *Id*. ¶ 7. Each time these defined terms appear in the Petition, it is an explicit reference to the Medicaid Ban.

Each count refers to the Medicaid Ban through incorporation of the defined terms. In so doing, the Petition raises an overt challenge to the constitutionality of the Medicaid Ban under the Equal Protection, D2 ¶¶ 217-22, 225, 232, 240-41; Natural Rights and Due Process, *id.* ¶¶ 249-51, 259-60; Right to Enjoyment of the Gains of One's Own Industry, *id.* ¶¶ 264-65, 271-72; and Special Law Limitation Clauses, *id.* ¶¶ 275, 280, 283-84.

Appellants are not required to use terms preferred by Respondents in their pleadings. The trial court's adoption of Respondents' position that "none of those counts mentions Medicaid" is contrary to the Petition itself.

Additionally, each count, after asserting constitutional challenges to the Medicaid Ban, further develops the constitutional claims with specific factual allegations that are more than sufficient to state the respective claims. D2 ¶¶ 214-84; App 240. Accordingly, the trial court erred in finding Appellants' counts either fail to "clearly challenge" the Medicaid Ban or leave that challenge "undeveloped." D185 pp. 45-46; App 1. Even more, each count explicitly incorporates the preceding paragraphs of the Petition, which include numerous other allegations explicitly referring to Medicaid, Appellants' standing to bring their constitutional challenges, and the disparate harm the Medicaid Ban is wreaking on transgender Missourians. *See, e.g.*, D2 ¶¶ 214, 243, 261, 273 (incorporating preceding paragraphs); 16-18, 32, 168 (discussing Southampton's, Dr. Donovan's, and Nurse Carr's treatment of transgender patients on Medicaid); 34, 185 (alleging PFLAG's membership includes families whose GAMC is covered by Medicaid); and 97-101 (discussing the scope of the Medicaid Provision and its effect on transgender Missourians); App 240.

The trial court erred in finding Appellants failed to plead their claims challenging the Medicaid Ban.

Point III: The trial court erred in finding Appellants failed to argue and prove their constitutional challenge to the Medicaid Ban because it misapplied the law and disregarded undisputed evidence, in that, as discussed, Appellants demonstrated standing to raise this claim, the Medicaid Ban violates the Missouri Constitution, and the record lacks evidence to justify banning GMAC coverage for adults.

I. Standard of Review and Preservation of Error

Following a bench-tried case, "[a]n appellate court must sustain the decree or judgment of the [circuit] court unless there is no substantial evidence to support it, unless it is against the weight of the evidence, unless it erroneously declares the law, or unless it erroneously applies the law." *Millstone Prop. Owners Ass'n v. Nithyananda Dhyanapeetam of St. Louis*, 701 S.W.3d 633, 640-41 (Mo. banc 2024) (cleaned up). Because the determination of whether a law violates the constitution is a legal question, it is reviewed *de novo*. *State v. Sisco*, 458 S.W.3d 304, 312 (Mo. banc 2015). "The person challenging the validity of the statute has the burden of proving the act clearly and undoubtedly violates the constitution." *St. Louis Cnty. v. Prestige Travel, Inc.*, 344 S.W.3d 708, 712 (Mo. banc 2011) (cleaned up). No post-trial motion was required. This issue was raised at the earliest possible time, was fully briefed, and is preserved.

II. Argument

The case law relied on by the trial court to find that Appellants failed to argue or prove that the Medicaid Ban violates the Missouri Constitution is largely inapposite, and the trial court misapplied the law to the undisputed facts in this case.

A review of Appellants' brief and evidence below defeats the finding that Appellants did not develop any argument tailored to challenging the Medicaid Ban. In the

very first paragraph, Appellants state that the law challenged in this case includes a challenge to the prohibition of the "coverage of [medically necessary care] for adolescents and adults with gender dysphoria whose coverage comes through MO HealthNet, Missouri's Medicaid program." D70 p. 1. Further, Appellants' challenge to the Medicaid Ban concerns the prohibition of Medicaid coverage of treatments for minors and adults when such treatment is for GAMC. *Id.* at 4.

Consistent with this, with respect to their Equal Protection challenge, Appellants argued in their pretrial brief that the Medicaid Ban imposes differential treatment based on the birth-assigned sex of an individual, such that Missouri's Medicaid program "will cover estrogen for a woman assigned female at birth but will deny coverage for the same medication when prescribed to a woman assigned male at birth for the purpose of gender transition." *Id.* at 32-34. Accordingly, as Appellants argued, the Medicaid Ban prohibits Medicaid coverage of medical interventions "when they relate to 'gender transition,'" or, in other words, prohibits medical care when provided "in a manner the State deems 'different from his or her biological sex,'" which is, unavoidably, sex-based discrimination. *Id.* at 34. Appellants also cited similar constitutional challenges to state Medicaid bans on coverage of GAMC, where courts found such programs drew lines "on the basis of sex, plain and simple." *Id.* at 33 (citing to *Rust v. Weida*, 679 F.Supp.3d 1271, 1290 (N.D. Fla. 2023)). Appellants' pretrial brief makes similar arguments regarding the Medicaid Ban's disparate treatment based on transgender status. D70 p. 39.

The trial court ignores these arguments, citing instead to inapposite case law related to challenges of Medicaid coverage under the First Amendment's Establishment Clause or

the Fifth Amendment's Due Process Clause. D185 p. 46 (citing to *Harris v. McRae*, 448 U.S. 297, 316 (1980) and *Rust v. Sullivan*, 500 U.S. 173, 193 (1991)); App 1. These decisions' rationales are inapplicable.

The only case on which the trial court's order relies that examines Medicaid coverage restrictions under Equal Protection found that serious statutory questions may be presented if, like the Medicaid Ban, a state Medicaid plan excludes necessary medical treatment from coverage. *Id.* (citing *Beal v. Doe*, 432 U.S. 438, 445-47 (1997)). This is exactly what the Medicaid Ban does. Appellants have argued and submitted evidence demonstrating that GAMC is medically necessary—evidence Respondents contested virtually exclusively with reference to care for minors, even though the Medicaid Ban applies to transgender patients of all ages. The Medicaid Ban plainly restricts care for transgender Medicaid beneficiaries with gender dysphoria, as the same exact medications and procedures are available to Missourians not diagnosed with gender dysphoria.

As explained in greater detail in Points IV, V, and VI, *infra*, which are incorporated herein, heightened scrutiny applies to Appellants' challenge to the Medicaid Ban. But whether analyzed under heightened scrutiny or rational basis, the undisputed facts do not support the trial court's finding that Appellants failed to argue or prove their constitutional challenges to the Medicaid Ban are meritorious. *See infra* Point VII.

Moreover, Respondents presented no evidence that Provider Appellants did not provide the challenged care and presented virtually no testimony, nor any documentary evidence, as to the provision of GAMC to *adults*. None of Respondents' witnesses, expert or fact, testified that provision of GAMC to adults is improper. Indeed, some of

Respondents' experts explicitly cabined their testimony to offer opinions only about GAMC for *minors*. Trial Tr. 1982:6-13, 2086:13-2087:3, 2400:24-2401:2. Many of Respondents' witnesses specifically testified that they did not oppose and/or that they support the provision of GAMC to adults. Trial Tr. 1722:2-6, 1838:24-1839:5, 2086:13-15, 2304:20-2305:2, 2686:25-2687:3. In fact, many of Respondents' experts have provided and/or continue to provide GAMC to adults and testified to seeing benefits in their adult patients receiving such care. Trial Tr. 1951:18-1952:10, 2097:23-2098:2, 2099:3-9, 2107:19-25, 2465:23-2466:1. Drs. Bailey and Levine have written letters on behalf of adult patients experiencing gender dysphoria to support their receipt of GAMC. Trial Tr. 1951:18-1952:10, 2465:23-2466:1.

The trial court erred in finding Appellants failed to argue or prove their claims against the Medicaid Ban.

Point IV: The trial court erred in denying Parent Appellants' due process claim because it misapplied the law by failing to apply strict scrutiny in that Parent Appellants have a fundamental right to direct the medical care of their children, and the Act violates that right.

I. Standard of Review and Preservation of Error

Because the determination of whether a law violates the constitution is a legal question, it is reviewed *de novo*. *Sisco*, 458 S.W.3d at 312. This issue was raised at the earliest possible time, no post-trial motion was required, and it is preserved for appeal.[11]

[11] The standard of review and preservation of error related to the determination of whether a law violates the constitution is the same for Points IV, V, VI, IX, and X, *infra*, and is therefore not repeated below.

II. Argument

As one of Respondents' *own* experts put it at trial, "the ultimate responsibility" for whether a child should be permitted to access GAMC "should rest upon the parents." Trial Tr. 2455:24-2456:2; *see also* Trial Tr. 2463:2-5 ("I think doctors ought to be informing parents … [a]nd the parents have this weighty decision that they make with their child."). Parent Appellants have asserted their right "to make decisions concerning the care, custody, and control" of their children, *Troxel v. Granville*, 530 U.S. 57, 72 (2000), which includes the right to make "decisions regarding their children's medical care." *PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1197 (10th Cir. 2010).

Article I, section 2 of the Missouri Constitution provides "that all persons have a natural right to life, liberty, the pursuit of happiness and the enjoyment of the gains of their own industry," and its protections are, at minimum, co-extensive with the Due Process Clause of the Fourteenth Amendment. *Comm. for Educ. Equal. v. State*, 294 S.W.3d 477, 490 (Mo. banc 2009); *In re Marriage of Woodson*, 92 S.W.3d 780, 783 (Mo. banc 2003). Nonetheless, the trial court rejected Appellants' parental rights claim in three terse paragraphs. D185 p. 70; App 1. The trial court does not squarely address the parental rights aspect of Appellants' due process claim but focuses on the right to obtain medical treatment in general, finding it would be "strange" to "conclude that there is a substantive due process right to obtain an intervention that the legislature has taken off the table." *Id.*

This is a tortured recasting of Parent Appellants' due process claim, which is that "the parent-appellants enjoy a fundamental right to seek a specific form of health care for their children, subject to a physician's independent examination and medical judgment,

which would include the gender-affirming medical care banned by" the Act. *Moe v. Yost*, 2025 WL 844497, at *22 (Ohio App. 10 Dist., 2025), *appeal docketed*, No. 2025-0472 (Ohio 2025). The Act invades Parent Appellants' "fundamental right to" direct "medical care for their children … in conjunction with their adolescent child's consent and their doctor's recommendation." *Brandt v. Rutledge*, 551 F.Supp.3d 882, 892-93 (E.D. Ark. 2021), *aff'd*, 47 F.4th 661 (8th Cir. 2022); *Poe ex rel. Poe v. Labrador*, 709 F.Supp.3d. 1169, 1195 (D. Idaho 2024). Because the Act interferes with Parent Appellants' fundamental right to direct the medical upbringing of their children, the trial court erred in failing to apply heightened scrutiny.

A. The trial court failed to recognize or analyze Parent Appellants' fundamental right to direct their child's medical care.

Courts "begin, as [they] do in all due process cases, by examining our Nation's history, legal traditions, and practices." *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997). "[T]he interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by this Court." *Troxel*, 530 U.S. at 65; *see also T.W. ex rel. R.W. v. T.H.*, 393 S.W.3d 144, 147 (Mo. App. E.D. 2013) (acknowledging "fundamental constitutional right to make decisions concerning the care, custody, and control of [one's] child"). This includes parents' right "to direct the upbringing and education of children under their control." *Pierce v. Soc'y of the Sisters of the Holy Names of Jesus and Mary*, 268 U.S. 510, 534 (1925); *see also Santosky v. Kramer*, 455 U.S. 745, 753 (1982); *Parham v. J.R.*, 442 U.S. 584, 602 (1979); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). This includes "some level of protection for

parents' decisions regarding their children's medical care." *Jensen*, 603 F.3d at 1197. Ultimately, parents are presumed to be acting in the best interest of their children. *Parham*, 442 U.S. at 602. Though one parent's notion of the "best interest" for their child may differ from another's, that does not negate the fundamental right nor the fact that it must be protected for *all* parents. Indeed, in upholding a statute permitting parents to involuntarily commit their children to psychiatric institutions, the U.S. Supreme Court held that parents, not the government, have "plenary authority" to make decisions concerning their children's healthcare and "to seek and follow medical advice" for their children. *Id.* "Neither state officials nor federal courts are equipped to review such parental decisions." *Id.* at 604.

As such, the state may not, without justifications surviving *strict scrutiny*, invade the fundamental right of parents to direct the medical care of their children. The trial court summarily rejects this notion, stating that there is no right of parents to obtain "whatever drug they want," and, therefore, that the statute must survive rational basis only. D185 p. 71; App 1. But Parent Appellants do not assert a right to obtain for their children "whatever drug they want." Rather, they assert their fundamental right to make "decisions regarding their children's medical care." *Jensen*, 603 F.3d at 1197. In other words, the ability to seek individualized medical advice for a diagnosed medical condition, and to make decisions in conjunction with their doctor in pursuing a well-accepted medical intervention to treat their child's diagnosis. *See Brandt v. Rutledge*, 677 F.Supp.3d 877, 923 (E.D. Ark. 2023); *Yost*, 2025 WL 844497, at *26. And although the trial court recognized that "a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized," *Parham*, 442 U.S. at 603; D185 p. 70; App 1, the relevant

language from *Parham* concerned "the *respective* rights and prerogatives of the child and parent." 442 U.S. at 604. The trial court offered no justification for declining to apply strict scrutiny where the parents, the child, and their physician all agree on a particular course of treatment.

The trial court impermissibly distorts the rights Parent Appellants asserted below. So long as a parent "is fit," there is "no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children." *Troxel*, 530 U.S. at 68-69. Here, the trial court did not engage in any analysis of whether Parent Appellants possessed this fundamental right. Its failure to do so was error.

The trial court satisfied itself that no further analysis was needed by citing a series of five cases it described as "rejecting" the argument that "[a]ny person" would "be able to obtain anything from meth, to ecstasy, to abortion"[12] if recommended by a doctor. D185 p. 70; App 1.[13] One of these cases is a challenge under the Commerce Clause, and two involve treatments not approved by the FDA for *any* use, with no indication of broader medical support. *See Gonzales v. Raich*, 545 U.S. 1, 9 (2005) (Commerce Clause); *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980) (FDA regulation of "folk

[12] A minor can obtain an abortion with parental consent or a judicial order, regardless of whether it is recommended by a doctor. § 188.028.

[13] This straw man ignores that determining the level of scrutiny is only step one of the analysis. A prohibition on minors obtaining methamphetamine would undoubtedly survive strict scrutiny. It is insulting and inaccurate to compare GAMC to providing methamphetamine to children.

medicine" use); *Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 697 (D.C. Cir. 2007) (FDA regulation of medications not approved for any condition). The trial court did not explain how cases about an investigational drug that has not even begun human trials or been approved for any use bear on a parent's fundamental right to direct their child's medical care by pursuing a course of treatment involving medications long approved for general use, recommended by their doctors, and supported by the medical establishment.

The trial court's reliance on *Glucksberg* does not justify its lack of analysis. The *Glucksberg* court concluded that there was an insufficient historical foundation for the liberty interest in a person's "decision to commit suicide with the assistance of another." 521 U.S. at 725. By contrast, Parent Appellants here "do not allege a new category of fundamental rights. Rather, they assert a long-recognized and well-established fundamental liberty interest …: the right of parents to make decisions concerning the care, custody, and control of their children." *Yost*, 2025 WL 844497, at *23. "Physician-assisted suicide was never expressed as a form of 'health care' in *Glucksberg*" and Parent Appellants "are not required to show a right to a ***particular*** treatment or a ***particular*** provider." *Id.* "Rather, the question is whether the state has proven that the treatment it seeks to regulate … falls outside the fundamental right recognized in *Parham*." *Id.* Moreover, the trial court erred in adopting Respondents' hyper-specific framing of the right at issue. While fundamental rights are "carefully defined," *Glucksberg*, 521 U.S. at 721, they are not microscopically so. *See Obergefell v. Hodges*, 576 U.S. 644, 671 (2015).

B. The undisputed testimony was that Parent Appellants engaged in careful decision making with the guidance of their experienced medical providers, and that the ultimate responsibility for the decision whether to pursue medical transition for an adolescent lies with Parent Appellants.

Parent Appellants have "a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's [assent] and their doctor's recommendation, make a judgment that medical care is necessary." *Brandt*, 551 F.Supp.3d at 892; *see also Poe*, 709 F.Supp.3d at 1197; *Yost*, 2025 WL 844497, at *26.

Each parent testified about the long process of understanding their child's experiences of gender dysphoria, including extensive counseling for each child. Trial Tr. 1298:25-1303:8, 1217:5-1220:7, 1155:16-1162:8; Ex. 360. Though N.N. had not entered puberty and thus had not yet initiated any medical interventions at the time of trial, he had nonetheless been seeing a therapist for four years. Trial Tr. 1301:23-1303:8. Each family sought the guidance of expert medical professionals, who gave extensive information about risks and benefits, informed them of their options, and never pushed them toward any medical intervention. Trial Tr. 1303:23-1304:8, 1219:18-1228:20, 1158:24-1172:21; Ex. 384; *see also* Exs. 349, 352, 353, 356 (handouts detailing risks and benefits). Each child received a biopsychosocial assessment. Trial Tr. 1302:24-1303:8, 1220:23-1221:18, 1223:6-12, 1167:8-23; Exs. 456, 360, 372. Each family provided informed consent, and A.K. and C.J. were able to initiate some form of GAMC, but the Act prevented each from progressing along their treatment plan (and, for N.N., initiating puberty blockers) under the care of their Missouri doctors. Trial Tr. 1306:23-1307:20, 1230:24-1241:10, 1170:2-74:25.

Even the state's expert, Dr. Levine, testified that GAMC is appropriate for some youth and that he has previously supported it for adolescents. Trial Tr. 2465:5-13. Parent Appellants are asking for nothing more than this. Dr. Levine has faced "situations" where he felt GAMC was "the only thing" that could help a particular child and supported that treatment "follow[ing] an extensive period of working with the family and working with the child." Trial Tr. 2450:5-15. In fact, Dr. Levine described the ideal practice as matching what each Family Appellant did in this case, and what the guidelines recommend: "this treatment is a possibility … what I am advocating for, that is a comprehensive psychiatric evaluation followed by an extended period of psychotherapy, not just an evaluation. I think we can do that." Trial Tr. 2451:2-23; *see also* Ex. 5, at S48. No justification is identified for state intervention in the care of, for example, a minor like C.J., who has been in therapy since a very early age, has been assessed multiple times, and has no mental health conditions interfering with treatment.

Indeed, Dr. Levine testified it would be concerning to force an adolescent who has "been stabilized on hormones in their new gender identity" (like Appellants A.K. and C.J.) to discontinue care—that would be "a crisis for that child and for their supportive parents. And crises mean that there's danger." Trial Tr. 2480:2-4. This would be "a cruel problem … to somebody who has redefined their sense of self." Trial Tr. 2480:6-7. Considering this undisputed testimony from medical professionals on both sides who agreed that the ultimate responsibility for medical decision-making lies with parents, and the unrebutted testimony that Parent Appellants were prevented from making those decisions under the care and guidance of their Missouri medical providers, the trial court erred in failing to

apply heightened scrutiny. Even if a compelling interest were presented, as discussed in Point VII, *infra*, a total ban on GAMC would not satisfy strict scrutiny.

Point V: The trial court erred in denying Appellants' due process claim related to the fundamental right to autonomy in making healthcare decisions because the court misapplied the law in that it failed to apply heightened scrutiny and erroneously held that there is no protection for an individual's fundamental right to autonomy in making healthcare decisions.

I. Standard of Review and Preservation of Error

See Standard of Review and Preservation of Error for Point IV.

II. Argument

Individual transgender Missourians, like all Missourians, have a fundamental right to autonomy in healthcare. *See Cruzan v. Harmon*, 760 S.W.2d 408, 416 (Mo. banc 1988), *aff'd*, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) (observing a long-held "common law" right in Missouri to "individual autonomy over decisions relating to one's health and welfare"). Bans on GAMC violate an individual's fundamental right to make treatment decisions concerning "a particular lawful medical procedure from a health care provider that has been determined by the medical community to be competent to provide that service and who has been licensed to do so." *Cross*, 560 P.3d at 656 (quotation omitted); *see also Yost*, 2025 WL 844497, at *17. Appellants pressed this constitutional right below. D2 ¶¶ 244, 246; D70 p. 53; App 240.

The trial court did not acknowledge this argument, stating "how strange it would be to conclude that there is a substantive due process right" to make medical treatment decisions. D185 p. 70; App 1. Yet Missouri's courts already *have* recognized the right the trial court found "strange." *Cruzan*, 760 S.W.2d at 417. This Court in *Cruzan* recognized

that treatment decisions reflect "the value society places on a person's autonomy and as the primary vehicle by which a person can protect the integrity of his body," explicitly acknowledging that such decisions receive protection under the Missouri Constitution. *Id.* at 417. The trial court conflated acknowledgment of the right with the state's ability to regulate it, but the proper question is whether the regulation is narrowly tailored to effectuate a compelling state interest.

In the case of minors, there are instances where "the juvenile's liberty interest may … be subordinated to the State's 'parens patriae interest in preserving and promoting the welfare of the child.'" *Schall v. Martin*, 467 U.S. 253, 265 (1984).[14] However, this interest must be weighed carefully against the right "to decide whether [to] receive health care services recommended by medical professionals and widely accepted by the professional medical community as the appropriate treatment protocols for an appropriately diagnosed medical condition." *Yost*, 2025 WL 844497, at *17. This is especially true when, as described in Point VII, *infra*, the state demonstrates scant evidence to support the regulation. The trial court failed to consider Appellants' fundamental right to autonomy, as recognized in *Cruzan*; failed to weigh the invasion on Appellants' fundamental right against *any* competing interests, much less a compelling one; and failed to determine whether the Act's means are tailored to any such interest. Failure to do so was error.

[14] This interest does not apply to adults; Respondents cannot justify the Medicaid Ban's interference with this right for *adult* Medicaid beneficiaries.

Point VI: The trial court erred in denying Appellants' claim that the Act violates the Equal Protection Clause because the trial court should have applied heightened scrutiny and, even if it did not, the Act does not satisfy rational basis review, in that the Act classifies and purposely discriminates based on sex and transgender status.

I. Standard of Review and Preservation of Error

See Standard of Review and Preservation of Error for Point IV.

II. Argument

The Missouri Constitution provides "that all persons are created equal and are entitled to equal rights and opportunity under the law." Mo. Const. Art I, § 2. Under this provision, the equal protection analysis conducted by Missouri courts can be guided by federal law because, at a minimum, "Missouri's equal protection clause provides the same protections as the United States Constitution." *State v. Young*, 362 S.W.3d 386, 396 (Mo. banc 2012); *see also Glossip v. Mo. Dep't of Transp. & Highway Patrol Emps. Ret. Sys.*, 411 S.W.3d 796, 805 (Mo. banc 2013). "Missouri's Constitution may contain additional protections" relative to the U.S. Constitution, which thus sets only a floor. *Comm. for Educ. Equal.*, 294 S.W.3d at 490.

Here, the Act violates the equal protection clause of Missouri's Constitution by targeting transgender Missourians in at least two ways. First, the Care Ban on its face singles out transgender adolescents for a categorical prohibition on safe and effective medications and procedures that remain available to others. Second, the Medicaid Ban singles out Medicaid transgender beneficiaries, regardless of age, for discrimination by prohibiting coverage of safe and effective medical treatments that remain available to others. The Act, therefore, classifies based on sex and transgender status, triggering

heightened scrutiny under Missouri's Constitution. It is also subject to heightened scrutiny because it purposely discriminates against a vulnerable minority and politically unpopular group—namely, transgender people. *See infra* Point VI.A.1. The Act cannot survive this "exacting" test. *United States v. Virginia* ("*VMI*"), 518 U.S. 515, 555 (1996).

Both the Care Ban and the Medicaid Ban fail any level of scrutiny, as described more fully below. Rather than protecting minors or Medicaid beneficiaries, the Act harms them.

A. The Act is subject to heightened scrutiny because it purposely discriminates against transgender Missourians.

The Act explicitly singles out certain medical interventions only when they are related to "gender transition," which it defines as "identifying with and living as a gender different from" one's birth-assigned sex, and which "may involve social, legal, or physical changes." § 191.1720.2(4). In all other cases, the Act explicitly allows the provision or coverage of the same medical interventions for patients of any age. Because the Act classifies based on sex and transgender status, it triggers heightened scrutiny, imposing an exacting burden on Respondents to justify their discriminatory line-drawing and to demonstrate that the classification substantially advances an important governmental interest. In "[d]etermining whether a statute violates equal protection" under the Missouri Constitution, courts apply heightened scrutiny to classifications by sex and certain quasi-suspect classes. *Glossip*, 411 S.W.3d at 801; *Ambers-Phillips v. SSM DePaul Health Ctr.*, 459 S.W.3d 901 n.10 (Mo. banc 2015) (referencing quasi-suspect class for claims of gender discrimination); *see also Gallagher v. City of Clayton*, 699 F.3d 1013, 1018 (8th Cir. 2012).

Such classifications place on the state "the burden of demonstrating that the statute serves important government interests and is substantially related to achieving those interests." *Glossip*, 411 S.W.3d at 802.

In adopting Respondents' faulty legal analysis, the trial court failed to engage with Appellants' equal protection claims. For example, the trial court acquiesced to Respondents' attempt to establish a new, lower threshold for the State and found that under *Gonzales v. Carhart*, 550 U.S. 124, 165 (2007), all a state must do to draw classifications amongst its people is establish that *some* medical dispute exists. D185 p. 50; App 1. There is no authority for the proposition that *Gonzales* immunized state laws regarding the medical profession from constitutional challenge merely because some voices (no matter how fringe) disagree with the medical consensus, and the trial court's findings of "uncertainty" is unsupported, as described in Point VII.B, *infra*. Courts may not "abandon the field when government officials with experts in tow seek to infringe a constitutionally protected liberty." *S. Bay United Pentecostal Church v. Newsom*, 141 S.Ct. 716, 718 (2021). True, in *United States v. Skrmetti*, 145 S.Ct. 1816 (2025), the Supreme Court referenced *Gonzales*, but only after determining that Tennessee's law was subject to rational basis review, *id.* at 1835-36, and after finding that the plaintiffs had not presented any evidence of pretext. *Id.* at 1833. Neither condition is present here.

If anything, this case establishes that a state could likely generate the appearance of *some* dispute in *any* area of medicine; however, that is a far cry from establishing that there is a *credible*, *genuine* disagreement within the medical community. As described in Point VII.A, *infra*, the trial court's factual findings are adopted virtually verbatim from

Respondents' proposed findings, and as a result, rely extensively on facts not offered, proved, or admitted. In fact, even Respondents' own experts agreed with the central premises underlying GAMC, and two of them acknowledged writing that they support care for adolescents. Trial Tr. 1964:22-1965:3 (Bailey previously stating "[i]f your child's gender dysphoria persists well into adolescence, … let's say age 14 or so, she or he is much more likely to transition. At that point, in [my] opinion, parents should consider supporting transition."); Ex. 399 (Cantor stating in 2020 that "youth should be permitted to begin to transition, socially and/or medically," at "age 12 … because that is what the (current) evidence supports."). And those who most vehemently *disagreed* with this position also disagreed with principles so basic and foundational that their disagreement can hardly be said to justify the constitutionality of the Act. *Cf. infra* Point VIII.A-B.

1. The Act classifies based on transgender status.

As courts have increasingly recognized, laws that single out transgender people receive heightened scrutiny because they discriminate against transgender people as a class. *See*, *e.g.*, *Doe v. Horne*, 115 F.4th 1083, 1102 (9th Cir. 2024); *Hecox v. Little*, 104 F.4th 1061, 1079 (9th Cir. 2024), as amended (June 14, 2024); *Kadel v. Folwell*, 100 F.4th 122, 143 (4th Cir. 2024) (*en banc*), *vacated and remanded*, 2025 WL 1787687 (U.S. 2025); *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 607 (4th Cir. 2020), as amended (Aug. 28, 2020); *Karnoski v. Trump*, 926 F.3d 1180, 1200-01 (9th Cir. 2019); *see also Cross*, 560 P.3d at 656 (McKinnon, J., concurring); *Dekker*, 679 F.Supp.3d at 1291-92; *Brandt*, 677 F.Supp.3d at 917-18; *Ray v. McCloud*, 507 F.Supp.3d 925, 937-38 (S.D. Ohio 2020); *Evancho v. Pine-Richland Sch. Dist.*, 237 F.Supp.3d 267, 288 (W.D. Pa. 2017). This is just

as true for laws that target "gender transition" or "gender dysphoria" as it is for laws that refer textually to transgender people. *Kadel*, 100 F.4th at 149; *cf. Horne*, 115 F.4th at 1105. Indeed, *Skrmetti* did not reject the notion that laws that target people who experience *gender dysphoria* classify based on transgender status and therefore should receive heightened scrutiny. *Skrmetti*, 145 S.Ct. at 1834 n.3 (distinguishing Tennessee's law from one that "regulates a class of *persons* identified on the basis of a specified characteristic").

By targeting "gender transition," the Act necessarily classifies based on transgender status: it is transgender people who undergo "gender transition" as part of treatment for gender dysphoria, and "a person cannot suffer from gender dysphoria without identifying as transgender." *C.P. ex rel. Pritchard v. Blue Cross Blue Shield of Ill.*, 2022 WL 17788148, at *6 (W.D. Wash. Dec. 19, 2022), *appeal pending*, No. 23-4331 (9th Cir., argued Jan. 17, 2025); *see also Kadel*, 100 F.4th at 149 n.21. "The excluded treatments aim at addressing incongruity between sex assigned at birth and gender identity, the very heart of transgender status." *Kadel*, 100 F.4th at 146.

The trial court rejected the notion that transgender people are a suspect class, concluding that "every suspect class recognized by the U.S. Supreme Court is an immutable group." D185 p. 68; App 1. This is incorrect as a matter of law. The test is not limited to immutability, and "[n]o obvious badge is necessary." *Windsor v. United States*, 699 F.3d 169, 183 (2d Cir. 2012) (quotations omitted). Rather, "the test is broader," *id.*, as it also includes whether individuals exhibit "distinguishing characteristics that define them as a discrete group." *Bowen v. Gilliard*, 483 U.S. 587, 602 (1987); *see also Lyng v. Castillo*,

477 U.S. 635, 638 (1986).[15] For example, courts have held that "classifications based on alienage … are inherently suspect" even though alienage is obviously not an immutable characteristic. *Graham v. Richardson*, 403 U.S. 365, 372 (1971). The same holds true for illegitimacy. *See Mills v. Habluetzel*, 456 U.S. 91, 98-99 (1982). Such is the case here, where transgender people are easily a distinguishable and discrete group.

And although the trial court did not analyze the question, the other indicia of a suspect class also are present here—it cannot seriously be disputed that transgender people are politically powerless.[16] *See F.V. v. Barron*, 286 F.Supp.3d 1131, 1145 (D. Idaho 2018). Legislation targeting transgender people has proliferated across the country in recent years. Among other things, these laws prohibit the mention of transgender people in schools, prohibit transgender people from obtaining identity documents consistent with their gender identity, prohibit them from accessing sex-designated facilities in a manner consistent with their gender identity, and, as here, ban or restrict the provision or coverage of GAMC.

This year alone, the federal government has: sought to erase any mention or recognition of transgender people from any part of the federal government and has

[15] "Rather than asking whether a person could change a particular characteristic, the better question is whether the characteristic is something that the person should be required to change [in order to avoid government discrimination] because it is central to a person's identity." *Wolf v. Walker*, 986 F.Supp.2d 982, 1013 (W.D. Wis. 2014), *aff'd sub nom. Baskin v. Bogan*, 766 F.3d 648 (7th Cir. 2014); *see also Latta v. Otter*, 771 F.3d 456, 464 n.4 (9th Cir. 2014).

[16] ACLU, Mapping Attacks on LGBTQ Rights in U.S. State Legislatures, https://www.aclu.org/legislative-attacks-on-lgbtq-rights.

demanded the same from federal contractors and grantees;[17] sought to eliminate or restrict existing protections for transgender people and enacted myriad affirmative policies to discriminate against transgender people in education, employment, health care, and housing, s*ee Talbott v. United States*, 2025 WL 842332, at *35 (D.D.C. Mar. 18, 2025); banned transgender people from serving in the military;[18] and directed the immediate defunding of medical institutions that provide GAMC to transgender people under the age of nineteen, under the premise that expressing a gender identity contrary to one's birth-assigned sex constitutes a "false claim."[19]

"[T]hese attacks are part of a much larger, coordinated effort to erase transgender people entirely."[20] Some of the State's own evidence makes this painfully clear. *E.g.*, Exs. 8025, 8018. These documents illustrate not just transgender people's lack of political power, but also the history of discrimination they have experienced at the hands of society and their government. This history is longstanding, and it ranges from cross-dressing bans first enacted in the mid-nineteenth century to explicit exclusions from federal civil rights protections. *See, e.g.*, Kate Redburn, *Before Equal Protection*, *1963-86*, 40 L. & Hist.

---

[17] *See, e.g.*, Exec. Order No. 14168, *Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8650 (Jan. 20, 2025) ("Gender EO").

[18] Exec. Order No. 14183, *Prioritizing Military Excellence and Readiness*, 90 Fed. Reg. 8757 (Jan. 27, 2025).

[19] Exec. Order No. 14187, *Protecting Children From Chemical and Surgical Mutilation*, 90 Fed. Reg. 8771 (Jan. 28, 2025); Gender EO § 2(f).

[20] Movement Advancement Project, *Under Fire: Banning Medical Care and Legal Recognition for Transgender People* (Sept. 2023), https://tinyurl.com/mr36ppnx.

Rev. 679, 679-723 (2022); Kevin M. Barry et al., *A Bare Desire to Harm*, 57 B.C. L. Rev. 507 (2016). Indeed, "one would be hard-pressed to identify a class of people more discriminated against historically or otherwise more deserving of the application of heightened scrutiny when singled out for adverse treatment, than transgender people." *Grimm*, 972 F.3d at 610-11; *see also Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017); *Ray*, 507 F.Supp.3dat 937; *M.A.B. v. Bd. of Educ. of Talbot Cnty.*, 286 F.Supp.3d 704, 720 (D. Md. 2018).

Like the Act, these actions are premised on the demeaning notion that transgender people do not exist. One "cannot fathom discrimination more direct than the plain pronouncement of a policy resting on the premise that the group to which the policy is directed does not exist." *PFLAG, Inc. v. Trump*, 769 F.Supp.3d 405, 444 (D. Md. 2025).

Given the above, the Court should find that the indicia of a suspect class are met and join the growing number of courts that have recognized state laws that classify based on transgender status, as the Act does, warrant heightened scrutiny.

2. The Act classifies based on sex.

Even if the Act did not classify based on transgender status, it would receive heightened scrutiny as a state law that draws sex-based classifications. The Act classifies based on sex in three distinct ways. First, the Act facially draws distinctions based on sex and uses explicitly gendered terms. Second, the Act relies on sex stereotypes relating to a person's sex assigned at birth. Third, the Act classifies based on a person's failure to identify with their assigned sex, i.e., their transgender status. *See Cross*, 560 P.3d at 655 (McKinnon, J., concurring).

First, as multiple courts (including the Eighth Circuit) have held, statutes like the Act facially impose differential treatment based on the sex an individual is assigned at birth "[b]ecause the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law." *Brandt*, 47 F.4th at 669; *see also Kadel*, 100 F.4th at 153; *Poe*, 709 F.Supp.3d at 1192; *Dekker*, 679 F.Supp.3d at 1290; *Brandt*, 677 F.Supp.3d at 917; *cf. R.M.A. by Appleberry v. Blue Springs R-IV Sch. Dist.*, 568 S.W.3d 420, 427-29 (Mo. banc 2019) ("*R.M.A. I*").

For example, the Act does not prevent a minor assigned male at birth from receiving testosterone, nor does it prevent a minor assigned female at birth from receiving estrogen. *Cf. Lampley v. Mo. Comm'n on Hum. Rts.*, 570 S.W.3d 16, 24 (Mo. banc 2019) ("[I]t is clear an employer … [is] engaging in sex discrimination [where] the discrimination would not occur but for the victim's sex.") (citations omitted); *accord Bostock v. Clayton Cnty.*, 590 U.S. 644, 660 (2020) (holding that taking adverse action against "a transgender person who was identified as a male at birth but who now identifies as a female," while not taking such action against "an otherwise identical [person] who was identified as female at birth," "intentionally penalizes" the transgender person based on their birth-assigned sex).[21] Nevertheless, the Act prevents a transgender female minor who was assigned male at birth from receiving estrogen, and a transgender male minor who was assigned female at birth from receiving testosterone. Similarly, Missouri's Medicaid program covers estrogen for a woman assigned female at birth but denies such coverage when prescribed to a woman

[21] The application of the but-for analysis contained in *Skrmetti*, 145 S.Ct. at 1834, does not apply here where the Act facially turns on "gender transition."

assigned male at birth for the purpose of gender transition. The Act's provisions "cannot be stated without referencing sex" and are therefore "inherently based upon a sex-classification." *Whitaker*, 858 F.3d at 1051.

If the legislature cannot "writ[e] out instructions" for determining whether treatment is permitted "without using the words man, woman, or sex (or some synonym)," the law classifies based on sex. *Bostock*, 590 U.S. at 668-69. Here, the Act prohibits medical interventions, and Medicaid coverage thereof, when they relate to "gender transition," §§ 191.1720.4(1), 208.152.15, which it defines as "the process in which an individual transitions from identifying with and living as a *gender that corresponds to his or her biological sex* to identifying with and living as a *gender different from his or her biological sex*," § 191.1720.2(4) (emphasis added). In other words, the Act prohibits the provision of necessary medical care when the care is provided in a manner the State deems "different from *his or her biological sex*." § 191.1720.2(4) (emphasis added); *see R.M.A. v. Blue Springs R-IV Sch. Dist*., 2025 WL 1645216, at *5 (Mo. banc June 10, 2025) ("*R.M.A. II*"). By "discriminating against transgender persons," the Act "unavoidably discriminates against persons with one sex identified at birth and another today." *Bostock*, 590 U.S. at 669.

True, *Skrmetti* held that this textualist analysis did not apply to the Tennessee ban because that law referenced a diagnosis, and as such, "changing the minor's sex … does not automatically change the operation of [Tennessee's] ban." *Skrmetti*, 145 S.Ct. at 1835. But that is not the case here.

The Act conditions the provision or coverage of medications and procedures solely on whether "an individual transitions from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex." § 191.1720.2(4). In other words, changing the minor's or Medicaid beneficiary's sex is the but-for cause for the Act's operation.

Respondents offered a few reasons why, in their view, the Act does not constitute sex discrimination. None is persuasive. First, Respondents argued that the Act applies equally because it bans the relevant medications when used for the purpose of "identifying with and living as a gender *different from* his or her biological sex," for all people, regardless of their birth-assigned sex. But that is not how our equal protection jurisprudence works. A law that punishes people for believing in a religion different from the religion in which they were raised is not a religion-neutral policy against conversion merely because it applies to people of all religious statuses. *See Hobbie v. Unemployment Appeals Comm'n*, 480 U.S. 136, 144 (1987). A law that bans people from adopting a child "different from" their own race is not race-neutral merely because it applies regardless of the adopter's race. *Cf. Palmore v. Sidoti*, 466 U.S. 429, 434 (1984). And a law prohibiting all people from working in professions "different from" those typical of their sex is not a sex-neutral policy of "conform[ing] to 1950s gender roles." *Bostock*, 590 U.S. at 673. "It is axiomatic that ... classifications do not become legitimate on the assumption that all persons suffer them in equal degree." *Powers v. Ohio*, 499 U.S. 400, 410 (1991).

Next, Respondents argued that *Bostock* does not apply to Appellants' equal protection claims because *Bostock* was limited to the context of employment. But what

constitutes sex discrimination does not vary based on the context of the discrimination. *See Gen. Elec. Co. v. Gilbert*, 429 U.S. 125, 145 (1976), *superseded by statute*, 42 U.S.C. § 2000e(k);[22] *Kadel*, 100 F.4th at 179 (Richardson, J., dissenting) ("At their cores, Title VII and the Equal Protection Clause both target the same conduct: treating people who are otherwise similarly situated differently because of their membership in a protected class."). As such, this Court should join the others in applying *Bostock*'s reasoning to the equal protection context. *See Fowler v. Stitt*, 104 F.4th 770, 790 (10th Cir. 2024), *vacated and remanded on other grounds*, 2025 WL 1787695 (U.S. 2025); *Kadel*, 100 F.4th at 153; *Hecox*, 104 F.4th at 1079-80.

3. The Act is subject to heightened scrutiny because it engages in purposeful discrimination.

The Act represents purposeful discrimination against transgender people by the legislature. On this basis, it is independently subject to heightened scrutiny, which further distinguishes this case from *Skrmetti*. The Act was adopted "because of," not "in spite of," its adverse effects on transgender people's ability to live in accordance with their gender identity. *See Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 279 (1979).

It is no accident that the Act targets transgender young people, transgender Medicaid beneficiaries, and is accompanied by provisions targeting incarcerated transgender people.[23] The Act's overall package was enacted simultaneously with Senate Bill 39, which

[22] While *Gilbert* was superseded by statute, its broader point about what constitutes sex discrimination remains. That said, legal fictions like the ones created in *Geduldig* and *Skrmetti* are not transferable to the statutory context.

[23] Senate Substitute 2 also amended § 221.120(1) to prohibit "gender transition (continued…)

banned transgender student athletes, including pre-pubescent children, from participating in scholastic athletic programs. § 163.048. Together, these laws reveal a clear legislative scheme to roll back and restrict the rights of transgender people throughout Missouri and thus demonstrate a discriminatory legislative intent.

What is more, the Act was precisely drafted to impact only transgender people seeking GAMC. § 191.1720.8. Rather than banning particular treatments across the board, it targets transgender people and explicitly enforces sex stereotypes and gender conformity by prohibiting an individual from obtaining medical care intended to aid in one's "transition[] from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex." § 191.1720.2(4).[24] Under the Act, transgender adolescents and Medicaid beneficiaries are "required effectively to maintain [their] natal sex characteristics." *Boyden v. Conlin*, 341 F.Supp.3d 979, 997 (W.D. Wis. 2018).

This context indicates that the Act was adopted with the express purpose of targeting transgender people for disparate treatment. *See Fowler*, 104 F.4th at 786; *Horne*, 115 F.4th at 1103, 1104. That the statute "allows children to have these treatments—but only so long as they are used for any reason other than as gender-affirming medical care," makes it clear that "'[t]he State's goal in passing [the challenged Act] was not to ban a treatment. It was

---

surgery" for incarcerated people.

[24] In other words, the Act purposely discriminates against transgender people by imposing traditional sex stereotypes. *See, e.g.*, *Bostock*, 590 U.S. at 660-64. Imposing sex stereotypes is another reason why the Act discriminates based on sex. *See Smith v. Avanti*, 249 F.Supp.3d 1194, 1201 (D. Colo. 2017); *Whitaker*, 858 F.3d at 1048.

to ban an outcome that the State deems undesirable.'" *Poe*, 709 F.Supp.3d at 1193 (quoting *Brandt*, 551 F.Supp.3d at 892).

Finally, "Defendants' inability to proffer a legitimate justification for the Policy suggests it was motivated by animus towards transgender people." *Fowler*, 104 F.4th at 788. For one, the Act was "motivated in substantial part by the plainly illegitimate purposes of disapproving transgender status and discouraging individuals from pursuing their honest gender identities," which is "purposeful discrimination against transgender[] [people]." *Dekker*, 679 F.Supp.3d at 1293. For another, Respondents presented no evidence at trial—no testimony from any representatives of the state as witnesses, nor any documentary evidence or statements attributable to the government from which any specific state interests could be inferred.

Other courts have found the same regarding similar laws to purposely discriminate against transgender people. *See Doe v. Ladapo*, 737 F.Supp.3d 1240, 1268-82 (N.D. Fla. 2024); *Dekker*, 679 F.Supp.3d at 1293; Order Granting Pls.' Mot. Summ. J., *Cross v. Montana*, No. DV-23-541 (Missoula Cnty. Dist. Ct., Mont. May 13, 2025), at 33-34, https://tinyurl.com/4vh8r2bz.

B. *United States v. Skrmetti* does not control the outcome of Appellants' Equal Protection Claim.

The recent decision in *United States v. Skrmetti*, 145 S.Ct. 1816, does not control the outcome of Appellants' equal protection claim. In *Skrmetti*, the Court upheld the Sixth Circuit's decision to reverse a preliminary injunction against Tennessee's ban on GAMC for minors. In doing so, the Court relied on *Geduldig v. Aiello*, 417 U.S. 484 (1974), to

hold that Tennessee's ban "does not exclude any individual from medical treatments on the basis of transgender status but rather removes one set of diagnoses—gender dysphoria, gender identity disorder, and gender incongruence—from the range of treatable conditions." *Skrmetti*, 145 S.Ct. at 1833.

First, it is critical to recognize that *Skrmetti*'s analysis hinges on the Court's finding that Tennessee's ban classified based on age and medical condition. 145 S.Ct. at 1829. That is not the case here, where the Act irrationally targets transgender people of *all* ages; it prohibits not only the provision of GAMC to minors, but also the coverage of such care for Medicaid beneficiaries *regardless of age*. In addition, Tennessee's ban discriminated based on medical condition by prohibiting the medications and procedures at issue only when provided "for the purpose of … [t]reating purported discomfort or distress from a discordance between the minor's sex and asserted identity." Tenn. Code Ann. § 68-33-101(n)(2). Here, in contrast, the Act prohibits the medications and services at issue when provided "for the purpose of a gender transition," § 191.1720(4)(1), § 208.152(2)(15), *regardless of medical condition*. In other words, the Act here operates differently than the ban at issue in *Skrmetti*, such that *Skrmetti*—even when taken at face value—does not control this case's equal protection analysis.

Second, by design, Missouri's Constitution is meant to be more protective than the U.S. Constitution. This Court has historically recognized that the "Missouri Constitution due process and equal protection clauses provide more protection than United States Constitution where United States Supreme Court precedent 'dilute[s] these important

rights.'" *Weinschenk v. State*, 203 S.W.3d 201, 212 (Mo. banc 2006) (quotation omitted); *see also State v. Rushing*, 935 S.W.2d 30, 34 (Mo. banc 1996).

Accordingly, this Court must decline to follow *Skrmetti* and decline to import *Geduldig* into Missouri's equal protection jurisprudence. Since its inception, *Geduldig* has been widely criticized as an illogical aberration that has diminished sex discrimination protections under the Fourteenth Amendment. *See, e.g.*, *Coleman v. Ct. of Appeals of Md.*, 566 U.S. 30, 54-59 & n.6 (2012) (Ginsburg, J., dissenting); *see also* E. Chemerinsky, *Constitutional Law* 759 (3d ed. 2006); Herma Hill Kay, *Equality and Difference*, 1 Berkeley Women's L.J. 1, 31 (1985); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. 955, 983-84 (1984) (noting scholars "have condemned" *Geduldig*'s "approach and the result" and that "[e]ven the principal scholarly defense of *Geduldig* admits that the Court was wrong"); Kenneth L. Karst, *The Supreme Court 1976 Term Foreword*, 91 Harv. L. Rev. 1, 54, n.304 (1977) (stating *Geduldig* and *Gilbert* "with their Alice-in-Wonderland view of pregnancy as a sex-neutral phenomenon, are good candidates for early retirement"). Indeed, following the Supreme Court's import of *Geduldig*'s reasoning into Title VII in *Gilbert*, Congress quickly amended Title VII to "unambiguously express[] its disapproval of both the holding and the reasoning of the Court in the *Gilbert* decision." *Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C.*, 462 U.S. 669, 678 (1983).

More than forty years ago, this Court disagreed with the reasoning of *Geduldig/Gilbert*, holding "that an allegation that an employee's pregnancy was a factor motivating an adverse employment action could establish a prima facie case of

discrimination 'because of ... sex.'" *Self v. Midwest Orthopedics Foot & Ankle, P.C.*, 272 S.W.3d 364, 366 (Mo. App. W.D. 2008) (citing *Midstate Oil Co. v. Mo. Comm'n on Hum. Rts.*, 679 S.W.2d 842, 846 (Mo. banc 1984) (allegation that "a gender-related trait—pregnancy—was a factor in respondent's decision to discharge her … was sufficient to establish an inference of discrimination." (cleaned up)). Consistent with this precedent, this Court should decline to adopt *Geduldig*'s reasoning in the context of Missouri's equal protection clause. To do otherwise would be to do grave violence to the promise that "all persons are created equal and are *entitled to equal rights and opportunity under the law*" contained in Missouri's Constitution. Mo. Const. art I, § 2.

Equal protection jurisprudence has long drawn a fundamental distinction between sex-neutral classifications (which trigger heightened scrutiny only when passed, at least in part, for a discriminatory purpose) and facial sex classifications (which always trigger heightened scrutiny). *See Feeney*, 442 U.S. at 273-74. As such, "*Geduldig* must be read in light of" equal protection cases "all of which say that a state cannot immunize itself from violating the Equal Protection Clause by discriminating against only a subset of a protected group." *Kadel*, 100 F.4th at 146. Here, the Act facially classifies based on transgender status and sex, requiring that in each instance a person's sex be known and used to determine whether treatment is permitted or covered. *See supra* Point VI.A.1-2; *see also L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 502 (6th Cir. 2023) (White, J., dissenting), *aff'd*, 145 S.Ct. 1816.

Third, "*Geduldig* is best understood as standing for the simple proposition that pregnancy is an insufficiently close proxy for sex. The same cannot be said for the

inextricable categories of gender dysphoria and transgender status." *Kadel*, 100 F.4th at 146. The centrality of gender transition to transgender identity further distinguishes this case from *Geduldig*—something that the majority opinion in *Skrmetti* failed to acknowledge. Unlike the pregnancy exclusion in *Geduldig*, the Act is based on a characteristic that defines membership in the excluded group. Pregnancy is not the defining characteristic of womanhood. By contrast, living in accord with one's gender identity rather than one's birth-assigned sex is the defining characteristic of a transgender person.

Further, *Geduldig* and *Skrmetti* themselves recognized that where, as here, distinctions are "mere pretexts designed to effect an invidious discrimination against the members of one [protected class] or the other," such distinctions are unconstitutional. *Geduldig*, 417 U.S. at 496 n.20; *see also Skrmetti*, 145 S.Ct. at 1833. The Supreme Court found that the plaintiffs in *Skrmetti* "ha[d] not argued that [Tennessee]'s prohibitions are mere pretexts designed to effect an invidious discrimination against transgender individuals." 145 S.Ct. at 1833. Appellants have done so here. App 212. The intent to treat transgender persons differently pervades the Act's history and context and showcases its discriminatory purpose. *See supra* Point VI.A.3. Moreover, "[s]ome activities may be such an irrational object of disfavor that, if they are targeted, and if they also happen to be engaged in exclusively or predominantly by a particular class of people, an intent to disfavor that class can readily be presumed." *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993). The Act is plain: GAMC, and Medicaid coverage thereof, is prohibited only if provided for the purpose of "gender transition." That conclusively shows pretext.

Further distinguishing *Skrmetti* from this case is the fact that *Skrmetti* declined to address two arguments presented here, which demonstrate the Act's discriminatory nature. First, the Court observed that it "has not previously held that transgender individuals are a suspect or quasi-suspect class," and did not find reason to do so in that case considering its application of *Geduldig*. *Skrmetti*, 145 S.Ct. at 1832-33. Second, the Court noted it "ha[d] not yet considered whether *Bostock*'s reasoning reaches beyond the Title VII context, and we need not do so here." *Id.* at 1834.[25]

C. Defendants failed to carry their burden under heightened scrutiny.

"Under intermediate or heightened scrutiny, [a] classification is permissible only if it is substantially related to the achievement of important governmental objectives." *Glossip*, 411 S.W.3d at 812. In evaluating whether the Act is substantially related to an important governmental interest, "[t]he Court retains an independent constitutional duty to review [legislative] factual findings when constitutional rights are at stake." *Gonzales*, 550 U.S. at 165. The "burden of justification is demanding"—not "deferential"—and it "rests entirely on the State." *VMI*, 518 U.S. at 533, 555. The State cannot carry its demanding burden in view of the well-established consensus (or at least, overwhelming majority view) in the medical profession that GAMC is medically necessary and that there are no evidence-based alternatives to treat gender dysphoria. Nor is there any justification for

[25] This Court's decision in *R.M.A. II*, 2025 WL 1645216, at *5, does not foreclose such application. First, *R.M.A. II* must be read in context with this Court's earlier decision making clear that state action that targets transgender people by classifying based on birth-assigned sex *does* constitute a sex classification. *Id.* at *6; *R.M.A. I*, 568 S.W.3d at 428. Second, this Court clarified that its decision was cabined by the statutory context of the MHRA. *R.M.A. II*, 2025 WL 1645216, at *4.

treating GAMC differently from other health care that poses similar risks and benefits and is supported by comparable evidence of efficacy.

Respondents presented no credible testimony or documentary evidence attributable to the State of Missouri establishing any genuine or legitimate interest. Respondents identified several putative state interests in their pre-trial briefing but made no attempt to establish that these interests were genuine government objectives rather than "hypothesized or invented *post hoc* in response to litigation." *VMI*, 518 U.S. at 533. Nonetheless, even assuming that the State's proffered interests are genuine, Respondents did not present sufficient evidence to establish that the Act's means are substantially related to the achievement of important governmental objectives.[26] Indeed, for the reasons explained in Point VII, *infra*, the record demonstrates that the Act *harms*, rather than helps, those it seeks to protect.

Furthermore, all the evidence presented by Respondents pertained to care for minors; Respondents have not adduced any evidence whatsoever to justify their ban on coverage for adult Medicaid beneficiaries to whom the Act applies. Given this lack of evidence, the Court should, at a minimum, hold that the Medicaid Ban is unconstitutional as applied to adults. And while the Equal Protection Clause may not always require

[26] Respondents (and the Judgment) relied on numerous opinion pieces, news reports, expert reports, documents from some foreign government agencies, and others. As articulated in Point VII, *infra*, most of these documents were either not offered at trial or were deemed inadmissible. Respondents did not present the State's alleged evidence through actual testimony from a government actor. Given Respondents' burden, this Court should look only to the evidence actually admitted for its truth.

perfectly drawn lines, the Act's unprecedented and gross over-inclusivity further shows its justifications are pretextual.

Point VII: The trial court erred in denying Appellants' claims based on its erroneous factual findings because those factual findings are not supported by the record and any conclusions based on them are against the weight of the evidence in that by adopting almost verbatim Respondents' proposed findings, the trial court relied on evidence it either excluded during the trial and/or that is not in the record thereby making factual findings that have no support in the record, much less carry any weight, and including factual findings that contradicted the trial court's evidentiary rulings.

I. Standard of Review and Preservation of Error

Following a bench-tried case, "[a]n appellate court must sustain the decree or judgment of the [circuit] court unless there is no substantial evidence to support it, unless it is against the weight of the evidence, unless it erroneously declares the law, or unless it erroneously applies the law." *Millstone Prop. Owners Ass'n*, 701 S.W.3d at 640-41 (cleaned up). An appellate court will "review the evidence in the light most favorable to the trial court's decision." *Davis v. Dir. of Revenue*, 346 S.W.3d 319, 322 (Mo. App. E.D. 2011). "All reasonable inferences are drawn in favor of the verdict and all contrary evidence and inferences are disregarded." *Id.* "If facts are contested, [the appellate court is] obliged to defer to the trial court's determination of those facts." *Id*.

"Weight of the evidence means its weight in probative value, not its quantity …. The weight of evidence is not determined by mathematics, but on its effect in inducing belief." *Wildflower Cmty. Ass'n, Inc. v. Rinderknecht*, 25 S.W.3d 530, 536 (Mo. App. W.D. 2000) (cleaned up). "A circuit court's judgment is against the weight of the evidence only if the circuit court could not have reasonably found, from the record at trial, the existence

of a fact that is necessary to sustain the judgment." *Ivie v. Smith*, 439 S.W.3d 189, 206 (Mo. banc 2014). "When the evidence poses two reasonable but different conclusions, appellate courts must defer to the circuit court's assessment of that evidence." *Id.* "Evidence not based on a credibility determination, contrary to the circuit court's judgment, can be considered in an appellate court's review of an against-the-weight-of-the-evidence challenge."[27] *Id.*

In this point on appeal, Appellants identify several "challenged factual proposition[s], the existence of which [are] necessary to sustain the judgment.'" *Sellers v. Woodfield Prop. Owners Ass'n*, 457 S.W.3d 357, 362 (Mo. App. S.D. 2015). The record evidence either does not exist in the way the trial court claims it does, or contradicts the trial court's factual findings. Accordingly, as the trial court based its decision on these factual findings, the trial court's legal conclusions based upon those erroneous findings are against the weight of the evidence and must be reversed. This is true regardless of the trial court's credibility determinations, to which Appellants acknowledge this Court gives deference.

No post-trial motion was required to preserve this issue for appeal and all exhibits referenced herein were addressed in the trial record; it is therefore preserved.

[27] As noted, the trial court relied on testimony from both Appellants' and Respondents' fact and expert witnesses. Thus, the question here is whether the appropriate weight was given to that testimony considering the entire record at trial.

II. Argument

A. The trial court's factual findings were adopted nearly verbatim from Respondents' proposed findings of fact below, and as a result, swept in and incorporated pervasive and overwhelming factual errors.

"The judiciary is not and should not be a rubber-stamp for anyone." *State v. Griffin*, 848 S.W.2d 464, 471 (Mo. banc 1993). The Missouri Constitution's guarantee of equal protection and fundamental rights means that when the state singles out a particular group for unfair treatment, or invades a fundamental right, courts review the state's reasoning to ensure it is sound. But here, the trial court's judgment, including the vast majority of the factual findings on which its legal conclusions are based, is almost identical to the proposed findings and conclusions submitted by Respondents. *Compare* D185 (App 1) *with* D182 (App 75). The trial court's "findings of fact" section is, excluding the pages that simply reproduce the statutory text of the Act, approximately ninety percent adopted verbatim from Respondents' proposed findings. D185 pp. 5-38 (App 1); D182 pp. 4-30 (App 75).

Submitting proposed findings of fact and conclusions of law is common practice in trial courts. However, here, the proposed findings of fact were drafted before the trial transcript, covering the testimony of thirty-four witnesses, was available; cited and purported to rely on exhibits that were excluded or never offered; and frequently contradicts both witness testimony and the court's own evidentiary rulings.

While a trial court's adoption of one party's proposed findings of fact and conclusions, alone, may not be "'*per se* error[,]'" that is true only "[w]here there are no inconsistencies between the factual findings and the actual facts and where the legal conclusions are sufficiently specific to permit meaningful review…." *See Klinkerfuss v.*

Cronin, 289 S.W.3d 607, 613 (Mo. App. E.D. 2009). Unlike the circumstances in *Klinkerfuss*, here, there *are* "discrepancies between the facts found in the record and those contained in the order adopted by the court." *Goad v. State*, 839 S.W.2d 749, 751 (Mo. App. W.D. 1992). Because of the overwhelming discrepancies between the facts in the record and those in the court's findings, a reversible error has occurred, one that permeates the trial court's subsequent purported analysis of Appellants' claims.

B. The trial court's conclusion that the Act withstands either heightened scrutiny or rational basis review is erroneously based upon pervasive factual errors.

In support of this point on appeal, factual findings that are either directly contradicted by the record or lack any support whatsoever include, but are not limited to:

Exhibits. The trial court's order cites to and relies on exhibits never offered or admitted into evidence at trial and erroneously states that certain exhibits were "admitted" when the transcript demonstrates otherwise. For example, Respondents referenced Exhibit 1024, a World Health Organization document put forth during Dr. Shumer's testimony that was never offered into evidence. Trial Tr. 465:8-466:12. The court's order, however, refers to that document as "(admitted)." Respondents' Exhibits 1001, 1018, and 11124, none of which were offered into evidence at trial, are also all relied upon in the court's order. D185 pp. 9, 16, 51; App 1; *see also* Trial Tr. 389:23-392:22, 470:22-472:22, 790:20-793:23, 1927:11-1930:11. The trial court also relied directly on statements from exhibits not offered or admitted—for example, many of its claims about neurological function are derived from Ex. 1062, which was never offered into evidence. Trial Tr. 428:9, 837:41.

These instances exemplify the pervasive factual errors based on the trial court's adoption of Respondents' brief.

Moreover, throughout its order, the trial court relied heavily on the final "Cass Report," a non-peer-reviewed report issued by a UK doctor with no experience with GAMC, as substantive evidence concerning the safety, efficacy, and evidence base underlying GAMC for adolescents. *See*, *e.g.*, D185 pp. 4, 17, 18, 20, 21, 50, 51, 53; App 1. However, the Cass Report was *not* admitted at trial. When Respondents offered it for admission, Appellants objected on hearsay and authentication grounds. The trial court did not admit it as substantive evidence or for its truth. Rather, it allowed Respondents to submit it as an offer of proof. Trial Tr. 401:19-402:2, 2416:4-25. Later, the trial court took the same approach to other foreign governmental reports. Trial Tr. 1888:13-18.

The Cass Report should not have been relied upon as substantive evidence. The court accepted it as an offer of proof—which "provide[s] the trial court and opposing counsel with the substance of the excluded [evidence] in enough detail for" the reviewing court "to determine whether the exclusion of the evidence was erroneous and whether Defendant was prejudiced thereby." *Id.*; *State v. Campbell*, 675 S.W.3d 223, 228 (Mo. App. E.D. 2023). Here, however, Respondents have not cross-appealed the non-admittance of the Cass Report. It is simply not part of the record.

The trial court also relied on several other foreign governmental reports that were not admitted for their truth. For example, the court claims that "[t]he Swedish guidelines say that the harms from these interventions outweigh the benefits" and that "[t]he Finnish guidelines similarly declare these interventions to be experimental." D185 p. 21; App 1.

But neither of these guidelines were offered as exhibits at trial. With respect to the Swedish guidelines, a summary of such guidelines was shown to one expert, and though counsel implied the above statement in his question, the witness's testimony did not establish it. Trial Tr. 692:16-694:9 (discussion of Ex. 11086). As for the Finnish guidelines, no document containing the guidelines was shown to any witness. Respondents' counsel showed a document from the Finnish government to one witness but did not ask any questions regarding any conclusion that GAMC is "experimental;" and that exhibit, too, was neither offered nor admitted. Trial Tr. 691:8-692:13 (discussion of Ex. 11087). It was error for the trial court to rely on either of these unadmitted exhibits.

Admitting the final Cass Report or any of the foreign governmental reports into evidence would also have been error. As a document authored by a doctor in the United Kingdom (who did not testify) and commissioned by the UK's National Health Service, the Cass Report is hearsay not admissible for its truth. The same is true of the Finnish and Swedish guidelines. Missouri's statutory exception for records of "public offices" applies only to records "kept in any public office *of the United States, or of a sister state*." § 490.220 (emphasis added). And neither would they be admissible under Missouri's public records or business records exceptions, both of which require a custodian to establish authenticity. *Hanks v. Lab. & Indus. Rels. Comm'n*, 639 S.W.2d 252, 255 (Mo. App. W.D. 1982) (business records); *State v. Blakeburn*, 859 S.W.2d 170, 177 (Mo. App. W.D. 1993) (public records). "Even if a document falls under the business record exception, however, the document will not be admissible if the underlying statement is inadmissible hearsay." *State v. Sutherland*, 939 S.W.2d 373, 377 (Mo. banc 1997).

This is no mere procedural technicality. Appellants understood that foreign governmental reports are inadmissible hearsay and thus elicited testimony from experts that care is not restricted in Australia, New Zealand, Northern Ireland, Germany, Spain, Denmark, the Netherlands, Canada and "many other countries." Trial Tr. 587:11-15. Because the foreign reports are inadmissible hearsay, the trial court's reliance on them—in contradiction with its own evidentiary rulings—is reversible error.

A similar error arises in the trial court's assertion that it "reviewed documents filed in court by the United States suggesting that WPATH has suppressed research unfavorable to its agenda" without citing to any exhibit or document. D185 p. 54; App 1. Without more information, it is impossible to discern what Respondents meant the trial court was supposed to have reviewed when they added this statement to their proposed findings below. No exhibit establishing the trial court's conclusion was admitted at trial.

Quality of Evidence. The trial court's factual findings regarding the quality of evidence underlying GAMC depart significantly from the record. The court asserts that the parties "agreed" at trial that GAMC lacks "any high quality" or "even moderate quality" evidence under GRADE (and elsewhere, claimed that systematic reviews "unanimously determined" the same thing). D185 pp. 4, 19, 50, 51; App 1. These conclusions are incorrect and ignore critical context supplied by the experts. First, the descriptors "low" or "very-low," as invoked by the witnesses, are terms of art. Furthermore, "low" or "very-low" quality evidence is *the norm* across all areas of medicine. Dr. Antommaria testified that it was "very common" for clinical practice guidelines to make recommendations based on "low" or "very low" quality evidence under GRADE and noted that "only

approximately 14 percent of systematic reviews provided high quality evidence." Trial Tr. 734:5-7; 733:4-12. For example, other Endocrine Society guidelines for pediatric care (unrelated to GAMC) contain *no* recommendations based on high-quality evidence: thirty percent were based on moderate quality evidence, and sixty percent were based on low or very-low quality evidence. Trial Tr. 733:13-18. This is not limited to endocrinology or pediatric care—the American Heart Association's guidelines for CPR, for example, make one-hundred recommendations, *ninety-six* of which are based on low or very-low quality evidence. Trial Tr. 733:19-734:7.

Putting aside that *most* systematic reviews find low quality evidence, the trial court's claim that the parties "agree" that systematic reviews have only found low quality evidence directly contradicts testimony from both sides. In fact, the testimony was that—despite their rarity in medicine—there *are* numerous "moderate" and "high" quality studies supporting GAMC, as categorized by systematic reviews. Trial Tr. 703:9-20, 704:19-705:4. Even Respondents' own experts agreed that there were studies categorized as both moderate and high quality by systematic reviews; he simply quibbled with how that categorization was reached. Trial Tr. 1840:9-11, 1845:12, 1846:9, 1846:12, 1842:12-21. And Appellants' evidence included several reports that directly contradict this characterization. Exs. 205, 320, 321, 322; *see also* Exs. 506, 507 (exhibits admitted at Trial Tr. 2697:17-19).

The trial court singled out a particular set of studies and incorrectly asserted that "Defendants identify systematic reviews that have graded the quality of the de Vries studies to be 'very low.'" D185 p. 51; App 1. The testimony was instead that *one outcome* of *one*

of the de Vries studies was so categorized, but another systematic review identified one of the de Vries studies to be of moderate quality and another of the "Dutch" studies to be of high quality. Trial Tr. 467:20-24, 703:9-12 (moderate quality), 703:15-18 (high quality).

Finally, the trial court claimed that Dr. Antommaria "acknowledged that guidelines are supposed to be based on systematic reviews—but that WPATH's guidelines are not." D185 p. 23; App 1. Again, this is contrary to the record. Dr. Antommaria testified that it is "uncommon for clinical practice guidelines to be based on systematic methods," and noted one study that found only approximately one-third of clinical practice guidelines synthesize the available evidence based on systematic reviews. Trial Tr. 740:13-741:16. When asked, he clarified that WPATH *did* conduct systematic reviews, just not of the recommendations in every chapter. Trial Tr. 773:6-8.

WPATH Standards of Care. The trial court offers six purported examples of WPATH's SOC8 acknowledging "limitations" to the evidence underlying GAMC. D185 p. 22; App 1. However, four of these six examples discuss treatments *other than GAMC.* The second and third bullets (which discuss "limited research" or "little research") both appear in the same passage and refer to the "assessment of individuals who wish to detransition," not undergo GAMC. Ex. 5, at S41. Similarly, the fifth bullet, viewed in context, refers not to GAMC but to the recommendation to provide counseling "on future fertility, and options for fertility preservation." *Id.* at S75. Finally, the last bullet refers specifically to limited long-term research regarding cancer screening and risks, noting that "cancer screening should commence, in general, according to local guidelines." *Id.* at S144.

Assessment. A particularly telling example of the problems created by the trial court's adoption of Respondents' framing of the facts—even when it contradicts the testimony at trial—is the trial court's discussion of assessment. The WPATH SOC8 provide that minor patients should receive a "comprehensive biopsychosocial assessment" by a qualified provider before initiating any medical interventions. Ex. 5, at S48. According to the WPATH SOC8, this assessment should include, *inter alia*, confirming (1) the patient "meets the diagnostic criteria;" (2) their "experience of gender diversity/incongruence is marked and sustained over time;" (3) they "demonstrate[] the emotional and cognitive maturity required to provide informed consent/assent;" and (4) "mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and … treatments have been addressed." *Id.*

From the outset of this case, Respondents conflated the biopsychosocial assessment with a confusing term of their own invention: the "comprehensive psychological or psychiatric assessment." *See, e.g.*, PI Tr. 328:14-15; D6 p. 41. Respondents never defined this ambiguous phrase, which seems to imply that the assessment must be done by a psychologist or psychiatrist. The guidelines, however, recommend that the biopsychosocial assessment be done by a "qualified mental health provider"—this includes a licensed clinical social worker, for example. Ex. 5, at S49. It is unsurprising that when Respondents employed their invented terminology in questioning, it led to confusing results. One Parent Appellant, misunderstanding Respondents' unfamiliar phrasing, testified at the PI hearing that their child (who had not yet reached puberty and so *had not yet pursued any medical interventions*) had not received a "psychological or psychiatric evaluation assessment

[sic].” Another testified that their child saw a licensed therapist but had not received a “psychological” or “psychiatric” evaluation. PI Tr. 304:13-23, 328:14-16.

However, all three Parent Appellants confirmed at trial that their children had received the *comprehensive biopsychosocial assessment*. This is the only term recognized as describing the recommended mental health assessment for determining adolescents’ eligibility to initiate GAMC. Trial Tr. 1205:20-21, 1206:12-20, 1328:12-16, 1223:9-12. The trial court ignored the clear testimony that all three minors had received extensive mental health counseling, and the letters or records from the minors’ mental health providers admitted into evidence confirming their assessments. Exs. 372, 360, 456. Instead, the trial court accepted Respondents’ framing of an evaluation that does not exist and is not required and claimed that two of the Minor Appellants had “been provided” care “without practitioners first ensuring that the individuals have received” the requisite assessment. D185 p. 44; App 1. This conclusion is incorrect. It also ignores that one of the Minor Appellants in question *hadn’t yet initiated any medical interventions at the time of trial*. Trial Tr. 1326:14-20.

Fertility. The trial court’s conclusions regarding fertility are contrary to the evidence. The judgment claims that “possible infertility” is one of the “probable irreversible changes” associated with GAMC. D185 p. 10; App 1. Later, the judgment states that “several” of the state’s witnesses experienced “difficulty with fertility.” D185 pp. 25-26; App 1. This is incorrect.

Rather than experiencing infertility, Ms. Hawes gave birth to and breastfed two children despite having taken testosterone as an adolescent. Trial Tr. 2327:5-22, 2329:24-

2330:10. Ms. Cole did not testify to fertility. Trial Tr. 2667:7-10. Of the two witnesses assigned male at birth, neither testified regarding the effects of treatment on fertility. Mr. Garcia testified he was unaware of any such effects from his treatment. Trial Tr. 2265:16-23, 2268:8-11. Mr. Williams, who began his transition at age 28, did not testify about his fertility. The trial court *did* hear testimony regarding the steps available to preserve fertility in the context of GAMC. Trial Tr. 338:14-343:13. Dr. Shumer also emphasized that fertility is a subject about which doctors spend considerable effort educating their transgender patients and their families, and that access to reversible interventions like puberty blockers allow for patients to make these decisions at later ages. Trial Tr. 340-41, 379.

Moreover, testimony demonstrates that the Care Ban *directly contributed* to a loss of fertility. Amy Salladay testified that she and her child were counseled on the options available to preserve fertility and had a plan in place. Trial Tr. 1427:1-1428:23. However, because of the Act, Ms. Salladay's child was forced to proceed with GAHT prior to preserving fertility or risk losing care altogether. Trial Tr. 1429:15-31:5.

Suicidality. The trial court's finding that Appellants' experts presented "no evidence" that GAMC "decreases the risk of suicide" is contradicted by the record. D185 p. 29; App 1. Appellants' experts emphasized that there is a great body of evidence linking access to care with reductions in suicidality. Trial Tr. 131:5-20, 201:8-11, 261:21-262:3, 484:21-485:19, 551:15-552:16, 554:10-555:14.

Appellants' expert discussed a study that "demonstrated … clinically significant and statistically significant improvement in depression with an improvement in quality of life" from puberty blockers and hormones. Trial Tr. 551:1-14. The expert also discussed a study

finding that those who were able to access GAHT "had lower odds of depression, and … lower odds of suicidality" than those who wanted, but did not have, such access. Trial Tr. 551:15-552:16; Ex. 142 (admitted as demonstrative). The testimony also touched on a study of a cohort of transgender adolescents in Missouri who accessed GAMC, which demonstrated "a decline in the suicidality scores and an improvement in general wellbeing." Trial Tr. 554:7-555:14. Finally, the York systematic review—upon which Respondents rely—demonstrated that "adolescents who received puberty suppression [before GAHT] had fewer symptoms of depression, anxiety, stress, and suicidal thoughts" compared with those who had no access to puberty blockers before GAHT. Trial Tr. 634:10-635:2.

Increases in Prevalence of Gender Dysphoria. The trial court makes several findings based upon the discredited theory of "rapid onset gender dysphoria" ("ROGD") and the premise that GAMC itself may be altering gender identity and causing a spike in the rates of gender dysphoria diagnosis. Both assertions (or that experts "agreed" on them) are unsupported by the record.

Underpinning these findings in the judgment is the theory that the rise in the number of referrals to gender clinics is caused by "social contagion." This theory was propagated in a paper about ROGD—a study that was flawed for numerous reasons, was retracted, and has since been heavily criticized (as demonstrated at trial). Trial Tr. 273:25-275:5. Respondents' own expert conceded that this study was not a representative sample and ninety-seven percent of the study participants would not have met diagnostic criteria for gender dysphoria. Trial Tr. 1935:4-24, 1963:20-1964:6. The witness was able to point to

only one other study regarding "ROGD"—a study he co-authored with a lay person who runs a website decreeing that transgender people are "NOT normal." Trial Tr. 1939:4-25, 1961:11-21. That study was retracted because, among other things, it failed to obtain consent from survey respondents. Trial Tr. 1942:6-23.

A rise in the number of referrals to gender clinics in recent years also does not justify the Care Ban. Appellants' experts offered grounded explanations for this increase, such as increased access to care, greater societal acceptance, and changes in insurance coverage. Trial Tr. 152:19-153:18, 250:19-251:11, 588:20-591:10. Respondents' experts were not able to attribute the increase to any cause. Trial Tr. 1802:24-1804:8.

The trial court's only support for the notion that puberty blockers might change the "trajectory" of gender dysphoria is a single *hypothesis* from the excluded, non-peer reviewed Cass Report. D185 p. 17; App 1. Dr. Shumer testified against the conclusion that puberty blockers could "cause" gender dysphoria. Trial Tr. 416:14-18. Dr. Shumer's review of the literature indicates that a more likely explanation for this phenomenon is that those for whom gender dysphoria is likely to persist are simply much more likely to be interested in pursuing puberty blockers. Trial Tr. 417:16-20.

Desistance and Detransition. The judgment incorrectly found that "a vast majority of children who are diagnosed with gender dysphoria outgrow the condition" and that "an overwhelming percentage of adolescents who complain of gender dysphoria will eventually and naturally grow out of the symptoms."[28] D185 pp. 3, 9; App 1.

[28] This finding is contrary to the evidence. *See*, *e.g.*, Trial Tr. 272:3-6 ("Q. [w]hat is (continued…)

The testimony at trial, however, noted the critical distinction between pre-pubertal children and adolescents, and the studies Respondents (and therefore the court's judgment) relied on examine whether *pre-pubertal children* will cease to identify as transgender.[29] When it comes to transgender *adolescents*, there is broad agreement that their gender dysphoria is very likely to persist. Trial Tr. 417:16-25, 603:2-7; PI Tr. 61:7-11, 231:21-25. One of Respondents' experts acknowledged this: "If your child's gender dysphoria persists well into adolescence, again, the ages vary by child, but let's say age 14 or so, she or he is much more likely to transition. At that point, in [my] opinion, parents should consider supporting transition." Trial Tr. 1964:22-1965:3. Another of Respondents' experts takes the position that "youth should be permitted to begin to transition, socially and/or medically," at "age 12 … because that is what the (current) evidence supports: … the majority of kids who continue to feel trans after puberty rarely cease." Trial Tr. 1882:8-1883:3; Ex. 399.

Finally, the court found that "detransitioners often have come to regret these interventions." D185 p. 26; App 1. This is unsupported and the evidence shows that regret is uncommon among those who receive GAMC as adolescents. Trial Tr. 585:1-17. Dr. Moyer reported that "less than one percent of people in [her] study" regretted ever initiating

---

your reaction to the claim that young people with gender dysphoria will grow out of it? A. That is unsupported by the research evidence or our clinical experience.), 417:16-25, 582:11-14, 584:3-4.

[29] These studies counted as "desisters" large proportions of young people who would not even meet diagnostic criteria and be considered transgender. Trial Tr. 1958:19-1959:21.

care. Trial Tr. 271:1-19. A more recent study with an even larger survey response rate "had almost exactly the same results." Trial Tr. 271:18-19.

The Cass Report. As discussed *supra*, the Cass Report was inadmissible as substantive evidence. Even if the Report were admissible, the trial court's conclusions purportedly based on it are largely unsupported. For example, the trial court erroneously found that **all** experts at trial "agree" that the Cass Report "concluded that these interventions rest on 'remarkably weak evidence.'" D185 p. 4; App 1. But Appellants' experts testified that they did *not* agree with the Cass Report's characterization of the evidence. Trial Tr. 189:2-9, 193:16-194:2, 282:21-283:1, 454:10-18, 787:11-788:7. Additionally, as one of Appellants' experts pointed out, the Cass Report in fact found moderate quality evidence for GAMC. Trial Tr. 790:9-11.

Jamie Reed. The trial court made several claims about the testimony of Jamie Reed that are nowhere reflected in the record. For example, the record does not support a finding that "gender transition surgeries" and "sex change surgeries" were "regularly facilitated or directly provided … for minors" in Missouri. D185 p. 13; App 1. The trial court reached this broad factual finding based upon Ms. Reed's testimony and Exhibit 273, the Center's Internal Review. But that exhibit found that her "allegations of substandard care causing adverse outcomes for patients at the Center are unsubstantiated" and that "Washington University physicians and staff … treat patients according to the currently accepted standard of care." Ex. 273.[30]

[30] At most, Ms. Reed testified that *she* referred patients to surgeons and saw surgical (continued…)

Another example of the trial court overreading Ms. Reed's testimony is its conclusion that she "offered unrebutted testimony undiagnosed individuals routinely received these interventions." D185 p. 29; App 1. At most, Ms. Reed testified that she felt that one of the endocrinologists with whom she worked *believed* patients did not need a diagnosis *to consider someone transgender*. Trial Tr. 1615:10-15. (Unsurprising, as being transgender is not an illness.) However, she did not testify that medications were prescribed without a diagnosis, and in fact, was clear that patients seeking medical interventions needed a letter reflecting an assessment from a mental health professional—which under the applicable standards of care *requires a diagnosis*. Trial Tr. 1614:24-1615:2; Ex. 5, at S48. And certainly, Ms. Reed's allegations about lax treatment protocols were broadly rebutted: for example, many families came forward after her affidavit was published to dispute her allegations about how care was provided. Ex. 273 (admitted at PI Hearing as Plts.' PI Ex. 16) at 2; PI Tr. 598:3-601:21; *see also* Trial Tr. 1172:25-1173:7, 1225:2-5, 1274:1-5, 1306:12-15, 1499:6-8.

The trial court similarly claimed that Ms. Reed testified that "many individuals were not receiving these assessments at all." D185 p. 30; App 1. In fact, Ms. Reed testified that some patients did not receive assessments *from Washington University* but rather from outside mental health providers. Trial Tr. 1617:1-13. Respondents offered only one letter reflecting supposedly poor documentation of an outside assessment, and even that

---

scars on patients at the Center. Trial Tr. 1653:13-1654:11. Providing patients with the names of possible surgeons is not "facilitating," much less "directly providing" surgical care.

document is dated 2018 and does not indicate that it concerns a minor, nor does Ms. Reed's testimony. Ex. 1200; Trial Tr. 1619:15-22. All told, Ms. Reed was able to point to just one young person—not "many"—who apparently received care without a documented assessment, and the decision in that case was to *continue* to provide care as that patient had already initiated GAHT before coming to the clinic. Trial Tr. 1620:5-6.

Surgery. Many of the trial court's factual findings regarding surgery are contradicted by the record. The court found that "professionals at trial agreed that no person under eighteen years of age should receive surgical treatment for gender dysphoria." D185 p. 10; App 1. Not so. While surgical interventions are generally reserved for adults, for some older adolescents, masculinizing chest surgery can prove beneficial. Trial Tr. 332:5-8, 571:21-24. The trial court's claim that Appellants "provided no testimony" that Minor Appellants were seeking surgical care is also incorrect. Placement of a puberty blocker implant, which N.N. was seeking, is an outpatient surgical procedure. Trial Tr. 572:8-21. Thus, while an incision for a puberty blocker *is* different than a mastectomy, it is still surgery. D190 p. 42. Moreover, Provider Plaintiffs refer transgender adult patients on Medicaid for surgery and provide them with post-surgical follow-up care. Trial Tr. 1024:13-20, 1124:14-17.

The trial court also incorrectly states that Appellants provided no evidence about the "safety or efficacy of various surgeries." D185 p. 42; App 1. This overlooks research discussed in the guidelines, Ex. 5, and Dr. Olson-Kennedy's testimony that "[a]cross the research, examining the impact of central blockers, and gender-affirming hormones, and surgical care, that body of evidence demonstrates a positive impact and a safety profile,"

Trial Tr. 538:10-13, and that "the studies on chest masculinizing surgery demonstrate positive impact of that intervention." Trial Tr. 571:25-572:1; *see also* Ex. 232. Dr. Janssen similarly testified that surgical interventions improved patients' sense of bodily integrity, gender dysphoria symptoms, quality of life, and mental health. Trial Tr. 143:7-9.

Bicalutamide. The trial court concluded that "there is no medical consensus" around the use of bicalutamide as part of GAMC, because the WPATH SOC8 "do not recommend its routine use." Ex. 5, at S124. For one, the *only* expert testimony concerning bicalutamide was that "it is not commonly used, but it has been reported for use" and that "it could be" an "appropriate treatment in some instances for someone with gender dysphoria." Trial Tr. 396:5-6, 483:3-12. There was no testimony or documentary evidence establishing that "there is no medical consensus" concerning its use in certain circumstances. At most, Jamie Reed alleged that the Center sometimes prescribed bicalutamide and, when doing so, warned patients of its potential risks. Trial Tr. 1659:9-21. Nothing in her testimony establishes any lack of medical consensus regarding bicalutamide, nor disputes that its use could be appropriate in certain circumstances. The allegation in her affidavit, which was excluded at trial, that bicalutamide led to liver injury in a single patient was based on inaccurate second-hand communications, which Ms. Reed ultimately acknowledged. PI Tr. 593:13-19; Trial Tr. 1697:6-17.

Ethics. The trial court found that there was "an almost total lack of consensus as to the medical ethics of adolescent gender dysphoria treatment" and claimed that "[t]he evidence at trial showed severe disagreement as to whether adolescent ... treatment was ethical at all." D185 pp. 2, 3; App 1.

This finding is not supported by the record. To be sure, there were disagreements between each side's experts. Dr. Antommaria testified that GAMC is not experimental—it has been available in the United States since at least the 1950s; and GAMC for adolescents, since at least the 1990s. Trial Tr. 724:3-11, 723:7-10; *see also id.* at 508:17-24, 362:13-18. The evidence base is comparable to the evidence base across other areas of medicine, and, given the lack of clinical equipoise, it would be unethical for practitioners to deny care to patients in favor of continued research. Trial Tr. 726:2-736:5. He further testified that the Act would "prohibit [doctors] from fulfilling one of their core ethical obligations … to benefit their patients" with medically indicated care. Trial Tr. 743:16-21. Dr. Antommaria testified that "there's not" any "medical or ethical basis" for singling out GAMC and taking the care decision away from families and doctors. Trial Tr. 751:2-12.

In contrast, Respondents' expert Dr. Curlin, who expressed a negative view of GAMC and denied that there was a consensus as to the ethics of this care, could not identify any views or opinions—other than his own—within ethics that amounted to a "lack of consensus," other than vague references to "a number" of people in meetings he had attended. Trial Tr. 2368:20-2369:4, 2369:24-2370:7. On cross, he acknowledged that he was not aware of any scientific literature demonstrating that ethicists disagree with the provision of GAMC and knew of only "two" members of the American Society of Bioethics and Humanities who held such a view. Trial Tr. 2396:6-9. Indeed, as set forth in Point VIII.A, *infra*, Dr. Curlin was neither qualified nor had a basis for his opinions. He made no effort to contradict testimony that the criticisms of GAMC proffered by Respondents' experts likewise applied to other forms of medical care not regulated by the

Act. Trial Tr. 2350:5-24, 2351:11-2352:12, 2401:3-15. Thus, the trial court's finding of a "lack of consensus"—based on the opinion of a single, unqualified dissenting voice—is error.

The "Dutch Protocol." The trial court's most specific factual criticism of the medical science underlying GAMC comes in its conclusion that "Plaintiffs' experts rely extensively on … the 'Dutch Protocol,'" followed by the claim that "the demographics of patients involved in the formation of the Dutch Protocol are very different from adolescents presenting to gender clinics today." D185 p. 14; App 1. But only one of Appellants' experts mentioned "the Dutch Protocol," and did so to explain the history of GAMC. This testimony established that the studies documenting the protocol were relevant to her treatment of minors who presented before adolescence but were *not* necessarily relevant to her treatment of those presenting in adolescence. Trial Tr. 510:10-511:14. None of Appellants' other experts mentioned the "Dutch Protocol" except to reference a study of medical decision-making in response to Respondents' counsel's question. Trial Tr. 754:5. It was *Respondents'* experts who discussed the "Dutch Protocol."

Neither were the trial court's various claims about the "Dutch Protocol" supported by the record. First, the trial court pointed to an increase in prevalence of gender dysphoria, but its primary factual support for this claim was an exhibit that it *expressly acknowledged was not admitted for its truth.* D185 p. 16 n.2 ("[T]his exhibit, including this graph, were reviewed by the Court during expert testimony *though the full exhibit was not admitted*." (emphasis added)); App 1. This brazen instance of the court backtracking on its own

evidentiary rulings is emblematic of the evidentiary double standard the trial court applied in this case.

Next, the trial court asserted that age and sex ratios of those presenting to gender clinics today differed from those examined in the Dutch studies—but experts at trial presented grounded explanations for this shift, and the trial court presented no reason why this divergence should cast doubt on the provision of care in clinics in Missouri in the present day. Trial Tr. 605:3-11, 606:17-19, 523:2-24, 444:8-21. And though the trial court claimed "Plaintiffs' experts acknowledged that they currently have no way to prove one theory over any other," D185 p. 16; App 1, it was in fact Respondents' expert who made this acknowledgment; none of Respondents' experts was able to attribute shifting demographics to any particular cause that might support any particular criticism of GAMC as it is practiced today. *See, e.g.*, Trial Tr. 1803:1-9.

Appellants offer a few more discrete examples of error:

- The finding that "there is no consensus as to proper medical treatment … for adolescents," but in fact, experts on both sides acknowledged having assessed and supported adolescents receiving GAMC, and one of Respondents' own experts testified that the ultimate responsibility for whether a child transitions should rest upon the parents and the minor after being informed by their doctors. D185 p. 10; App 1; Trial Tr. 2451:10-14, 2451:20-23, 2455:24-2456:3, 2462:25-2464:19.
- The finding that Dr. Olson-Kennedy "testified that individuals who are born female outnumber individuals born male in her clinic by a ratio of 4:1." D185 p.

14; App 1. In fact, the testimony reflected a completely different (and smaller) ratio. Trial Tr. 606:18-19.

- The finding that Dr. Levine testified that "life expectancy for" those who received GAMC "is 10 to 20 years shorter" appears nowhere in the cited portion of the transcript. D185 p. 24; App 1. Rather, he testified that "a number of studies" showed "increased mortality" and made passing references to a few unadmitted studies, none of which support the court's conclusion. PI Tr. 633:4-20.
- The finding, in discussing the de Vries studies, that "another study (Carmichael) tried to replicate the de Vries study and found no improvement." D185 p. 51; App 1. Appellants are unable to find any reference to this anywhere in the testimony—Respondents used a study by Carmichael (not offered into evidence) during the testimony of one of Appellants' experts, but the court's conclusion is not supported by this testimony. Trial Tr. 791:1-6, 792:18-23, 793:16-18.

C. Considering its factual errors, the trial court's conclusions that the Act withstands heightened scrutiny or rational basis review are against the weight of the evidence.

Considering its pervasive factual errors, the trial court's analysis of whether the Act withstands heightened scrutiny or rational basis review is against the weight of the evidence. "Under intermediate or heightened scrutiny, the classification is permissible only if it is substantially related to the achievement of important governmental objectives." *Glossip*, 411 S.W.3d at 812. The "burden of justification is demanding"—not "deferential"—and it "rests entirely on the State." *VMI*, 518 U.S. at 533, 555. Respondents

presented no testimony or documentary evidence attributable to the State of Missouri establishing a genuine, legitimate (much less persuasive) interest. Respondents did identify several putative state interests in their pre-trial briefing, but they relied overwhelmingly on inadmissible exhibits that were not admitted or even offered at trial and made no attempt to establish that these interests were genuine *government* objectives rather than "hypothesized or invented *post hoc* in response to litigation." *Id*. The State failed to offer even one government witness to help establish what interest, if any, the government had in the Act. Nonetheless, even if the interests offered through Respondents' briefing are genuine and deemed part of the trial evidence (which Appellants oppose), Respondents did not present evidence establishing that the Act's means are substantially related to the achievement of important governmental objectives.

The trial court's conclusions on a supposed lack of consensus regarding GAMC, the quality and quantity of the underlying scientific evidence, ethical considerations, practices in other countries, off-label use, consent, regret, detransition, and desistance are wholly without record support and gloss on evidence not actually presented at trial. When considered in context of the actual record, none of these conclusions substantiate any state interest, nor do the Act's means bear any relationship to those interests.

With respect to the Medicaid Ban and regulation of GAMC for adults, Respondents advanced no state interest that would be served by regulating care for adults. The trial court asserted in passing that "[s]tates have limited resources and are not able to fund everything … [they may] focus resources on procedures that increase life longevity by years rather than expensive procedures that modestly decrease pain for a short time." D185 pp. 46-47;

App 1. First, financial cost is not a justification for restricting Medicaid coverage in violation of the constitution. *See Mem'l Hosp. v. Maricopa Cnty.*, 415 U.S. 250, 263 (1974); *Graham*, 403 U.S. at 375. Second, Respondents did not present *any* evidence at trial about the coverage costs of GAMC under Medicaid, nor any evidence to demonstrate that GAMC is a less worthwhile outcome on which to expend state resources. By contrast, Appellants presented extensive evidence that GAMC for both adults and minors reduces suicidality and improves overall well-being. Trial Tr. 551:6-552:16, 554:7-555:14, 559:10-560:2.

With respect to the Care Ban, Respondents explicitly offered two state interests: preserving health and welfare and protecting the integrity of the medical profession. But GAMC is neither harmful nor experimental, and the trial court pointed to no testimony establishing otherwise. *See Brandt*, 47 F.4th at 671; *Poe*, 709 F.Supp.3d at 1194-95; *Dekker*, 679 F.Supp.3d at 1283; *Brandt*, 677 F.Supp.3d at 890. Furthermore, the trial court's claims of a lack of ethical consensus are belied by the record, wherein Respondents' expert was not able to substantiate any broad disagreement among ethicists or in peer-reviewed literature. Trial Tr. 2370:2-4, 2396:6-9; *see also supra* Point VIII.A. The Act's means are further removed from any interest in protecting health and welfare in that even Respondents' experts acknowledged that there is *no* evidence of *any* quality demonstrating that psychotherapy alone is effective to treat gender dysphoria. Trial Tr. 588:14-19, 750:13-22, 1796:8-10, 2468:10-15; PI Tr., 81:14-21, 666:12-16.

Moreover, the Act's means are underinclusive with respect to potential state interests. The Act does not target all medical care whose clinical practice guidelines are

supported by "low" quality evidence. Such a law would, as the record reflects, ban *most* medical care. Trial Tr. 734:5-7, 733:4-12, 733:13-18, 733:19-734:7. The Act does not target all medical care that carries risk, or any particular risk. "There is nothing unique about the risks of GAMC for adolescents that warrants taking this medical decision out of the hands of adolescent patients, their parents, and their doctors." *Brandt*, 677 F.Supp.3d at 902; *see also Dekker*, 679 F.Supp.3d at 1295. Nor does the Act regulate all medical care when it is used off-label—indeed, such a law would prohibit broad categories of medical care, including *most* pediatric medicine. Trial Tr. 319:21-25. Specifically, with respect to fertility, the Act is both underinclusive *and* overinclusive. As described above, it regulates GAMC regardless of whether the care might impair fertility, and it does not touch broad categories of care (even for minors) that carry the same or greater risk to fertility. *Brandt*, 677 F.Supp.3d at 903.

Ultimately, the Act fails even rational basis review. The Medicaid Ban is without *any* factual support and serves *no* asserted state interest—Respondents' evidence at trial exclusively concerned care for minors. Furthermore, given that the Act harms, rather than helps, transgender minors or Medicaid beneficiaries, its means are "so far removed from [the asserted] justifications that ... it [is] impossible to credit them." *Romer v. Evans*, 517 U.S. 620, 635 (1996).

Thus, because the trial court's analysis of the Act's justifications relies overwhelmingly on pervasive factual errors (imported from Respondents' proposed findings), and because the Act is otherwise without any justification, the trial court erred in finding that the Act survived heightened scrutiny or rational basis review.

Point VIII: The trial court erred in admitting and relying on testimony of Drs. Curlin and Lappert because neither satisfies the evidentiary requirements for expert testimony in that both lack any relevant experience or expertise in the areas to which they testified, are biased and prejudiced, and their testimony is unreliable and irrelevant.

I. Standard of Review and Preservation of Error

"Expert testimony in civil cases is inadmissible unless it satisfies the evidentiary requirements of section 490.065." *Linton ex rel. Linton v. Carter*, 634 S.W.3d 623, 626 (Mo. banc 2021). "This Court reviews a circuit court's decision to admit or exclude expert testimony for an abuse of discretion." *Spalding v. Stewart Title Guar. Co.*, 463 S.W.3d 770, 778 (Mo. banc 2015). "A circuit court abuses its discretion when its ruling is clearly against the logic of the circumstances then before the court and is so unreasonable and arbitrary that it shocks the sense of justice and indicates a lack of careful, deliberate consideration.'" *Shallow v. Follwell*, 554 S.W.3d 878, 881 (Mo. banc 2018) (quotation omitted). An abuse of discretion occurs if the circuit court erroneously finds that the requirements of the expert witness statute are met. *See Kivland v. Columbia Orthopaedic Grp., LLP*, 331 S.W.3d 299, 311 (Mo. banc 2011).

"Section 490.065 mirrors FRE 702 and 703, which affirms the circuit court's role as gatekeeper for the admissibility of expert testimony." *State v. Addie*, 655 S.W.3d 456, 459 (Mo. App. W.D. 2022). Like Federal Rule of Evidence 702, § 490.065 therefore "imposes a special gatekeeping obligation on the trial judge to ensure that an expert's testimony both rests on a *reliable* foundation and is *relevant* to the task at hand." *Sardis v. Overhead Door Corp.*, 10 F.4th 268, 281 (4th Cir. 2021) (cleaned up); *see also Lauzon v. Senco Prod., Inc.*, 270 F.3d 681, 686 (8th Cir. 2001); *Kivland*, 331 S.W.3d at 311.

Appellants filed timely *Daubert* motions seeking to exclude these two experts, which were not ruled on before the trial, and Appellants objected to these experts being accepted as such at trial. The error is preserved for appeal.

II. Argument

A. Dr. Curlin

The trial court improperly relied on Dr. Curlin for the proposition "that gender dysphoria … is a 'disorder of perception." D185 p. 34; App 1. It further improperly relied on Dr. Curlin's opinions that "we have not had prospective, well-designed studies that have followed children long enough" and that "we are not at a point where we could find that child and adolescent gender treatment are in the minor's best interest." D185 pp. 35-36; App 1. The admission of Dr. Curlin's testimony and reliance on each was an abuse of discretion.

Dr. Curlin was not qualified to offer any of these opinions. His experience as a hospice and palliative care physician who treats adult patients does not qualify him to testify about pediatrics or pediatric subspecialties, subjects outside of his practice area. Trial Tr. 2389:3-18. Dr. Curlin concedes he is not a pediatrician, endocrinologist, psychologist, or psychiatrist. D105 pp. 88:13-89:15; Trial Tr. 2391:25-2393:22. In fact, except for a handful of "physically mature adolescents," Dr. Curlin's practice has been exclusively limited to the treatment of adult patients. D105 pp. 57:12-14; 79:4-21; 80:3-7 81:15-24; Trial Tr. 2392:19-22.

Dr. Curlin is likewise unqualified to testify about the nature of gender dysphoria as a diagnosis. He has no experience diagnosing or setting a medical treatment plan for

someone with gender dysphoria. D105 pp. 89:24-90:6; 84:23-85:6; *see also* Trial Tr. 2394:12-14. And he has never provided a diagnosis of gender dysphoria, treated a single patient for gender dysphoria, or even sat in a meeting between a provider and patient pertaining to the diagnosis or treatment of gender dysphoria. D105 pp. 87:24-90:6; 84:23-85:6; 87:17-88:8.

It is well-established that under § 490.065, "the opinion offered by a[n] [expert] witness must necessarily be one within the witness's area of expertise." *Moore v. Monsanto Co.*, 699 S.W.3d 516, 522 (Mo. App. E.D. 2024); *see also Kadel v. Folwell*, 620 F.Supp.3d 339, 360 (M.D.N.C. 2022); *Sigrist ex rel. Sigrist v. Clarke*, 935 S.W.2d 350, 357 (Mo. App. S.D. 1996); *Brennan v. St. Louis Zoological Park*, 882 S.W.2d 271, 273 (Mo. App. E.D. 1994); *Cebula v. Benoit*, 652 S.W.2d 304, 308 (Mo. App. W.D. 1983). Missouri and federal courts "ha[ve] held that medical professionals are not permitted to opine on all things medical simply because they are medical professionals." *Moore*, 699 S.W.3d at 522; *see also, e.g.*, *Johnson v. State*, 58 S.W.3d 496, 499 (Mo. banc 2001); *O'Conner v. Commonwealth Edison Co.*, 807 F. Supp. 1376, 1390 (C.D. Ill. 1992), *aff'd*, 13 F.3d 1090 (7th Cir. 1994); *Diviero v. Uniroyal Goodrich Tire Co.*, 919 F.Supp. 1353, 1355-56 (D. Ariz. 1996) , *aff'd*, 114 F.3d 851 (9th Cir. 1997); *cf. State Bd. of Registration for Healing Arts v. McDonagh*, 123 S.W.3d 146, 156 (Mo. banc 2003). This is particularly true in the context of the treatment of gender dysphoria. *See Kadel*, 100 F.4th at 158.

Furthermore, experts "may not simply repeat or adopt the findings of another expert without attempting to assess the validity of the opinions relied upon." *In re Polypropylene Carpet Antitrust Litig.*, 93 F.Supp.2d 1348, 1357 (N.D. Ga. 2000); *see also Am. Key Corp.*

v. Cole Nat'l Corp., 762 F.2d 1569, 1580 (11th Cir. 1985). Here, Dr. Curlin has not examined nor systematically reviewed the literature pertaining to the efficacy of GAMC; instead, he relies on the opinions of select others. Trial Tr. 2401:3-14; D105 p. 172:4-9; *see also* D106 ¶¶ 15-16, 19, 21, 36-45. As such, the trial court abused its discretion in admitting and relying on expert testimony that merely restated facts or opinions provided by other trial witnesses.

In addition, medical experts may opine based only "upon the established standard of care and not upon a personal standard." *See Dine v. Williams*, 830 S.W.2d 453, 457 (Mo. App. W.D. 1992); *McDonagh*, 123 S.W.3d at 156. Not only is widespread acceptance an important factor in assessing the reliability of an expert's opinions, *see Nease v. Ford Motor Co.*, 848 F.3d 219, 229 (4th Cir. 2017), but the fact that "a known [theory] which has been able to attract only minimal support within the community ... may properly be viewed with skepticism." *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 594 (1993) (quotations omitted).

Here, Dr. Curlin cannot name a single major American medical association that supports banning access to GAMC. D105 pp. 107:18-108:6. Nor does he know a single pediatric ethicist or member of the American Society for Bioethics and Humanities who has publicly stated that GAMC is unethical. D105 pp. 116:23-117:4; 118:6-11; 121:16-21; *see also* Trial Tr. 2398:7-2399:12. He stands on a desolate island.

Though Dr. Curlin testified that his testimony was limited to the question of ethics, Trial Tr. 2343:12-14, his testimony at trial far exceeded the scope for which he was proffered. And given the fact he has "little or no experience treating transgender patients

and no specialized training in the field," his testimony was "not based on [his] professional expertise." *Ladapo*, 737 F.Supp.3d at 1256 n.19. It was an abuse of discretion for the trial court to admit, let alone rely on, his opinions about the nature of gender dysphoria and the efficacy of GAMC—opinions it should have excluded.

Finally, Dr. Curlin testified that he was "not express[ing] an opinion [] as to the ethics of gender-affirming care as it relates to adults." Trial Tr. 2400:24-2401:2. It was an abuse of discretion to rely on his testimony in upholding the Medicaid Ban as it pertained to adults.

B. Dr. Lappert

The trial court also improperly relied on Dr. Lappert's opinions comparing gender dysphoria to body integrity disorder and "that gender affirming drug treatment and surgery on adolescents, ethically, [is] the same as removing the healthy limb in the body integrity disorder case." D185 p. 37; App 1. The trial court's admission of Dr. Lappert's testimony and reliance on each of these opinions was an abuse of discretion.

First, during his deposition, Dr. Lappert characterized his testimony as "very narrow" yet "substantively" the same as prior opinions, and said it would touch on, for example, "the risks of surgery, questions about indications for surgery…" D99 p. 15:3-12. He represented that his testimony would not reach the "history" or "broader issues" of transgenderism and that any testimony he gave would be limited accordingly. D99 p. 15:13-23. It was not so limited at trial. Additionally, as previously explained, neither of the surgeries ("surgical penile and vagina construction") for which the trial court found Dr. Lappert's testimony to be "educational," D185 at 37; App 1, are performed on minors.

Trial Tr. 332:3-8; PI Tr. 70:2-7. The testimony was entirely irrelevant to the Care Ban and the treatment of gender dysphoria in transgender adolescents.

Second, Dr. Lappert is a zealous opponent of transgender care. He has described adolescent GAMC as "mutilation" and "child abuse." D99 pp. 114:1-7, 207:17-24. As Dr. Lappert testified in a federal case on the same subject, he believes that "gender-affirming care is a 'lie,' a 'moral violation,' a 'huge evil,' and 'diabolical.'" *Dekker*, 679 F.Supp.3d at 1279; *see also* Trial Tr. 2610:23-2612:9.

While the fact that bias in an expert's testimony is usually an issue of credibility as opposed to one of admissibility, when an expert's opinions are based on bias and prejudice, as opposed to scientific or medical knowledge, then the question of bias becomes one of reliability and admissibility. Indeed, reliability is a flexible inquiry wherein courts must ensure that an expert's opinion is based on scientific, technical, or other specialized knowledge and not on personal beliefs or speculation. *See United States v. Frazier*, 387 F.3d 1244, 1262 (11th Cir. 2004); *see also* Fed. R. Evid. 702 advisory committee's note (2000 amends.). Here, Dr. Lappert's testimony was so permeated and tainted by his personal bias as to render it unreliable. *Cf. Sanchez v. Esso Standard Oil de Puerto Rico, Inc.*, 2010 WL 3809990, at *4 (D.P.R. Sept. 29, 2010).

In any event, by his own admission, Dr. Lappert is not "an expert on gender dysphoria," nor has he ever provided gender-affirming surgery. Trial Tr. 2526:10-15, 2527:3-5; *see also* D102 pp. 168:15-169:5; D99 p. 27:17. As courts have found, he "is not qualified to render opinions about the diagnosis of gender dysphoria, its possible causes, the efficacy of the DSM, the efficacy of puberty blocking medication or hormone

treatments, the appropriate standard of informed consent for mental health professionals or endocrinologists," or "to opine on the efficacy of randomized clinical trials, cohort studies, or other longitudinal, epidemiological, or statistical studies of gender dysphoria." *Kadel*, 620 F.Supp.3d at 368-69; *see also Brandt*, 677 F.Supp.3d at 915.

Dr. Lappert has never performed vaginoplasty (vaginal reconstruction) or metoidioplasty (penile reconstruction) on any transgender patient and has not performed some on *any* patient. D102 pp. 167:3-168:14; Trial Tr. 2518:9-15. These are the very surgeries about which he testified. Furthermore, he is neither a psychiatrist nor a psychologist. Trial Tr. 2527:6-9. He "refer[s] persons claiming gender identity issues to psychiatrists," "because somebody who's not qualified [such as him] in the mental health area should not be advising on matters falling within the psychiatric area." Trial Tr. 2528:7-14. Additionally, he is not a medical ethicist, nor does he hold himself out as an expert in medical ethics. Trial Tr. 2528:20-2529:2. And as noted, the mere fact that he is a doctor does not qualify him to opine on all medical issues. *See supra* Point VIII.A.

It was an abuse of discretion for the trial court to admit and rely on Dr. Lappert's opinions about gender-affirming treatment or surgery.

Point IX: The trial court erred in denying facial and as-applied relief because it misapplied the law, in that it erroneously required Appellants to demonstrate the Act has no constitutional applications to prevail on a facial challenge and failed to evaluate the as-applied claims on their merits.

I. Standard of Review and Preservation of Error

See Standard of Review and Preservation of Error for Point IV.

II. Argument

In denying the request for facial relief, the trial court overextends federal and state precedent in concluding that Appellants must demonstrate that §§ 191.1720, 208.152.15 in their entirety have *no constitutional applications* to obtain the facial relief sought in this case. Not only does this approach ignore the distinct challenges Appellants brought to various provisions of the Act, but it also conflicts with precedent.

A. Appellants challenge the Act as applied to the contexts of the provision of GAMC for adolescents and coverage of GAMC for adolescent and adult Medicaid beneficiaries, consistent with established medical guidelines.

The trial court, through its *verbatim* adoption of Respondents' framing, erroneously described Appellants' claims as a facial challenge such that Appellants were challenging every *conceivable* application of the Act. But Appellants' claims are best understood as challenging the validity of the Care Ban as applied to transgender adolescents and the Medicaid Ban as applied to Medicaid beneficiaries regardless of age.

The Petition reveals that Appellants' claims are focused and seek to prevent enforcement of the Care Ban as it pertains to the Act's denial of "*medically necessary*" care and insurance coverage to transgender adolescents and transgender Medicaid beneficiaries, regardless of age, consistent with "medical advice." *See, e.g.*, D2 ¶¶ 218, 219, 227 (equal protection); *id.* ¶¶ 249, 253 (natural rights and due process); *id.* ¶ 265 (gains of industry); App 240. In this way, Appellants facially challenged *the application of the Act in the context of the provision of medically necessary GAMC*, *i.e.*, GAMC provided consistent with the established guidelines.

Specifically, Appellants challenged only the Care Ban (*i.e.*, the prohibitions on the provision of *medically necessary* "hormones," "puberty-blocking drugs," and "gender transition surgery" to transgender adolescents, §§ 191.1720.4(1), 191.1720.3, and Medicaid Ban, § 208.152.15. It was error for the Court to consider Appellants to be challenging any other applications of the Act, no matter how farfetched.

B. The trial court erred in its application of *Salerno* and Appellants are entitled to facial relief against the challenged provisions of the Act.

The trial court relied on *United States v. Salerno*, 481 U.S. 739 (1987), to hold that Appellants were not entitled to facial relief under *Salerno*'s "no set of circumstances" test. But the trial court erred in both its understanding and application of *Salerno*.

First, the proper test for a facial challenge encompasses *Salerno*'s "no set of circumstances" test, as well as whether a challenger "shows that the law lacks a 'plainly legitimate sweep.'" *Moody v. NetChoice, LLC*, 603 U.S. 707, 723 (2024) (quoting *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008)). Indeed, since *Salerno*, the U.S. Supreme Court has instructed that "[i]n determining whether a law is facially invalid, [a court] must be careful not to go beyond the statute's facial requirements and speculate about 'hypothetical' or 'imaginary' cases." *Wash. State Grange*, 552 U.S. at 449-50. Yet, this is exactly what the trial court did here by adopting Respondents' hypotheticals. But the state may not defeat a facial challenge by inventing irrelevant hypotheticals to rescue a statute that bans conduct unconstitutionally.

Second, the U.S. Supreme Court has explained in its jurisprudence since *Salerno*, that "[t]he proper focus of the constitutional inquiry is the group for whom the law is a

restriction, not the group for whom the law is irrelevant." *City of Los Angeles v. Patel*, 576 U.S. 409, 418 (2015); *see also Brandt*, 47 F.4th at 672; *Weinschenk*, 203 S.W.3d at 206 (holding that, though only three to four percent of Missourians lack the requisite photo ID, that did not preclude facial relief).

Further, where, as here, a plaintiff affirmatively seeks to have a law declared unconstitutional and is part of the class burdened by the law, Missouri courts adjudicate constitutional claims seeking facial declaratory and injunctive relief without requiring that the plaintiff meet the "no set of circumstances" standard. *See, e.g.*, *No Bans on Choice v. Ashcroft*, 638 S.W.3d 484, 491-92 (Mo. banc 2022) (reviewing constitutional provision under applicable constitutional standard rather than the "no set of circumstances" test). Indeed, "there is no one test that applies to all facial challenges." *Doe v. City of Albuquerque*, 667 F.3d 1111, 1124 (10th Cir. 2012). In *Citizens United v. FEC*, the U.S. Supreme Court determined that "the distinction between facial and as-applied challenges is not so well defined that it has some automatic effect or that it must always control the pleadings and disposition in every case involving a constitutional challenge." 558 U.S. 310, 331 (2010). Instead, the distinction "goes to the breadth of the remedy employed by the Court, not what must be pleaded in a complaint." *Id.* Thus, even assuming Appellants bring a facial challenge, such a fact "does not automatically compel the application of a specific test, much less the *Salerno* formulation." *City of Albuquerque*, 667 F.3d at 1124.

"The idea that the Supreme Court applies the 'no set of circumstances' test to every facial challenge is simply a fiction, readily dispelled by a plethora of Supreme Court authority." *Id.*; *see also Berkley v. United States*, 287 F.3d 1076, 1090 n.14 (Fed. Cir. 2002)

(noting that "in equal protection cases involving facial challenges, the Supreme Court has thus far not discussed or applied the *Salerno* test"). In a case like this one, "the claimed constitutional violation inheres in the terms of the statute, not its application." *Ezell v. City of Chicago*, 651 F.3d 684, 698 (7th Cir. 2011); *see also No Bans on Choice*, 638 S.W.3d at 491.

The proper question is whether the Act is unconstitutional under the applicable standards for each of Appellants' claims. This is consistent with this Court's and U.S. Supreme Court's cases that have "repeatedly considered facial challenges simply by applying the relevant constitutional test to the challenged statute without attempting to conjure up whether or not there is a hypothetical situation in which application of the statute might be valid." *City of Albuquerque*, 667 F.3d at 1124 (collecting cases); *see also No Bans on Choice*, 638 S.W.3d at 492 (holding "the standard for determining if a law violates [the fundamental right to referendum] is whether the law 'interferes with or impedes' the *right* of referendum, not whether it 'interferes with or impedes' any particular referendum effort"); *State ex rel. Upchurch v. Blunt*, 810 S.W.2d 515 (Mo. banc 1991). Here, for the reasons set forth in Points IV, V, and VI, *supra*, and Points X and XI, *infra*, the Act is not constitutional, and therefore facial relief is warranted. *See No Bans on Choice*, 638 S.W.3d at 492.

1. Even if the "no set of circumstances" test applies, Appellants' claims still prevail.

Appellants were not required to prove that GAMC is appropriate to treat gender dysphoria in every hypothetical medical scenario that might be conjured to prove the Act's

unconstitutionality. Rather, the Act's categorical prohibition against *any* prescription of broad categories of interventions to *all* patients, regardless of individual circumstances, is an invasion of Appellants' constitutional rights, and is impermissibly over- and under-inclusive in its means. *See supra* Point VII.C. Hypothetical scenarios in which medical practitioners might operate outside the purported applicable standard of care do not obviate the unconstitutional discrimination and invasion of a fundamental right caused by an over- and under-inclusive categorical ban on broad classes of interventions, particularly when there is an "evidentiary record against which to assess the[] assertions." *Wash. State Grange*, 552 U.S. at 455.

Here, the trial court erred in relying on three hypothetical circumstances in which it opined (incorrectly) that enforcement of the Act would be constitutional.

a. Bicalutamide

Without citation or support, the trial court suggested that the Act would be constitutional as applied to the prescription of bicalutamide. D185 p. 41; App 1. As discussed in Point VII.B, however, the record does not support the trial court's factual conclusions regarding the propriety of bicalutamide.

b. Surgery

The trial court concluded that the Act's ban on surgery was constitutional because Appellants "presented no evidence about any of these surgeries." D185 p. 42; App 1. As explained in Point VII.B, this is incorrect. Appellants presented extensive testimony regarding surgery, including that placing an implant of puberty-delaying medication is an outpatient surgical procedure. Trial Tr. 572:8-14; *see also* Trial Tr. 2029:16-18. The trial

court ignored this testimony, appearing to adopt a strained position that questioned whether placement of an implant is sufficiently surgical because it involves an incision that is "tiny." D185 p. 42. But the Act does not draw distinctions between surgeries that are "tiny" and surgeries that are not—it is a categorical ban on all surgical procedures "performed for the purpose of assisting an individual with a gender transition." Such a distinction is logically and legally unsound. Moreover, no genital surgeries, the surgeries discussed by the trial court as examples based on Dr. Lappert's testimony, D185 p. 42 (*but see supra* Point VIII.B); App 1, are performed on minors. Trial Tr. 332:3-8, 571:21-23; Ex. 5, at S66; Ex. 306, at 3872. Upholding the Care Ban on these grounds is therefore divorced from the facts.

c. *Assessment*

Finally, the trial court identifies a third circumstance in which the Act could be enforced: when care is provided without an assessment. D185 p. 44; App 1. As described in Point VII.B, the trial court's conclusion that care in Missouri is provided without a proper assessment is unsupported by the record. All three Minor Appellants were assessed by their mental health providers. Trial Tr. 1302:24-1303:4, 1328:3-4, 1223:9-12, 1205:20-21, 1206:18-20. Moreover, it is undisputed that the guidelines provide for the biopsychosocial assessment of transgender adults and adolescents requesting medical treatment. Exs. 5, 306. The notion that a medical practitioner might *at some hypothetical point in the future* provide care in disregard of the applicable standard of care does not immunize a categorical ban on that medical care from a facial challenge.

2. If this Court finds facial relief inappropriate, it should fashion a narrower remedy.

Even if this Court finds that Appellants have failed to mount a successful facial challenge, the solution is not a rejection of Appellants' entire case. Instead, this Court should enjoin the statute in its unconstitutional applications, either under an analysis of Appellants' as-applied claims, or under this Court's principles of severability and constitutional remedy.

Though the trial court failed to address narrower relief at all, Appellants' Petition below raises as-applied claims. "An as-applied claimant asserts that the acts of his that are the subject of the litigation fall outside what a properly drawn prohibition could cover." *Free Speech Coal., Inc. v. Att'y Gen*. U.S., 974 F.3d 408, 422 (3d Cir. 2020) (cleaned up). Appellants clearly pleaded and proved that the provisions of the Act directly impact them in concrete ways, and they requested a facial injunction *or* "such other relief the Court deems just and proper." D2 p. 49; App 240. The trial court should have analysed whether the Act is unconstitutional as applied to Appellants.

"Generally speaking, when confronting a constitutional flaw in a statute, … [w]e prefer, for example, to enjoin only the unconstitutional applications of a statute while leaving other applications in force, *see United States v. Raines*, 362 U.S. 17, 20-22, (1960), or to sever its problematic portions while leaving the remainder intact, *United States v. Booker*, 543 U.S. 220, 227-29 (2005)." *Ayotte v. Planned Parenthood of N. New Eng.*, 546

U.S. 320, 328-29 (2006); *see also Off. of the U.S. Tr. v. John Q. Hammons Fall 2006, LLC*, 602 U.S. 487, 495 (2024).

In *Ayotte*, the Court found that "only a few applications of [the challenged statute] would present a constitutional problem" but that, nonetheless, "the lower courts can issue a declaratory judgment and an injunction prohibiting [the statute's] unconstitutional application." 546 U.S. at 331.

Here, as in *Ayotte*, Appellants asked the court to "[g]rant[] such other relief the Court deems just and proper." D2 p. 49; App 240; *Ayotte*, 546 U.S. at 331. As such, the proper course for the trial court was not to reject Appellants' constitutional claims wholesale, but to analyse whether, as applied to certain circumstances, the laws are unconstitutional.

Point X: The trial court erred in finding that the Act does not violate the "Gains of Industry" Clause because the trial court misapplied the law in that such clause is not limited to "workplace slavery" or laws that require the provision of services without pay.

I. Standard of Review and Preservation of Error

See Standard of Review and Preservation of Error for Point IV.

II. Argument

Article I, section 2 of the Missouri Constitution provides "that all persons have a natural right to life, liberty, the pursuit of happiness and the enjoyment of the gains of their own industry." Mo. Const. art. I, § 2.

In its Judgment, the trial court found that Provider Appellants and GLMA's "gains of industry" claims failed because "[t]his clause was enacted to prohibit 'workplace slavery' and thus has no applicability here" and because the Act "does not compel medical

providers to issue these interventions without pay." D185 p. 71; App 1. The trial court erroneously declared the law.

This clause is not limited to "workplace slavery." This Court held the opposite in *Fisher v. State Highway Comm'n of Mo.*, 948 S.W.2d 607 (Mo. banc 1997), where it noted that, although "[t]he origin of the 'enjoyment of the gains of their own industry' phrase is in workplace slavery," it has been invoked outside that context, including "when the state prevented individuals from selling a lawful product." *Id.* at 610.

The trial court also cited Judge Wolff's dissent in *Kansas City Premier Apartments, Inc. v. Mo. Real Est. Comm'n*, 34 S.W.3d 160 (Mo. banc 2011), to support its finding that the "enjoyment of the gains of their own industry" clause applies only to "workplace slavery." D185 p. 71; App 1. However, Judge Wolff wrote the opposite: "It seems farfetched to argue … that article 1, section 2 ... should be confined in contemporary times to discouraging or outlawing slavery." *Kansas City Premier Apartments*, 34 S.W.3d at 174 n.6.

Nor is the "enjoyment of the gains of their own industry" clause limited to laws that require persons to provide services without pay. Indeed, this Court has recognized that it has "invoked this phrase" when the State "prevented individuals from selling a lawful product." *See Fisher*, 948 S.W.2d at 610. For this clause to apply, it is enough that the Act forbids medical providers from providing otherwise lawful medical care. *See State ex rel. Knese v. Kinsey*, 282 S.W. 437, 439 (Mo. banc 1926).

The trial court erred in finding that the "enjoyment of the gains of their own industry" clause applies only to laws that compel the provision of services without pay.

CONCLUSION

For the foregoing reasons, this Court should reverse the judgment of the trial court and enter the judgment in favor of Appellants that the trial court should have entered.

Respectfully Submitted,

/s/ *Gillian R. Wilcox*

GILLIAN R. WILCOX, #61278
JASON ORR, #56607
ACLU of Missouri Foundation
406 West 34th Street, Ste. 420
Kansas City, MO 64111
Phone: (816) 470-9938
gwilcox @aclu-mo.org
jorr @aclu-mo.org

KRISTIN M. MULVEY, #76060
JONATHAN D. SCHMID, #74360
ACLU of Missouri Foundation
906 Olive Street, Suite 1130
St. Louis, Missouri 63101
Phone: (314) 652-3114
kmulvey @aclu-mo.org
jschmid @aclu-mo.org

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

NORA HUPPERT*
Lambda Legal Defense and Education Fund, Inc.
3656 North Halsted Street
Chicago IL 60613
(312) 663-4413
nhuppert @lambdalegal.org

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

J. BENNETT CLARK, #30907
MICHAEL E. ROWAN, #72992
TORI ANDREW, #76929
Bryan Cave Leighton Paisner LLP
One Metropolitan Square
211 North Broadway, Suite 3600
St. Louis, MO 63102
(314) 259-2000
ben.clark @bclplaw.com
michael.rowan @bclplaw.com
tori.andrew @bclplaw.com

Attorneys for Appellants

CERTIFICATE OF SERVICE AND COMPLIANCE

The undersigned hereby certifies that on July 8, 2025, the foregoing brief was filed electronically and a copy of it was served automatically on counsel for all parties.

The undersigned further certifies that pursuant to Rule 84.06(c), this brief: (1) contains the information required by Rule 55.03; (2) complies with the limitations in Rule 84.06; (3) contains 30,965 words, in compliance with Rule 84.06(b), as determined using the word-count feature of Microsoft Office Word, which includes all material in the brief other than the cover, certificate of service, signature block, and separately filed appendix. Finally, the undersigned certifies that electronically filed brief was scanned and found to be virus free.

/s/ *Gillian R. Wilcox*