No. 23-477

In the Supreme Court of the United States

UNITED STATES OF AMERICA,

Petitioner,

v.

JONATHAN THOMAS SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

Whether Tennessee Senate Bill 1 (SB1), Tenn. Code Ann. §68-33-101 *et seq*., violates the Equal Protection Clause of the Fourteenth Amendment.

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INTRODUCTION

The Constitution vests politically accountable state officials with primary responsibility for protecting the public health and welfare. With such power has always come wide discretion to regulate medical practices, particularly in areas of scientific uncertainty. That legislative leeway enables differing approaches to evolving medical disputes. This case asks whether the Equal Protection Clause requires courts to short-circuit democratic resolution of one such dispute—the appropriateness of providing life-altering gender-transition procedures to minors.

In recent years, there has been a rapid rise in the provision of puberty blockers, hormones, and surgeries to transgender-identifying youth. Traditionally, most U.S. doctors declined to provide these interventions to minors. But following the lead of several European countries, the practice exploded in the 2010s. Over time, though, many of the European countries that pioneered these interventions have pulled back, restricting minors' access based on safety and efficacy concerns.

So when media reports flagged a Tennessee hospital performing gender-transition interventions on minors, lawmakers examined this live medical dispute. The Tennessee legislature surveyed systematic reviews, took stock of tightened restrictions in Europe, and heard firsthand accounts of regret and harm from detransitioners. The legislature then passed SB1 to restrict pharmaceutical and surgical interventions for gender transition until a person turns 18. Twenty-three other States have adopted similar protections.

The federal government seeks to displace Tennessee's legislative judgment by reading its preferred policies into the Constitution. But the Equal Protection Clause does not commission this Court as the nation's "*ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States." *Planned Parenthood v. Danforth*, 428 U.S. 52, 99 (1976) (White, J., concurring and dissenting in part). It protects against discriminatory classifications, and SB1 contains none.

SB1 includes no sex classification. It draws a line between minors seeking drugs for gender transition and minors seeking drugs for other medical purposes. And boys and girls fall on both sides of that line.

With no claim under the existing framework, the government seeks a novel path to heightened review under *Bostock v. Clayton County*, 590 U.S. 644 (2020). But constitutionalizing *Bostock*'s but-for-sex test would defy this Court's equal-protection precedents, distort *Bostock*'s Title VII-centric reasoning, and perversely permit use of sex-based scrutiny to roll back women's rights. This Court should decline that doctrinal revolution, especially because sex is not a but-for cause of SB1's age- and use-based restrictions.

Nor should this Court break new ground by striking down SB1 on a transgender-discrimination theory. SB1 does not classify based on transgender status. And the government's cursory argument for heightened review fails to justify expanding this Court's limited list of quasi-suspect classifications for the first time in half a century.

SB1 is subject to—and easily satisfies—rational-basis review. It passes constitutional muster under any standard. The government insists that SB1 bucks a "medical consensus" on gender-transition interventions for minors. But that account altogether ignores the risk-benefit assessment of European health authorities and discounts the good-faith decisions of half the States in this country. Willful ignorance of conflicting medical views cannot erase the unknowns. And this Court grants "state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty"—even in heightened-review cases. *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). While the government is free to favor its transition-first, ask-questions-later approach, the Constitution does not bind Tennessee to that same choice.

This case involves a routine exercise of state power that touches on a controversial topic. But not every contentious social issue calls for a constitutional override. The Sixth Circuit should be affirmed.

STATEMENT OF THE CASE

Since the founding, States have governed the practice of medicine within their borders. States license doctors. They restrict medical practices. And they exercise "broad police powers in regulating the administration of drugs." *Whalen v. Roe*, 429 U.S. 589, 603 n.30 (1977). This case concerns an exercise of that power: Tennessee's attempt to protect minors from the life-altering risks of uncertain gender-transition interventions.

A. Gender-Transition Interventions for Minors Rapidly Rise.

Recently, there has been an "unexplained" spike in minors identifying as transgender and receiving a gender-dysphoria diagnosis. J.A. 644, 677. "The percentage of youth identifying as transgender has doubled from 0.7% of the population to 1.4% in the past few years, while the percentage of [transgender-identifying] adults (0.5% of the population) has remained constant." Pet. App. 6a-7a. And 2021 saw "three times more diagnoses of gender dysphoria among minors than 2017." Pet. App. 7a; *see* J.A. 644.

The patient population has also shifted. Historically, gender dysphoria—a psychiatric condition characterized by mental distress associated with identifying as a gender different from one's sex—primarily arose in adult men and young boys. J.A. 60-61, 380-82, 544-45. Now, it is overwhelmingly seen in adolescent girls. J.A. 544-45, 644-45. The United Kingdom reports that "the number of adolescent girls seeking sex transitioning exploded over 4,000% in the last decade." J.A. 544. The "[c]ases commonly appear to occur within clusters of peers in association with increased social media use and among people with autism or other mental health issues." J.A. 394, 616-17.

Doctors use three primary methods to address gender dysphoria in minors: watchful waiting, psychotherapy, and affirmation. J.A. 620-26.

The watchful-waiting model calls for monitoring a minor's development and treating psychological causes of distress. If left untreated by transition methods, gender dysphoria goes away on its own for

the "large majority" (about 85%) of children. J.A. 384, 505-06, 620-21; D.Ct.Doc.113-10 (Endocrine Society (ES) Guidelines) at 3879. Such desistence is also increasingly observed among adolescents. J.A. 652-55.

Psychotherapy involves counseling that seeks to identify and address the cause of dysphoria. J.A. 621-22, 884-89. It helps patients "understand the commonality of discomfort with the body's physiology, the growth process, and the struggle to accept oneself during the pubertal developmental process." J.A. 623. After psychotherapy, some individuals no longer "feel the need to feminize or masculinize their body." WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 8 (7th ed. 2012).

The "gender affirming" model encourages gender-transition interventions. These interventions proceed in four escalating steps: (1) social transition, (2) puberty-blocking drugs (for those in early pubertal stages), (3) cross-sex hormones, and (4) surgery.

"[N]o one disputes" that these interventions "carry risks." Pet. App. 50a. Puberty blockers interfere with signals from the pituitary gland to the sex glands, preventing the sex glands from producing hormones (testosterone for males or estrogen for females). J.A. 754-68. This causes diminished bone density, undeveloped sex organs, and "compromised fertility" if "subsequently … treated with sex hormones." ES Guidelines at 3882; J.A. 760-68. Puberty blockers threaten normal brain maturation too, since delaying puberty may eliminate "a critical period for experience-dependent

rewiring of neural circuits underlying executive function." J.A. 430-31 (Dr. Hilary Cass); *see* J.A. 370 (Norwegian health authority); ES Guidelines at 3883 (noting unknown effects on "cognitive function").

Nearly all minors placed on puberty blockers progress to cross-sex hormones, which heighten the risks. J.A. 554, 659-60, 761. For both boys and girls, cross-sex hormones can cause lifelong infertility. ES Guidelines at 3878, 3887; D.Ct.Doc.113-9 (WPATH-8) at S39; J.A. 339, 520-22, 682-83, 781-82, 809. Moreover, giving girls high doses of testosterone induces severe hyperandrogenism that can cause clitoromegaly, atrophy of the lining of the uterus and vagina, irreversible vocal cord changes, blood-cell disorders, and increased risk of heart attack. J.A. 772-79; ES Guidelines at 3886. Risks also include liver dysfunction, coronary artery disease, cerebrovascular disease, hypertension, and breast or uterine cancer. ES Guidelines at 3886. And giving boys high doses of estrogen induces hyperestrogenemia, leading to a "[v]ery high risk of" blood clots and increased risk of tumors, breast cancer, coronary artery disease, cerebrovascular disease, sexual dysfunction, and gallstones. J.A. 779-81; ES Guidelines at 3886.

The final step, gender-transition surgeries, removes functioning organs and raises serious risks of ongoing complications. J.A.782-86.

Of course, underlying all these interventions is the risk that a person's gender identity might "shift[]." WPATH-8 at S61. For some individuals, gender identity remains fluid for years. That means some people

irreversibly alter their bodies, only to later detransition (to the extent possible). J.A. 903-08, 915-17.

B. The Rising Use of Gender-Transition Interventions for Minors Spurs Debate.

The use of gender-transition interventions for minors is a relatively recent practice. In the 1960s and 1970s, some doctors administered cross-sex hormones to and performed surgeries on adults with gender dysphoria—though many stopped when a 1979 study showed that these interventions "did not alleviate … mental distress." Pet. App. 2a-3a. It was not until decades later that pharmaceutical interventions in minors became more prevalent.

The practice started in Europe in the late 1990s, with Dutch healthcare providers administering puberty blockers to minors. Pet. App. 5a; J.A. 420-21, 443-45. In 1998, the World Professional Association for Transgender Health (WPATH) went from recommending no pharmaceutical interventions for minors to recommending puberty blockers at the onset of puberty and cross-sex hormones at 16. Pet. App. 4a-5a. WPATH further relaxed its guidelines in 2012 to recommend cross-sex hormones for minors under 16. Pet. App. 5a.

In recent years, though, many of the European countries that pioneered gender transitioning in minors reversed course. Pet. App. 28a. Health authorities in Sweden, Finland, Norway, and the United Kingdom have all concluded that these interventions pose significant risks with unproven benefits:

- ***Sweden***: Sweden's Board of Health and Welfare found that "the evidence on treatment efficacy and safety is still insufficient and inconclusive" and that "the risks" of puberty blockers and cross-sex hormones "currently outweigh the possible benefits." J.A. 337-40, 715-29.
- ***Finland***: Finland's Council for Choices in Health Care found that "gender reassignment of minors is an experimental practice" and that "[t]he reliability of the existing studies" is "highly uncertain." J.A. 583-84.
- ***Norway***: The Norwegian Healthcare Investigation Board concluded that the "research-based knowledge for gender-affirming treatment (hormonal and surgical) ... is insufficient," especially for "the teenage population." J.A. 341-42.
- ***United Kingdom***: The United Kingdom's lauded independent review found "remarkably weak evidence" on gender-transition interventions, emphasizing that the benefits of using "puberty blockers and masculinizing/feminizing hormones in adolescents are unproven." *Independent Review of Gender Identity Services for Children and Young People: Final Report* 13, 33, 194 (April 2024) (Cass Review); J.A. 333-35, 364-68.

Across these reviews, authorities confronted the "suggest[ion] that hormone treatment reduces the elevated risk of death by suicide" in transgender-identi-

fying youth; as the Cass Review emphasized, "the evidence found did not support this conclusion." Cass Review at 33; *see also* J.A. 660-75. Based on the available evidence, these countries now consider medical gender-transition interventions experimental in minors and have effectively banned them outside of controlled research settings. J.A. 332-42, 409-11, 726-27.

Undeterred, advocacy groups have doubled down on aggressive interventions for minors. WPATH—the "leading association," U.S. Br. 3—crafted the most recent version of its guidelines "to have serious effect in the law and policy ... even if the wording isn't quite correct," Ex. 184 at 24, *Boe v. Marshall*, 2:22-cv-184 (M.D. Ala.), Doc. 560-34. And indeed, "ideology, not science" drove WPATH's drafting process. *Eknes-Tucker v. Governor of Alabama*, 114 F.4th 1241, 1261 (11th Cir. 2024) (Lagoa, J., concurring in the denial of rehearing en banc).

WPATH initially commissioned a Johns Hopkins-led review to provide evidence-based backing for the Guidelines. But it "abandoned" that approach after the review "found little to no evidence about children and adolescents" benefitting from gender-transition interventions. *Boe*, Doc. 560-23 at 22-23; J.A. 375-76. As one contributor put it, "[o]ur concerns, echoed by the social justice lawyers we spoke with, is that evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits." *Eknes-Tucker*, 114 F.4th at 1261 (Lagoa, J., concurring) (quoting *Boe*, Doc. 560-24 at 2). Instead, the Guidelines purport to rely on a "consensus-based" process that incorporates opinions

approved by 75% of committee members. WPATH-8 at S8, S247. WPATH's "consensus" process left the door open for prioritizing politics over science. And that is exactly what happened.

Federal officials intervened in the Guidelines' drafting. HHS Assistant Secretary for Health Rachel Levine pressured WPATH to issue the Guidelines because its "failure" to do so was "proving a barrier to optimal policy progress." *Boe*, Doc. 560-34 at 54. Then, after receiving a preview of the near-final Guidelines, Levine's staff asked WPATH to remove the recommended age minimums because the "listings of ages [would] result in devastating legislation for trans care." *Boe*, Doc. 560-36 at 28-29. On a later Zoom call, Levine conveyed that "the Biden administration" worried about the inclusion of age limits for political reasons and "asked [WPATH] to remove them." *Id.* at 11.

WPATH members questioned the "ethic[s]" of "allowing US politics to dictate" the Guidelines. *Id.* at 32. They "explained to" Levine that WPATH "could not just remove" all age minimums "at this stage." *Id.* at 11. After all, the "expert opinion" that called for those limits was the Guidelines' "only evidence." *Id.* at 57.

But the reality that the drafters' "expert opinion" "would be influenced by politics" soon set in. *Id.* at 32-33. The dam broke when the American Academy of Pediatrics (AAP) indicated it would oppose the Guidelines if *any* age minimums were included. *Boe*, Doc. 560-37 at 100-01. One co-chair objected that accepting AAP's request would "make a joke of our methodology." *Id.* at 101.

WPATH caved anyway. Within days of the Guidelines' release, it abandoned all age minimums. Nowhere do the Guidelines disclose WPATH's eleventh-hour departure from the "consensus-based" process it now touts. WPATH-8 at S8.

C. Troubling Disclosures in Tennessee Prompt SB1.

Around the same time, media reports disclosed that Vanderbilt University Medical Center was providing gender-transition procedures to minors. J.A. 161-64. Some patients "started gender-affirming hormones at 13 or 14." Ex. 1-B, D.Ct.Doc.113-1 (video at 45:41-45:45). Others received "top surgery"—i.e., mastectomies. J.A. 181. Recordings revealed one doctor stating that "top surgeries" and "routine hormone treatment" would "make a lot of money" for the hospital. Ex. 1-D, D.Ct.Doc.113-1 (video at 0:11-0:47).

Yet, by Vanderbilt physicians' own admissions, they "ha[d] very, very little data to guide [the] treatment" and were "still figuring it out!" Ex.1-G, D.Ct.Doc.113-1 (video at 37:29-37:32); J.A. 231. Vanderbilt's gender-clinic director presented a seminar titled "Caring for the Transgender Patient: With little evidence, but a lot of love." Ex. 1-H, D.Ct.Doc.113-1, PageID#1060. She noted the absence of "real consensus" about appropriate cross-sex hormone levels. J.A. 231. And she conceded that doctors "ha[d]n't been doing this ... long enough to know the long-term effects" of cross-sex hormones, "particularly ... in [the] pediatric population." Ex.1-G, D.Ct.Doc.113-1 (video at 38:08-38:20). Still, Vanderbilt broadly offered these

procedures to youth. And it warned potential "conscientious" objectors, "[i]f you don't want to do this kind of work, don't work at Vanderbilt." Ex.1-E, D.Ct.Doc.113-1 (video at 0:01-0:08, 1:10-1:14).

Following these revelations and tracking European developments, a bipartisan coalition of Tennessee lawmakers passed SB1 to "protect the health and welfare of minors." Tenn. Code Ann. §68-33-101(a). The legislature acknowledged gender dysphoria as a condition involving "distress from a discordance between" a person's sex and asserted gender identity. *Id.* §68-33-101(c). But it detailed concerns with using pharmaceutical and surgical interventions to address this condition in minors.

Specifically, SB1's legislative findings recognized that gender-transition interventions "can lead to [a] minor becoming irreversibly sterile, having increased risk of disease and illness, or suffering adverse and sometimes fatal psychological consequences." *Id.* §68-33-101(b). The law further observed that the harms associated with these interventions "are [not] yet fully known." *Id.* And it noted that "health authorities in Sweden, Finland, and the United Kingdom … have found no evidence that the benefits of these procedures outweigh the risks." *Id.* §68-33-101(e). At the same time, the legislature found that "minors lack the maturity to fully understand and appreciate the life-altering consequences of such procedures." *Id.* §68-33-101(h). SB1 drew attention to the "many individuals ... express[ing] regret for medical procedures that were performed ... on them ... when they were minors." *Id.* Indeed, the legislature heard from a detransitioner

who explained that she was not "capable of making informed lifelong decisions" as a teenager, and yet doctors provided transition treatments that severely damaged her body. House Health Subcommittee (Jan. 31, 2023), tinyurl.com/5n8ewdsv (59:15-1:02:22).

SB1 regulates medical practice to address these concerns. It prohibits "healthcare provider[s]" from performing certain "medical procedure[s]" "for the purpose of" either "[e]nabling a minor to identify with, or live as, a purported identity inconsistent with the minor's sex" or "[t]reating purported discomfort or distress from a discordance between the minor's sex and asserted identity." Tenn. Code Ann. §68-33-103(a)(1). Regulated procedures include "[s]urgically removing, modifying, altering, or entering into tissues, cavities, or organs" and "[p]rescribing, administering, or dispensing any puberty blocker or hormone." *Id.* §68-33-102(5). SB1 allows these procedures to treat different conditions, like congenital defects, precocious puberty, disease, and physical injuries. *Id.* §68-33-103(b)(1)(A). And it leaves other long-used treatments, such as psychotherapy, available to minors. *Id.* §68-33-101(c).

D. The District Court Preliminarily Enjoins SB1, but the Sixth Circuit Reverses.

Three minors, their parents, and a doctor brought a pre-enforcement challenge to SB1, asserting substantive-due-process and equal-protection theories. The federal government intervened. Then, days before SB1's effective date, the district court held the law facially unconstitutional and preliminarily enjoined all but the surgical prohibition. Pet. App. 130a-218a,

219a-221a. The Sixth Circuit stayed that injunction. Pet. App. 102a-124a.

The Sixth Circuit then reversed. Pet. App. 1a-101a. On the equal-protection claim, Chief Judge Sutton, joined by Judge Thapar, concluded that SB1's restrictions do not "turn[] on sex" or impose a sex classification. Pet. App. 32a. Rather, SB1's "classifications turn on presumptively valid age and medical conditions." Pet. App. 36a. And in imposing those restrictions, SB1 "treat[s] similarly situated individuals evenhandedly." Pet. App. 31a. Given SB1's presumptively valid restrictions, the court held that the law "does not trigger" heightened review. Pet. App. 33a. Applying heightened scrutiny, the court recognized, would transfer "trying policy choices" and "fraught line-drawing dilemmas" from the "arena of public debate and legislative action" to the unelected federal judiciary. Pet. App. 44a-45a. That the government "disagree[s] with the States' assessment of the risks and the right response to those risks ... does not suffice to invalidate a democratically enacted law." Pet. App. 50a.

Judge White dissented. Pet. App. 56a-101a. She concluded that intermediate scrutiny applies and that SB1 fails that standard, largely based on her assessment of the interventions' risks and efficacy. Pet. App. 59a, 85a-87a.

SUMMARY OF ARGUMENT

I. Through SB1, Tennessee lawfully exercised its power to regulate medicine by protecting minors from risky, unproven gender-transition interventions. It is not unconstitutional discrimination to say that drugs can be prescribed for one reason but not another. Weighing risks and benefits, States (and the federal government) draw age- and use-based distinctions for drugs all the time.

II. SB1 contains no sex classification that warrants heightened review. It creates two groups: minors seeking drugs for gender transition and minors seeking drugs for other medical purposes. Each of these groups "includes members of both sexes," so no facial sex classification exists. *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974). Not every law that mentions sex *classifies* based on sex.

The government's newfound focus on "gender conformity" flouts law and fact. Repeatedly claiming that SB1 requires conformity does not create a sex-based line, and the Equal Protection Clause confers no substantive right to non-conforming behavior. SB1's risk-benefit assessment of gender-transition interventions does not push conformity ends anyway.

Heightened review also does not apply because boys and girls are not similarly situated for purposes of SB1. It defies biological reality to suggest, as the government does, that males and females are medically the same for purposes of receiving testosterone and estrogen.

Pivoting, the government seeks to overhaul this Court's established equal-protection framework by constitutionalizing *Bostock*'s but-for-sex test. Decades of precedent foreclose that maneuver. Importing a but-for approach to identify classifications under the Constitution would jettison longstanding limits on disparate-impact liability, drastically expand the application of heightened review, and clash with other legal protections. This Court should reject the government's *Bostock* premise and the resulting doctrinal fallout.

A doctrinal sea change would be for naught because sex is not a but-for cause in SB1. Under the but-for test, courts "change one thing at a time and see if the outcome changes." *Bostock*, 590 U.S. at 656. For puberty blockers, changing sex changes nothing since both males and females take the same drug; medical purpose alone dictates the availability of the drug under SB1. And for cross-sex hormones, the government must change both sex *and* medical purpose to reach a different outcome.

III. The challengers' transgender-discrimination argument does not justify heightened review. SB1 does not classify based on transgender status. And even if it did, this Court should not get back in the fraught business of creating suspect classes. Transgender status does not uniquely warrant expanding the list of quasi-suspect classifications for the first time in nearly 50 years.

IV. Though rational-basis review applies, SB1 readily satisfies intermediate scrutiny too. The law "substantially relate[s]" to Tennessee's undisputedly

compelling interests. *Nguyen v. INS*, 533 U.S. 53, 68 (2001). Even under heightened review, this Court defers to legislative factfinding and gives States "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales*, 550 U.S. at 163. That discretion makes this case easy: SB1 contains specific findings and imposes restrictions in an area of medical uncertainty.

The government convinced the district court to weigh the risks and benefits itself with no deference to legislative findings. That is not the proper legal standard or the judiciary's role. Nor should this Court credit the government's claim of "medical consensus" given its credibility killing silence on the European health authorities *that SB1 itself references*. The government's one-sided telling of the evidence misreports the medical landscape. And its over- and under-inclusivity arguments both ignore medical reality and fail to rebut SB1's substantial relation to Tennessee's compelling interests.

The Court should affirm.

ARGUMENT

The Equal Protection Clause prohibits a State from "deny[ing] to any person within its jurisdiction the equal protection of the laws." That language "was not designed to compel uniformity in the face of difference," *Whitney v. State Tax Comm'n*, 309 U.S. 530, 542 (1940), or to "forbid classifications" entirely, *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). Rather, it "keeps governmental decisionmakers from treating differently persons who are in all relevant respects alike." *Id.*

To make out an equal-protection claim, a plaintiff must first identify the classifications drawn by the challenged action. A law contains a facial classification only when it "distinguish[es] between individuals" based on a particular characteristic. *Shaw v. Reno*, 509 U.S. 630, 642 (1993). For legislation "neutral on its face," a plaintiff must show that a law disparately impacts a particular group *and* prove that the legislature acted with "discriminatory intent or purpose." *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 265-66 (1977).

"When those who appear similarly situated are ... treated differently," this Court looks to the government's basis for the differential treatment. *Engquist v. Oregon Dep't of Agric.*, 553 U.S. 591, 602 (2008). It applies strict scrutiny when a law classifies based on a suspect class (race, alienage, or national origin) and intermediate scrutiny when a law classifies based on a quasi-suspect class (sex or illegitimacy). *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440-41 (1985). Otherwise, "legislation is presumed to be valid

and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest." *Id.* at 440.

Those principles compel upholding SB1. The law regulates the practice of medicine by placing age- and use-based restrictions on medical procedures. It does not classify based on any protected characteristic. And SB1's approach satisfies intermediate scrutiny regardless.

I. SB1 Sets Age- and Use-Based Limits on Medical Procedures

States exercise broad power over "health and safety matters." *Hillsborough Cnty. v. Automated Med. Lab'ys*, 471 U.S. 707, 719 (1985). This power includes "regulat[ing] the practice of medicine." *McNaughton v. Johnson*, 242 U.S. 344, 348-49 (1917). Indeed, "[t]here is perhaps no profession more properly open to … regulation" by States. *Watson v. Maryland*, 218 U.S. 173, 176 (1910).

States routinely exercise their public-health authority by regulating "medical treatments for adults and children." Pet. App. 19a. They prohibit or severely restrict irreversible practices like assisted suicide and euthanasia, *Washington v. Glucksberg*, 521 U.S. 702, 719 (1997); *Vacco v. Quill*, 521 U.S. 793, 797 (1997), "intrusive and possibly hazardous" measures like "psychosurgery and shock treatment," *Aden v. Younger*, 57 Cal. App. 3d 662, 668, 673 (1976), and the good-faith "administration, sale, prescription, and use of dangerous ... drugs," *Minnesota ex rel. Whipple v. Martinson*, 256 U.S. 41, 45 (1921). States' power over

permissible medical practices is "so manifest" and "firmly established" that it cannot "be successfully called in question." *Id*.

Tennessee exercised this power when it passed SB1. That law prohibits "healthcare provider[s]" from performing specific "medical procedure[s]" "for the purpose of" either (1) "[e]nabling a minor to identify with, or live as, a purported identity inconsistent with the minor's sex" or (2) "[t]reating purported discomfort or distress from a discordance between the minor's sex and asserted identity." Tenn. Code Ann. §68-33-103(a)(1). And it allows these "procedures" for other medical uses. *Id.* §68-33-103(b)(1)(A).

SB1 expressly draws an age-based line between adults and minors. That type of "distinguishing" is "not unusual" in medicine or the law generally. Pet. App. 31a; *see* Tenn. Code Ann. §62-38-211(a) (tattoos); *id.* §§36-3-105, -106 (marriage); W. Va. Code Ann. §16-11-1 (sterilization). And "age is not a suspect classification." *Gregory v. Ashcroft*, 501 U.S. 452, 470 (1991).

SB1 further distinguishes between the medical purpose for using certain "medical procedure[s]." It bars certain procedures—surgery, puberty blockers, and cross-sex hormones—"for the purpose of" gender transition. Tenn. Code Ann. §68-33-103(a)(1). But it lets physicians use those surgeries and drugs to address distinct medical conditions—e.g., precocious puberty, congenital defects, disease, and trauma. *Id.* §68-33-103(b)(1)(A). Put otherwise, SB1 separates the use of certain surgeries and drugs to facilitate gender transition from their use for different medical reasons.

Eknes-Tucker v. Governor of Alabama, 80 F.4th 1205, 1233 (11th Cir. 2023) (Brasher, J., concurring).

Sound medical practice *depends* on such distinctions. A procedure's risks cannot be isolated from its reason for use, since the medical purpose informs the risk-reward calculus. That is why FDA approves drugs—including those at issue here—only for specific labeled "use[s]." 21 U.S.C. §355(b)(1), (d); *Benefit-Risk Assessment in Drug Regulatory Decision-Making*, FDA (Mar. 30, 2018), https://tinyurl.com/4xzcw9br. And it is why States frequently impose use-driven restrictions in medicine. Doctors can use morphine to treat a patient's pain but not to assist a patient's suicide. Tenn. Code Ann. §39-13-216; *see Vacco*, 521 U.S. at 808-09. Doctors can perform pelvic surgery on women who have "given birth" but not on women being subjected to ritualistic genital mutilation. Tenn. Code Ann. §39-13-110. Doctors can perform an abortion to address risks to a mother's life or health but not for elective purposes, in many States. *Id.* §39-15-213. Doctors can prescribe testosterone to address hormonal imbalance but not to "increase muscle mass, strength or weight without medical necessity." *Id.* §39-17-430(a)(2). The list goes on.

A State may "reasonably" deem a procedure "safe when used for one purpose but risky when used for another, especially when" the procedure "is being put to a relatively new use." Pet. App. 31a-32a. Tennessee did just that: The legislature determined that the cost-benefit calculus warranted permitting the surgeries and drugs subject to SB1 for some reasons and not

others. That is not discrimination. It is an even-handed "regulation of a medical procedure" that turns on the reason for the procedure's use. *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 236 (2022); *Eknes-Tucker*, 80 F.4th at 1227.

II. SB1 Contains No Sex Classification that Warrants Heightened Scrutiny

A. SB1 does not classify based on sex.

The government cannot point to a sex classification under the traditional equal-protection framework. And its "gender conformity" argument cannot salvage that failure. The Sixth Circuit correctly held that SB1 turns on age and use—not sex.

1. SB1 draws no sex-based line.

Facial sex classification occurs when a law "distinguish[es] between individuals" based on sex. *Shaw*, 509 U.S. at 642. A university excludes "women." *United States v. Virginia*, 518 U.S. 515, 520 (1996). A State imposes different rules for "males" versus "females." *Craig v. Boren*, 429 U.S. 190, 192 (1976). A law provides that "males must be preferred to females" for the handling of property. *Reed v. Reed*, 404 U.S. 71, 73 (1971). *These* are "classic sex classification[s]." L.W. Br. 18.

Tennessee's law draws no similar "sex-based line[]." U.S. Br. 19. SB1 does not "prefer one sex over the other," "include one sex and exclude the other," "bestow benefits or burdens based on sex," or "apply one rule for males and another for females." Pet. App.

32a. It does not "draw any distinctions between persons" based on sex. *Vacco*, 521 U.S. at 800.

The government claims (at 21) that SB1 "defin[es] the prohibited medical care based on the patient's sex." The law references "sex," but it does not "differentiate" based on sex. *Nordlinger*, 505 U.S. at 10. And that is what matters.

Assessing the lines drawn by SB1 reveals the absence of any sex classification. The law creates two groups: (1) minors seeking to use puberty blockers and cross-sex hormones for gender transition, and (2) minors seeking to use puberty blockers and cross-sex hormones for other medical purposes. The first group "includes members of both sexes"—neither boys nor girls can use these drugs for gender transition. *Geduldig*, 417 U.S. at 496 n.20. The second group also "includes members of both sexes"—both boys and girls can use these drugs for other medical purposes. *Id.* Under *Geduldig*, this "lack of identity" between sex and the "groups" created by SB1's line drawing means that no facial "sex" classification exists. *Id.*

The government's requested remedy is telling too. The government has not sought an injunction that would "treat boys and girls the same"; it wants an injunction to "allow" "puberty blockers and hormones" to be administered for additional purposes. *Eknes-Tucker*, 80 F.4th at 1233 (Brasher, J., concurring); *see* Pet. App. 37a-38a. That request shows that "the classification drawn by the statute" concerns the drugs' prescribed *use*, not a patient's sex. *Cleburne*, 473 U.S. at 440.

The government pivots (at 21) to SB1's mere "referenc[e]" to sex. But not every law that mentions sex classifies based on sex. Pet. App. 36a. Take this hypothetical statute: "Neither men nor women may drive an automobile without a license." It uses "sex-based terms," U.S. Br. 2, 13, but draws no sex-based lines. The mere "use of gender specific" versus "neutral" terms has never controlled the sex-classification inquiry. *Cf. Nguyen*, 533 U.S. at 64. Otherwise, myriad laws without sex or race classifications would "require heightened review." Pet. App. 35a. This Court rejects that approach. *See Dobbs*, 597 U.S. at 232 n.14; *Jam v. Int'l Fin. Corp.*, 586 U.S. 199, 208 (2019) (42 U.S.C. §1981, which mentions "white" citizens, treats all races equally). So while SB1 uses "the word 'sex,'" it does not include "a sex *classification*" within the meaning of "equal-protection caselaw." *Eknes-Tucker*, 80 F.4th at 1233 (Brasher, J., concurring).

That conclusion in no way threatens the Fourteenth Amendment's protection of "individual[s]." U.S. Br. 24. Tennessee's point is *not* that laws like SB1 can classify by sex yet avoid sex-based scrutiny by harming boys and girls "in equal degree." L.W. Br. 27-28; *accord* U.S. Br. 24. The point is that SB1 contains no sex classification at all. A law taxing all citizens burdens both men and women, but like SB1, it does not burden both men and women through a sex classification. The cases cited by the challengers (at U.S. Br. 24; L.W. Br. 27-28) drive home this distinction: Striking a juror because he's a man (*J.E.B.*) or because he's black (*Powers*) are actions that classify based on sex or race. No such sex classification exists in SB1; the law differentiates based on age and use.

2. The government's gender-conformity assertions show no sex classification.

Nor does SB1 classify based on sex by restricting minors from engaging in "non-conforming" behavior. U.S. Br. 22-23, 41; L.W. Br. 22-23, 28.

For starters, not all restrictions on non-conforming behavior involve a sex-based classification. Consider a pair of contrasting examples: (1) a school dress code that requires boys to wear pants and girls to wear skirts and (2) a school dress code that permits only pants. A boy wants to wear a skirt, asserting a nonconformity interest. Under the first policy, a sex-based line regulates the boy: girls can wear skirts, and boys cannot. Under the second policy, by contrast, no sex-based line exists: no one can wear skirts. In both examples, the boy wants to engage in a "non-conforming" activity that is "inconsistent" with stereotypical attire. And in both examples, the boy is prohibited from doing so. Yet only the first policy draws a sex-based line. The second policy, like SB1, does not.

The plaintiffs err (at 22, 28) by equating SB1 to laws that expressly classify religions, races, or the sexes. A law prohibiting "people from working in professions 'inconsistent with' their sex" creates sex-based lines: for some jobs, a male can have the job and a female cannot, and vice versa. SB1 imposes no similar classification.

And no authority permits an equal-protection claim for "people who fail to conform" *absent* any sex-based classification. L.W. Br. 21; *see* U.S. Br. 23. Instead, cases like *Craig* (different male-female alcohol

purchasing rules), *Virginia* (different male-female admissions rules), and *Morales-Santana* (different male-female immigration rules) all involved clear, facial sex classifications. *Craig*, 429 U.S. at 198-99; *Virginia*, 518 U.S. at 532-33; *Sessions v. Morales-Santana*, 582 U.S. 47, 62-63 (2017). Though they discussed stereotyping in applying intermediate scrutiny, they did not use that concept to conjure a sex classification from a sex-neutral rule.

To the extent the government now attempts to backdoor in an *Arlington Heights* discriminatory-purpose claim through "conformity," U.S. Br. 22, that argument likewise fails. The government never meaningfully pressed this argument below, and it points to no disparate impact on one sex. More important, SB1's aim is not "[e]nforcing conformity." L.W. Br. 42.

Tennessee enacted SB1 "to protect the health and welfare of minors." Tenn. Code Ann. §68-33-101(a). In detailed findings, SB1 catalogs Tennessee's interests in regulating early gender-transition interventions to protect minors and the integrity of the medical profession. *Id.* §68-33-101(b)-(m). Along the way, SB1 mentions encouraging minors "to appreciate" and not be "disdainful of their sex" as they "undergo puberty." *Id.* §68-33-101(h), (m). But contra challengers' repeated assertions, that language is no smoking gun. *Cf.* L.W. Br. 1, 23, 42, 52; U.S. Br. 2, 8, 16-18, 22, 27, 32-34, 49. It simply acknowledges the problems with using unproven gender-transition interventions on minors. Given high desistance rates among youth and the tragic "regret" of detransitioners, it was not improper to conclude that kids benefit from additional time to

"appreciate their sex" before embarking on body-altering paths. Tenn. Code Ann. §68-33-101(h), (m). Nor is it improper for the State to protect minors from procedures that "encourage [them] to *become* disdainful of their sex"—and thus at risk for serious psychiatric conditions. *Id.* (emphasis added). Especially when research shows that gender-transition interventions can make mental distress worse. J.A. 400-01.

The government may disagree with that research. But it cannot cast SB1 as stereotype-driven by caricaturing legislative findings that detail a range of health concerns. Chanting a "conformity" mantra does not overcome the heavy "presumption of legislative good faith," *Abbott v. Perez*, 585 U.S. 579, 603 (2018), or drown out the compelling concerns that drove SB1. And it is insincere because—even if that language were omitted—the government would be here challenging SB1's restrictions all the same.

3. The Sixth Circuit properly applied the sex-classification framework.

The government's claim that Chief Judge Sutton "fundamentally misunderstood" equal-protection law distorts the decision below. U.S. Br. 16. The Sixth Circuit did not spottily concede a sex classification "at times." U.S. Br. 18-19, 24-25. It found "no" sex-based line in SB1, period. Pet. App. 32a. Having concluded that SB1 lacks any sex classification, the court properly declined to apply heightened review. Pet. App. 32a-33a.

That decision in no way "conflates the classifications drawn by the law with the state's justification for

it." U.S. Br. 26. The Sixth Circuit recognized that the "cost-benefit analysis" or "risk-reward assessment" for a procedure depends on the reason for the procedure's use. Pet. App. 34a, 37a. It highlighted that fact to help explain that SB1 classifies by procedures' distinct medical uses, not patients' sex. *Id.*

The challengers attack the Sixth Circuit for stating that the "necessity of heightened review[] will not be present every time that sex factors into a government decision." L.W. Br. 2 (quoting Pet. App. 39a); U.S. Br. 24-25. But that's just a rejection of the government's attempted use of but-for causation to create a novel class of *Bostock*-based equal-protection claims. *See infra* Part II.C. As the Sixth Circuit recognized, *Dobbs* and *Geduldig* reject heightened scrutiny for sex-adjacent restrictions that draw no sex-based lines. Pet. App. 39a; *infra* 33-34. Whether those decisions are characterized as concluding that no sex classification exists, *infra* 32-35, or that heightened scrutiny does not apply to sex-adjacent claims, Pet. App. 39a, the result is the same. It is the government and plaintiffs, not the Sixth Circuit, that "break[] from a half century of this Court's precedents." L.W. Br. 2.

B. Boys and girls are not similarly situated for purposes of SB1.

The challengers' arguments fail for the independent reason that boys and girls "are not similarly situated" for purposes of SB1's restrictions. *Michael M. v. Superior Court*, 450 U.S. 464, 469 (1981) (plurality). As the Sixth Circuit correctly noted, the sexes' biological differences provide yet another basis for declining heightened scrutiny. Pet. App. 39a.

This Court has never read the Equal Protection Clause to "require things which are different in fact or opinion to be treated in law as though they were the same." *Tigner v. Texas*, 310 U.S. 141, 147 (1940). It has instead analyzed a law's justifications only *after* determining that "those who appear similarly situated are … treated differently." *Engquist*, 553 U.S. at 602. Scores of lower-court cases agree and treat this "similarly situated" question as a *threshold* inquiry.[1]

Under this approach, "the absence of similarly situated individuals treated differently is … simply a way of saying that the plaintiff failed at the first step to prove intentional discrimination"—a step that must be satisfied "[*b*]*efore* a court may get to the business of assessing" the law's justifications. *SECSYS v. Vigil*, 666 F.3d 678, 688-89 (10th Cir. 2012) (Gorsuch, J.).

Nguyen's mention of "similarly situated" in applying scrutiny is not to the contrary. *Cf.* L.W. Br. 35-36; U.S. Cert. Reply 5. That discussion came only *after* concluding that a law treated men and women differently "under like circumstances." *Nguyen*, 533 U.S. at 60. And whether boys are similarly situated to girls

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[1] *See, e.g.*, *People v. Whitfield*, 888 N.E.2d 1166, 1172-73 (Ill. 2007), *as modified* (Apr. 23, 2008); *Timberland Partners XXI v. Iowa Dep't of Revenue*, 757 N.W.2d 172, 175 (Iowa 2008); *In re Weisgerber*, 169 P.3d 321, 328 (Kan. 2007); *Benitez v. Rasmussen*, 626 N.W.2d 209, 219 (Neb. 2001); *Morrison v. Garraghty*, 239 F.3d 648, 654 (4th Cir. 2001); *Barney v. Pulsipher*, 143 F.3d 1299, 1312-13 (10th Cir. 1998); *Women Prisoners v. D.C.*, 93 F.3d 910, 924 (D.C. Cir. 1996); *Klinger v. Dep't of Corr.*, 31 F.3d 727, 731 (8th Cir. 1994).

for purposes of SB1 matters at the outset, even if it *also* matters when analyzing means-ends fit.

The challengers' reliance on "*Bostock*'s framework for identifying sex discrimination" supports the similarly situated inquiry's gatekeeping role. L.W. Br. 18; U.S. Br. 27. *Bostock* stated that discrimination requires showing that the plaintiff was treated "worse than others who are similarly situated." 590 U.S. at 657. It just deemed that prerequisite met since "homosexuality or transgender status is not relevant to employment decisions." *Id.* at 660. If this Court constitutionalizes *Bostock*'s but-for standard (it should not, *see infra* Part II.C), then *Bostock*'s similarly situated requirement must travel alongside.

The government previously proposed shoehorning the similarly situated requirement into the *application* of intermediate scrutiny. U.S. Cert. Reply 5. But it never explains how the similarly situated inquiry fits into that analysis or why boys and girls are similar for purposes of receiving cross-sex hormones. Instead, it generally contests the evidentiary basis for restricting gender-transition procedures for minors. U.S. Br. 39-50. That analysis ducks the similarly situated inquiry altogether.

Here, there is no question that boys' and girls' "enduring" "[p]hysical differences" keep them from being similarly situated with respect to SB1's restriction on cross-sex hormones. *Virginia*, 518 U.S. at 533. Providing testosterone to a boy with delayed puberty *addresses* a distinct medical condition, whereas providing it to a girl *causes* a physical condition (severe hyperandrogenism). *Supra* 6; J.A. 500-01, 521-

22, 769-79. Similarly, providing estrogen to a girl with premature ovarian insufficiency *addresses* a distinct medical condition, whereas providing it to a boy *causes* a physical condition (hyperestrogenemia). *Supra* 6; J.A. 779-81; ES Guidelines at 3886.

The government's sex-discrimination argument would compel this Court to accept that males and females are medically the same for SB1's purposes—and that providing testosterone to a female to transition is the "same treatment" as providing it to a male with a physical malady. U.S. Br. 2, 15, 18, 28. No equal-protection test requires this anti-science mendacity.

C. *Bostock* does not render SB1 sex based.

Failing the traditional equal-protection framework, the government asks this Court to create a new category of sex classifications based on *Bostock*'s but-for logic. U.S. Br. 21-23. The briefing pitches this step as "simple" and "obvious[]." L.W. Br. 16; U.S. Br. 21. But "this wolf comes as a wolf." *Morrison v. Olson*, 487 U.S. 654, 699 (1988) (Scalia, J., dissenting). Using but-for-sex reasoning to trigger heightened scrutiny would make a hash of this Court's equal-protection jurisprudence. It would conflict with *Bostock*'s reasoning. And it would drastically expand heightened review. This Court should reject the government's misuse of *Bostock*. But even under the but-for test, the government loses.

1. This Court has never taken a but-for approach to equal-protection classifications.

Constitutionalizing *Bostock*'s but-for rule would abrogate decades of equal-protection jurisprudence.

Currently, a challenger has two paths to heightened equal-protection review: a facial classification or a disparate impact plus discriminatory purpose. SB1 does not facially classify by sex. *Supra* Part II.A. So that leaves only the "sensitive inquiry" into whether facially neutral laws were in fact driven by "discriminatory intent or purpose." *Arlington Heights*, 429 U.S. at 265-66. To make that showing, the asserted "discriminatory intent or purpose" must target *the suspect characteristic at issue*—not some other characteristic. *Id.* at 265; *see Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993) (sex-based claim "demand[s] ... at least a purpose that focuses upon women *by reason of their sex*").

The government invents a third path. It claims that heightened review applies when some *non*-sex-based classification incorporates sex as a but-for matter. That argument contradicts scores of cases.

Most obviously, but-for causation conflicts with this Court's sexual-orientation cases. For decades, this Court has faced claims of sexual-orientation discrimination under equal-protection theories—including *Romer v. Evans*, 517 U.S. 620 (1996); *United States v. Windsor*, 570 U.S. 744 (2013); and *Obergefell v. Hodges*, 576 U.S. 644, 651 (2015). "But in those cases, the Court never suggested that sexual orientation dis-

crimination is just a form of sex discrimination." *Bostock*, 590 U.S. at 797 (Kavanaugh, J., dissenting). It is "implausible" to suggest that "in all of those sexual orientation cases" the Court "overlook[ed] the fact that sexual orientation discrimination is actually a form of sex discrimination" under the Constitution. *Id.* at 798.

Pregnancy and abortion cases also belie a but-for approach. In *Geduldig*, this Court assessed whether excluding conditions arising from pregnancy from disability benefits coverage denied women equal protection. 417 U.S. at 489. It said no, even though sex is a but-for cause of pregnancy and despite the dissent's counter that "[i]n effect, one set of rules is applied to females and another to males." *Id.* at 501 (Brennan, J., dissenting). The Court kept its focus on the "legislative classification" and the groups that classification created. *Id.* at 496 n.20. It emphasized that a pregnancy-related restriction "is a far cry from cases like *Reed* … and *Frontiero v. Richardson*, 411 U.S. 677 (1973), involving discrimination based upon gender *as such*." *Id.* (emphasis added).

Bray reiterated that reasoning when rejecting an argument that anti-abortion demonstrations constituted "*ipso facto*" discrimination "against women as a class." 506 U.S. at 271. *Bray* reached that result over a dissent that contended that "[a] classification based on pregnancy is a sex-based classification" because "the capacity to become pregnant is a characteristic necessarily associated with one" sex. *Id.* at 323 n.20, 327 (Stevens, J., dissenting). This Court has declined to "revisit" this line of precedent. *Coleman v. Ct. of*

Appeals, 566 U.S. 30, 54 (2012) (Ginsburg, J., dissenting). It remains good law. *Dobbs*, 597 U.S. at 236.

More generally, a but-for approach is incompatible with the conceptual underpinning of equal-protection jurisprudence. Heightened review rests on the idea that "certain classifications … supply a reason to infer antipathy" on the part of lawmakers. *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 272 (1979). The Court replaces the presumption of legislative validity with heightened review only after a robust showing tied to a particular characteristic. *Infra* 44-45. But in the government's view, non-suspect classes (here, transgender-identifying persons) could receive heightened protection by leveraging a *different* suspect characteristic (here, sex). That approach transforms the object of heightened protection and, in doing so, divorces heightened scrutiny from its justification.

Plaintiffs' but-for argument finds no support in cases applying heightened scrutiny when sex is one among several classifications. L.W. Br. 30. Courts sometimes face laws that classify based on sex and something else. For example, in *Craig*, a state law prohibited the sale of beer to males under 21 and females under 18, drawing lines based on sex and age. 429 U.S. at 192. Packaging sex classifications with other considerations does not somehow immunize the sex classification from scrutiny. But there must *be* a classification based on sex itself to trigger heightened review. None of plaintiffs' cited cases (at 30) support using but-for reasoning to transform a non-sex-based classification into a sex classification. This Court's

task is "only to measure the basic validity of the legislative classification" drawn. *Feeney*, 442 U.S. at 272.

2. A but-for approach to equal-protection classifications defies *Bostock*'s reasoning.

Bostock disavowed any extension of its Title VII reasoning to other laws, like the Equal Protection Clause. For good reason. "The Constitution is not a statute," *R.R. Ret. Bd. v. Alton R. Co.*, 295 U.S. 330, 346-47 (1935), and this Court has "never held that the constitutional standard for adjudicating claims of invidious ... discrimination is identical to the standards applicable under Title VII," *Washington v. Davis*, 426 U.S. 229, 239 (1976). And *Bostock*'s reasoning refutes the government's attempt to transplant Title VII's but-for test.

First, *Bostock*'s analysis was driven by Title VII's "starkly broad" text. 590 U.S. at 680. That text makes it "unlawful … for an employer" to take certain employment actions "because of ... race, color, religion, sex, or national origin." 42 U.S.C. §2000e-2(a)(1). With that wording, it is "*always* unlawful" (absent an enumerated defense) to take covered actions "because of" sex. *Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll. (SFFA)*, 600 U.S. 181, 309 (2023) (Gorsuch, J., concurring). And *Bostock* read Title VII's "because of" language to require a "focus[] on but-for discrimination." Pet. App. 40a. But the Equal Protection Clause "contains none of the text that the Court interpreted in *Bostock*." *Eknes-Tucker*, 80 F.4th at 1229. Instead, in language adopted almost a century earlier, the Equal Protection Clause directs

a "focus[] on the denial of equal protection." Pet. App. 40a. Unlike Title VII, that constitutional requirement "addresses all manner of distinctions between persons" and has been read to "impl[y] different degrees of judicial scrutiny for different kinds of classifications." *SFFA*, 600 U.S. at 308 (Gorsuch, J., concurring). "That such differently worded provisions should mean the same thing is implausible on its face." *Id.*; *see Alexander v. South Carolina NAACP*, 144 S.Ct. 1221, 1260 (2024) (Thomas, J., concurring).

Second, structural considerations cut differently. Title VII incorporates a "sweeping" but-for standard yet cabins liability to certain employment actions and employers. *Bostock*, 590 U.S. at 656-57. As *Bostock* noted, Title VII's non-discrimination rule also interacts with the statute's defenses and protections appearing in the Religious Freedom Restoration Act. *Id.* at 681-82; Pet. App. 41a. Those statutory features check the extension of broad but-for-based liability beyond Title VII's limited coverage. By contrast, the Equal Protection Clause governs all governmental action and lacks the deliberate checks that *Bostock* stressed. Subjecting all governmental action to but-for liability would collide with religious liberties and other constitutional rights in a manner *Bostock* nowhere endorsed.

Third, *Bostock*'s but-for standard fits with this Court's "three ... leading precedents" on Title VII. 590 U.S. at 663. But as discussed, this Court's equal-protection precedents cut the opposite way. *Supra* 32-35.

Fourth, congressional revisions to Title VII drive home key distinctions between Title VII and the Equal

Protection Clause. Originally, this Court applied *Geduldig*'s classification test to reject the argument that Title VII's reference to "because of … sex" covers pregnancy discrimination. *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125, 133-36 (1976). Congress responded by specifying that "because of sex" includes discrimination "on the basis of pregnancy," 42 U.S.C. §2000e(k)—confirming that Title VII's causal inquiry sweeps beyond the classification-focused Equal Protection Clause.

3. A but-for approach to equal-protection classifications would subvert sex-based review.

Constitutionalizing a but-for approach would remove important guardrails on heightened review.

Adopting the government's logic would open the door to disparate-impact liability under the Constitution. Laws relating to sex-specific medical procedures—whether prostate cancer treatments, circumcisions, erectile-dysfunction medications, or breast-feeding therapies—may have to "run[] the gauntlet of skeptical judicial review" under the theory that sex is a but-for cause. Pet. App. 35a-36a. The same would go for pregnancy-related restrictions, contra *Geduldig*, and for abortion regulations, contra *Dobbs*.

The heightened-scrutiny fallout would spiral beyond sex. Are government employers' no-visa-sponsorship policies unconstitutional because national origin is a but-for cause of needing a visa? Is race a but-for cause when a university credits an applicant's essay about how racial discrimination "affected his or

her life"? *SFFA*, 600 U.S. at 230. Is racial lineage a but-for cause of any law regulating tribal members? *See* 25 U.S.C. §1915(a); 1 Navajo Nation Code §701. Accepting the government's theory would leave courts puzzling through these and whatever other but-for conundrums creative lawyers concoct.

A but-for approach would also allow new classes to wield heightened scrutiny in a way that harms women. Women's heightened legal protections reflect their history of being targeted with "pervasive" discrimination and disadvantage. *Feeney*, 442 U.S. at 273. But if the government's theory holds, men who *identify* as women could claim constitutionally based access to women's bathrooms,[2] women's locker rooms,[3] and women's sports.[4] Accepting that theory would perversely erode women's rights and jeopardize landmark statutes protecting women's equal access to schools, winners' podiums, and beyond.

On top of all that, the but-for causation test would set the Equal Protection Clause on a collision course with the Free Exercise Clause. Conflicting rights will arise for doctors at State-run hospitals with conscientious objections, students whose religious convictions prevent the sharing of intimate spaces with the opposite sex, and so on. Unlike Congress in the statutory

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[2] U.S. Br., *Adams v. Sch. Bd. of St. John's Cnty.*, No. 18-13592, (11th Cir.), Doc. 254.

[3] U.S. Statement, *Roe v. Critchfield*, No. 1:23-cv-00315-DCN (D. Idaho), Doc. 41.

[4] U.S. Br., *B.P.J. v. W. Va. State Bd. of Educ.*, No. 23-1078 (4th Cir.), Doc. 68.

context, this Court could not carve the government's proposed but-for-sex mandates out of the Constitution to protect "sincere[]" religious views. *Religious Sisters of Mercy v. Becerra*, 55 F.4th 583, 598 (8th Cir. 2022). Nor would "federal conscience laws" be an out, since the Constitution would trump. *FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 387 (2024). The impossible task of measuring the relative import of conflicting religion and equal-protection claims is yet another problem attending the government's but-for test.

4. Regardless, sex is not a but-for cause in SB1.

This Court should reject the but-for test outright. But the government loses even under its own test because sex is not a but-for cause in SB1. Under the but-for test, courts "change one thing at a time and see if the outcome changes." *Bostock*, 590 U.S. at 656. Changing a person's "sex" does not change the availability of the drugs regulated by SB1.

Puberty Blockers: The government's argument barely mentions puberty blockers. Fitting, because "puberty blockers involve *the same drug* used equally by gender-transitioning boys and girls." Pet. App. 38a (emphasis added). If a boy seeks puberty blockers to transition, he cannot have them. If a girl seeks puberty blockers to transition, she cannot have them. So "holding other things constant but changing the minor's sex" does not, in fact, "yield a different outcome." U.S. Br. 22 (cleaned up). Sex does not dictate SB1's limits on puberty blockers, even as a but-for matter.

Cross-Sex Hormones: The same goes for cross-sex hormones. No boy can receive hormones to transition; likewise, no girl can receive hormones to transition. But either can receive hormones to treat physical abnormalities. Medical purpose, not sex, dictates availability under SB1. *Cf. Kadel v. Folwell*, 100 F.4th 122, 181-82 (4th Cir. 2024) (Richardson, J., dissenting) (finding no sex-discrimination while applying *Bostock*'s but-for test).

The government's counter changes both sex *and* medical purpose. It claims (at 21-22) that a female "cannot receive … testosterone to live and present as a male, but an adolescent assigned male at birth can." But the provision of testosterone to boys "to treat a minor's congenital defect, precocious puberty, disease, or physical injury," Tenn. Code Ann. §68-33-103(b)(1)(A), does not serve the same medical purpose as the provision of testosterone to a girl who wants to transition. The same drug is at issue. But it is used at different dosages and for different medical purposes. *See* J.A. 769-70. Just like administering morphine to "ease [a] patient's pain" is not the same as using morphine to assist a patient's suicide. *Vacco*, 521 U.S. at 802. The government's argument conflates "distinct uses of testosterone and estrogen." Pet. App. 34a.

Separately, biological realities mean that only boys use estrogen for the purpose of transitioning to an "identity inconsistent with the minor's sex." Tenn. Code Ann. §68-33-103(a)(1)(A). So too with girls and testosterone. But laws regulating treatments "'that only one sex can undergo' ordinarily do not 'trigger

heightened constitutional scrutiny.'" Pet. App. 33a (quoting *Dobbs*, 597 U.S. at 236); *supra* 32-35.

The upshot: "[H]olding other things constant but changing the minor's sex" does not change the outcome under SB1. U.S. Br. 22 (cleaned up). The government must change both sex *and* medical purpose to show any differential outcome. It fails its own but-for-sex test.

III. SB1 Contains No Transgender Classification that Warrants Heightened Scrutiny

The government's transgender-discrimination argument likewise gets it nowhere. SB1 contains no transgender-based classification. And heightened scrutiny would not apply in any event.

A. SB1 does not classify based on transgender status.

The government assumes (at 16, 28-29) that SB1 contains facial transgender classifications, even in the face of a circuit split on the issue. But SB1 regulates based on medical use, not transgender status. Transgender-identifying minors are in both "groups" created by SB1. *Geduldig*, 417 U.S. at 496 n.20. A transgender-identifying minor *can receive* puberty blockers for some purposes (e.g., to treat precocious puberty); a transgender-identifying minor *cannot receive* puberty blockers for other purposes (e.g., to transition). Tenn. Code Ann. §68-33-103(a)(1). The same goes for cross-sex hormones. Transgender-identifying persons fall on both sides of the line. There is thus a "lack of identity" between transgender status and the

groups created by SB1. *Geduldig*, 417 U.S. at 496 n.20.

Any disparate impact on transgender-identifying persons does not create a classification under the Equal Protection Clause. *Feeney*, 442 U.S. at 274-78. Again, heightened scrutiny does not apply to "[t]he regulation of a medical procedure that only one sex can undergo" unless "the regulation is a 'mere pretext designed to effect an invidious discrimination.'" *Dobbs*, 597 U.S. at 236 (cleaned up) (quoting *Geduldig*, 417 U.S. at 496 n.20); *see Bray*, 506 U.S. at 271 (similar). So too with a transgender-discrimination claim: The government must show that SB1 is a "pretext for invidious discrimination" against transgender-identifying individuals. *Eknes-Tucker*, 80 F.4th 1229-30; *see Kadel*, 100 F.4th at 174 (Richardson, J., dissenting).

The government has not "made the case that animus toward transgender individuals as a class drives this law." Pet. App. 46a-47a. Again, the parties did not meaningfully press this argument below. And this Court "has long disfavored arguments based on alleged legislative motives." *Dobbs*, 597 U.S. at 253. Judicial attempts to ascertain these "motivation[s]" necessarily "represent a substantial intrusion into the workings of other branches of government." *Arlington Heights*, 429 U.S. at 268 n.18. Courts are even more "reluctan[t] to attribute unconstitutional motives to the states," *Mueller v. Allen*, 463 U.S. 388, 394 (1983), given the federalism stakes. Here, the government flippantly suggests that Tennessee, 23 "other States," and apparently much of Europe have followed "far-

right interest groups" to "target[] transgender individuals." U.S. Br. 7 n.3, 8; *see* L.W. Br. 53. But charges of discriminatory purpose demand more than tired talking points.

Nor could the government clear the *Arlington Heights* bar if it tried. SB1 arose from a publicized controversy about ill-supported medical practices at a major Tennessee hospital. It contains substantial factual findings exhibiting the legislature's sincere concern with protecting kids. And it leaves open gender-transition interventions for transgender-identifying adults. Although the government tries (at 8) to situate SB1 in a "series" of Tennessee laws "targeting" transgender-identifying people, that narrative ignores that many such measures countered federal efforts to impose unprecedented gender-identity mandates governing pronouns, bathroom and sports access, and more. *See, e.g.*, *Tennessee v. Dep't of Educ.*, 104 F.4th 577, 586 (6th Cir. 2024). None of the government's sideswipes surmount the heavy "presumption of legislative good faith." *Abbott*, 585 U.S. at 603.

That leaves the argument that the Court should *presume* animus under a "proxy"-discrimination theory. But winning that argument requires showing that "no rational, nondiscriminatory explanation exists for the law's classification." *Kadel*, 100 F.4th at 170 (Richardson, J., dissenting). The restricted activity must be "such an irrational object of disfavor that … an intent to disfavor [a] class can readily be presumed"—in the same way a "tax on wearing yarmulkes" would be considered a "tax on Jews." *Bray*, 506

U.S. at 270. Regulating yarmulkes is an "*irrational* surrogate." *Id.* (emphasis added).

Here, though, rational explanations beyond bare "hostility" abound. *Yick Wo v. Hopkins*, 118 U.S. 356, 374 (1886). SB1 could (and did) spring from the "common and respectable" impetus to protect minors from unproven procedures that can permanently alter their lives. *Bray*, 506 U.S. at 270; *see Feeney*, 442 U.S. at 274-75 (declining to presume animus when "legitimate and worthy purposes" supported the Act). That these treatments are sought primarily by transgender-identifying persons cannot alone support a presumption of animus, lest this Court's restrictions on disparate-impact claims disappear. *See Feeney*, 442 U.S. at 274-75; *Geduldig*, 417 U.S. at 496 n.20; *Bray*, 506 U.S. at 270.[5]

B. Heightened scrutiny does not apply to transgender-related classifications.

Intermediate scrutiny would not follow anyway. This Court has never recognized transgender-identifying persons as a suspect class, *Cleburne*, 473 U.S. at 440-41 (listing five protected classes), and it should not add to the short list of protected characteristics.

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[5] Notably, the government is not equating gender dysphoria with transgender status. It knows that "not all transgender persons have gender dysphoria." J.A. 61. And like transgender-identifying persons, gender-dysphoric persons can be in both groups created by SB1. Moreover, this Court's precedent forecloses the application of heightened scrutiny based on disability, *infra* 47, and the federal government has elsewhere designated gender dysphoria as "a disability," 89 Fed. Reg. 40,066, 40,068-69 (May 9, 2024).

This Court long ago "lost interest" in creating new quasi-suspect classes beyond the few already recognized. *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 318-19 (1976) (Marshall, J., dissenting). Over the past half-century, it has declined repeated requests to expand its list of protected characteristics—declining heightened review to homosexual individuals, *Windsor*, 570 U.S. at 770; close relatives, *Lyng v. Castillo*, 477 U.S. 635, 638 (1986); the mentally disabled, *Cleburne*, 473 U.S. at 441-46; and the aged, *Murgia*, 427 U.S. at 313. Rightfully so. Both assessing putative "suspectness" and applying means-end scrutiny verge on a "judge-empowering interest-balancing inquiry" beyond the judicial ken. *N.Y. State Rifle & Pistol Ass'n v. Bruen*, 597 U.S. 1, 22 (2022) (quotations omitted). This Court should not reopen that door.

And it certainly should not recognize a new quasi-suspect class here. To justify heightened scrutiny, this Court has asked whether a "discrete group" warrants special protection in light of its "immutable" characteristics, "political[] powerless[ness]," and history of discriminatory treatment. *Lyng*, 477 U.S. at 638. The government falls short on each.

First, transgender-identifying persons do not "exhibit obvious, immutable, or distinguishing characteristics that define them as a discrete group." Pet. App. 45a (quoting *Bowen v. Gilliard*, 483 U.S. 587, 602 (1987)). No one argues that transgender status is an "immutable" characteristic. U.S. Br. 30; L.W. Br. 38. Nor is there a credible claim that transgender status is "obvious," since gender identity turns on each person's internal and often fluid "sense of belonging to a

particular gender." J.A. 9; *see* WPATH-8 at S41. And far from being a "discrete group," U.S. Br. 30, "transgender" can describe "a huge variety of gender identities and expressions," WPATH-8 at S15. According to WPATH, a transgender-identifying person can be "more than one gender identity simultaneously or at different times (e.g., bigender)," "not have a gender identity or have a neutral gender identity (e.g., agender or neutrois)," "have gender identities that encompass or blend elements of other genders (e.g., polygender, demiboy, demigirl)," or "have a gender that changes over time (e.g., genderfluid)." *Id.* at S80, S88, S252. As the government's *amici* put it, "transgender" is an "umbrella term" that covers "varied groups." Br. of American Psychological Association as *Amicus Curiae* 6 n.7.

Second, it blinks reality to assert that transgender-identifying persons do not "wield political power." U.S. Br. 30. The current Administration has prioritized "Preventing and Combating Discrimination on the Basis of Gender Identity" across Executive Branch functions. Exec. Order No. 13,988, 86 Fed. Reg. 7,023 (Jan. 20, 2021). The current President has "appointed a record number of openly LGBTQI+ leaders." White House, A Proclamation on Transgender Day of Visibility (Mar. 30, 2023), perma.cc/VZN6-4ATC. And federal agencies have written gender-identity directives into every nook and cranny of federal law, creating new transgender-specific regulations for the workplace, educational system, healthcare field, and foster-care programs. Transgender-identifying persons have flexed their po-

litical muscle at the state level, too, persuading legislatures to provide enhanced statutory rights. *E.g.*, Cal. Educ. Code §221.5(f); Va. Code Ann. §38.2-3449.1; Wash. Rev. Code Ann. §28A.642.080. Against this backdrop (and with more than a third of the U.S. House in support, *see* Br. of 164 Members of Congress as *Amicus Curiae*), it is impossible to argue that transgender-identifying persons are "politically powerless in the sense that they have no ability to attract the attention of lawmakers." *Cleburne*, 473 U.S. at 445. That they have not found success on every issue in every State does not prove powerlessness. Pet. App. 46a.

Third, the government and plaintiffs cannot rest their case for heightened scrutiny on a "history of discrimination." L.W. Br. 38. In *Cleburne*, the Court declined to hold that the mentally disabled constituted a quasi-suspect class "despite a history of compulsory sterilization, exclusion from public schools, and a system of 'state-mandated segregation and degradation' 'that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow.'" *Eknes-Tucker*, 114 F.4th at 1266 (Lagoa, J., concurring) (quoting *Cleburne*, 473 U.S. at 462-63 (Marshall, J., concurring and dissenting in part)). The answer to further instances of "invidious" discrimination, the Court explained, was to analyze animus case by case, "not to create a new quasi-suspect classification and subject all governmental action based on that classification to more searching evaluation." *Cleburne*, 473 U.S. at 446. Likewise, laws regulating the physically disabled fall under rational-basis review despite the history of discrimination against that group. *Board of*

Trustees v. Garrett, 531 U.S. 356, 365-68 (2001). The challengers nowhere explain why transgender-identifying persons warrant more favorable treatment.

At bottom, creating a new quasi-suspect class will remove "trying policy choices" from the "arena of public debate and legislative action" and vest them in the federal judiciary. Pet. App. 45a. "Bathrooms and locker rooms. Sports teams and sports competitions. Others are sure to follow." Pet. App. 45a. And this Court, rather than the democratic process, would have to resolve every last issue through open-ended interest balancing. It should not start down that path.

IV. SB1 Survives Constitutional Scrutiny

SB1 passes constitutional review under any standard. "[L]ike other health and welfare laws," it warrants only rational-basis scrutiny, *Dobbs*, 597 U.S. at 301, and easily satisfies that test, Pet. App. 48a-50a. Even under intermediate scrutiny, SB1 poses no constitutional problem. Its age- and use-based limits permissibly serve "important" ends through "substantially related" means, *Virginia*, 518 U.S. at 533, particularly given lawmakers' "wide discretion" in areas of "medical and scientific uncertainty," *Gonzales*, 550 U.S. at 163.

A. Tennessee has compelling governmental interests.

All agree that Tennessee's "interest in safeguarding the physical and psychological well-being of a minor is compelling." *New York v. Ferber*, 458 U.S. 747, 756-57 (1982) (quotations omitted). Tennessee has "authority, in truth a responsibility, to look after the

health and safety" of minors in the State. Pet. App. 115a. And "protecting minors from dangerous and risky treatments" is part and parcel of that duty. L.W. Br. 41; U.S. Br. 19.

Tennessee has an independent interest "in protecting the integrity and ethics of the medical profession." *Glucksberg*, 521 U.S. at 731. History is punctuated with shocking stories of medical "abuse [and] neglect," *id.*—with many questionable practices (like lobotomies and eugenics) initially finding support from the medical establishment. States thus have an important interest in ensuring the integrity and ethics of medical practice within their borders. Tenn. Code Ann. §68-33-101(m).

B. SB1 substantially relates to Tennessee's interests.

SB1's restrictions are in "substantial furtherance" of Tennessee's interests. *Nguyen*, 533 U.S. at 70. The government second-guesses elected lawmakers' judgment and asks this Court to do the same. But this Court should not snuff out legislative developments in an evolving area by enshrining the government's skewed science into the Constitution.

SB1 reflects lawmakers' resolution of a genuine medical debate. In circumstances like these, "legislative options must be especially broad and courts should be cautious not to rewrite legislation." *Kansas v. Hendricks*, 521 U.S. 346, 360 n.3 (1997) (quotations omitted). "It is not a part of [the courts'] functions to conduct investigations of facts entering into questions of public policy." *Powell v. Pennsylvania*, 127 U.S. 678,

685 (1888); *Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 195 (1997). Federal judges are no more equipped to resolve such issues than "people picked at random from the ... telephone directory." *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring).

Recognizing as much, the Court has *repeatedly* stressed that lawmakers have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales*, 550 U.S. at 163; *see, e.g.*, *Dobbs* 597 U.S. at 274; *Hendricks*, 521 U.S. at 360 n.3; *Jones v. United States*, 463 U.S. 354, 364 n.13, 370 (1983); *Marshall v. United States*, 414 U.S. 417, 427 (1974); *Williamson v. Lee Optical*, 348 U.S. 483, 488-89 (1955). Such deference is appropriate even when heightened scrutiny applies. *Gonzales*, 550 U.S. at 163-64 (undue-burden standard). Any other approach would raise the problem of setting "judicially manageable standards for ascertaining whether a treatment is 'established' or 'necessary.'" Pet. App. 28a (citation omitted).

This deferential framework for assessing legislative judgments on unsettled health questions makes upholding SB1 straightforward. SB1's age- and use-based restrictions reflect lawmakers' well-informed judgment about the rise, risks, and disputed benefits of gender-transition procedures. Tenn. Code Ann. §68-33-101. After receiving evidence and holding hearings, the legislature made specific findings sourced in its assessment of the regulated interventions' serious "risks and harms" and concerns over minors' ability to provide informed consent. *Id.*; *see* J.A.

893-97, 905. Against those risks, the legislature concluded that the putative benefits of such procedures remain unproven. Tenn. Code Ann. §68-33-101(b), (g). So it determined that deferring certain gender-transition procedures until adulthood was the best course. That approach substantially furthers lawmakers' interest in protecting minors and medical ethics.

Tennessee's view of the science is well founded, but the State unquestionably legislated in an area of scientific uncertainty. Many authorities, from leading European agencies to courts, have recognized the uncertainty surrounding gender-dysphoria treatments. *See supra* 8; Pet. App. 47a-48a; *Eknes-Tucker*, 80 F.4th at 1225; *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019); *State v. Loe*, 692 S.W.3d 215, 222 (Tex. 2024). So have pro-intervention advocacy groups like WPATH and the Endocrine Society. WPATH-8 at S33 (citing need for "future research"); ES Guidelines at 3874 (emphasizing need for "more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols"). And SB1 arose after a leading provider of gender-transition procedures for Tennessee minors admitted she was "still figuring it out!" *Supra* 11. The uncertainty surrounding minors' gender-transition treatments provides a "sufficient basis" to uphold SB1. *Gonzales*, 550 U.S. at 164.

The government, by contrast, would have this Court choose a side in this contested medical debate. U.S. Br. 33-49. But its arguments for displacing Tennessee's legislative judgment fail.

Clear error. The government says (at 36) that the clear-error standard requires upholding the district

court's "findings." But the district court failed to review Tennessee's *legislative* "factfinding under a deferential standard," as required. *Gonzales*, 550 U.S. at 165; *Turner*, 520 U.S. at 195. And this Court does not give clear-error weight to findings made under an "erroneous standard." *Inwood Laboratories v. Ives Laboratories*, 456 U.S. 844, 855, n.15 (1982); *Abbott*, 585 U.S. at 607 (same, when failed to presume good faith). Regardless, the district court did clearly err in "evaluat[ing] Defendants' evidence in light of the prevailing standards of care and conclusions contained in the WPATH and Endocrine Society guidelines." Pet. App. 181a.

Risks and benefits. The government's one-sided telling of the risk-benefit evidence misstates (at 34-44) the legislative record and medical landscape. Tennessee did not "ignore[]" the "medical benefits associated with gender-affirming care." U.S. Br. 34-36 (capitalization altered). In fact, SB1's findings specifically reference the potential "benefits" of gender-transition surgeries; the legislature just found—relying on European health authorities—a dearth of "evidence that the benefits of these procedures outweigh the risks." Tenn. Code Ann. §68-33-101(e). Tennessee's consideration of evidence was "meaningful," even if the government would have preferred a different result.

The government's assertion that SB1 bucks "medical consensus" (at 36) is hard to take seriously. Half of the States have restricted access to pharmaceutical and surgical gender-transition procedures for minors—each making their own good-faith findings. Doctors have publicly questioned the propriety of

providing these interventions to minors.[6] And many of the European countries that pioneered these treatments have pulled back on their use because of the uncertainty surrounding efficacy and safety. *Supra* 8; Tenn. Code Ann. §68-33-101(e) (citing shift). The government cannot manufacture "consensus" by ignoring European health authorities that SB1 references. U.S. Br. 36; Tenn. Code Ann. §68-33-101(e).

Nor does citing a "majority" view of "medical organization[s]" negate the legislature's prerogative. U.S. Br. 35. Organizational say-so does not "shed light on the meaning of the Constitution." *Dobbs*, 597 U.S. at 273. Any other approach "would mean that the state and federal legislatures would lose authority to regulate the healthcare industry whenever the subject of regulation—the medical profession and drug companies—found such regulation unnecessary" or misguided. Pet. App. 28a. And what if these organizations "change course in the future? Would the States' authority reappear at that point?" Pet. App. 29a. Shifting deference from legislative findings to organizations only redirects power from accountable officials to interest groups.

This case highlights the dangers of medical organizations driving constitutional law. Below, the challengers argued that WPATH's Guidelines reflect "[t]he best evidence of the correct standard of care." Pet. App. 29a. And they convinced the district court to rely

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[6] Kaltiala et al., *Youth Gender Transition Is Pushed Without Evidence*, Wall St. J. (July 13, 2023), perma.cc/P9GM-MHF7.

on WPATH's Guidelines as the framework for "evaluat[ing] Defendants' evidence." Pet. App. 181a. Now, with WPATH's credibility shot, the government turns (at 35) to *other* organizations—the AAP and the American Medical Association—that push the same policies. But AAP's positions have been debunked too. J.A. 448-49; Appendix 2, D.Ct.Doc. 113-3 at 184-91. The Constitution does not require States to play whack-a-mole with whatever advocacy organization's stance suits challengers' needs.

The government invokes the oft-repeated claim that laws like SB1 increase suicide risk and mental-health problems. U.S. Br. 36-38; L.W. Br. 44-45. But "real, hard science" for this position is lacking. *Florida v. HHS*, 2024 WL 3537510, at *16 (M.D. Fla. July 3, 2024). No studies document a reduction in suicide rates due to gender-transition interventions—as the lauded Cass Review noted. J.A. 398-401, 671-75; Cass Review at 33. And the evidence supporting mitigated suicidality is inconclusive and conflicts with other studies—including one showing that hormonal interventions *increased* mental distress. J.A. 400-01, 452-55, 462-67, 664-70; *Florida*, 2024 WL 3537510, at *19 n.17.

The government cannot dodge the countervailing risks posed by gender-transition interventions. The government downplays desistence (at 41) with expert testimony asserting that adolescent desistence is "rare[]." But desistence is not theoretical. Minors can and do grow up to regret the life-long results transition treatments produce. Tenn. Code Ann. §68-33-

101(h). Apparently, even though "many detransitioners" are telling their tragic stories, "[a]cknowledgement that de-transition exists to even a minor extent is considered off limits" for the government. *See Eknes-Tucker*, 114 F.4th at 1269 (Lagoa, J., concurring) (quotations omitted). The Constitution does not compel lawmakers to shield their eyes from detransitioners' experiences.

And no amount of rose-colored ink overwrites the documented downsides of puberty blockers and cross-sex hormones. *Supra* 5-6; Tenn. Code Ann. §68-33-101(b). The government's portrayal of the risks contradicts even the advocacy organizations on which it relies. *Compare* U.S. Br. at 3, 42-44, *with* ES Guidelines at 3874, 3882, 3886-87.

Tailoring. The government claims (at 44-49) that SB1 is both too narrow and too broad. The government's underinclusiveness argument presumes that prescribing these drugs always poses the same "risks." U.S. Br. 44-47; L.W. Br. 19, 42-43. That premise fails: The medical risks differ because of biological differences between boys and girls, *supra* 30-31, *and* the risk of desistance is not present in other circumstances of medical need. Moreover, medical risk doesn't arise in a vacuum; it instead must be measured against the benefits of the procedure. A double mastectomy might carry the same risk when performed on a woman with breast cancer and on a 17-year-old girl who wants to identify as a man. But the measurable benefits differ. The contrary view recycles the government's incorrect

attempt to equate giving minors drugs for gender transition with employing the same drugs to treat physical deficiencies or abnormalities.

Nor do claims of "severe overinclusiv[ity]" work. U.S. Br. 47-49; L.W. Br. 48-50. SB1 does not "prohibit[] *all* treatment for all transgender adolescents." L.W. Br. 49. It leaves open "less invasive approaches that are likely to result in better outcomes for the minor," Tenn. Code Ann. §68-33-101(c)—the watchful-waiting and psychotherapy methods that predominated until the past decade, *supra* 4-5; Pet. App. 29a.

Even the government seems to accept that providers should not use "*any* medical intervention to treat gender dysphoria before the onset of puberty." U.S. Br. 41. And it has (at least at times) agreed that surgeries should be off-limits for all minors. So its tailoring disagreement boils down to disputing SB1's restrictions on medications from the onset of puberty to adulthood. That argument, though, does not turn on differential treatment based on sex; it turns on *the age at which SB1 drew its line*. And so long as "the age classification in question is rationally related to a legitimate state interest," States may draw lines without "match[ing] age distinctions" to the "interests they serve with razorlike precision." *Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 83 (2000).

The remaining tailoring arguments also fail. Even if "at least *some* transgender adolescents would benefit from the banned treatments," L.W. Br. 48, that ignores doctors' inability to "predict" which minors will later regret these interventions, J.A. 643. The govern-

ment's preferred policies—like "gatekeeping," "licensing, certification, or reporting requirements"—likewise fail to account for detransitioners. U.S. Br. 48. In any event, intermediate scrutiny does not require SB1 to "be capable of achieving its ultimate objective in every instance," *Nguyen*, 533 U.S. at 70, or mandate that Tennessee allow experimental research on kids, *Eknes-Tucker*, 80 F.4th at 1235-36 (Brasher, J., concurring).

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Many doctors, States, and countries share Tennessee's view on gender-transition interventions for minors; the federal government and others do not. This "earnest and profound debate about the morality, legality, and practicality" of controversial medical practices can continue only if this Court refrains from constitutionalizing one side's position. *Glucksberg*, 521 U.S. at 735. The question is not whose assessment of the medical dispute is best, but whether the States in 1868 ceded their power to enact age- and use-based limits on pharmaceutical interventions like SB1's. They did not.

CONCLUSION

The Court should affirm the judgment of the court of appeals.

Respectfully submitted,

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