No. 23-477

In The Supreme Court of the United States

UNITED STATES OF AMERICA,
Petitioner,
v.
JONATHAN THOMAS SKRMETTI, ET AL.,
Respondents,
and
L.W., BY AND THROUGH HER PARENTS AND NEXT FRIENDS, SAMANTHA WILLIAMS AND BRIAN WILLIAMS, ET AL.,
Respondents in Support of Petitioner.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

REPLY BRIEF FOR RESPONDENTS IN SUPPORT OF PETITIONER

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REPLY BRIEF FOR RESPONDENTS IN SUPPORT OF PETITIONER

Tennessee accuses the federal government of "seek[ing] to displace Tennessee's legislative judgment." Br. 2. But noticeably absent from Tennessee's brief are the families at the center of this case whose painstaking decisions the government of Tennessee has displaced.

Parents Samantha and Brian Williams, Jane and James Doe, and Rebecca Roe have not pursued what Tennessee derisively describes as a "transition-first, ask-questions-later" approach. Br. 3. They spent years grappling with how to support their struggling children. They cried, prayed, researched, and consulted with trusted clergy, therapists, and doctors. As Jane Doe reflected, "no parent would . . . choose a harder path in life for their children." JA 95. But for Jane and her husband, as for many other parents, "nothing would be harder than denying the reality of who [their child] is." JA 95-96.

SB1 overrides these deeply personal and informed decisions by banning puberty-delaying medication and hormone treatments if *and only if* the treatment is prescribed to allow an adolescent to live or identify as a gender inconsistent with their sex assigned at birth. The statutory prohibition explicitly treats individual adolescents differently based on their birth-assigned sex and does so based on the stated goal of encouraging adolescents to conform to the State's expectations of how each sex should live, behave, and identify.

That express sex classification triggers and fails heightened scrutiny. Though Tennessee asserts an interest in protecting children, its concern apparently does not extend to the overwhelming majority of transgender adolescents for whom this care has been a lifeline. Categorically banning gender-affirming medical care to prevent regret in a small minority of patients, while seriously harming the majority of patients who benefit from it, lacks any semblance of the close means-ends fit required by heightened scrutiny.

The Court should vacate and remand for application of heightened scrutiny, or reverse the judgment below.

I. SB1 CLASSIFIES BASED ON SEX

A. SB1's Prohibition Of Treatments That Enable Adolescents To Live In A Manner "Inconsistent With" Their Birth-Assigned Sex Is A Facial Sex Classification.

SB1's prohibition of treatments "[e]nabling a minor to identify with, or live as, a [gender] identity inconsistent with the minor's sex" assigned at birth is a sex classification. It treats individual adolescents differently based on their birth-assigned sex, and in so doing enforces two mutually reinforcing sex-based stereotypes about how individuals should live and identify—one for birth-assigned males and another for birth-assigned females. Allowing Tennessee to evade heightened scrutiny would break with fifty years of

precedent and upend fundamental principles of equal protection.[1]

1. By its terms, SB1 prohibits puberty-delaying medication and hormone therapy if—and only if—those treatments are provided "for the purpose" of "[e]nabling" an adolescent to "identify with, or live as," a gender "inconsistent with the minor's sex" assigned at birth, or to treat distress "from a discordance between the minor's sex" assigned at birth and gender identity. TCA § 68-33-103(a)(1). An adolescent assigned male at birth cannot receive medical treatment enabling them to "identify with or live as" a girl. And an adolescent assigned female at birth cannot receive medical treatment enabling them to "identify with or live as" a boy.

That is a sex classification. It turns on (a) an adolescent's sex assigned at birth and (b) whether the treatment would enable the adolescent to live "inconsistent with" that birth-assigned sex. Tennessee compares SB1 to a hypothetical law stating: "Neither men nor women may drive an automobile without a license." Br. 24. But the proper analogy would be to a law declaring: "Neither men nor women may drive an automobile inconsistent with their sex," thus prohibiting men from driving pink cars and women from driving blue ones. That law does not merely

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[1] Private plaintiffs agree with the United States that SB1 independently triggers heightened scrutiny because it also discriminates based on transgender status, which meets all the indicia of a quasi-suspect classification under this Court's precedents, L.W. Br. 37-38, and incorporate by reference the arguments made in the government's reply brief.

mention sex; it treats individuals differently *based on* their sex and enforces distinct sex-based rules on men and women. It therefore triggers heightened scrutiny.

Similarly, SB1 on its face allows and disallows medical treatment based on whether it is gender conforming. The law prohibits minors from receiving medical treatment that would depart from Tennessee's expectations of what is typical for their sex assigned at birth, while expressly permitting procedures to be performed on an intersex infant solely for purposes of enforcing consistency with sex assigned at birth despite the risk, lack of testing, and high rates of regret. TCA § 68-33-103(b)(1)(A); *see* Amicus Br. of interACT 17-20. And SB1 draws that distinction for the avowed purpose of "encouraging minors to appreciate their sex" and barring treatment "that might encourage minors to become disdainful of their sex." TCA§ 68-33-101(m).

SB1 thus intervenes in some of the most personal decisions adolescents and their families, in consultation with their doctors, can make in order to impose distinct but "mutually reinforcing stereotypes" about how people with a particular sex assigned at birth should live, act, and identify. *Nevada Dep't of Hum. Res. v. Hibbs*, 538 U.S. 721, 736 (2003). "Classifications like these—motivated by perceptions of 'typically male or typically female tendencies'—are the kind of 'generalizations' at which courts must 'take a hard look.'" Pet. App. 73a (White., J, dissenting) (quoting *United States v. Virginia*, 518 U.S. 515, 541 (1996)).

2. Tennessee resists that conclusion. It insists that SB1's prohibition on treatments "[e]nabling" an adolescent to "identify with, or live as," a gender "inconsistent with [their] sex" assigned at birth is facially sex neutral. But Tennessee admits that 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." Br. 25. Tennessee further admits that a law prohibiting boys and girls from dressing in a manner "inconsistent with" their sex would "draw[] . . . sex-based line[s]" because "girls can wear skirts, and boys cannot." *Id.*

These concessions cannot be reconciled with Tennessee's position that SB1 is not a sex classification. As with Tennessee's own examples, SB1's prohibition on treatments "inconsistent with" an adolescent's birth-assigned sex treats individuals differently based on their sex assigned at birth. Birth-assigned males can receive hormones to appear more typically masculine (*e.g.*, testosterone for boys with delayed puberty or idiopathic short stature, Pet. App. 266a), but birth-assigned females cannot. Birth-assigned females can receive medication to appear more typically feminine (*e.g.*, estrogen for girls with delayed puberty or testosterone suppressants for girls with facial hair, Pet. App. 266a), but birth-assigned males cannot.

The same is true for puberty-delaying medication. Birth-assigned males can receive puberty-delaying medication to bring their bodies into alignment with a typical male puberty, but birth-assigned females cannot. Birth-assigned females can

receive puberty-delaying medication to bring their bodies into alignment with a typical female puberty, but birth-assigned males cannot. The fact that both birth-assigned males and birth-assigned females receive the same drug to pause puberty, Tenn. Br. 39, does not make the prohibition sex neutral because the sex classifications in SB1 are not bans on particular medications. Rather, the bans operate when (and only when) a medication is being used to allow birth-assigned males and females to "live" and "identify" in ways that Tennessee considers inconsistent with their sex assigned at birth. A law that prohibits hairdressers from using scissors to give haircuts "inconsistent" with a person's birth-assigned sex still classifies based on sex, even though the same prohibited tool would be used to achieve the nonconforming haircut for each sex.

3. Tennessee's contrary arguments assume away the critical fact that SB1 classifies based on sex. Tennessee points out, for example, that "neither boys nor girls can use these drugs for gender transition" and that "both boys and girls can use these drugs for other medical purposes." Br. 23. But because a ban on "gender transition" is itself a sex classification, it does not matter whether it applies "equally" to both sexes—just as it does not matter whether a ban on marriage for interracial couples applies equally to people of different races or whether a ban on religious conversion applies equally to people of all religions. *See* L.W. Br. 28. In each of these examples, the laws do not actually apply "equally" because, at the level of the individual, they impose different sets of rules based on an individual's race, religion, or sex assigned at birth.

Indeed, Tennessee recognizes that a sex classification cannot "avoid sex-based scrutiny by harming boys and girls 'in equal degree.'" Br. 24.

Tennessee's contention that SB1 is sex neutral because it *also* classifies based on age does not save the law from heightened scrutiny either. As Tennessee acknowledges, "[p]ackaging sex classifications with other considerations does not somehow immunize the sex classification from scrutiny." Br. 34. In such cases, this Court has still applied heightened scrutiny to the sex classification. *See, e.g.*, *Craig v. Boren*, 429 U.S. 190 (1976) (applying heightened scrutiny to law that classified based on sex and age). It should do so here as well.[2]

Tennessee's claim that SB1 classifies based on specific medical "use" gets it no further. Br. 20. To avoid heightened scrutiny, the "use" a law prohibits must itself be sex neutral. Although Tennessee is correct that "administering morphine to ease a patient's pain is not the same as using morphine to assist a patient's suicide," neither classifies based on sex (or any other classification subject to heightened scrutiny). Br. 40. Banning treatment only when "inconsistent" with someone's birth-assigned sex does.[3]

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[2] All of Tennessee's arguments for why SB1 is purportedly sex neutral would apply even if SB1 banned hormone therapy for *adults* to live or identify as a gender "inconsistent" with their sex assigned at birth.

[3] Tennessee asserts that the FDA approves medications only for specific uses. Br. 21. But once the FDA approves medication,

Tennessee asserts it is entitled to deference in regulating the medical profession as part of its "broad power over 'health and safety matters,'" Br. 19 (citation omitted), but a "[s]tate may not, under the guise of prohibiting professional misconduct, ignore constitutional rights." *NAACP v. Button*, 371 U.S. 415, 439 (1963). As with any other exercise of Tennessee's police powers, heightened scrutiny still applies to public health regulations that "involve suspect classifications." *Roman Cath. Diocese of Brooklyn v. Cuomo*, 592 U.S. 14, 24 (2020) (Gorsuch, J., concurring). To the extent that asserted "biological realities" in the practice of medicine might justify sex-based classifications (Tenn. Br. 40), "[s]uch circumstances can be considered in applying [heightened] scrutiny, which is designed to take relevant differences into account." *Johnson v. California*, 543 U.S. 499, 515 (2005). They are not a basis for exempting medical regulations from heightened scrutiny at the outset.

4. *Geduldig* and *Dobbs* also do not help Tennessee. Relying on *Geduldig*, this Court concluded in *Dobbs* that the law at issue did not use facial sex classifications because it involved a "regulation of a medical procedure that only one sex can undergo." *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 236 (2022). That is not the case here. The medications prohibited by SB1 are prescribed to adolescents of both sexes. But instead of prohibiting a particular

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medical providers are generally free to prescribe the medication for other uses too. Pet. App. 92a-93a n.8, 202a-203a; Amicus Br. of Professors of Law, Medicine, and Public Health 13-16.

procedure across the board, SB1 on its face imposes different restrictions based on an individual's sex assigned at birth, forbidding masculinizing treatments for those assigned female at birth and forbidding feminizing treatments for those assigned male at birth.

Tennessee (Br. 33) quotes a footnote from *Geduldig* stating that an insurance policy excluding disability benefits for pregnancy-related disability "divides potential recipients into two groups—pregnant women and nonpregnant persons. While the first group is exclusively female, the second includes members of both sexes." *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974). But that footnote did not purport to articulate a test for identifying facially sex-based classifications. Rather, the discussion of "two groups" was intended to explain why a classification the Court regarded as facially sex neutral was not a proxy for invidious discrimination because "[t]he fiscal and actuarial benefits of the program . . . accrue to members of both sexes" comprising the "nonpregnant persons" group. *Id.*

When a law contains a sex classification on its face, this Court has never required that the law draw a line encompassing *all* members of the classified group to trigger heightened scrutiny. *See, e.g.*, *Rice v. Cayetano*, 528 U.S. 495, 516-17 (2000) ("Simply because a class . . . does not include all members of [a] race does not suffice to make the classification race neutral."); *Mathews v. Lucas*, 427 U.S. 495, 504 n.11 (1976) ("That the statutory classifications challenged here discriminate among illegitimate children does not mean, of course, that they are not also properly

described as discriminating between legitimate and illegitimate children."). A law prohibiting women with red hair from being doctors would create two groups, with women "fall[ing] on both sides of that line." Tenn. Br. 2. But the line would still be a facial sex classification requiring heightened scrutiny.

Moreover, nothing in *Dobbs* or *Geduldig* authorizes the government to ban medical procedures based on gender nonconformity. To the contrary, *Dobbs* and *Geduldig* show that even a facially *sex neutral* regulation of a medical procedure would trigger heightened scrutiny if "the regulation is a 'mere pretex[t] designed to effect an invidious discrimination against members of one sex or the other.'" *Dobbs*, 597 U.S. at 236 (quoting *Geduldig*, 417 U.S. at 496 n.20). Here, however, no inquiry into pretext is necessary because the face of the statute explicitly classifies based on the law's stated goal of deterring adolescents from "identify[ing] with, or liv[ing] as" a gender "inconsistent with" their sex assigned at birth.

5. Tennessee also argues (Br. 29) that heightened scrutiny is inappropriate because birth-assigned males and birth-assigned females are not "similarly situated" under SB1. But whether members of different sexes are similarly situated is determined *while* applying heightened scrutiny, not beforehand as a threshold step. *See Tuan Anh Nguyen v. I.N.S.*, 533 U.S. 53, 64 (2001) (determining that sexes were not similarly situated while applying heightened scrutiny); *Michael M. v. Superior Ct. of Sonoma Cnty.*, 450 U.S. 464, 471 (1981) (plurality) (same). When the government classifies based on sex, it cannot evade

heightened scrutiny by preemptively asserting that differences between the two sexes justify the differential treatment.

The only time a "similarly situated" analysis plays a role *before* applying heightened scrutiny is when there is no explicit sex classification, and the plaintiff must show through indirect evidence that sex discrimination has occurred. *Cf. McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973). In that circumstance, "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" through indirect evidence. *SECSYS, LLC v. Vigil*, 666 F.3d 678, 689 (10th Cir. 2012) (Gorsuch, J.). But that "circumstantial evidence" is unnecessary where, as here, "the challenged rule discriminates on its face." *Id.*

B. *Bostock* Confirms That SB1 Classifies Based On Sex.

Bostock v. Clayton County confirms that SB1 facially classifies based on sex. *Bostock* held that discrimination based on sexual orientation or transgender status is necessarily a form of discrimination "because of" sex. 590 U.S. 644, 661 (2020). To engage in such discrimination, the Court reasoned, the employer "must intentionally discriminate against individual men and women in part because of sex." *Id.* at 662. That logic does not change from the statutory to the constitutional setting.

In its effort to sidestep *Bostock*, Tennessee attacks a straw man. Tennessee characterizes

Bostock's discussion of "but for" causation as a disparate-impact inquiry that considers whether liability may be imposed even when an employer does not intentionally discriminate. But *Bostock*'s "but for" test refers to discrimination that would not occur but for the employer's intentional differential treatment on the basis of sex. As the Court explained, "[w]hen an employer fires an employee because she is homosexual or transgender, two causal factors may be in play—*both* the individual's sex *and* something else (the sex to which the individual is attracted or with which the individual identifies)." 590 U.S. at 661. The "employer's ultimate goal might be to discriminate on the basis of sexual orientation. But to achieve that purpose the employer must, along the way, intentionally treat an employee worse based in part on that individual's sex." *Id.* at 662. That is intentional sex discrimination.

Under *Bostock*, then, the question is not whether "some *non*-sex-based classification incorporates sex as a but-for matter," as Tennessee contends. Br. 32. It is whether a classification necessarily requires intentional differential treatment based on sex. As the Court emphasized, "an employer who discriminates" against or treats differently an employee because the individual is transgender (*i.e.*, identifies as a gender "inconsistent with" their birth-assigned sex) "inescapably *intends* to rely on sex in its decisionmaking." 590 U.S. at 661. The same is true here.

Disparate impact cases are different. A policy of firing employees for "supporting the wrong sports team," *Bostock*, 590 U.S. at 660, might affect more

female than male employees, and if so would have a disparate impact on women. But it would not be sex-based discrimination on its face. In that circumstance, the employer could write out its policy "without using the words man, woman, or sex (or some synonym)." *Id.* at 668. Tennessee cannot.

Tennessee's remaining attempts to distinguish *Bostock* fall flat. Tennessee argues that there are important differences between Title VII and the Equal Protection Clause. Br. 35-36. But those differences all relate to the ultimate *permissibility* of sex-based differential treatment, not to the threshold determination of whether a sex classification exists. Tennessee's reliance on Justice Gorsuch's concurrence in *Students for Fair Admissions, Inc. v. President & Fellows of Harvard College*, 600 U.S. 181 (2023), is misplaced for the same reason: The opinion argued that Title VI prohibits all racial classifications regardless of whether the classifications can survive strict scrutiny. It did not suggest that race or sex classifications barred by Title VI and Title VII are somehow exempt from heightened equal protection scrutiny.

Moreover, contrary to Tennessee's assertion, application of heightened scrutiny under the Equal Protection Clause would not irreconcilably "collide with religious liberties and other constitutional rights." Br. 36. The Equal Protection Clause applies only to state actors, and "[t]he First Amendment ensures that religious organizations and persons are given proper protection." *Obergefell v. Hodges*, 576 U.S. 644, 679 (2015). Religious convictions of public-school teachers and employees at state-run hospitals

are protected by the Free Speech and Free Exercise Clauses, and this Court has not hesitated to enforce those protections. *See, e.g.*, *Kennedy v. Bremerton Sch. Dist.*, 597 U.S. 507 (2022); *Fulton v. City of Philadelphia*, 593 U.S. 522 (2021). "But how these doctrines protecting religious liberty interact with [the Equal Protection Clause] are questions for future cases," not this one. *Bostock*, 590 U.S. at 682.

II. SB1 FAILS HEIGHTENED SCRUTINY

A. The Court Should Remand For Application Of Heightened Scrutiny, Especially In Light Of Tennessee's Reliance On Extra-Record Material.

Tennessee does not dispute that remand is appropriate where this Court reverses on a threshold question. Remand is especially necessary here because Tennessee's factual presentation includes extensive reference to extra-record "evidence." *See* Br. 8-10, 46, 54-55.

In particular, Tennessee selectively cites from an over 100,000-page document production provided by the World Professional Association for Transgender Health ("WPATH") in a different case, *Boe v. Marshall*, No. 2:22-cv-184 (M.D. Ala.) ("*Boe* production"). Br. 9-10. None of those heavily redacted documents is part of this record, and neither the court of appeals nor the district court has reviewed any part of the *Boe* production or assessed the documents' accuracy or relevance to this case. *See Eknes-Tucker v. Governor of Alabama*, 114 F.4th 1241, 1291 (11th Cir. 2024) (Rosenbaum, J., dissenting from denial of

rehearing en banc) (explaining why the *Boe* documents were not properly before the court).

To take just one example, Tennessee relies on the *Boe* production to claim WPATH "crafted" the Standards of Care (ed. 8) "to have serious effect in the law and policy." Br. 9. But the document cited is an out-of-context, redacted portion of one e-mail from an unknown sender whose views may or may not have had a role in finalizing the standards. *Id.* (citing *Boe v. Marshall*, 2:22-cv-184 (M.D. Ala), Doc. 560-34).[4]

Tennessee also relies on the "Cass Review" to defend SB1's categorical ban on treatment. Br. 8-9, 54. But like the *Boe* production, this 388-page report from the UK was not in the record below. Additionally, the Cass Review's "methodology and conclusions" have been roundly criticized as "so deeply flawed that it should not be credited as reliable, scientific evidence." Amicus Br. of Expert Researchers and Physicians 10. The Cass Review also includes only studies up to 2022, lacking the most recent data showing the efficacy of the banned care. *Id.* at 14-15. Even so, the Cass Review does *not* recommend banning treatment altogether. *Id.* at 28-29.

If Tennessee believes it has discovered new facts relevant to the State's justifications for SB1, it may seek to present that evidence to the district court on remand. As "a court of final review, not of first view," this Court should not short-circuit the lower courts'

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[4] Tennessee spends pages attacking WPATH, but the district court's factual findings also relied on the Endocrine Society guidelines, which Tennessee itself invokes in its presentation of the facts. Br. 4-5, 6, 31, 51.

review of this evidence based on Tennessee's selective presentation of it now. *Montejo v. Louisiana*, 556 U.S. 778, 798 (2009) (internal quotation marks omitted).

B. Heightened Scrutiny Requires Courts To Independently Examine SB1's Legislative Findings.

Tennessee seeks shelter in SB1's legislative findings. The district court, however, engaged with those findings extensively. In some instances, the court noted that Tennessee did not rely on the legislative findings in defense of the law. Pet. App. 193a n.52. In others, the court found them "unsupported," "not convinc[ing]," or unexplained. *See, e.g.*, Pet. App. 185a, 187a, 192a.

Unable to show that the district court's factual findings were clearly erroneous, Tennessee contends that courts may not "second guess[]" the assertions made by "elected lawmakers." Br. 49. That demand for deference turns heightened scrutiny on its head. This Court has consistently held that under heightened scrutiny, "[t]he burden of justification is demanding and it rests entirely on the State." *Virginia*, 518 U.S. at 533.

Nothing in *Gonzales v. Carhart* alters that conclusion. *Contra* Tenn. Br. 50. To the contrary, *Gonzales* reaffirmed that "[t]he Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake." 550 U.S. 124, 165 (2007). The *Gonzales* Court thus reviewed the statute's legislative findings in light of "[t]he evidence presented in the District Courts" and concluded that "[u]ncritical deference to Congress'

factual findings" was "inappropriate." *Id.* at 166. After all, "[t]he whole point of [heightened] scrutiny is to test the government's assertions." *South Bay United Pentecostal Church v. Newsom*, 141 S. Ct. 716, 718 (2021) (statement of Gorsuch, J.).

C. SB1 Is Not Substantially Related To An Asserted Interest In Protecting Minors.

SB1 is not substantially related to Tennessee's asserted interest in protecting minors from unsafe or risky treatments. Many treatments prohibited by SB1 do not carry the risks that Tennessee claims. To the extent they pose potential risks, those risks are low and present when the same medications are used for other purposes. Pet. App. 265a-266a; JA 130-31. The only interest to which SB1 is tailored is the one appearing on its face: deterring adolescents from living as a gender inconsistent with their birth-assigned sex.

Tennessee asserts an interest in protecting children, but that concern seems limited to the well-being of the exceedingly small number of people who later "detransition" and regret receiving treatment. JA 132. Tennessee has remarkably little to say about the health and safety of the vast majority of transgender adolescents who never regret the medical treatment they receive. SB1 forces those adolescents to undergo irreversible changes from pubertal development that increase lifelong dysphoria and the need for future surgery while exacerbating serious mental health risks, including anxiety, depression, and suicidality. Pet. App. 270a-272a, 295a; JA 158. Tennessee's law thus imposes severe irreparable harms on the great

majority of those seeking treatment in the name of avoiding harm for a tiny minority. That categorical ban on treatment for everyone lacks any semblance of tailoring and is the opposite of the "close means-ends fit" required by heightened scrutiny.

1. SB1 Is Not Substantially Related to the Asserted Interest in Preventing Risks and Side Effects.

SB1 fails heightened scrutiny because it is both overinclusive and underinclusive with respect to the law's asserted ends.

Overinclusive. Tennessee has no answer to SB1's overinclusivity. First, the record shows that the risk of adverse side effects from the banned medications is low. Pet. App. 269a. Second, each medication at issue carries a different set of potential side effects, but Tennessee bans them all equally when they are used for gender transition. *See, e.g.*, Pet. App. 267a. The ban is not tailored to harm, but to whether the treatment is sought for purposes "inconsistent" with Tennessee's expectations for an individual's birth-assigned sex.

Defendants' only response to SB1's (overinclusive) prohibition on *all* medical treatment "inconsistent" with an individual's birth-assigned sex is that the law does not prohibit "watchful-waiting and psychotherapy." Br. 56. But there are no evidence-based psychotherapeutic treatments to resolve gender dysphoria, and "watchful waiting" is used to treat pre-pubertal children, not adolescents. JA 147; Pet. App. 294a. Even gender clinics using the "watchful waiting" approach for prepubertal children provide puberty-delaying medication and hormone therapy to treat

gender dysphoria in patients whose dysphoria has persisted past the onset of puberty. *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 905 (E.D. Ark. 2023).

Although Tennessee claims to be following the lead of some European countries, none of those countries bans medical treatment across the board for gender dysphoria. *See* JA 134-36; Amicus Br. of Foreign Non-Profit Orgs. Advocating for the Rights of Transgender People 4-13. Rather, each country applies unique standards to puberty-delaying medication, hormone therapy, and surgery (which is not at issue here) to account for the different risks and benefits of each form of treatment. *Id.* "While there is certainly ongoing research and dialogue about how to optimize meeting the physiological and mental health needs of adolescents with gender dysphoria, there is no 'ongoing debate' in the medical and mental health communities as to the reasonableness of banning care." Amicus Br. of Dr. Erica Anderson et al. 6.

Underinclusive. Tennessee's defense of SB1's underinclusivity only underscores the lack of tailoring. Tennessee offers a series of criticisms that apply to virtually all pediatric medicine: the treatment is associated with side effects, there are insufficient studies with randomized controlled trials, and there is still more to learn. As the district court explained, Tennessee's criticisms "would leave several [other] pediatric treatments . . . vulnerable to severe limitations on access." Pet. App. 198a. Under heightened scrutiny (or any standard) Tennessee cannot single out particular treatments for prohibition on grounds that apply equally to most other forms of pediatric care.

The presence of risks or side effects certainly cannot distinguish treatments for gender dysphoria from other medical treatments—including the same treatments used for other conditions. "[V]irtually all medical procedures" carry "the risk of negative side effects," and there is nothing uniquely risky about the banned treatments. Pet. App. 192a; JA 127. Indeed, the risks Tennessee identifies exist regardless of the purpose for which the medication is used. Pet. App. 192a, 266a-267a; JA 966-77.

For puberty-delaying medication, for example, concerns about delayed rates of bone mineralization are present, but manageable, regardless of whether the medication is prescribed for precocious puberty or gender dysphoria. Pet. App. 189a, 266a-267a; JA 966-68. The only unique potential risk Tennessee identifies from using puberty-delaying medication to treat gender dysphoria—delayed brain maturation—was rejected by the district court as unsupported in the record. Pet. App. 185a.

Tennessee's approach to hormone therapy is similarly underinclusive. Many of the alleged "side effects"—such as masculinizing birth-assigned females and feminizing birth-assigned males—are not adverse impacts but rather the intended effects of the treatment. Tenn. Br. 6. The other potential risks that Tennessee flags are almost all the same regardless of the condition for which hormone therapy is used. Pet. App. 265a; JA 131. The only unique risk Tennessee identifies for treating gender dysphoria is the potential impact on fertility. Br. 5-6, 12. But the district court found that the "record overwhelmingly demonstrates that many individuals receiving . . .

cross-sex hormones will remain fertile for procreation purposes." Pet. App. 185a. And the record shows that many other types of pediatric medicine can impact fertility yet have not been banned and, in the case of surgical interventions on intersex infants, are expressly authorized under the statute. JA 127-28.

Tennessee's criticisms of the evidence supporting treatment for gender dysphoria further highlight the law's underinclusiveness. The clinical practice guidelines from WPATH and the Endocrine Society that provide guidance to clinicians treating gender dysphoria are comparable to guidelines used across medicine, including those used by endocrinologists to treat polycystic ovarian syndrome and congenital adrenal hyperplasia. Pet. App. 179a; L.W. Br. 46-47. The WPATH guidelines' "development process was at least as rigorous as the process typical for clinical practice guidelines in the United States, so the State defendants' attacks would cast doubt on most guidelines used every day nationwide." Amicus Br. of Clinical Practice Guideline Experts 25. Notably, Tennessee's proposed alternatives for treating adolescents with gender dysphoria—psychotherapy and "watchful waiting"—are supported by no guidelines or research studies at all. Pet. App. 294a.

2. Tennessee's Interest in Protecting Detransitioners from Regret Cannot Justify Its Categorical Ban.

Tennessee's main concern about the banned medical care appears to be the possibility that some individuals may come to regret the treatment they received. But the risk of regret is not unique to the

treatment of gender dysphoria and cannot justify a sweeping ban that prohibits treatment for all transgender adolescent patients. The vast majority who rely on such treatments to live happy and fulfilling lives never regret accessing it.

Detransition and desistence are rare. Tennessee claims that "[i]f left untreated . . . gender dysphoria goes away on its own for the 'large majority' (about 85%) of children." Br. 4-5. But that figure refers to "prepubertal" children—a group everyone agrees are never prescribed the banned medical treatments, which are used only once puberty begins.[5] Endocrine Society, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons Guidelines* at 3879 (2017); JA 151-53. The rate of regret among those who have actually received medical treatment for gender dysphoria is exceedingly low. JA 132-33 (noting studies documenting rates of regret below 1%). The only evidence Tennessee cites is its expert's testimony claiming that "desistence is increasingly observed among adolescents," Br. 5, but the testimony

[5] The 85% figure cited by Tennessee is also from older studies that did not use the current DSM-V "gender dysphoria in childhood" diagnosis but rather used the outdated "gender identity disorder in children" diagnosis, which did not require a child to identify as a gender identity different from the child's birth-assigned sex. The latter captured many children who were never transgender and therefore unsurprisingly did not "persist" in such an identity into adulthood. Those criteria were corrected with the current DSM, which is what is used today and requires cross-gender identification in childhood to receive a gender dysphoria diagnosis. JA 152-53.

cites to no data about *changing* rates of detransition.[6] Instead, that testimony is focused on anecdotal observations about numbers of people who have detransitioned—not increasing or decreasing rates of detransition. JA 652-55. The exact same testimony from the same expert was offered at trial in a different case and that court found it "inconsistent and unreliable." *Brandt*, 677 F. Supp. 3d at 921; *see* Pet. App. 189a (citing *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1188 (N.D. Cal. 2015) (giving expert's opinions "very little weight" because his report "contains illogical inferences")).[7]

Moreover, regret is not unique to treatment for gender dysphoria; it is a feature of all medical care, including treatments SB1 permits. JA 131-33. For example, 38% of caregivers report regret for allowing genital surgery to be performed on infants with congenital adrenal hyperplasia, which SB1 expressly allows. *Id.* Either SB1 is grossly underinclusive with respect to concerns over regret, or Tennessee's

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[6] Tennessee also claims that 2021 "saw 'three times more diagnoses of gender dysphoria among minors than 2017.'" Br. 4. But that claim refers only to an uncited reference in the Sixth Circuit's opinion and an unsupported assertion by Tennessee's expert. The record shows that "while more people may be coming in for evaluation, the criteria for diagnoses and treatment remain stringent and a smaller percentage of patients are actually being diagnosed with gender dysphoria and referred on for medical treatment." JA 1023.

[7] On cross-examination in that case, the expert admitted that he had exaggerated the rates of detransition in his testimony. Tr. 920-925 (Nov. 28, 2022), *available at* https://www.aclu.org/cases/brandt-et-al-v-rutledge-et-al?document=Transcript-of-Bench-Trial-Volume-5.

concerns about regret are limited to regret associated with gender non-conformity.

To be sure, the Constitution "does not compel lawmakers to shield their eyes from detransitioners' experiences." Tenn. Br. 55. But equal protection does not allow Tennessee to classify on the basis of sex and then disregard the serious countervailing harm that SB1's ban exacts on the health and wellbeing of the overwhelming majority of transgender adolescents. Taking away gender dysphoria treatments from those who need them "has been linked to dramatic adverse mental health outcomes, including suicidality." JA 158. Indeed, one of Tennessee's own experts testified in a different case that "cutting off gender-affirming medical care for those currently receiving it" would be "devastating." *Brandt*, 677 F. Supp. 3d at 910.

Rejecting more narrowly tailored options such as "gatekeeping," "licensing, certification, or reporting requirements," Tennessee asserts that nothing short of a ban could "account for detransitioners." Br. 57. But Tennessee provides no support for that assertion. One of the purposes of robust mental health evaluations, for example, is to ensure that treatments are provided only to those who need it, thereby minimizing the possibility of regret. JA 152. For instance, concerned about detransitioning, West Virginia increased assessment and oversight processes but did not ban treatment outright. *See* W. Va. Code § 30-3-20(c)(5). "Thorough and proper individualized assessments play an essential role—ensuring that only young people who will most likely benefit from medical interventions will be treated with them." Amicus Br. of Dr. Erica Anderson et al. 4.

At bottom, SB1 is tailored not to protecting children from harm, but to promoting Tennessee's desire to stop gender transition—as the face of SB 1 says. In pursuit of that goal, Tennessee is even willing to override the aligned decisions of adolescents and their loving parents, who are otherwise constitutionally presumed to be acting in their children's best interest. *See Parham v. J.R.*, 442 U.S. 584, 602 (1979); Amicus Br. of William Eskridge, Jr., et al. (documenting the history of constitutional presumptions surrounding parental decision-making); Amicus Br. of Conservative Officials (same).

Most tellingly, despite Tennessee's claimed interest in protecting the health of minors, Tennessee's brief has literally nothing to say about L.W., John Doe, Ryan Roe, their families, and the countless other families with transgender adolescents whose lives Tennessee has ripped apart and whose critically needed health care the State has banned. *See* Amicus Br. of GRACE 7-8. Under any standard of scrutiny, Tennessee's preference that adolescents conform to the State's expectations of their birth-assigned sex does not provide an adequate justification for withholding necessary medical care.

CONCLUSION

The Court should vacate the decision below and remand for the application of heightened scrutiny, or reverse the judgment.

Respectfully submitted,

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