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

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 THE PETITIONER

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SB1 singles out and categorically bans medical treatments that thousands of doctors, parents, and transgender adolescents have found essential to treating a serious medical condition. SB1 defines the banned treatments in explicitly sex-based terms: It forbids prescribing medications to allow "a minor to identify with, or live as, a purported identity inconsistent with *the minor's sex*" or to treat "distress from a discordance between *the minor's sex* and asserted identity." Tenn. Code Ann. § 68-33-103(a)(1) (emphases added). And SB1 bluntly declares that it draws those sex-based lines

to "encourag[e] minors to appreciate their sex" assigned at birth. *Id.* § 68-33-101(m).

Respondents now disclaim the legislature's stated interest in discouraging adolescents from identifying as transgender. Instead, respondents assert that SB1 protects adolescents' health. But respondents spend most of their brief insisting that Tennessee had no obligation to substantiate that assertion or to tailor the law's prohibition to that interest. On their view, SB1 must be upheld so long as it is not wholly irrational—and, by necessary implication, the same deferential standard would apply to bans on gender-affirming care for adults.

That is wrong. SB1 classifies based on sex—and warrants heightened scrutiny—because its application depends on the regulated individual's sex. Someone assigned female at birth, for example, cannot receive puberty blockers or testosterone to live as a male, but someone assigned male at birth can. Respondents maintain (*e.g.*, Br. 2, 16) that SB1 classifies based on "medical purpose," not sex. But by their own description, the banned purpose—"gender transition" (*ibid.*)—is *defined* by sex. And respondents' various other attempts to secure mere rational-basis review have no grounding in precedent or principle.

Heightened scrutiny neither prohibits States from regulating gender-affirming care nor compels them to presume "that males and females are medically the same" (Resp. Br. 31). The very premise of heightened scrutiny is that "biological difference[s]" between men and women are sometimes a valid basis for legislation. *Nguyen* v. *INS*, 533 U.S. 53, 64 (2001). A decision recognizing that SB1 warrants heightened scrutiny would thus leave States room to regulate based on such differences, including by adopting "differing approaches to

evolving medical disputes" (Resp. Br. 1). It would simply require States to show that the lines they draw are, in fact, substantially related to their interest in protecting adolescent health.

Respondents assert that SB1 satisfies that standard, but their cursory analysis fails to grapple with the district court's factual findings and pervasively relies on a selective presentation of extra-record material. That provides further reason to remand for application of the correct standard—which could include reopening the record to evaluate the new material respondents invoke. But if the Court reaches the issue, it should hold that SB1 likely fails heightened scrutiny because Tennessee made no attempt to tailor the law to the State's asserted health concerns. SB1 categorically prohibits an entire class of care for transgender adolescents yet leaves the same medications entirely unrestricted when used for any other purpose—and makes no attempt to regulate a host of other treatments that implicate the State's asserted interests to an equal or greater degree.

I. SB1 WARRANTS HEIGHTENED SCRUTINY

Respondents emphasize (Br. 1-2, 19-20) that States generally have wide latitude to regulate medicine subject only to deferential review. But respondents acknowledge (Br. 2) that the Equal Protection Clause demands a more searching judicial inquiry for "discriminatory classifications." Respondents' plea for rational-basis review thus rests on their assertion (*ibid.*) that SB1 "includes no sex classification." That is wrong. And because SB1 also discriminates based on transgender status, it warrants heightened scrutiny twice over.

A. SB1 Warrants Heightened Scrutiny Because It Classifies Based On Sex

1. As our opening brief explained (at 19-23), a law classifies based on sex if its application to an individual turns on that individual's sex. At times, respondents agree. They concede, for example, that "[a] law prohibiting people from working in professions 'inconsistent with' their sex creates sex-based lines." Br. 25 (citation and internal quotation marks omitted). That is because "for some jobs, a male can have the job and a female cannot, and vice versa." *Ibid.* In other words, whether an individual can have a given job depends on that individual's sex.

SB1 draws precisely that kind of line. It bans puberty blockers and hormone therapy if—and only if—they are provided "for the purpose" of allowing a minor to "identify with" or "live as" a gender "inconsistent with the minor's sex," or treating distress "from a discordance between the minor's sex" and gender identity. Tenn. Code Ann. § 68-33-103(a)(1). Like a law restricting professions based on inconsistency with sex, SB1 restricts medical care when it would induce effects inconsistent with an individual's sex assigned at birth. And like the hypothetical professions law, SB1's application depends on sex assigned at birth: Changing the regulated individual's sex changes the result.

Consider medications provided "for the purpose" of allowing an adolescent to "identify" or "live as" a male—that is, medications to cause the development of masculine characteristics (or prevent the development of feminine characteristics). Was the patient assigned male at birth? Permitted. Assigned female at birth? Prohibited. Now take medications provided "for the purpose" of "enabling" an adolescent to "identify" or "live as" a

female—that is, medications to cause the development of feminine characteristics (or prevent the development of masculine characteristics). SB1's restriction flips. Was the patient assigned male at birth? Prohibited. Assigned female at birth? Permitted.

By its terms, therefore, SB1 "provides that different treatment be accorded to [individuals] on the basis of their sex." *Reed* v. *Reed*, 404 U.S. 71, 75 (1971). That is a facial sex classification.

2. In seeking to avoid that straightforward conclusion, respondents do not offer any principled theory of what constitutes a sex-based classification. And each of their arguments fails on its own terms.

a. Respondents principally assert (*e.g.*, Br. 23) that, although SB1 *references* sex, it *classifies* based on "medical purpose[]" by prohibiting "gender transition" for "both boys and girls." But unlike respondents' hypothetical law providing that "[n]either men nor women may drive an automobile without a license" (Br. 24), SB1 does not merely "reference" sex. That law could simply say: "No one may drive an automobile without a license." SB1, by contrast, uses sex to *define* the prohibited medical purpose; there is no way to articulate the law's prohibition *without* using sex-based terms.

Respondents' preferred formulation illustrates the point. They say (*e.g.*, Br. 2, 15, 20) that SB1 prohibits prescribing medications for the "purpose" of "gender transition." But that is just another way of saying that the law forbids treatments that induce characteristics inconsistent with a patient's sex assigned at birth—that is, that SB1's application depends on the patient's sex. And where, as here, the law's application changes depending on an individual's sex, a State cannot avoid heightened scrutiny by using other "labels." *Bostock* v.

Clayton County, 590 U.S. 644, 664-665 (2020); see, *e.g.*, *Los Angeles Dep't of Water & Power* v. *Manhart*, 435 U.S. 702, 713 (1978) (rejecting "longevity" label for policy because life expectancy was assessed based on sex).

Respondents assert (Br. 40) that SB1's application does not depend on sex even under *Bostock* because changing the sex of the patient receiving testosterone or estrogen "changes both sex *and* medical purpose." But *Bostock* rejected the materially identical argument that changing an employee's sex "change[ed] his sexual orientation too." 590 U.S. at 671. Like the prohibited purpose of "gender transition," sexual orientation is defined by reference to sex, so changing an individual's sex *necessarily* changes that characteristic as well.[1]

Relatedly, respondents assert (Br. 16) that SB1's restriction on puberty blockers cannot classify based on sex because "both males and females take the same drug." But that drug is prohibited only if it is provided "for the purpose" of "[e]nabling" an adolescent to "identify with" or "live as" a gender "inconsistent with the minor's sex." Tenn. Code Ann. § 68-33-103(a)(1). Because someone assigned male at birth cannot receive puberty blockers for the purpose of identifying or living as a girl, but someone assigned female at birth can (and

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[1] Respondents also err in asserting (Br. 40) that treatment for gender dysphoria involves "different dosages" than other uses of the relevant medications. Compare, *e.g.*, *Seattle Children's Gender Clinic Gender-Affirming Hormone Protocols* 2, 6, 12 (Feb. 2023), https://perma.cc/D49P-EH2L, with ACOG, *Hormone Therapy in Primary Ovarian Insufficiency* (May 2017), https://perma.cc/8TWU-JDUN; Rodolfo A. Rey and Romina P. Grinspon, *Androgen Treatment in Adolescent Males With Hypogonadism*, 14 Am. J. of Men's Health, at 11 (May 2020); and *Lupron*, https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/020263s053lbl.pdf (rev. Apr. 2023).

vice versa), SB1 classifies based on sex as to puberty blockers as well.

Respondents object (Br. 23) that the class regulated by SB1 (adolescents seeking the covered medications for "gender transition") and the class left unregulated (adolescents seeking them for "other medical purposes") each includes "both boys and girls." But the same could be said of the hypothetical professions law: The class seeking sex-inconsistent jobs and the class seeking sex-consistent jobs each includes both men and women. The law nevertheless classifies based on sex because its application to any individual depends on that individual's sex: Men cannot have jobs deemed insufficiently masculine and women cannot have jobs deemed insufficiently feminine. So too here.

b. Respondents next assert (Br. 25) that "not all restrictions on non-conforming behavior involve a sex-based classification." But unlike a "dress code that permits only pants" (*ibid.*), SB1 is not a sex-neutral rule that incidentally prohibits some gender-nonconforming conduct. Instead, SB1 explicitly classifies based on sex, prohibiting treatments to allow adolescents to "identify" or "live" in a manner "inconsistent" with their "sex." Tenn. Code Ann. § 68-33-103(a)(1). The proper dress-code analogy is prohibiting clothing "inconsistent with" the wearer's sex assigned at birth. And even respondents concede (Br. 25) that such a rule plainly classifies based on sex.

c. Respondents next advance (Br. 31-39) a multi-step argument about *Bostock*. They begin by assuming the conclusion, declaring (Br. 32) that "SB1 does not facially classify by sex." Relying on that premise, they assert (Br. 2, 32) that our argument uses *Bostock* to create "a novel path" to heightened scrutiny *absent* a facial

classification when "some *non*-sex-based classification incorporates sex as a but-for matter." And respondents maintain that such an approach would contradict precedent and lead to adverse consequences. All of that is wrong.

First, we do not contend that SB1 warrants heightened scrutiny because it classifies based on a "*non*-sex-based characteristic" that has some causal connection to sex. Rather, at the risk of belaboring the point, SB1 classifies *based on sex*—it says, explicitly, that whether a minor can receive certain medical care turns on the minor's "sex" assigned at birth. Tenn. Code Ann. § 68-33-103(a)(1); see pp. 4-7, *supra*.

Second, *Bostock* used but-for causation the same way we do: to identify "sex-based rules" that facially classify based on sex. 590 U.S. at 667. The question is not, as respondents suggest (*e.g.*, Br. 37-38), whether a policy has a disparate impact, or whether sex was a but-for cause of some *other* characteristic that triggers the policy. Instead, the question is whether sex *itself* determines how the policy applies: A policy facially discriminates based on sex "if changing the employee's sex would have yielded a different choice by the employer," even if "other factors may contribute to the decision." *Id.* at 659, 661.

Third, there is nothing novel about applying those "'simple' and 'traditional'" but-for principles, *Bostock*, 590 U.S. at 656 (citation omitted), in this context. This Court's equal-protection decisions have long identified sex-based classifications by asking whether changing the plaintiff's sex would have changed the law's application. See, *e.g.*, *Weinberger* v. *Wiesenfeld*, 420 U.S. 636, 640-641 (1975) ("If [Mr. Wiesenfeld] had been a woman, he would have received [social-security benefits]."); *Orr*

v. *Orr*, 440 U.S. 268, 273 (1979) ("Mr. Orr bears a burden he would not bear were he female."). Respondents disclaim any argument that sex must be the *sole* basis for a law's application, acknowledging (Br. 25) that "[p]ackaging sex classifications with other considerations does not somehow immunize the sex classification from scrutiny." And respondents do not offer any test for identifying a sex-based classification *other* than asking whether an individual's sex determines the law's application.

Fourth, respondents err in asserting (Br. 28, 33-34) that our position is inconsistent with *Geduldig* v. *Aiello*, 417 U.S. 484 (1974). There, the Court held that although "only women can become pregnant," a policy based on pregnancy did not facially classify based on sex. *Id.* at 496 n.20. Respondents say (Br. 28) that *Geduldig* "reject[ed] heightened scrutiny for sex-adjacent restrictions that draw no sex-based lines." But again, SB1 is not a "sex-*adjacent* restriction[]"; it explicitly draws lines based on "sex."

Fifth, respondents' warnings about the implications of our position (Br. 37-39) are misplaced. Because *Bostock* used but-for causation to identify disparate *treatment*, adhering to but-for principles here would not "open the door to disparate-impact liability under the Constitution" (Resp. Br. 37). Respondents likewise err in invoking (Br. 38) the ongoing debate about the application of sex-specific policies on "bathrooms," "locker rooms," and "women's sports" to transgender individuals. Because those policies unquestionably draw sex-based lines, they will trigger heightened scrutiny even if respondents prevail here; the legal issue in those contexts is not whether a sex-based classification exists, but instead whether the policies are justified under

heightened scrutiny. See, *e.g.*, *Adams* v. *School Bd. of St. Johns County*, 57 F.4th 791, 803 (11th Cir. 2022) (en banc) (upholding sex-specific bathroom policy under "intermediate scrutiny"). Lastly, applying heightened scrutiny to laws like SB1 will not undermine conscience rights for "doctors at State-run hospitals" (Resp. Br. 38). SB1's constitutional flaw is that it draws sex-based lines to *prohibit* doctors from providing care that they, their patients, and their patients' parents agree is essential. No one suggests that the Equal Protection Clause could *compel* doctors to provide gender-affirming care to which they religiously object.

3. Although respondents spend much of their brief insisting that SB1 does not classify based on sex at all, their final argument against heightened scrutiny takes a different (and contradictory) approach: They assert that even though SB1 treats boys and girls differently, that differential treatment does not warrant heightened scrutiny because "boys and girls 'are not similarly situated' for purposes of SB1's restrictions." Br. 28 (citation omitted). But a State's assertion that a sex-based classification is *justified* has never been a basis for dispensing with heightened scrutiny altogether.

No one disputes that legislatures may sometimes classify based on sex when "biological difference[s]" mean that men and women "are not similarly situated." *Nguyen*, 533 U.S. at 57, 63-64. But as *Nguyen* and this Court's other decisions demonstrate, those considerations are relevant only in determining whether a sex-based classification *survives* heightened scrutiny. U.S. Br. 24-26. Indeed, the Court developed the heightened-scrutiny framework in large part to test the validity of asserted biological justifications for laws treating men and women differently. NWLC Br. 18-21.

Respondents do not cite any decision from this Court suggesting that a court must ask whether the sexes are similarly situated before applying heightened scrutiny to a sex-based classification. Indeed, the decisions on which they rely (Resp. Br. 29 & n.1) did not involve facial classifications at all. Respondents also do not explain what work heightened scrutiny would do if it applied only when courts had already determined that men and women are similarly situated. The Court should reject respondents' invitation to add a novel and unworkable threshold step to the familiar heightened-scrutiny framework.

B. SB1 Warrants Heightened Scrutiny Because It Discriminates Against Transgender Individuals

SB1 also warrants heightened scrutiny because it discriminates against transgender individuals, who qualify as a quasi-suspect class.

1. Although the Sixth Circuit held that transgender-based classifications do not warrant heightened scrutiny, it did not doubt that SB1 targets transgender individuals. Pet. App. 44a. Respondents, however, assert (Br. 41-44) that SB1 does not discriminate against transgender individuals because—while the law bars them from receiving gender-affirming treatments that they and their doctors deem essential—they may receive the covered medications for *other* purposes, such as if they happen to have precocious puberty. That argument blinks reality.

SB1's text confirms that it "expressly and exclusively targets transgender people." Pet. App. 152a. The defining characteristic of transgender individuals is that their gender identity does not align with their sex assigned at birth. U.S. Br. 29. SB1 specifically targets that characteristic, prohibiting treatments

intended to allow an adolescent to "identify with, or live as, a purported identity inconsistent with the minor's sex." Tenn. Code Ann. § 68-33-103(a)(1). And SB1 explicitly seeks to discourage adolescents from identifying as transgender, forthrightly asserting a state interest in preventing minors from "becom[ing] disdainful of their sex" assigned at birth. *Id.* § 68-33-101(m). The conclusion that SB1 targets transgender individuals thus does not rest on any inquiry into unenacted "legislative motives." Resp. Br. 42-43 (citation omitted). It simply takes the Tennessee legislature at its word.

2. Respondents assert (Br. 44-45) that this Court should decline to recognize transgender status as a quasi-suspect classification. But transgender individuals satisfy the established criteria for "extraordinary protection from the majoritarian political process." *Massachusetts Bd. of Ret.* v. *Murgia*, 427 U.S. 307, 313 (1976) (per curiam) (citation omitted); see U.S. Br. 29-31.

Most obviously, transgender Americans have historically been subject to discrimination—and such hostility is rising rather than abating. In recent years, States across the Nation have enacted a staggering number of laws targeting transgender individuals. NAACP Br. 6-7. And the accompanying rhetoric underscores how transgender individuals face a distorted political process. Legislators have called transgender Americans "mutants," "demons," "imps," "filth," and "delusional." *Doe* v. *Ladapo*, 676 F. Supp. 3d 1205, 1223 n.62 (N.D. Fla. 2023); NAACP Br. 8; Members of Congress Br. 8-9. That underscores the need for "more searching evaluation" than bare rationality review, *Cleburne* v. *Cleburne Living Center, Inc.*, 473 U.S. 432 (1985), to ensure that laws targeting transgender individuals do not reflect stereotypes or prejudice.

Respondents' contrary arguments (Br. 45-48) are unpersuasive. The fact that "[t]he current Administration" has sought to protect transgender individuals from discrimination (Br. 46) does not vitiate the need for heightened judicial scrutiny. And respondents err in invoking *Murgia* and *Cleburne*, which declined to recognize age and mental disability as suspect classifications. *Murgia* emphasized that "old age does not define a 'discrete and insular' group" because it "marks a stage that each of us will reach if we live out our normal span." 427 U.S. at 313-314 (citation omitted). Similarly, *Cleburne* reasoned that individuals with mental disabilities are a "large and diversified group" that does not face a distorted political process. 473 U.S. at 442-443.

Transgender individuals, in contrast, are a discrete minority accounting for roughly one percent of the population. Their transgender status bears no relation to their ability to contribute to society, yet they face a wave of hostile legislation targeting them in all areas of life. And that wave will undoubtedly grow if this Court holds that laws discriminating against transgender Americans—which could include, for example, laws prohibiting them from adopting children or becoming licensed as teachers—warrant only the most deferential review under the Equal Protection Clause.

II. SB1 CANNOT SURVIVE HEIGHTENED SCRUTINY

The Sixth Circuit did not consider whether SB1 can survive heightened scrutiny. Respondents now assert that it can, but they devote only a few perfunctory pages to that issue. And respondents neither meaningfully engage with the district court's factual findings nor offer anything resembling a traditional heightened-scrutiny analysis. Instead, they rely heavily on a selective presentation of developments postdating the close of

the preliminary-injunction record, such as the United Kingdom's Cass Review and evidence from an entirely different case.

Respondents provide no reason for this Court to be the first to consider that new material or to depart from the usual practice of remanding to allow the Sixth Circuit to apply heightened scrutiny in the first instance—which could include reopening the record to evaluate that new material. U.S. Br. 32. But if the Court instead decides the issue itself based on the current record, it should hold that SB1 likely fails heightened scrutiny.

A. This Case Is Governed By Ordinary Principles Of Heightened Scrutiny And Clear-Error Review

At the outset, respondents assert (Br. 50) that even if SB1 is subject to heightened scrutiny, it must be assessed under a special "deferential framework" because it addresses "unsettled health questions." But this Court has never suggested that a State receives deference when it classifies based on sex. To the contrary, "[t]he burden of justification" for any sex-based line "rests entirely on the State." *United States* v. *Virginia*, 518 U.S. 515, 533 (1996); see, *e.g.*, *Sessions* v. *Morales-Santana*, 582 U.S. 47, 59 (2017).

Of course, States are entitled to legislate in response to risks and uncertainties, so a State may be able to *justify* a law based on medical uncertainty. But respondents do not identify a single sex-discrimination case in which this Court merely deferred to legislative findings rather than requiring an independent judicial assessment of whether the challenged statute is substantially related to an important government interest. Respondents cite *Gonzales* v. *Carhart*, 550 U.S. 124 (2007), but that decision applied a different constitutional standard

in a different context. And even then, the Court emphasized courts' "independent constitutional duty to review factual findings when constitutional rights are at stake" and rejected congressional findings that the district courts had found to be "incorrect." *Id.* at 165-166.

Respondents likewise err in asserting that the district court's factual findings are not entitled to "clear-error weight" because the court did not defer to SB1's legislative findings. Br. 52. Even when some deference to the legislature is warranted, *Gonzales* confirms that district courts must make independent findings of fact. And in any event, the Tennessee legislature did not make any specific findings on most of the issues addressed by the district court, so the court cannot have applied an "erroneous standard" (Br. 52) even under respondents' novel approach to factfinding in constitutional cases.

B. Respondents Continue To Disregard The Benefits And Overstate The Risks Of Gender-Affirming Care

Although SB1 is perfectly crafted to serve the State's declared interest in "encourag[ing] minors to appreciate their sex," Tenn. Code Ann. § 68-33-101(m), respondents do not defend SB1 on that basis. To the contrary, they minimize that express legislative purpose as an "[a]long the way" aside, Resp. Br. 26—effectively acknowledging that a State has no legitimate interest in encouraging "boys and girls to *look* and *live* like boys and girls," Pet. App. 85a (White, J., dissenting); see U.S. Br. 33-34.

Instead, respondents try to defend SB1 as a routine medical regulation, arguing that it reflects lawmakers' "well-informed judgment" about a "dangerous and risky treatment." Br. 49-50. But the district court carefully examined the evidence and found that it does not

support respondents' characterization of either the benefits or the risks of gender-affirming care. Pet. App. 181a-199a. Respondents make no real effort to grapple with those findings.

1. Respondents acknowledge (*e.g.*, Br. 21, 52) that a State cannot justify sex-based regulation of medical care by focusing on risks alone—it must also consider the benefits. U.S. Br. 34-36. But respondents ignore the district court's finding, based on extensive evidence, that gender-affirming care is associated with significant mental-health benefits in adolescents, such as lower rates of depression, disruptive behaviors, and anxiety. U.S. Br. 37-38. Critically, treatment with puberty blockers and hormones is associated with meaningfully reduced suicidality, including suicide attempts. U.S. Br. 36-37. And respondents further ignore the evidence that providing such treatment during adolescence can have life-long benefits, allowing transgender individuals to live and be accepted in accordance with their identity without invasive and less-effective procedures, including surgery, later in life. U.S. Br. 38-39.

Respondents assert (Br. 54) that the evidence supporting reduced suicidality is "inconclusive and conflicts with other studies." But the record evidence nearly uniformly shows that gender-affirming care is associated with sharp reductions in the risk of suicidal ideation and suicide attempts—just as the district court found. U.S. Br. 37; see Pet. App. 264a, 290a & n.14, 293a & nn.17-18 (collecting studies); J.A. 143-146 & nn.5-12 (same).[2]

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[2] Respondents say (Br. 54) that "one [study] shows that hormonal interventions *increased* mental distress." But adolescents who received gender-affirming care reported *improvements* in body dissatisfaction, depression, and anxiety. See Laura E. Kuper et al.,

Tellingly, moreover, respondents offer no viable alternative to gender-affirming care. Respondents have not identified any studies suggesting that psychotherapy alone results in mental-health benefits comparable to those associated with gender-affirming medical care. J.A. 147, 1031. And "watchful waiting" in a State that has categorically banned any medical care—no matter what such monitoring reveals about a given patient's need for that care—amounts to no treatment at all.

Respondents assert (Br. 4-5) that left untreated, gender dysphoria "goes away on its own" for "about 85%" of "children." But that is deeply misleading: The studies underlying that claim (referenced at J.A. 384-385, 505-506) involved mostly prepubertal children, many of whom merely departed from gender stereotypes rather than exhibiting actual gender dysphoria. The treatments at issue here are available only to adolescents with marked, sustained gender dysphoria. And "*no* studies" "support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth." AAP Br. 25. Indeed, respondents do not appear to dispute that some transgender adolescents are at risk of serious harm from gender dysphoria. But SB1 categorically bans the only evidence-based treatment for that condition, leaving affected patients with no viable alternative.

2. On the other side of the ledger, respondents renew their assertion that gender-affirming care carries

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Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145 Pediatrics, no. 4 (Apr. 2020). Although more adverse events occurred following treatment than in the short period immediately prior, it is unsurprising that more such events happened over a many-times-longer period.

serious risks. But they fail to address the district court's findings that those risks are exaggerated.

Intended effects. Respondents again err (Br. 5-6) in describing as risks effects such as delayed puberty, increased levels of estrogen in transgender girls, increased levels of testosterone in transgender boys, and associated development of masculine or feminine characteristics. Those are the *intended effects* of puberty blockers and hormone therapy—effects that can be critical to reducing distress from gender dysphoria—not risks or side effects. U.S. Br. 41.

Medical risks. Respondents assert (Br. 5-6) that prescribing puberty blockers and hormones for gender transition carries medical risks. Of course, all drugs have risks. But the district court found that respondents had failed to substantiate some of the alleged risks; that others—such as decreased bone mineral density from puberty blockers—do not have lasting consequences; and that serious side effects are limited and infrequent. U.S. Br. 5-7, 41-42; see Pet. App. 263a-269a. Even more to the point, the court found that the relevant medications generally carry similar risks, whether prescribed for gender-affirming care or for any of the other reasons that SB1 leaves unregulated. Pet. App. 204a-205a, 267a. Respondents make no effort to explain why the district court's findings were wrong or to rehabilitate their cited evidence; they simply restate the same alleged risks as fact. See Resp. Br. 5-6, 55-56.

Fertility. Respondents note (Br. 5-6, 12) fertility risks associated with hormone therapy. But SB1 bans puberty blockers even though pubertal suppression itself has no impact on fertility. U.S. Br. 33-34. And as to hormone therapy, the district court found that many individuals receiving cross-sex hormones remain fertile

and that patients can be provided with fertility-preserving options. Moreover, as our opening brief explained (U.S. Br. 46-47), similar or greater risks—including fertility risks—attend various pediatric treatments, yet SB1 singles out and bans only gender-affirming care. Respondents cannot reconcile SB1 with the State's general approach to pediatric care.

Uncertainty. Respondents also invoke (Br. 6, 53) "unknown effects" and medical "uncertainty." But gender-affirming care is not new; the same treatments have been safely prescribed for decades to treat a variety of conditions, including gender dysphoria. U.S. Br. 7. As the district court found, the evidence supporting such care is consistent with the type and quality of evidence relied on across clinical practice, especially in the pediatric context. Pet. App. 179a-180a; see U.S. Br. 39; Clinical Practice Guideline Experts Br. 25-38. Respondents do not engage with that finding—let alone explain why any uncertainty justifies cutting off all access to this care alone.

Regret. Finally, respondents emphasize the risk that individuals who receive gender-affirming care may not persist in their transgender identity and may come to regret that care. But the evidence shows that the only patients medically eligible to receive the treatments that SB1 bans—adolescents with marked and sustained gender dysphoria—are highly likely to persist in their gender incongruence and dysphoria in adulthood. U.S. Br. 40-41. That is not to deny that "de-transition exists" (Resp. Br. 54-55). But all available evidence suggests that it is very rare. And respondents never explain why the risk of regret among a small fraction of the relevant patient population justifies banning care for all adolescents—particularly when many other medical

procedures, including those that SB1 specifically permits, pose equal or greater risks of regret. See J.A. 131-133; interACT Br. 15, 22-24 (observing that "for infants with many intersex variations, the initial sex assignment will prove incorrect from 10% to more than 60% of the time," yet SB1 expressly "permits *all* so-called 'normalizing' treatments when performed on intersex minors—even those that are highly invasive and unquestionably irreversible").

3. Respondents' failure to meaningfully engage with the evidence establishing the significant benefits of gender-affirming care—or to weigh the asserted risks against those benefits—is especially problematic given the medical community's position that such care is appropriate and medically necessary for adolescents where clinically indicated. U.S. Br. 35. Respondents criticize (Br. 9-11) the drafting process for WPATH's clinical guidelines, selectively citing out-of-context excerpts from the unadjudicated summary-judgment record in a different case. But it is not just WPATH that supports gender-affirming care for adolescents in appropriate cases. To the contrary, "[t]he widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria." AAP Br. 8. That care is supported by the Nation's major medical organizations—including the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, and the Endocrine Society—as well as leading children's hospitals. See *id.* at 8-28; APA Br. 10-33. Respondents dismiss (Br. 54) those respected medical organizations as "advocacy" groups, but respondents do not engage with the evidence on which that medical judgment rests.

C. SB1 Is Not Tailored To The State's Asserted Interest In Protecting Adolescent Health

Heightened scrutiny does not foreclose laws regulating gender-affirming care. To the contrary, this Court has repeatedly recognized that sex-based classifications can be legitimate responses to "biological difference[s]." *Nguyen*, 533 U.S. at 64. But when a State regulates using sex-based classifications, it cannot rely on sweeping and untailored measures if "more accurate and impartial lines can be drawn." *Morales-Santana*, 582 U.S. at 63 n.13. Requiring such tailoring has long been a critical function of heightened scrutiny. And although respondents protest that courts should not second-guess legislatures on matters of medical science or policy, courts are well-equipped to judge the "congruence" between a sex-based law and the legislature's stated objectives. *Craig* v. *Boren*, 429 U.S. 190, 197-199 (1976).

That traditional judicial inquiry is fatal to SB1: States undoubtedly have a compelling interest in protecting adolescent health, but SB1 is completely untailored to that interest—even accounting for legislatures' freedom to regulate in the face of uncertainty. SB1 is severely underinclusive because it singles out and categorically bans the use of the covered medications to treat transgender adolescents suffering from gender dysphoria, while leaving the same medications available for all other minors for all other uses—and likewise leaving decisions about all other pediatric treatments to parents, doctors, and minors themselves. U.S. Br. 44-47.

SB1 is also severely overinclusive because it makes no effort to tailor its prohibition to the concerns the State has identified. A range of more tailored laws could respond to those concerns while preserving access to care where appropriate—including gatekeeping

requirements; waiting periods; licensing, certification, and reporting requirements; requirements aimed at fertility preservation; two-parent consent; counseling; psychological evaluations; readiness criteria; and age recommendations. U.S. Br. 48-49.

Respondents do not explain why more tailored laws would not address the State's asserted concerns, other than to say (Br. 57) that these measures do not account for individuals who regret receiving gender-affirming care. But gatekeeping, licensing, and counseling requirements, as well as psychological evaluations and waiting periods, *would* directly address concerns about regret by ensuring that specialized mental-health professionals evaluate adolescents for sustained gender dysphoria and rule out confounding diagnoses. See Anderson Br. 4. Given that such regret is already rare among the relevant patient population, respondents cannot establish that this concern justifies a blunderbuss ban on gender-affirming care for all adolescents no matter their individual circumstances.

Respondents repeatedly invoke (*e.g.*, Br. 1, 7-9, 17) various European countries' "tightened restrictions" on gender-affirming care. But each of the countries they identify has adopted measures aimed at further developing an individualized, evidence-based approach to gender-affirming care, while simultaneously ensuring that transgender adolescents can continue to receive such care in appropriate cases. None of those countries has adopted a categorical ban like SB1.[3] Those more

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[3] See Foreign Non-Profit Organizations Br. 4-13 (documenting access to care in Sweden, the United Kingdom, and Norway); Foreign Non-Profit Organizations Cert. Br. 3-12 (documenting access in Finland). Respondents also repeatedly cite (Br. 8, 54) the Cass

nuanced regulatory approaches cannot justify cutting off access to care altogether for transgender adolescents in Tennessee.

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In the final analysis, SB1 is nothing like a typical medical regulation. Respondents insist that SB1 is designed to help transgender adolescents, but SB1 categorically prohibits medical treatments that have been safely provided for decades and that many transgender adolescents—along with their parents and doctors—have found essential to their health and wellbeing. And SB1 enacts that across-the-board prohibition in a stark departure from the State's regulation of pediatric care in all other contexts, including those involving similar risks and uncertainties. Indeed, SB1 acknowledges on its face that it is *not* just a medical regulation. The law declares that its very purpose is to "encourag[e] minors to appreciate their sex" and to ban treatments "that might encourage minors to become disdainful of their sex." Tenn. Code § 68-33-101(m). The State's decision to single out and ban gender-affirming care is precisely tailored to *that* interest—and to that interest only.

Against that backdrop, the question in this case is not whether States can seek to protect adolescents' health; everyone agrees that they can. And the Equal Protection Clause unquestionably leaves States room to

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Review. But the British Medical Association is undertaking a public evaluation of the Cass Review in light of concerns about its methodological weaknesses. British Med. Ass'n, *BMA to undertake an evaluation of the Cass Review* (July 31, 2024), https://tinyurl.com/43t7jtrr. And the Cass Review notably does not recommend an outright ban on gender-affirming care but instead recognizes that medical treatment is appropriate for some adolescents with gender dysphoria. See *Independent Review of Gender Identity Services for Children and Young People: Final Report* 21, 30 (Apr. 2024).

regulate gender-affirming care in the face of uncertainty, including by adopting different approaches to these challenging issues. But where, as here, a State regulates by drawing sex-based lines, the Constitution demands more than bare rationality. And if heightened scrutiny means anything, it must mean that a State cannot invoke health and safety to categorically foreclose critical medical treatments for a disfavored minority while leaving the same treatments—and a host of other treatments that impose the same or greater risks—entirely unregulated when used for any other purpose.

The judgment of the court of appeals should be vacated and the case remanded for further proceedings.

Respectfully submitted.

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