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

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Whether Tennessee Senate Bill 1 (SB1), which categorically prohibits all medical treatments intended to allow "a minor to identify with, or live as, a purported identity inconsistent with the minor's sex" or to treat "purported discomfort or distress from a discordance between the minor's sex and asserted identity," Tenn. Code Ann. § 68-33-103(a)(1), violates the Equal Protection Clause of the Fourteenth Amendment.

PARTIES TO THE PROCEEDING

Petitioner (intervenor-appellee in the court of appeals) is the United States of America.

Respondents in support of petitioner (plaintiffs-appellees in the court of appeals) are L.W.; Samantha Williams; Brian Williams; John Doe; Jane Doe; James Doe; Rebecca Roe; Ryan Roe; and Susan N. Lacy.

Respondents (defendants-appellants in the court of appeals) are Jonathan Thomas Skrmetti, in his official capacity as the Tennessee Attorney General and Reporter; the Tennessee Department of Health; Ralph Alvarado, in his official capacity as the Commissioner of the Tennessee Department of Health; the Tennessee Board of Medical Examiners; Melanie Blake, in her official capacity as the President of the Tennessee Board of Medical Examiners; Stephen Loyd, in his official capacity as Vice President of the Tennessee Board of Medical Examiners; Randall E. Pearson, Phyllis E. Miller, Samantha McLerran, Keith G. Anderson, Deborah Cristiansen, John W. Hale, John J. McGraw, Robert Ellis, James Diaz-Barriga, and Jennifer Claxton, in their official capacities as members of the Tennessee Board of Medical Examiners; and Logan Grant, in his official capacity as the Executive Director of the Tennessee Health Facilities Commission.

RELATED PROCEEDINGS

United States District Court (M.D. Tenn.):

L.W. v. *Skrmetti*, No. 23-cv-376 (June 28, 2023)

United States Court of Appeals (6th Cir.):

L.W. v. *Skrmetti*, No. 23-5600 (Sept. 28, 2023)

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Carla M. Lopez et al., *Trends in the "Off-Label" Use of GnRH Agonists Among Pediatric Patients in the United States*, 57 Clinical Pediatrics 1432 (2018) 40

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-101a) is reported at 83 F.4th 460. A prior opinion of the court of appeals (Pet. App. 102a-124a) is reported at 73 F.4th 408. The opinion of the district court (Pet. App. 130a-218a) is reported at 679 F. Supp. 3d 668.

JURISDICTION

The judgment of the court of appeals was entered on September 28, 2023. The petition for a writ of certiorari was filed on November 6, 2023, and granted on June 24, 2024. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATEMENT

For decades, transgender adolescents suffering from gender dysphoria have received medical treatment, including puberty blockers and hormone therapy. But in the last three years, 22 States have enacted laws banning that gender-affirming care. Those laws do not mandate informed consent, impose gatekeeping requirements, or otherwise regulate the covered treatments; instead, they categorically forbid critical medical treatment for a condition that can cause serious mental and physical harm.

This case is about the ban enacted in Tennessee. The Tennessee law declares that the State has an "interest in encouraging minors to appreciate their sex" and in prohibiting treatments "that might encourage minors to become disdainful of their sex." Tenn. Code Ann. § 68-33-101(m). And the law frames its prohibition in explicit sex-based terms: The covered treatments are banned if they are prescribed "for the purpose" of "[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." *Id.* § 68-33-103(a)(1). But the law leaves the same treatments entirely unrestricted if they are prescribed for any other purpose, such as treating delayed or precocious puberty. Thus, for example, a teenager whose sex assigned at birth is male can be prescribed testosterone to conform to a male gender identity, but a teenager assigned female at birth cannot.

A divided panel of the Sixth Circuit nonetheless held that Tennessee's ban does not discriminate based on sex, applied only rational-basis review, and upheld the law under that highly deferential standard. The question

presented is whether that analysis is consistent with the Equal Protection Clause.

A. Medical Standards For Gender-Affirming Care

1. Roughly one percent of Americans are transgender. Pet. App. 161a. Transgender people can suffer from gender dysphoria, a medical condition characterized by clinically significant distress resulting from incongruence between a person's gender identity and sex assigned at birth that has persisted for at least six months. *Id*. at 251a-252a. Left untreated, gender dysphoria can result in severe physical and psychological harms. *Ibid.* Those harms include "debilitating distress," "depression," "substance use," "self-injurious behaviors," and "even suicide." *Edmo* v. *Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019) (per curiam), cert. denied, 141 S. Ct. 610 (2020). The numbers are stark: Studies show, for example, that as many as one-third of transgender high school students attempt suicide in a given year.[1]

2. The World Professional Association of Transgender Health (WPATH), the leading association of medical professionals treating transgender individuals, and the Endocrine Society, an organization of more than 18,000 endocrinologists, have published evidence-based guidelines for the treatment of gender dysphoria. Pet. App. 178a-179a; see *id.* at 252a. The Nation's leading medical and mental health organizations recognize those guidelines as reflecting the accepted standard of care for treating gender dysphoria. See *Edmo*, 935 F.3d

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[1] Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students*, 68 Morbidity & Mortality Wkly. Rep. 67, 70 (2019) (cited at J.A. 544 n.157).

at 769; Pet. App. 178a-181a. And the guidelines are "widely followed by clinicians." *Brandt* v. *Rutledge*, 677 F. Supp. 3d 877, 890 (E.D. Ark. 2023), appeal pending, No. 23-2681 (8th Cir. argued en banc Apr. 11, 2024).

Under the guidelines, the appropriate treatment for gender dysphoria varies based on an individualized assessment of each patient's needs. Pet. App. 253a, 289a-290a. The guidelines also differ for children, adolescents, and adults. *Id.* at 253a.

Before puberty, treatment "does not include any drug or surgical intervention." Pet. App. 255a. Treatment may instead include social transition—that is, allowing transgender children to live in accordance with their gender identity, including their clothing, hairstyle, name, and pronouns. *Ibid.*

Once puberty commences, the permanent physical changes that occur can cause "extreme distress." Pet. App. 256a. Without appropriate treatment, adolescents with gender dysphoria are at risk of serious psychological and physical harm, including depression, eating disorders, substance abuse, self-harm, and suicidality. *Id.* at 194a-197a, 252a. Moreover, "there is broad consensus in the field" that "adolescents [who have] reach[ed] the early stages of puberty and [have] experience[d] gender dysphoria"—that is, clinically significant distress or impairment over a sustained period, see p. 3, *supra*—are "very unlikely" to "subsequently identify" as their sex assigned at birth. *Brandt*, 677 F. Supp. 3d at 921; see J.A. 151-153.

The guidelines thus permit medical interventions for transgender adolescents in appropriate cases, after a comprehensive assessment to ensure that any intervention is medically necessary. Pet. App. 253a-254a, 256a-260a. Under the guidelines, such care is appropriate

only when an adolescent has marked and sustained gender dysphoria that has worsened with the onset of puberty; no health issues that would interfere with treatment; and the capacity to provide informed consent. *Id.* at 256a-259a, 287a-288a. Consistent with the "general ethical principles" governing pediatric care, J.A. 124, both the patient and the patient's parents must provide consent after receiving counseling about the risks and benefits of each treatment. J.A. 961-962, 991; Pet. App. 186a n.45, 257a-259a, 262a-263a.

Potential treatments for adolescents include puberty-suppressing medication, also called "puberty blockers," and hormone therapy. Pet. App. 256a, 258a. Puberty blockers "allow[] adolescents with gender dysphoria to pause their endogenous puberty, thereby avoiding the heightened gender dysphoria and permanent physical changes that puberty would cause." *Id.* at 256a. Treatment with puberty blockers is "reversible"; it "pauses puberty only for the duration of the treatment and gives a young person time to further understand their gender identity." *Ibid.* If puberty blockers are discontinued without further treatment, "endogenous puberty resumes." *Id.* at 261a. The guidelines also recognize that it may be medically appropriate to provide hormone therapy to induce puberty consistent with a patient's gender identity. *Id.* at 258a. Hormone therapy consists of providing feminizing hormones (estrogen or androgen suppressants) to transgender girls and masculinizing hormones (testosterone) to transgender boys, which cause patients to develop physical characteristics consistent with their gender identity. *Ibid.*

Medical evidence and clinical experience demonstrate that such care, provided in appropriate cases, meaningfully improves the health and wellbeing of

transgender adolescents with gender dysphoria. Pet. App. 194a-197a. Because such treatment aligns patients' bodies with their gender identity—allowing them to live and identify consistently with that identity—multiple studies show that it "lowers rates of depression" and "additional mental health issues." *Id.* at 196a. Clinical experience further confirms "the substantial benefits of pubertal suppression and gender-affirming hormones as treatment for adolescents with gender dysphoria." *Id.* at 263a; see *id.* at 275a; J.A. 98-99, 105-107, 1004.

Serious side effects from puberty blockers and hormones are limited and infrequent. Pet. App. 267a-269a. Like all medications, they are not risk free—but the same medications have been prescribed for decades to treat a variety of conditions, including delayed or precocious puberty; polycystic ovary syndrome; intersex conditions; premature ovarian failure; endometriosis; and cancer. See *id.* at 263a-265a; J.A. 127, 130-131.

Every major American medical organization with a position on the appropriate treatment of gender dysphoria in adolescents, including the American Academy of Pediatrics and the American Medical Association, agrees that puberty blockers and hormone therapy "are appropriate and medically necessary treatments for adolescents when clinically indicated." Pet. App. 198a. And the Nation's leading children's hospitals are equipped with centers that offer such care to adolescent patients in appropriate cases.[2]

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[2] Those include (among others) the Cincinnati Children's Hospital; the Boston Children's Hospital; the Nationwide Children's Hospital in Columbus, Ohio; the UPMC Children's Hospital of Pittsburgh; Duke Children's Hospital & Health Center; the Children's Hospital of Philadelphia; Children's National Hospital in the

B. Tennessee SB1

1. Puberty blockers have been used to treat gender dysphoria for 20 years and precocious puberty for more than 30 years. J.A. 964, 967. And hormone therapy has been used even longer—for at least 60 years to treat gender dysphoria in adults, and at least 20 years in adolescents. See Pet. App. 2a, 5a, 265a.

In the last three years, however, state legislatures have adopted a wave of bans on gender-affirming care for minors based on model legislation and legislative findings circulated by advocacy groups. In 2021, Arkansas became the first state to enact a ban. See Ark. Code Ann. § 20-9-1502(a). In 2022, Alabama followed. See Ala. Code § 26-26-4. And in the year and a half since, 20 other States have done the same.[3]

2. This case is about the ban Tennessee adopted in March 2023, the Prohibition on Medical Procedures Performed on Minors Related to Sexual Identity, Senate Bill 1, Tenn. Code Ann. §§ 68-33-101 *et seq*. (SB1).

District of Columbia; Children's Hospital Colorado; and Johns Hopkins Children's Center in Maryland.

[3] See Fla. Stat. § 456.52(1); Fla. Admin. Code Ann. § 64B8-9.019; Ga. Code Ann. § 31-7-3.5; Idaho Code Ann. § 18-1506C; Ind. Code § 25-1-22-13; Iowa Code § 147.164; Ky. Rev. Stat. Ann. § 311.372; La. Rev. Stat. Ann. § 40:1098.2; Miss. Code Ann. §§ 41-141-1 *et seq.*; Mo. Rev. Stat. Ann. § 191.1720; Ch. No. 306, 2023 Mont. Laws 858-862; Neb. Rev. Stat. §§ 71-7301 *et seq.*; N.C. Gen. Stat. §§ 90-21.150 *et seq.*; N.D. Cent. Code § 12.1-36.1-02; Ohio Rev. Code Ann. §§ 3129.01 *et seq.*; Okla. Stat. tit. 63, § 2607.1; S.C. Code Ann. §§ 44-42-310 *et seq.*; S.D. Codified Laws §§ 34-24-33 *et seq.*; Tenn. Code Ann. §§ 68-33-101 *et seq.*; Tex. Health & Safety Code §§ 161.701 *et seq.*; Wyo. Stat. Ann. §§ 35-4-1001 *et seq*. Two additional States have adopted bans with limited exceptions. See Utah Code Ann. §§ 58-1-603, 58-1-603.1; W. Va. Code § 30-3-20. See generally Jeff McMillan et al., *Many transgender health bills came from a handful of far-right interest groups, AP Finds*, Associated Press (May 20, 2023).

Like similar laws in other States, SB1 was enacted as part of a series of laws targeting transgender individuals.[4] Some of SB1's findings describe asserted risks of the covered treatments. *Id.* § 68-33-101(b)-(e) and (h). But SB1 also declares that Tennessee has a "compelling interest in encouraging minors to appreciate their sex, particularly as they undergo puberty," and in prohibiting treatments "that might encourage minors to become disdainful of their sex." *Id.* § 68-33-101(m).

SB1 prohibits healthcare providers from "[p]rescribing, administering, or dispensing any puberty blocker or hormone" if that treatment is provided "for the purpose" of "[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. §§ 68-33-102(5)(B), 68-33-103(a)(1).[5] SB1 defines "[s]ex" as the "immutable characteristics of the reproductive system that define the individual as male or female, as determined by anatomy and genetics existing at the time of birth." *Id.* § 68-33-102(9).

Because SB1's prohibition applies only when a covered treatment is prescribed to allow individuals to live in conformity with a gender identity other than their sex assigned at birth, the law does not restrict the

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[4] See, *e.g.*, Tenn. Pub. Ch. 285 (enacted Apr. 28, 2023) (Tenn. Code Ann. § 49-50-805) (limiting students to participating in interscholastic athletic events "only in accordance with the student's sex" at birth); Tenn. Pub. Ch. 448 (enacted May 17, 2023) (Tenn. Code Ann. § 49-6-5102) (specifying that public school teachers need not refer to a student by pronouns inconsistent with the student's sex assigned at birth).

[5] SB1 also prohibits surgical procedures provided for the same purposes, but that prohibition is not at issue here. Pet. App. 9a-10a, 140a-142a.

provision of puberty blockers or hormones for any other purpose. The law also explicitly exempts those treatments when they are prescribed "to treat a minor's congenital defect, precocious puberty, disease, or physical injury." Tenn. Code Ann. § 68-33-103(b)(1)(A). The terms "[c]ongenital defect" and "disease" are defined to include an "abnormality present in a minor that is inconsistent with the normal development of a human being of the minor's sex" but specifically exclude "gender dysphoria, gender identity disorder, [and] gender incongruence." *Id.* §§ 68-33-102(1), 68-33-103(b)(2).

Violations of SB1 are punishable by civil penalties of $25,000 for each prohibited treatment, professional discipline, and potential civil liability in private suits. Tenn. Code Ann. §§ 68-33-105 to 68-33-107. The law took effect on July 1, 2023.

C. The Present Controversy

1. Private plaintiffs are L.W., Ryan Roe, and John Doe, three transgender adolescents who live in Tennessee; their parents; and a Tennessee doctor who treats adolescents with gender dysphoria. Pet. App. 9a.

L.W. is a 16-year-old transgender girl whose dysphoria over a period of many years made her feel like she was "trapped in the wrong body" and "drowning." Pet. App. 223a. In 2021, after extensive assessments and consideration of risks and benefits, L.W. began treatment at Vanderbilt University Medical Center, first with puberty blockers and then, a year later, with estrogen. *Id.* at 225a-227a. L.W. is "terrified" of the permanent changes that would happen if that "care was taken away"; she "would not be able to think about anything else." *Id.* at 228a.

L.W.'s mother, Samantha Williams, says that "[o]nce L.W. started treatment, I could immediately see the

heavy weight being lifted off her shoulders." J.A. 83. Ms. Williams adds that, "[a]s a mother, I could not bear watching my child go through physical changes that would destroy her well-being and cause her life-long pain." J.A. 86.

Ryan Roe is a 16-year-old transgender boy. Pet. App. 233a. As he entered adolescence, he got "more and more anxious about puberty," to the point that he would "throw[] up before school every morning." *Id.* at 234a, 236a. He also "considered going mute to protect [himself] from the pain and anxiety that [his] voice caused." *Id.* at 235a. In 2022, after two years of psychotherapy and extensive counseling, Ryan began hormone therapy at Vanderbilt. *Id.* at 236a-237a. Since beginning treatment, he has "found [his] voice again," raising his hand in class, participating in school, and looking at himself in the mirror. *Id.* at 237a; see *id.* at 234a. Ryan says: "Gender-affirming health care saved my life and the idea of losing it terrifies me." *Id.* at 234a.

Ryan's mother, Rebecca Roe, says "[t]his treatment has changed my son's life." Pet. App. 244a. Ryan "suffered" from dysphoria "[f]or years," but he has now "transformed back into the vocal, outgoing child that we saw before puberty." *Ibid.* His mother says that "trying to manage medical care outside of Tennessee or being forced to move would be terribly difficult" for their family. *Id.* at 245a. But for Ms. Roe and her husband, "[i]t is simply not an option to cut Ryan off from this care"; as she put it, "I worry about his ability to survive and losing him would break me." *Id.* at 246a.

John Doe is a 13-year-old transgender boy. Pet. App. 229a-230a. From an early age, he knew he was a boy, choosing a male name for himself and socially transitioning in school. *Id.* at 230a. He is terrified of

"under[going] the wrong puberty" because he knows that "some of those changes could be permanent." *Id.* at 232a. In 2021, after years of psychotherapy and endocrine monitoring, and extensive discussion of the risks and benefits of further treatment, John was allowed to start puberty-delaying medication. *Id.* at 231a. If John "didn't have access to this medication," he "would have an incredibly difficult time wanting to be around other people and go to school." *Id.* at 232a. He says: "I've gone through a lot to finally get to the happy, healthy place where I am and I desperately hope that doesn't all get taken away from me." *Ibid.*

John's mother, Jane Doe, says that John "knew from a very young age who he was," and when he started puberty blockers after a "slow and deliberative" "informed consent process," "it was like a weight was lifted for him." J.A. 88, 92. John's "relief at no longer having to carry the stress of an impending puberty that felt completely wrong for him was palpable." J.A. 92. "John's gender transition has not been easy," and his mother "shed many tears during the first year of this process." J.A. 95. But it is "the one thing" that gives Ms. Doe hope that "John will have a fulfilling life." J.A. 94.

2. Private plaintiffs sued respondents, Tennessee officials responsible for enforcing SB1, in the United States District Court for the Middle District of Tennessee. Among other claims, private plaintiffs alleged that SB1 violates the Equal Protection Clause. The United States intervened under 42 U.S.C. 2000h-2, which authorizes intervention in a private equal-protection suit "if the Attorney General certifies that the case is of general public importance."

3. The district court granted private plaintiffs' motion for a preliminary injunction. Pet. App. 130a-218a.

As relevant here, the court held that SB1 likely violates the Equal Protection Clause. *Id.* at 148a-205a.

The district court held that SB1 is subject to heightened scrutiny because it discriminates based on sex, both by "demarcat[ing] its ban(s) based on a minor's sex" and by "treat[ing] similarly-situated individuals differently based on transgender status." Pet. App. 164a, 175a; see *id.* at 161a-175a. The court also held that SB1 independently triggers heightened scrutiny because it "expressly and exclusively targets transgender people," who, the court held, constitute a quasi-suspect class. *Id.* at 152a; see *id.* at 151a-161a.

After reviewing extensive record evidence—including testimony from experienced pediatric endocrinologists, specialists in adolescent psychiatry, and leading researchers—the district court held that SB1 likely fails heightened scrutiny because it is not "substantially related to an important state interest." Pet. App. 182a. The court found that "the benefits of the medical procedures banned by SB1 are well-established." *Id.* at 197a. The court determined that the relevant clinical guidelines are reliable, supported by evidence, and provide "the prevailing standards of care." *Id.* at 181a; see *id.* at 178a-181a. At the same time, the court found that "the weight of the evidence" did not support respondents' contention that "either puberty blockers or cross-sex hormones pose serious risks" to transgender adolescents. *Id.* at 197a; see *id.* at 197a-199a. The court also emphasized that SB1 is "severely underinclusive" because "it bans [the prohibited] procedures for a tiny fraction of minors, while leaving them available for all other minors (who would be subjected to the very risks that the state asserts SB1 is intended to eradicate)." *Id.* at 204a-205a.

4. A divided panel of the Sixth Circuit granted respondents' motion for a stay pending appeal and, after expedited briefing, reversed the preliminary injunction. Pet. App. 1a-101a; see *id.* at 102a-124a (stay opinion).[6]

a. As relevant here, the Sixth Circuit rejected private plaintiffs' equal-protection claim. Pet. App. 30a-50a. The court held that despite SB1's explicit sex-based terms, the law is subject only to rational-basis review because it "regulate[s] sex-transition treatments for all minors, regardless of sex." *Id.* at 32a. The court held that a law that relies on sex triggers heightened scrutiny only if it "perpetuates invidious stereotypes or unfairly allocates benefits and burdens." *Id.* at 39a. And the court believed that SB1 is not such a law. *Ibid.* The court acknowledged that this Court adopted a different understanding of sex discrimination in *Bostock* v. *Clayton County*, 590 U.S. 644 (2020). But the Sixth Circuit held that *Bostock*'s "reasoning applies only to Title VII." Pet. App. 40a.

The Sixth Circuit did not question the district court's conclusion that SB1 discriminates based on transgender status. But the Sixth Circuit held that transgender individuals do not qualify as a quasi-suspect class and that discrimination based on transgender status therefore triggers only rational-basis review. Pet. App. 44a-46a.

Applying that deferential standard, the Sixth Circuit concluded that the Tennessee legislature could have

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[6] The Sixth Circuit consolidated this case for argument with *Doe 1* v. *Thornbury*, No. 23-5609, an appeal from a preliminary injunction against enforcement of a Kentucky law similar to SB1. Pet. App. 10a-12a. The plaintiffs in that case have also sought certiorari. See *Doe 1* v. *Kentucky*, petition for cert. pending, No. 23-492 (filed Nov. 3, 2023).

rationally concluded that SB1 was an appropriate response to perceived risks and uncertainties associated with puberty blockers and hormone therapy. Pet. App. 49a-50a. The court acknowledged the countervailing evidence reflected in the district court's findings, which it did not question. *Id.* at 50a. But the Sixth Circuit explained that the rational-basis standard does not allow a court to enjoin a law based on a disagreement with a State's "assessment of the risks and the right response to those risks." *Ibid.*

b. Judge White dissented. Pet. App. 56a-101a. Because "sex and gender conformity each 'play an unmistakable role'" in SB1's prohibitions, she concluded that the law presents "an open-and-shut case of facial classifications subject to intermediate scrutiny." *Id.* at 73a (brackets, citation, and ellipsis omitted). Under SB1, Judge White emphasized, "medical procedures that are permitted for a minor of one sex are prohibited for a minor of another sex." *Id.* at 72a (citation omitted). And Judge White explained that SB1 "condition[s] the availability of procedures on a minor's conformity with societal expectations associated with the minor's assigned sex" by "bar[ring] treatment when sought 'for the purpose of' inducing physiological changes, like secondary sex characteristics, that are 'inconsistent with' how society expects boys and girls to appear." *Ibid.* (quoting Tenn. Code Ann. § 68-33-103(a)).

Judge White concluded that SB1 cannot withstand heightened scrutiny because its "text[] effectively reveal[s] that [its] purpose is to force boys and girls to *look* and *live* like boys and girls." Pet. App. 85a. Nor, in her view, did respondents refute the district court's "robust factual findings" showing "that banning these treatments is [not] beneficial to minors." *Ibid.* And she

warned that minor plaintiffs face irreparable harm absent an injunction "because progressing through adolescence untreated leads to daily anguish and makes adult treatment more complicated." *Id.* at 98a.

SUMMARY OF ARGUMENT

I. SB1 warrants heightened scrutiny twice over: It explicitly classifies based on sex and it discriminates based on transgender status. Indeed, one of its declared purposes is to enforce gender conformity and discourage adolescents from identifying as transgender. The Sixth Circuit erred in holding that such a law is subject to no greater scrutiny than mundane economic regulation.

A. This Court has consistently held that all sex-based classifications are subject to heightened scrutiny because such classifications too often reflect stereotypes about how men and women should look or act. Heightened scrutiny allows States to draw sex-based lines when necessary to serve important interests, but it guards against the "danger" that "government policies that professedly are based on reasonable considerations in fact may be reflective of 'archaic and overbroad' generalizations about gender." *J.E.B.* v. *Alabama*, 511 U.S. 127, 135 (1994) (citation omitted).

By its terms, SB1 prohibits all medical treatments intended to allow "a minor to identify with, or live as, a purported identity inconsistent with the minor's sex" or to treat "purported discomfort or distress from a discordance between the minor's sex and asserted identity" —while permitting the exact same treatments when prescribed for any other purpose. Tenn. Code Ann. § 68-33-103(a)(1). Put simply, an adolescent assigned female at birth cannot receive puberty blockers or testosterone to live as a male, but an adolescent assigned

male at birth can. And that focus on sex and gender conformity is deliberate: SB1 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." *Id.* § 68-33-101(m). That is sex discrimination.

In holding otherwise, the Sixth Circuit contradicted this Court's precedent and fundamentally misunderstood the role of heightened scrutiny. Most strikingly, the Sixth Circuit asserted the authority to dispense with heightened scrutiny altogether for sex-based classifications it deemed benign or justified. But heightened scrutiny applies even when a legislature asserts that it had good reason to classify based on sex; indeed, the whole point of the inquiry is to give courts a principled yardstick for measuring such justifications. The Sixth Circuit seriously erred in refusing to apply heightened scrutiny based on considerations that are relevant only in determining whether a sex-based classification *withstands* the scrutiny this Court's precedents require.

B. SB1 also discriminates based on transgender status by restricting care only for transgender individuals based on an avowed interest in discouraging adolescents from identifying as transgender. Such discrimination independently warrants heightened scrutiny because transgender individuals satisfy all of the hallmarks of a quasi-suspect class: Transgender individuals have historically been and continue to be subject to discrimination; transgender status bears no relation to a person's ability to contribute to society; transgender individuals are a discrete and identifiable minority; and transgender individuals have not been able to meaningfully vindicate their rights through the political process in much of the country—as evidenced by the recent

wave of laws targeting transgender individuals in Tennessee and other States.

II. Because the Sixth Circuit held that SB1 was subject only to rational-basis review, it never asked whether SB1 could survive heightened scrutiny. This Court should adhere to its usual practice and remand to allow the Sixth Circuit to address that record-intensive question in the first instance. But if the Court considers the issue, it should hold that SB1 cannot survive heightened scrutiny. Although heightened scrutiny certainly does not foreclose regulation of gender-affirming care, SB1's categorical ban is not substantially related to an important government interest.

SB1 has two declared purposes. One is to encourage minors to "appreciate their sex" by prohibiting treatments "that might encourage minors to become disdainful of their sex." Tenn. Code Ann. § 68-33-101(m). The other is "to protect the health and welfare of minors," *id.* § 68-33-101(a), by prohibiting medical treatments that carry "risks and harms," *id.* § 68-33-101(d). SB1 is a near-perfect fit for the first interest—*i.e.*, for a legislature seeking to ban treatments "that might encourage minors to become disdainful of their sex." *Id.* § 68-33-101(m). But the State has never tried to argue that an interest in discouraging people from identifying as transgender or encouraging them to present consistent with their sex assigned at birth is an important governmental objective. For good reason: This Court has recognized that a "statutory objective" that rests on "stereotypic notions" about gender is itself "illegitimate." *Mississippi Univ. for Women* v. *Hogan*, 458 U.S. 718, 725 (1982).

The State thus must justify SB1 based on its other asserted interest—protecting the health and welfare of

adolescents. But as a medical regulation, SB1 suffers from glaring defects: The legislature ignored the benefits of gender-affirming care, substantially overstated the risks of that care, and adopted a categorical prohibition that is both severely overinclusive and severely underinclusive when viewed in light of those risks. Tennessee's invocation of health and welfare thus cannot justify its complete ban on medical treatments that offer critical benefits to adolescents and their families.

ARGUMENT

In the past three years, 22 States have enacted laws that categorically prohibit transgender adolescents from receiving evidence-based medical care to treat gender dysphoria—while imposing no restrictions when the same treatments are provided for any other purpose. By their terms, operation, and design, those laws classify based on sex and discriminate against transgender individuals. And the laws are inflicting profound harms on transgender adolescents and their families by denying medical treatments that the affected adolescents, their parents, their doctors, and medical experts have all concluded are appropriate and necessary to treat a serious medical condition.

The Sixth Circuit did not suggest that SB1 could survive heightened scrutiny. Instead, it held that some sex-based lines do not trigger heightened scrutiny at all—and that laws discriminating based on transgender status *never* warrant anything more than rational-basis review. Those holdings are wrong. And those errors resulted in the court applying the most deferential standard in constitutional law to a statute premised on a State's declared "interest in encouraging minors to appreciate their sex." Tenn. Code Ann. § 68-33-101(m).

No one doubts that States have a compelling interest in protecting minors and ample authority to regulate the practice of medicine. So long as a State does not legislate based on sex or transgender status, its regulations receive only deferential rational-basis review. And even when a State draws lines based on sex or transgender status, intermediate scrutiny leaves room for appropriately tailored regulations. But SB1's categorical ban on a widely accepted treatment for a serious medical condition cannot survive the more searching review that this Court's precedents demand.

I. SB1 WARRANTS HEIGHTENED SCRUTINY

SB1 warrants heightened scrutiny both because it relies on sex-based classifications and because it discriminates based on transgender status.

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

This Court has repeatedly held that all laws that classify based on sex are subject to heightened scrutiny because such classifications too often reflect stereotypes or overbroad generalizations about men and women. SB1 is just such a law: It draws explicit sex-based lines, and it does so in service of a declared state interest in ensuring that adolescents live in accordance with their sex assigned at birth. The Sixth Circuit's contrary conclusion contradicts this Court's precedent.

1. SB1 relies on sex-based classifications

a. The Equal Protection Clause provides that a State may not "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. Amend. XIV, § 1. Although the ratification of the Fourteenth Amendment wrote that enduring principle of equality into the Constitution, it did not immediately

end our Nation's "long and unfortunate history of sex discrimination." *J.E.B.* v. *Alabama*, 511 U.S. 127, 136 (1994) (citation omitted). To the contrary, laws discriminating based on sex remained common into the 20th century, and until the 1970s this Court reviewed sex-based classifications deferentially. See *United States* v. *Virginia*, 518 U.S. 515, 531-532 (1996) (*VMI*).

But in 1971, "for the first time in our Nation's history, this Court ruled in favor of a woman who complained that her State had denied her the equal protection of its laws." *VMI*, 518 U.S. at 532; see *Reed* v. *Reed*, 404 U.S. 71, 73 (1971). And just a few years later, the Court "announced that '[t]o withstand constitutional challenge, . . . classifications by gender must serve important governmental objectives and must be substantially related to achievement of those objectives.'" *VMI*, 518 U.S. at 558 (Rehnquist, C.J., concurring in the judgment) (quoting *Craig* v. *Boren*, 429 U.S. 190, 197 (1976)). This Court has "adhered to that standard of scrutiny ever since." *Ibid.* (collecting cases). It is thus firmly established that courts must apply "a heightened standard of review" to "[l]egislative classifications based on gender." *City of Cleburne* v. *Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985).

This Court has explained that sex-based classifications warrant heightened scrutiny because sex "generally provides no sensible ground for differential treatment," *City of Cleburne*, 473 U.S. at 440, and because sex-based lines all too often reflect stereotypes or "overbroad generalizations about the different talents, capacities, or preferences of males and females," *VMI*, 518 U.S. at 533. In the centuries before *Craig*, "the lawbooks of our Nation were rife with overbroad generalizations about the way men and women are." *Sessions*

v. *Morales-Santana*, 582 U.S. 47, 57, (2017). Such generalizations, "descriptive though they may be of the way many people still order their lives," "have a constraining impact," *id.* at 63—an impact that can be particularly harmful to individuals who fall "outside the average description," *VMI*, 518 U.S. at 550. Accordingly, "all gender-based classifications" must satisfy "heightened scrutiny." *Id.* at 555 (citation omitted); accord *Morales-Santana*, 582 U.S. at 57.

b. SB1 classifies based on sex, through and through. Most obviously, the law "creates a sex-based classification on its face" by defining the prohibited medical care based on the patient's sex assigned at birth. Pet. App. 164a. Specifically, SB1 bans puberty blockers 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" or treating distress "from a discordance between the minor's sex" and gender identity. Tenn. Code Ann. § 68-33-103(a)(1). Because SB1's prohibitions "cannot be stated without referencing sex," they are "inherently based upon a sex-classification." *Whitaker* v. *Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017), cert. dismissed, 583 U.S. 1165 (2018).

In operation, as mandated by its text, SB1 restricts care only when it would induce physiological effects inconsistent with an individual's sex assigned at birth. An adolescent assigned female at birth cannot receive puberty blockers or testosterone to live and present as a male, but an adolescent assigned male at birth can. See Tenn. Code Ann. § 68-33-103(a) and (b). And vice versa, an adolescent assigned male at birth cannot receive puberty blockers or estrogen to live and present as a

female, but an adolescent assigned female at birth can. See *ibid.*; Pet. App. 165a.

That is sex discrimination. As this Court has explained, when a law or policy "penalizes a person identified as male at birth for traits or actions that it tolerates in [a person] identified as female at birth," the person's "sex plays an unmistakable" role. *Bostock* v. *Clayton County*, 590 U.S. 644, 660 (2020). And because holding other things constant but "changing the [minor]'s sex * * * yield[s] a different" outcome, *id.* at 659—that is, "[b]ecause [a] minor's sex at birth determines whether or not the minor can receive certain types of medical care"—a ban on gender-affirming care necessarily "discriminates on the basis of sex." *Brandt* v. *Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022). Put differently, there is no way to determine whether these treatments must be withheld from any particular minor "without considering [the minor's] sex." *Bostock*, 590 U.S. at 668.

That sex-based line-drawing is not an incidental effect of SB1—it is the law's very purpose. By its own account, SB1 is designed to enforce conformity with sex assigned at birth. The statutory findings candidly declare that Tennessee has a "compelling interest in encouraging minors to appreciate their sex" and in prohibiting medical care "that might encourage minors to become disdainful of their sex." Tenn. Code Ann. § 68-33-101(m). And SB1 bars medical treatments only when sought "for the purpose of" inducing physiological changes, like secondary sex characteristics, that are "inconsistent with" how society expects boys and girls to appear. *Id.* § 68-33-103(a)(1)(A).

Indeed, SB1 specifically excludes medical interventions for those with a "disorder of sex development," meaning "a physical or chemical abnormality present in

a minor that is inconsistent with the normal development of a human being of the minor's sex" (sometimes called an intersex condition). Tenn. Code Ann. §§ 68-33-102(1), 68-33-103(b)(1)(A). In other words, SB1 expressly permits the very same medical interventions when provided to assist minors in physically *conforming to* their sex assigned at birth. For example, hypogonadotropic hypogonadism (the inability to produce sex hormones) in patients assigned female at birth is commonly treated with estrogen to bring on female puberty, Pet. App. 266a, and complete androgen insensitivity (a condition that prevents the body from responding to androgen) in patients assigned female at birth is commonly treated with hormone replacement therapy, J.A. 131.

"For close to a half century," the Court has "viewed with suspicion laws that rely on 'overbroad generalizations about the different talents, capacities, or preferences of males and females.'" *Morales-Santana*, 582 U.S. at 62 (citation omitted). SB1 shares that same design: It seeks to enforce conformity with characteristics that are "typically male or typically female." *VMI*, 518 U.S. at 541. Indeed, its "text[] effectively reveal[s] that [its] purpose is to force boys and girls to *look* and *live* like boys and girls." Pet. App. 85a (White, J., dissenting). SB1 is thus subject to heightened scrutiny.

2. The Sixth Circuit failed to justify its contrary holding

The Sixth Circuit failed to justify its refusal to apply heightened scrutiny. Indeed, the court's shifting rationales underscore its departure from the fundamental equal-protection principles reflected in this Court's precedents.

a. The Sixth Circuit at times appeared to deny that SB1 relies on sex-based classifications, asserting that the law regulates "evenhandedly" by prohibiting "sex-transition treatments for all minors, regardless of sex." Pet. App. 31a-32a. But whether a treatment is a prohibited "sex-transition treatment" for any given individual depends, of course, on the individual's sex assigned at birth. See pp. 21-23, *supra*. Prescribing estrogen to a minor identified at birth as female is permitted—but prescribing the same hormone to a minor identified at birth as male is a prohibited "sex-transition treatment." And this Court has rejected the argument that a law that classifies based on a protected characteristic such as race or sex is insulated from heightened review simply because it applies to members of all races or to both sexes. "It is axiomatic," for example, "that racial classifications do not become legitimate on the assumption that all persons suffer them in equal degree." *Powers* v. *Ohio*, 499 U.S. 400, 410 (1991); see *Flowers* v. *Mississippi*, 588 U.S. 284, 299 (2019).

The Sixth Circuit recognized that race-based classifications trigger strict scrutiny "even when they may be said to burden or benefit the races equally." Pet. App. 37a (citation omitted). And the court acknowledged this Court's admonition "that 'all' sex-based classifications receive heightened review." *Id.* at 38a (quoting *VMI*, 518 U.S. at 555). But the Sixth Circuit nonetheless maintained that sex-based lines do *not* invariably warrant heightened scrutiny, asserting that this Court's decisions "show only that the government cannot classify individuals by sex when doing so perpetuates invidious stereotypes or unfairly allocates benefits and burdens." *Id.* at 39a. The Sixth Circuit thus held that sex-based classifications that reflect "'enduring' differences

between men and women do not trigger heightened review." *Ibid.* (quoting *VMI*, 518 U.S. at 533).

The Sixth Circuit's assertion that courts can dispense with heightened scrutiny for an ill-defined set of sex-based classifications they regard as benign directly contradicts this Court's precedent. The Court has repeatedly instructed that heightened scrutiny applies to "all" sex-based classifications, not just some of them. Indeed, the Court has applied heightened scrutiny to statutes that classified in "gender specific terms" even when it ultimately *upheld* those sex-based classifications as legitimate responses to "biological difference[s]" between men and women. *Nguyen* v. *INS*, 533 U.S. 53, 64 (2001); see *id.* at 60-61; see also, *e.g.*, *Miller* v. *Albright*, 523 U.S. 420, 436, 444-445 (1998) (plurality opinion); *Michael M.* v. *Superior Ct.*, 450 U.S. 464, 471-473 (1981) (plurality opinion).

The Sixth Circuit emphasized this Court's statement that it has not "equated gender classifications, for all purposes, to classifications based on race." Pet. App. 37a (quoting *VMI*, 518 U.S. at 532) (brackets omitted). But the *VMI* Court was simply noting that sex-based classifications are subject to heightened scrutiny rather than the strict scrutiny that applies to race-based classifications. See 518 U.S. at 532 n.6 ("The Court has thus far reserved most stringent judicial scrutiny for classifications based on race or national origin."). And the Court has explained that a more forgiving standard applies in this context precisely because "[p]hysical differences between men and women" may sometimes justify legislative reliance on sex. *Id.* at 533. In other words, the very purpose of heightened scrutiny is to identify those sex-based classifications that reflect legitimate and appropriately tailored efforts to further important

state interests rather than reliance on stereotypes or generalizations. *Ibid.*; see *Nguyen*, 533 U.S. at 60-70. The Sixth Circuit seriously erred in refusing to apply heightened scrutiny at all based on considerations that are instead relevant only to whether SB1 *survives* the scrutiny this Court's precedents require.

b. The Sixth Circuit asserted that its approach was supported by this Court's decisions holding that "heightened review does not apply in the context of laws that regulate medical procedures unique to one sex or the other." Pet. App. 39a (citing *Dobbs* v. *Jackson Women's Health Org.*, 597 U.S. 215, 236-237 (2022), and *Geduldig* v. *Aiello*, 417 U.S. 484, 496 n.20 (1974)); see *id.* at 33a-34a. But SB1 fundamentally differs from the laws at issue in those cases because it regulates medical treatments that all individuals *can* receive, regardless of their sex: Healthcare providers can "[p]rescrib[e], administer[], or dispens[e] * * * puberty blocker[s] or hormone[s]" to any person regardless of the person's sex assigned at birth. Tenn. Code Ann. § 68-33-102(5)(B).

The Sixth Circuit suggested that prescribing those treatments for gender dysphoria is not the same as prescribing them for any other condition because the "cost-benefit analysis," Pet. App. 34a—or "risk-reward assessment," *id.* at 37a—differs. But once again, that "conflates the classifications drawn by the law with the state's justification for it." *Brandt*, 47 F.4th at 670. The strength of the State's justification—including the risks and benefits of gender-affirming care—may be highly relevant to determining whether SB1 survives heightened scrutiny. See pp. 34-49, *infra*. But it provides no basis for refusing to subject the law's facially sex-based classification to heightened scrutiny at all.

Relatedly, the Sixth Circuit posited that SB1 classifies based only on "medical condition," not sex. Pet. App. 31a. SB1's plain text shows otherwise. Again, SB1's declared goals include "encouraging minors to appreciate their sex" and banning treatments "that might encourage minors to become disdainful of their sex." Tenn. Code Ann. § 68-33-101(m). SB1 achieves that goal by drawing sex-based lines, prohibiting the covered treatments if they are provided "for the purpose of" inducing physiological changes "inconsistent with the minor's sex." *Id.* § 68-33-103(a)(1)(A). Reframing SB1 as a ban on certain treatments for gender dysphoria does not eliminate the sex-based classifications inherent in its terms and operation. See pp. 21-23, *supra*.

c. Finally, the Sixth Circuit held that *Bostock* is inapposite because the "text-driven reasoning" in that decision "applies only to Title VII." Pet. App. 40a. Of course, "Title VII and the Equal Protection Clause are not identical." *Id.* at 79a (White, J., dissenting). But the Sixth Circuit did "not explain why or how any difference in language" would "require[] different standards for determining whether a facial classification exists in the first instance," such that a restriction can simultaneously be sex-based under Title VII yet sex-neutral under the Equal Protection Clause. *Id.* at 80a. That inconsistency would make no sense—as the Fourth, Ninth, and Tenth Circuits have already recognized in holding that *Bostock*'s fundamental insight about the nature of sex discrimination applies in the equal-protection context. See *Kadel* v. *Folwell*, 100 F.4th 122, 153-154 (4th Cir. 2024) (en banc), petition for cert. pending, No. 24-90 (filed July 25, 2024), and petition for cert. pending, No. 24-99 (filed July 26, 2024); *Hecox* v. *Little*, 104 F.4th 1061, 1080 (9th Cir. 2024), petition

for cert. pending, No. 24-38 (filed July 11, 2024); *Fowler* v. *Stitt*, 104 F.4th 770, 793-794 (10th Cir. 2024).

In *Bostock*, the Court considered Title VII's prohibition on discrimination "against any individual * * * because of such individual's * * * sex." 590 U.S. at 655 (quoting 42 U.S.C. 2000e-2(a)(1)). In interpreting that language, this Court explained that Title VII "incorporates the 'simple' and 'traditional' standard of but-for causation." *Id.* at 656 (citation omitted). The Court concluded that "sex is necessarily a but-for cause" of discrimination on the basis of gender identity "because it is impossible to discriminate against a person for being * * * transgender without discriminating against that individual based on sex." *Id.* at 660, 661 (emphasis omitted).

So too here. As *Bostock* explained, if an employer "fires a transgender person who was identified as a male at birth" because the employee "now identifies as a female" yet "tolerate[s] the same trait" in "an employee identified as female at birth," the employer has engaged in discrimination based on sex because it has "intentionally penalize[d] a person identified as male at birth for traits or actions that it tolerates in an employee identified as female at birth." 590 U.S. at 660. Exactly the same thing is true under the Equal Protection Clause: If, for example, a State prohibits an adolescent assigned female at birth from receiving testosterone to live as a male, but allows an adolescent assigned male at birth to receive the same treatment, the State has relied on a sex-based classification—and thus must justify its law under heightened scrutiny.

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

SB1 is also subject to heightened scrutiny because it "expressly and exclusively targets" transgender

individuals, who satisfy all of the hallmarks of a quasi-suspect class. Pet. App. 152a. In determining whether to recognize a quasi-suspect class, this Court has considered four factors: (1) whether the class has historically "been subjected to discrimination," *Lyng* v. *Castillo*, 477 U.S. 635, 638 (1986); (2) whether the class has a defining characteristic that "frequently bears no relation to [the] ability to perform or contribute to society," *City of Cleburne*, 473 U.S. at 441 (citation omitted); (3) whether members of the class have "obvious, immutable, or distinguishing characteristics that define them as a discrete group," *Lyng*, 477 U.S. at 638; and (4) whether the class lacks political power, see *Bowen* v. *Gilliard*, 483 U.S. 587, 602 (1987).

Transgender individuals readily satisfy each of those requirements. First, it is undeniable that transgender individuals, as a class, have "historically been subject to discrimination including in education, employment, housing, and access to healthcare." Pet. App. 159a (citation omitted). Second, whether individuals are transgender plainly bears no relation to their ability to contribute to society. *Id.* at 160a. Third, transgender individuals are a minority accounting for roughly one percent of the population that shares "obvious, immutable, or distinguishing characteristics that define them as a discrete group," *Gilliard*, 483 U.S. at 602 (citation omitted): their gender identities do not align with their respective sexes assigned at birth. Pet. App. 160a. Finally, transgender individuals have not "yet been able to meaningfully vindicate their rights through the political process" in much of the Nation. *Grimm* v. *Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 613 (4th Cir. 2020), cert. denied, 141 S. Ct. 2878 (2021). They are "underrepresented in every branch of government." *Ibid.*

And in recent years, States across the country have enacted a host of laws targeting transgender individuals. See pp. 7-8 & nn. 3-4, *supra*. Many courts have thus recognized transgender status as a quasi-suspect classification. See *Hecox*, 104 F.4th at 1079; *Grimm*, 972 F.3d at 610 (collecting cases).

In holding otherwise, the Sixth Circuit appeared to rely primarily on its view that lower courts should not recognize a quasi-suspect class that this Court had not already recognized. Pet. App. 44a. Even if that view had merit, it has no bearing on this Court's consideration of the issue. The Sixth Circuit also asserted that transgender status "is not necessarily immutable." *Id.* at 46a. But even assuming that is correct, immutability is not required; it is sufficient that transgender individuals share "distinguishing characteristics that define them as a discrete group." *Lyng*, 477 U.S. at 638. "[C]lassifications based on alienage," for example, "are inherently suspect" even though alienage—*i.e.*, the status of being a noncitizen—is not immutable. *Graham* v. *Richardson*, 403 U.S. 365, 372 (1971).

The Sixth Circuit further asserted that transgender individuals are not subject to "a skewed or unfair political process." Pet. App. 46a. But the fact that the position of some transgender individuals in society "has improved markedly in recent decades," *Frontiero* v. *Richardson*, 411 U.S. 677, 685 (1973) (plurality opinion), does not suggest that transgender individuals as a class wield political power; the same was true of women when this Court recognized that sex-based classifications are subject to heightened scrutiny. *Id.* at 685-686. And the recent wave of legislation targeting transgender individuals across different areas of life decisively refutes

any suggestion that they have no need for the protection of the courts.

* * * * *

It is worth underscoring the implications of the Sixth Circuit's holding that laws like SB1 receive only the most deferential review. Most immediately, SB1 prohibits transgender adolescents, their parents, and their doctors from making critically important and intensely personal decisions about the appropriate medical treatment for what everyone agrees is a serious medical condition. For many parents, questions about how best to raise transgender adolescents—including whether and how to take steps to enable them to live in accordance with their gender identity—are extraordinarily challenging. John Doe's mother put the point in plain terms: "This is what I think many people don't understand: no parent would choose to make their child different, or choose a harder path in life for their child." J.A. 95. "As parents, we're supposed to pave the path so that our children's lives can be easier and better." *Ibid.* For parents of transgender children, however, there is no "easy" path in "a world full of hostility towards transgender people." *Ibid.* So "you don't put yourself and your child through this unless you know it is the right thing to do"—the necessary action to keep your child "happy," "healthy," and "safe[]." J.A. 94-96. SB1 prevents parents from making that deeply personal and consequential choice by drawing explicit sex-based lines—yet the Sixth Circuit held that it is subject to no more scrutiny than run-of-the-mill economic regulations.

Nor are the consequences of the Sixth Circuit's decision limited to this particular context. The necessary implication of the court's holding that SB1's sex-based

line-drawing does not trigger heightened scrutiny is that a law categorically banning gender-affirming care for *adults* would likewise receive only rational-basis review. The same would be true for any number of laws that a State might enact to further an asserted interest in encouraging individuals to "appreciate their sex," Tenn Code Ann. § 68-33-101(m)—including laws requiring transgender adolescents or adults to identify, dress, or otherwise present themselves in a manner consistent with their sex assigned at birth. The Sixth Circuit profoundly erred in holding that such laws are subject to no greater judicial scrutiny than a law banning compounded milk, regulating optometrists, or expelling hotdog pushcarts from New Orleans' French Quarter.

II. SB1 CANNOT SURVIVE HEIGHTENED SCRUTINY

To satisfy heightened scrutiny, Tennessee must show that SB1 serves "important governmental objectives," and that "the discriminatory means employed" is "substantially related to the achievement of those objectives." *VMI*, 518 U.S. at 533 (citation omitted). The State's justification "must be genuine, not hypothesized or invented *post hoc* in response to litigation." *Ibid.*

The Sixth Circuit never considered whether the State had carried that burden because it concluded that SB1 was subject only to rational-basis review. Because this Court is "a court of review, not of first view," its typical practice in such a case is to remand to allow the lower courts to apply the correct legal standard in the first instance. *Moody* v. *NetChoice, LLC*, 144 S. Ct. 2383, 2399 (2024) (citation omitted). That usual course is especially appropriate here, where the record evidence is extensive, disputed, and technically complex.

If, however, this Court considers the issue, it should hold that a categorical ban like SB1 cannot survive

heightened scrutiny, as every other court to consider the question has recognized. Pet. App. 181a-205a.[7] Heightened scrutiny "does not make sex"—or transgender status—"a proscribed classification." *VMI*, 518 U.S. at 533. And a decision holding that SB1 is invalid would not foreclose other, more tailored regulations of the use of puberty blockers or hormone therapy to treat gender dysphoria. But Tennessee has failed to justify its categorical ban on medical treatments that offer critical benefits to adolescents and their families.

A. Tennessee's Interest In Discouraging Minors From Becoming "Disdainful Of Their Sex" Cannot Justify SB1

SB1 declares that it has two distinct purposes. One is to "encourag[e] minors to appreciate their sex" by prohibiting treatments "that might encourage minors to become disdainful of their sex." Tenn. Code Ann. § 68-33-101(m). The other is "to protect the health and welfare of minors," *id.* § 68-33-101(a), by prohibiting medical procedures that carry "risks and harms," *id.* § 68-33-101(d); see *id.* at 68-33-101(b)-(e).

SB1 is perfectly crafted to serve the first interest—but the State has never tried to argue that an interest in discouraging people from being transgender or encouraging them to present as their sex assigned at birth is an "important governmental objective[]." *VMI*, 518 U.S. at 533; see Pet. App. 193a n.52. Nor could the State make that showing, because this Court has recognized that a "statutory objective" that rests on "stereotypic notions" about gender is itself "illegitimate."

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[7] See Pet. 28 & n.7 (collecting cases); see also *Doe* v. *Ladapo*, No. 23-cv-114, 2024 WL 2947123, at *28, *39 (N.D. Fla. June 11, 2024), appeal pending, No. 24-11996 (11th Cir. filed June 18, 2024), and appeal pending, No. 24-12100 (11th Cir. filed June 27, 2024).

Mississippi Univ. for Women v. *Hogan*, 458 U.S. 718, 725 (1982); accord, *e.g.*, *VMI*, 518 U.S. at 533; see pp. 19-21, *supra*. A law aimed at encouraging "boys and girls to *look* and *live* like boys and girls," Pet. App. 85a (White, J., dissenting), rests on just such notions. Although most people live their lives physically conforming to the usual expectations for their sex assigned at birth, some—including people who are transgender—do not. Measures aimed at enforcing such conformity thus necessarily rest on "overbroad generalizations about the way men and women are." *Morales-Santana*, 582 U.S. at 57.

Because one of SB1's two declared objectives is illegitimate, the State must justify SB1 based on its asserted interest in protecting the health and safety of adolescents. The State cannot do so. The State ignored the benefits of gender-affirming care, exaggerated the risks of that care, and adopted a sweeping categorical ban that it made no attempt to tailor to its asserted interest in protecting transgender adolescents' health. All of those features of SB1 make perfect sense for a legislature seeking to ban treatments "that might encourage minors to become disdainful of their sex." Tenn. Code Ann. § 68-33-101(m). But they are fatal to any argument that the law is substantially related to the State's asserted interest in protecting adolescent health.

B. SB1 Ignores The Benefits Of Gender-Affirming Care

"Few if any drugs are completely safe in the sense that they may be taken by all persons in all circumstances without risk." *United States* v. *Rutherford*, 442 U.S. 544, 555 (1979). States that regulate medicine in order to protect their citizens' health and safety thus necessarily consider not just the risks associated with a

given treatment, but also the benefits. And that principle applies with special force where, as here, the medical community and the nation's leading hospitals overwhelmingly agree that the relevant care is necessary in appropriate cases. But Tennessee largely ignored the evidence demonstrating the medical benefits of gender-affirming care in enacting SB1. And the State's litigation efforts to plug that gap in the legislative record by minimizing the benefits of gender-affirming care are unpersuasive.

1. Tennessee failed to meaningfully consider the medical benefits associated with the banned treatments

SB1 purports to be premised on the "risks and harms" associated with puberty blockers and hormone therapy. Tenn. Code Ann. § 68-33-101(d). As explained more fully below—and as the district court found—those risks were exaggerated by Tennessee's experts, can be mitigated, and in any event are comparable to the risks associated with permitted uses of these treatments and a wide range of other pediatric treatments. See pp. 41-49, *infra*. Notably absent from the Tennessee legislature's findings, however, was any meaningful consideration of any of the medical benefits associated with gender-affirming care. That silence is striking. As the district court found, "every major medical organization to take a position on the issue," including the American Academy of Pediatrics and the American Medical Association, "agrees that puberty blockers and cross-sex hormone therapy are appropriate and medically necessary treatments for adolescents when clinically indicated." Pet. App. 198a. And the Nation's leading children's hospitals have centers that provide such care in appropriate cases. See p. 6 & n.2, *supra*.

Of course, state legislatures are not bound to follow the views of the medical community uncritically. But here, Tennessee rejected the medical consensus without engaging with the basis for that consensus or attempting to conduct its own weighing of the perceived risks against the countervailing benefits. Instead, the law misrepresents the state of medical opinion, asserting without citation that the prohibited treatments "are not consistent with professional medical standards." Tenn. Code Ann. § 68-33-101(c).

2. Extensive studies and clinical experience establish that treatment with puberty blockers and hormone therapy has critical benefits in appropriate cases

Tennessee's approach is all the more problematic because the medical consensus is grounded in a wealth of studies and clinical experience demonstrating that puberty blockers and hormone therapy have critical benefits for adolescents in need of such care. As the district court determined in detailed findings reviewable only for clear error, "the benefits of the medical procedures banned by SB1 are well-established by the existing record." Pet. App. 197a; see *Brnovich* v. *Democratic Nat'l Comm.*, 594 U.S. 647, 687 (2021).

a. Most urgently, gender dysphoria is associated with strikingly high risks of suicide. A survey of more than 2,800 transgender high school students, for example, found that 34.6% reported attempting suicide in the last 12 months. See p. 3 & n.1, *supra*. For parents of adolescents suffering from gender dysphoria, that risk is "terrif[ying]." Pet. App. 245a. To take just one family's experience, before Ryan received appropriate care, his mother was frightened by "how much Ryan was suffering," including by "engag[ing] in self-harm." *Id.* at

242a. And she is "worr[ied] about his ability to survive" absent care. *Id.* at 246a.

Critically, as the district court found, Pet. App. 196a, the available data show that treatment with puberty blockers and hormones is associated with meaningfully reduced suicidality among individuals suffering from gender dysphoria. See, *e.g.*, *id.* at 264a, 290a & n.14, 293a (collecting studies); J.A. 143-144 & nn. 5-8, 145-146 & nn. 9-12 (same). For example, a 2020 study "published in Pediatrics, the official journal of the American Academy of Pediatrics," concluded that "[t]reatment with pubertal suppression * * * was associated with lower odds of lifetime suicidal ideation." Pet. App. 196a, 264a (brackets omitted). Studies focused on the effects of hormone therapy show similar results. J.A. 145-146 & nn. 9-12.

The district court also found that "[t]he weight of evidence in the record suggests" that "treatment for gender dysphoria lowers rates of depression" and "additional mental health issues faced by transgender individuals." Pet. App. 196a. "Studies have repeatedly documented that puberty-delaying medication and gender affirming hormone therapy are associated with mental health benefits in both the short and long term." *Id.* at 290a; see *id.* at 290a n.14 (citing studies). Among other things, "[p]eer-reviewed cross-sectional and longitudinal studies have found that pubertal suppression is associated with a range of improved mental health outcomes for adolescents with gender dysphoria," including "statistically significant improvements" in anxiety, depression, disruptive behaviors, and global functioning. J.A. 143-144 & nn. 5, 7-8 (collecting studies). Studies focused on the effects of hormone therapy likewise show "improved mental health outcomes," including

with respect to anxiety and depression, for adolescents with gender dysphoria. J.A. 145-146 & nn. 9-11.

Clinical experience bears that out. See Pet. App. 194a-197a. One expert clinician, for example, explained that puberty blockers "completely resolved" suicidal ideation for many of his patients and that hormone therapy rendered psychiatric medications "no longer necessary" for others. *Id.* at 294a. Because of such mental health improvements, "school performance often improves as well." J.A. 966. The plaintiffs' own experiences further reinforce the point. Ryan Roe says that access to such care "gave [him] hope and a positive outlook on the world that [he] had lost." Pet. App. 237a. And L.W.'s mother says that "there [would] be devastating harm to L.W.'s mental health from the loss of access to her medication and healthcare." J.A. 85.

Finally, treatment with puberty blockers and hormone therapy "can eliminate or reduce the need for" more invasive procedures, including "surgical treatment" later in life. Pet. App. 263a. As discussed below, see pp. 40-41, *infra*, the evidence shows that individuals who experience sustained gender dysphoria as adolescents are highly likely to persist in their transgender identity in adulthood. For such individuals, postponing gender-affirming care will likely be more painful, more costly, and less effective—and the individual will suffer continued distress from gender dysphoria all the while. As a leading pediatric endocrinologist explains, "[d]enying pubertal suppression treatment and gender-affirming hormones to a transgender adolescent who needs the treatment will not cause the adolescent to stop being transgender"—but it will cause the adolescent "to experience distress" in the meantime. Pet. App. 270a. L.W.'s mother warned, for example, that loss of access

to gender-affirming care would cause "irreversible physical harm as [L.W.] would experience a puberty completely foreign to her and inconsistent with her gender." J.A. 85-86.

b. As the district court found, Tennessee's various litigation efforts to undermine that body of evidence are unpersuasive.

Tennessee principally criticizes as "low quality" the many studies, including long-term observational studies, supporting the use of puberty blockers and hormone therapy to treat gender dysphoria. *E.g.*, Br. in Opp. 9-10, 36 (citations omitted). But all observational studies—as contrasted with randomized or placebo-controlled studies—are generally labeled "low quality" under the relevant nomenclature. J.A. 110-114. Yet it is "commonplace" for clinical care to be provided based on such evidence—particularly in the pediatric context. Pet. App. 180a (citation omitted). Indeed, because of "the low prevalence of childhood disease," the "small market share for therapeutic agents in children," low funding levels, and challenges enrolling minors in research, "[r]ecommendations for pediatric care made by professional associations in guidelines are seldom based" on "randomized controlled trials." J.A. 113-114. For example, less than one percent of the American Heart Association's pediatric guidelines were based on randomized clinical trials. J.A. 114. And the Food and Drug Administration (FDA) approved the use of puberty blockers to treat precocious puberty based on observational studies—not randomized trials. J.A. 981.

Tennessee emphasizes that the FDA has not approved puberty blockers or hormones specifically to treat gender dysphoria. Br. in Opp. 7-8; see Pet. App. 27a. But "once the FDA approves a drug, healthcare

providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient." FDA, *Understanding Unapproved Use of Approved Drugs "Off Label"* (Feb. 5, 2018), https://perma.cc/A9DG-ML23. The FDA does not sua sponte approve additional uses of drugs approved for other indications, and drug sponsors may choose not to incur the time and expense of seeking such approval for any number of reasons. Accordingly, as the district court found, "off-label" use of approved drugs "is common in medicine generally and particularly in pediatrics." Pet. App. 202a (citation omitted). As especially pertinent here, that includes off-label use of both puberty blockers and hormones to treat conditions other than gender dysphoria. See, *e.g.*, Carla M. Lopez et al., *Trends in the "Off-Label" Use of GnRH Agonists Among Pediatric Patients in the United States*, 57 Clinical Pediatrics 1432, 1434-1435 (2018) (discussing off-label use of puberty blockers to treat children with short stature and adolescents diagnosed with certain cancers); Rodolfo A. Rey, *Recent advancement in the treatment of boys and adolescents with hypogonadism*, 13 Therapeutic Advances in Endocrinology & Metabolism 1, 7, 9 (2022) (discussing off-label use of certain testosterone treatments to treat hypogonadism and infants suffering from microphallus); Andrea Cignarella et al., *Pharmacological Approaches to Controlling Cardiometabolic Risk in Women with PCOS*, 21 Int'l J. of Molecular Sciences 3-7 (2020) (discussing off-label use of anti-androgen drugs to treat females with polycystic ovary syndrome).

Ultimately, Tennessee dismisses the demonstrated benefits of gender-affirming care because it asserts that many minors diagnosed with gender dysphoria will

"desist[]" in experiencing gender incongruence in adulthood. Br. in Opp. 7-8; see Tenn. Code Ann. § 68-33-101(h). But that claim is not substantiated by any of the data Tennessee cites, which is limited to studies focused on the persistence of gender dysphoria or gender nonconforming behavior in pre-pubertal children. Rather, adolescents who continue to have marked and sustained gender dysphoria in puberty "rarely come to identify with their assigned sex at birth." J.A. 151 (capitalization and emphasis altered); see Pet. App. 279a n.1. That distinction between early childhood and adolescence is critical: None of the relevant clinical guidelines recommend *any* medical intervention to treat gender dysphoria before the onset of puberty. Pet. App. 255a, 286a. In other words, the only patients eligible to receive the treatments that SB1 bans are highly likely to persist in their gender incongruence and gender dysphoria in adulthood. J.A. 151-152.

C. Tennessee Overstates The Risks Of The Banned Treatments

As the district court found, Tennessee also errs on the other side of the ledger by greatly exaggerating the risks of the banned treatments.

1. As an initial matter, Tennessee errs in identifying the *intended effects* of gender-affirming care as medical risks that SB1 seeks to prevent. The State suggests, for example, that "irreversible vocal-cord changes" are a "risk[]" of gender-affirming care. Br. in Opp. 8. Again, ensuring conformity with the physical expectations for the sex assigned to an individual at birth is not a valid governmental objective, and the intended result of a medical treatment is not a risk. See pp. 33-34 *supra*.

2. The district court correctly found that many of the other risks identified by Tennessee were not

supported by the record. For example, Tennessee asserts (Br. in Opp. 35) that hormone therapy is associated with cardiovascular risks. But after carefully considering the record evidence, the district court determined that such risk was not elevated for transgender boys and that any such risk for transgender girls is usually present "only * * * when a patient is denied care and self-administers the treatment without appropriate clinical supervision." Pet. App. 190a (quoting J.A. 971).

Tennessee also identifies (Br. in Opp. 7-8, 35) purported effects on brain development and sexual dysfunction and an increased risk of cancer. The district court made detailed findings that these risks were unsubstantiated by the record. Tennessee's own expert admitted that there have been "no 'substantial studies to identify'" any impact on brain development from gender-affirming care, while the evidence submitted by the private plaintiffs showed that no such effect has been found. Pet. App. 184a-185a (quoting J.A. 432, 969). The district court also found that Tennessee's expert had cited neither "studies [n]or research" to support his contention that gender-affirming care results in sexual dysfunction. *Id.* at 187a; see *id.* at 187a-188a; J.A. 429-430, 763 (same for Tennessee's other experts). Finally, after considering the relevant data, the court found that the "weight of the evidence" does not support the conclusion that hormone therapy increases the risk of cancer. Pet. App. 191a-192a.

3. As to the remaining risks that Tennessee identifies, the district court correctly found that none were so substantial as to justify SB1's outright ban.

Tennessee argues, for instance, that puberty blockers are associated with a potential decrease in bone mineral density when used to treat gender dysphoria. Br.

in Opp. 6-7. But as the district court recognized, multiple studies have shown that there are no adverse effects on bone mineralization during the time interval that patients with gender dysphoria ordinarily take such blockers. Pet. App. 189a; J.A. 966-967, 969. Rather, the available evidence indicates that puberty blockers maintain the accrual of bone mineral density to a pre-pubertal rate until discontinued; when the individual then undergoes either endogenous puberty or puberty prompted by hormone therapy, bone mineralization accrues at the usual rate. J.A. 966-967; see also *Brandt*, 677 F. Supp. 3d at 903, 920. Accordingly, the district court concluded that the record did not establish that puberty blockers "pose a serious risk to a patient['s] bone density." Pet. App. 189a.

Tennessee also asserts that SB1's ban is justified by concerns that gender-affirming care may threaten a patient's future fertility. Br. in Opp. 8; see also Tenn. Code Ann. § 68-33-101(b). But SB1 bans puberty blockers even though all the available evidence demonstrates—and the State has never disputed—that "[p]ubertal suppression on its own has no impact on fertility." Pet. App. 267a. As to hormone therapy, the district court correctly found that the record "demonstrates that many individuals receiving * * * cross-sex hormones will remain fertile for procreation purposes, and that the risk of negative impacts on fertility can be mitigated." *Id.* at 185a; see *id.* at 267a-268a; J.A. 973-974 & nn. 9-11. "Transgender men and women" can "produc[e] eggs and sperm respectively both during and after the discontinuation of gender-affirming hormone treatment." J.A. 127-128; see J.A. 973-974. Furthermore, patients for whom hormone therapy is clinically indicated after treatment with puberty blockers

can first "preserve their sperm or eggs for future assisted reproduction by stopping puberty suppression briefly before initiating gender-affirming hormones." Pet. App. 292a. In all events, the relevant clinical guidelines and ethical principles governing pediatric care require patients and their parents to be thoroughly counseled on these risks, and to be provided with fertility-preserving options.

D. SB1 Is Not Tailored To Tennessee's Asserted Interest In Protecting Adolescents From Harmful Medical Procedures

SB1's complete lack of tailoring means that it is not substantially related to the State's asserted interest in protecting adolescents. States undoubtedly have legitimate interests in ensuring informed consent and regulating the practice of medicine. 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. That "close relationship" requirement "assure[s]" that "the validity of a classification is determined through reasoned analysis" rather than use of gender as a "proxy for other, more germane bases of classification." *Hogan*, 458 U.S. at 725-726 (citation omitted). SB1 flunks that test because it is severely under- and overinclusive.

1. SB1 is severely underinclusive

First, SB1 is "severely underinclusive" because "it bans [the prohibited] procedures for a tiny fraction of minors, while leaving them available for all other minors (who would be subjected to the very risks that the state asserts SB1 is intended to eradicate)." Pet. App. 204a-205a.

As the district court observed, "the medical procedures banned by SB1 because they are purportedly unsafe to treat gender dysphoria in minors * * * are not banned when provided to treat other conditions." Pet. App. 200a. Indeed, SB1 expressly permits the banned medications for conditions *other* than gender dysphoria, including "to treat a minor's congenital defect, precocious puberty, disease, or physical injury." Tenn. Code Ann. § 68-33-103(b)(1)(A).

Puberty blockers are routinely used to treat precocious puberty, to delay puberty for patients undergoing chemotherapy, to preserve fertility for patients with hormone-sensitive cancers, and to treat endometriosis. Pet. App. 263a-264a. Hormone therapy, too, is used to treat a range of conditions other than gender dysphoria, including to treat various intersex conditions, infants suffering from microphallus, and teenage boys with delayed puberty. *Id.* at 265a-266a. SB1 allows all those uses, across the board, even though many carry the same or greater risks as use of these medications to treat gender dysphoria. *Id.* at 266a-267a; see also J.A. 127-128, 963-974, 995-996. Instead, the line SB1 draws is non-medical in nature: SB1 bans the use of these treatments to assist minors in *departing from* the physical expectations consistent with their sex assigned at birth, and permits them for other purposes, including to assist minors in *conforming to* physical expectations consistent with their sex assigned at birth.

When compared to the State's regulation of other pediatric treatments, Tennessee's assertion that SB1 is substantially related to its interest in protecting adolescents becomes still less tenable. SB1 rests on the premise that adolescents lack the maturity to make informed medical decisions about the risks and benefits of

puberty blockers and hormone therapy in conjunction with their parents and doctors. See Tenn. Code Ann. § 68-33-101(h). But that concern applies with equal or more force to many pediatric treatments that are accompanied by similar or greater risks—none of which Tennessee (or any other State) has attempted to ban. For example, certain irreversible bariatric surgeries for weight loss are "commonly performed in the pediatric age group," despite the risk of serious complications, including splenic injury, hemorrhage, intestinal leaks, and blood clots.[8] The same is true for other medications and procedures with significant risks:

- Use of growth hormones to treat a minor's idiopathic short stature (potential risks include cancer and hemorrhagic stroke).[9]
- Use of anti-estrogen drugs to treat boys whose bodies overproduce breast tissue (potential risks include blood clots).[10]

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[8] Sarah E. Hampl et al., American Academy of Pediatrics, *Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity*, 151 *Pediatrics*, No. 2, at 63 (Feb. 2023); Peter L. Schilling et al., *National Trends in Adolescent Bariatric Surgical Procedures and Implications for Surgical Centers of Excellence*, 206 J. of Am. College of Surgeons 1, 3 (Jan. 2008).

[9] See, *e.g.*, Adda Grimberg et al., *Guidelines for Growth Hormone and Insulin-Like Growth Factor-I Treatment in Children and Adolescents: Growth Hormone Deficiency, Idiopathic Short Stature, and Primary Insulin-Like Growth Factor-I Deficiency*, 86 Hormone Research in Paediatrics 361 (2016).

[10] See, *e.g.*, Ashraf T. Soliman et al., *Management of adolescent gynecomastia: an update*, 88 Acta. Biomedica 204, 208-210 (2017); Anthony Zehetner, *Tamoxifen to treat male pubertal gynaecomastia*, 2 Int'l J. of Pediatrics & Adolescent Med. 152, 154 (2015).

- Use of mood stabilizers to treat minors with bipolar disorder (potential risks include menstrual abnormalities, infertility, osteoporosis, obesity, and reductions in bone mineral density).[11]
- Use of stimulants to treat minors with attention deficit hyperactivity disorder (potential risks include psychosis, tics, and negative impacts on linear growth).[12]
- Use of antidepressants to treat minors with depression and anxiety (potential risks include weight gain, increased suicidality, and sexual dysfunction).[13]

Despite the risks, Tennessee leaves decisions about all of those treatments to parents, doctors, and (where appropriate) the minors themselves. SB1 singles out—and bans—only treatments for gender dysphoria.

2. SB1 is also severely overinclusive

At the same time, SB1 "classif[ies] unnecessarily and overbroadly," *Morales-Santana*, 582 U.S. at 63 n.13, because it categorically bans all hormone treatments and

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[11] Danielle L. Stutzman, *Long-term use of antidepressants, mood stabilizers, and antipsychotics in pediatric patients with a focus on appropriate deprescribing*, 11 Mental Health Clinician 320, 329-330 (2021).

[12] See, *e.g.*, Ankita Nanda et al., *Adverse Effects of Stimulant Interventions for Attention Deficit Hyperactivity Disorder (ADHD): A Comprehensive Systematic Review*, 15 Cureus, no. 9, at 9 (Sept. 2023); Natalia M. Wojnowski et al., *Effect of stimulants on final adult height*, 35 J. of Pediatric Endocrinology & Metabolism 1337 (2022).

[13] Jeffrey R. Strawn et al., *Adverse Effects of Antidepressant Medications and their Management in Children and Adolescents*, 43 Pharmacotherapy 675, 683-684 (2023).

puberty blockers provided to treat gender dysphoria for all transgender minors under all circumstances.

Indeed, SB1 makes no effort—none—to tailor its restriction to the specific risks with which it is ostensibly concerned. If Tennessee's concern is that gender-affirming care is too readily available, see Tenn. Code Ann. § 68-33-101(g), one might expect to see gatekeeping requirements, waiting periods, or other guardrails. If Tennessee's concern is that some doctors are improperly prescribing these treatments beyond their expertise or for reasons other than the child's best interest, see *id.* § 68-33-101(i)-(m), one might expect to see licensing, certification, or reporting requirements. If Tennessee's concern is infertility, *id.* § 68-33-101(m), one might expect to see a law that exempts puberty blockers (which have no effect on fertility) or requirements aimed at fertility preservation. If Tennessee's concern is a minor's ability to make an informed decision about whether to receive such care, see *id.* § 68-33-101(h), one might expect to see requirements like two-parent consent or counseling. And if Tennessee's interest is consistency with aspects of the international landscape concerning treatment for gender dysphoria, see *id.* § 68-33-101(e), one might expect to see readiness criteria or age recommendations that still allow adolescents in appropriate cases to get the care they need.

At the very least, one might expect a law grounded in medical risks to allow care in cases in which gender-affirming care is necessary to limit the risk of self-harm or suicidality. Cf. W. Va. Code § 30-3-20(c)(5)(B) (restricting gender-affirming care to cases where "[t]he diagnosing medical professionals" opine "that treatment with pubertal modulating and hormonal therapy is medically necessary to treat the minor's psychiatric

symptoms and limit self-harm, or the possibility of self-harm, by the minor"). But SB1 instead categorically bans all such care—without regard for how necessary such care may be in an individual case or the potential consequences of withholding care.

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In short, SB1 lacks anything resembling a "close means-end fit" with Tennessee's asserted interest in protecting transgender adolescents from harmful medical treatments. *Morales-Santana*, 582 U.S. at 68. SB1 is a much better fit for Tennessee's other stated interest: "encouraging minors to appreciate their sex." Tenn. Code § 68-33-101(m). Or, put more plainly, "forc[ing] boys and girls to *look* and *live* like boys and girls." Pet. App. 85a (White, J., dissenting). But a law justified on that basis cannot withstand heightened scrutiny. Indeed, heightened scrutiny is designed to protect against the "danger" that "government policies that professedly are based on reasonable considerations in fact may be reflective of 'archaic and overbroad' generalizations about gender." *J.E.B.*, 511 U.S. at 135 (citation omitted). SB1 reflects just such overbroad generalizations, and Tennessee's invocation of a "reasonable consideration[]"—protecting adolescents' health—cannot justify its categorical ban.

CONCLUSION

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

Respectfully submitted.

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