No. 23-477

In the Supreme Court of the United States

UNITED STATES OF AMERICA,

Petitioner,

v.

JONATHAN SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, *et al.*,

Respondents.

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

BRIEF FOR THE STATES OF CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, HAWAIʻI, ILLINOIS, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW YORK, OREGON, PENNSYLVANIA, RHODE ISLAND, VERMONT, WASHINGTON, AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF PETITIONER

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INTERESTS OF AMICI

Amici States have a powerful interest in the issues presented by this case. Amici frequently defend their laws and policies against constitutional challenges, including under the Equal Protection Clause, and have a general interest in the proper application of constitutional standards. Amici also have a responsibility to protect and defend the constitutional rights of all of their residents—including those who are transgender. People who are transgender have a right to live openly and honestly, with dignity, free from discrimination. Further, amici regulate the practice of medicine in their jurisdictions, including by licensing doctors and other medical professionals; recognizing standards of care for a wide variety of medical procedures and treatments; and enforcing those standards and other related regulations. That experience informs amici's analysis of the question presented in this case.

SUMMARY OF ARGUMENT

Based on our experience regulating the practice of medicine, amici States agree with the conclusion of the majority of courts to consider the constitutionality of laws like SB1: "outright bans on gender-affirming medical care for adolescents with gender dysphoria" go much further than necessary to advance any legitimate state medical interests. Pet. App. 198a; *see, e.g.*, *id.* at 199a-205a; *id.* at 122a-123a & n.2 (collecting cases).[1]

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[1] This brief addresses SB1's ban on gender-affirming puberty blockers and hormone therapy. It does not address SB1's ban on gender-affirming surgery, as the district court held that the plaintiffs lack standing to challenge that provision and the plaintiffs did not appeal that holding. *See* Pet. App. 63a n.3; *id.* at 139a-142a.

Gender-affirming care can provide highly beneficial—indeed, "potentially life-saving"—treatment to transgender adolescents with gender dysphoria. *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 890 (E.D. Ark. 2021). And clinical standards of care account for any limited risks of that treatment by requiring doctors to make individualized findings that gender-affirming care is medically necessary. By categorically denying transgender adolescents with gender dysphoria access to a beneficial form of treatment that is endorsed by every major medical organization, SB1 departs from traditional norms of state medical regulation. And it violates the Constitution's guarantee of the equal protection of the laws.

ARGUMENT

I. THE CHALLENGED BAN ON CARE DEPARTS FROM TRADITIONAL NORMS OF STATE HEALTHCARE REGULATION

A. SB1 Categorically Bans a Form of Medical Care with Well-Documented Health Benefits and Manageable Risks

Amici States have carefully examined medical and scientific evidence about the provision of gender-affirming care to transgender adolescents with gender dysphoria, including the extensive record-based findings made by the district court in this case. *See* Pet. App. 176a-205a. Denying gender-affirming care can have tragic consequences for the physical and mental well-being of transgender adolescents. *See, e.g.*, *id.* at 195a-196a. Providing such care when medically necessary, by contrast, can lead to enormous improvements in health and quality of life. *See, e.g. id.*, *Poe v. Labrador*, No. 23-cv-269, 2023 WL 8935065, at *14 (D. Idaho Dec. 26, 2023) ("[E]vidence shows not only that gender-affirming medical care delivered in accordance

with [clinical] guidelines is helpful and necessary for some adolescents, but also that withholding such care is harmful."), *appeal filed*, No. 24-142 (9th Cir. 2024), *stayed in part*, 144 S. Ct. 921 (2024).

Transgender individuals are people "whose gender identity is different from their sex at birth." Pet. App. 131a n.3. Many transgender individuals suffer from gender dysphoria, a medical "condition where clinically significant distress results from the lack of congruence between a person's gender identity and the sex they were designated at birth." *Id.* at 251a; *see also id.* at 134a.[2] Left untreated, gender dysphoria can substantially affect quality of life, including by causing anxiety, depression, and substance-abuse problems. *See* Pet. App. 194a-197a, 251a-252a. It can also be fatal: suicide attempts are approximately *nine times* more common among transgender people than in the overall U.S. population (41% versus 4.6%). *See* Haas et al., *Suicide Attempts Among Transgender and Gender Non-Conforming Adults* 2 (2014), https://tinyurl.com/4baj2v3s; *see also, e.g.*, Pet. App. 196a, 207a-208a.

The risks of leaving gender dysphoria untreated are especially pronounced among transgender adolescents. The onset of puberty is "often a source of significant distress" for transgender adolescents.[3] When they develop physical features that are incongruent

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[2] "[G]ender dysphoria is a serious medical condition" that many, but not all, people who are transgender experience. Pet. App. 251a. "Being transgender," however, "is not itself a mental disorder or medical condition to be cured." *Id.*

[3] Lopez et al., *Statement on Gender-Affirmative Approach to Care from the Pediatric Endocrine Society Special Interest Group on Transgender Health*, 29 Current Op. Pediatrics 475, 477 (2017), https://pubmed.ncbi.nlm.nih.gov/28562420.

with their gender identity, a common result is "heightened gender dysphoria," *Brandt v. Rutledge*, 47 F.4th 661, 671 (8th Cir. 2022), which can lead to "severe anxiety, depression, self-harm, and suicidal ideation," Pet. App. 207a-208a; *see also Brandt*, 551 F. Supp. 3d at 892 (describing "lifelong physical and emotional pain" from irreversible changes brought on by puberty). In one recent study, 56% of transgender individuals aged 14 to 18 reported a previous suicide attempt and 86% reported having suicidal thoughts.[4]

After careful consideration of expert testimony, courts have repeatedly found that puberty blockers and hormone treatments can safely and effectively address gender dysphoria among transgender adolescents. *See, e.g.*, Pet. App. 194a-196a; *K.C. v. Individual Members of Med. Licensing Bd. of Indiana*, 677 F. Supp. 3d 802, 820 (S.D. Ind. 2023), *appeal filed*, No. 23-2366 (7th Cir. July 12, 2023), *stayed*, No. 23-2366, 2024 WL 811523, at *1 (7th Cir. Feb. 27, 2024); *Doe v. Ladapo*, 676 F. Supp. 3d 1205, 1222 (N.D. Fla. 2023), *appeal filed*, No. 23-12159 (11th Cir. June 27, 2023); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1150 (M.D. Ala. 2022), *rev'd* 80 F.4th 1205 (11th Cir. 2023). Many studies have reached similar conclusions. *See, e.g.*, Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. Adolescent Health 643, 647-648 (2022), https://tinyurl.com/5xa63k3j (use of gender-affirming hormone therapy for teens under the age of eighteen associated with lower odds of depression and suicide attempts

[4] Austin et al., *Suicidality Among Transgender Youth*, 37 J. of Interpersonal Violence 2696, 2703, 2706 (2022), https://tinyurl.com/373zmarf.

relative to adolescents who wanted—but did not receive—the therapy).[5]

"[L]ike any medical treatment," gender-affirming care may also carry risks. *Koe v. Noggle*, 688 F. Supp. 3d 1321, 1351 (N.D. Ga. 2023), *preliminary injunction stayed*, No. 1:23-CV-2904-SEG (N.D. Ga. Sept. 5, 2023). But the record in this case shows that any risks are limited. The district court systematically evaluated and debunked each of the claims of medical risk advanced in defense of SB1. *See, e.g.*, Pet. App. 185a, 187a (fertility); *id.* at 188a-189a (bone density); *id.* at 190a-191a (cardiovascular disease); *id.* at 192a (cancer). Other courts have deemed similar allegations of medical risks flawed or overstated. *See, e.g.*, *Brandt*, 47 F.4th at 671; *Ladapo*, 676 F. Supp. 3d at 1222; *Eknes-Tucker*, 603 F. Supp. 3d at 1145; *Koe*, 688 F.

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[5] *See also* Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 Pediatrics 1, 4-5 (2020), https://tinyurl.com/2npb584p (survey of almost 3,500 transgender adults showing that individuals who received pubertal suppression during adolescence had around 15% lower odds of lifetime suicidal thoughts compared to individuals who wanted that treatment but did not receive it); de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 1, 7 (2014), https://tinyurl.com/bdxa4pkf (longitudinal study of transgender adolescents finding that gender-affirming treatment resulted in improved psychological functioning over time); Arnoldussen et al., *Self-Perception of Transgender Adolescents After Gender-Affirming Treatment*, 9 LGBT Health 238, 241-243 (2022), https://tinyurl.com/5fvv5nas (study of transgender adolescents finding significant increase in reported self-worth after receiving gender-affirming treatment); Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 J. Am. Med. Ass'n Network Open 1, 6 (2022), https://tinyurl.com/4zxdaffw (gender-affirming care associated with lower odds of depression and self-harm).

Supp. 3d at 1350-1351*; Doe 1 v. Thornbury*, 679 F. Supp. 3d 576, 584 (W.D. Ky. 2023), *rev'd sub nom. L.W. by and through Williams v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023); *Poe*, 2023 WL 8935065, at *14 (any risks "associated with the treatments used in gender-affirming medical care are similar to risks associated with other types of healthcare families may seek for minors").[6]

In light of the clear benefits and the limited, manageable risks, "every major medical organization to take a position on the issue . . . agrees that puberty blockers and cross-sex hormone therapy are appropriate and medically necessary treatments for adolescents when clinically indicated." Pet. App. 198a. Medical organizations that "have formally recognized" the benefits of gender-affirming care "include the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Psychiatric Association, and at least a dozen more." *Ladapo*, 676 F. Supp. 3d at 1213.

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[6] A recent report commissioned by the U.K. National Health Service evaluated the risks and benefits of gender-affirming care and concluded that such care can be appropriate and medically necessary for certain transgender adolescents. *See generally* Cass Review, *Final Report: Independent Review of Gender Identity Services for Children and Young People* (2024), https://tinyurl.com/yc3yb65v. While the report stressed the need for "thoughtful, cautious assessments prior to considering medical [gender-affirming] care," it "*[did] not* conclude that gender-affirming medical care for adolescent gender dysphoria should be banned." McNamara et al., *An Evidence-Based Critique of "The Cass Review" on Gender-Affirming Care for Adolescent Gender Dysphoria* 5 (2024), https://tinyurl.com/5bby3f9p.

B. SB1 Bans Care Entirely, Rather than Merely Regulating It

In amici's experience as regulators of the practice of medicine, "outright ban[s]" on care (Pet. App. 187a) comparable to SB1 are extremely rare. SB1 prohibits an entire population group from accessing care with substantial benefits and limited evidence of risks—regardless of individual patient circumstances, and against the unanimous recommendation of every major medical organization. Respondents identify no good reason for that sweeping departure from ordinary norms of state medical regulation.

1. As a general matter, States ensure the quality of individualized care provided by doctors through licensing and disciplinary regimes. *See generally* Field, *Health Care Regulation in America* 19-24, 37-38 (2007). The medical profession is one of the most strictly regulated in the country. *See id.* at 3, 20. Before doctors can be certified to practice medicine, they must meet rigorous educational, training, and testing requirements. *See id.* at 20-22. Once doctors begin practicing, they must satisfy continuing medical education requirements. *See* Johnson & Chaudhry, *Medical Licensing and Discipline in America* 258-265 (2012). And doctors must adhere to the standard of care at all times.[7] If doctors deviate from the standard of care or otherwise act unethically or irresponsibly, they can be subject to discipline by state medical boards or held liable under state malpractice laws.

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[7] *See, e.g.*, Wash. Rev. Code § 7.70.040(1)(a) (standard of care requires "exercis[ing] that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs . . . acting in the same or similar circumstances"); W. Va. Code § 55-7B-3(a)(1) (similar).

See generally Field, *supra*, at 23, 37-38; Pegalis, *American Law of Medical Malpractice* § 1:1 (3d ed. 2024).

Even when forms of treatment involve heightened medical risks, States rarely enact categorical bans. For example, opioids present extraordinary and well-documented risks of addiction. *See Harrington v. Purdue Pharma L.P.*, 144 S. Ct. 2071, 2078-2079 (2024). But no State has categorically banned the use of opioids for the treatment of pain. Instead, state medical boards and other agencies have adopted policies on the prescription of opioids to reduce the potential for abuse and addiction. States typically require or advise doctors to discuss the risks and benefits of opioid medications with patients, to consider alternative treatments, to conduct a risk assessment, and to obtain informed consent before prescribing opioids.[8]

States have also adopted specialized medical regulations to ensure that minors and (where appropriate) their parents or guardians are fully apprised of the risks of certain healthcare decisions. Rather than ban care entirely, the longstanding approach of States in this area has been to enable minors and their parents to make informed medical decisions.[9] This approach

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[8] *See, e.g.*, Ariz. Dep't of Health Servs., *Arizona Opioid Prescribing Guidelines* 2 (2018), https://tinyurl.com/3k9k5k6w; Med. Bd. of Cal., *Guidelines for Prescribing Controlled Substances for Pain* 6-9 (2023), https://tinyurl.com/344tntrc; 24 Del. Admin. Code CSA 9.0; Ga. Comp. R. & Regs. 360-3.06; Mass. Gen. Laws ch. 94C, §§ 18 A, 18C; Okla. State Dep't of Health, *Oklahoma Opioid Prescribing Guidelines* 1-2 (2017), https://tinyurl.com/4x6k5rxf; Vt. Admin. Code § 12-5-53:4.0.

[9] *See, e.g.*, 24 Del. Admin. Code CSA 9.5.2 (limiting minors to seven-day supply of opioids at any time and requiring practition-

(continued…)

limits the risk of adverse outcomes while preserving access to beneficial medical care.[10]

2. Respondents do not seek to justify SB1 with "a policy argument that gender-affirming treatment is undesirable because gender-transitions are undesirable." Pet. App. 193a n.52. The "sole[]" concern invoked by respondents to defend SB1's categorical ban is purported "medical risks associated with gender-af-

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ers to discuss associated risks with parents and minor); S.D. Codified Laws § 27A-15-47 (permitting use of psychotropic medications on minors 16 or older only with oral and written consent of minor and parent and treating psychiatrist's written determination that medication is "least restrictive treatment alternative medically necessary"); Utah Admin. Code R523-8-5 (requiring informed consent, non-adversarial hearing, and other procedures prior to administering psychosurgery or electroshock treatment to certain minors); Wis. Stat. § 146.34(4) (allowing minors 12 years and older to consent to donating bone marrow to sibling following psychological evaluation and informed consent).

[10] On rare occasions, States have barred medical professionals from offering treatments that pose serious, well-documented health risks. For example, some States have barred licensed healthcare providers from practicing "conversion" therapy on minors—therapy that "'[e]very major medical and mental health organization has uniformly rejected . . . as unsafe and inefficacious." *Tingley v. Ferguson*, 47 F.4th 1055, 1078 (9th Cir. 2022), *cert. denied*, 144 S. Ct. 33 (2023) (No. 22-942). At the same time, however, those States have allowed certain non-licensed providers to offer conversion therapy, and so have not wholly prevented individuals from obtaining it. *See, e.g.*, *id.* at 1064 (exempting "[t]herapists, counselors, and social workers who 'work under the auspices of a religious denomination, church, or religious organization'") (quoting Wash. Rev. Code § 18.225.030(4)); *id.* at 1073 (similar with respect to California's restrictions on conversion therapy). By contrast, SB1 completely precludes transgender adolescents suffering from gender dysphoria from accessing gender-affirming care.

firming treatment." *Id.* (emphasis omitted). But Respondents have never explained why narrower regulatory measures would be inadequate to address that concern.

There are plainly narrower regulatory alternatives to banning gender-affirming care that would adequately account for any limited medical risks. For example, many States rely on "remedies already in place"—malpractice laws and licensing standards—to prevent doctors from providing "deficient medical care" to transgender adolescents. *Ladapo*, 676 F. Supp. 3d at 1224. Respondents identify no evidence that this standard regulatory approach, which has long worked for most other forms of medical treatment, *see supra* pp. 7-8, would be inadequate with respect to gender-affirming care. *See, e.g.*, Pet. App. 200a-201a.

States could also codify the current, widely accepted clinical guidelines for gender-affirming care for transgender adolescents. Under those guidelines, the "precise treatment for gender dysphoria depends on each person's individualized need." Pet. App. 253a. Doctors must make a comprehensive, individualized assessment to determine whether gender-affirming care is medically necessary and appropriate—that is, whether an "adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria" and whether any "psychological, medical, or social problems . . . could interfere with treatment." *Id.* at 256a-257a; *see id.* at 289a-290a. Clinical guidelines also require ongoing treatment to be evaluated on an individualized basis such that it "can be changed at any time by carefully tapering a patient off of the treatment." *Id.* at 261a; *see Ladapo*,

676 F. Supp. 3d at 1212 (describing "standards [of care] . . . widely followed by well-trained clinicians").

Some States have adopted or proposed other restrictions on gender-affirming medical treatment for adolescents—restrictions that are narrower than a categorical ban. Amici highlight several examples below—not because amici believe that such limits on gender-affirming care are necessary or appropriate, but because they underscore the overbreadth of SB1 and similar bans.

West Virginia, for instance, allows puberty blockers and hormonal treatments as lawful forms of treatment for transgender adolescents—but only if the adolescent "has been diagnosed as suffering from severe gender dysphoria by no fewer than two medical or mental health providers." W. Va. Code Ann. § 30-3-20(c)(5)(A).[11] State lawmakers had originally considered a categorical ban like SB1. *See* Willingham, *WV Senate Joins GOP Effort to Limit Trans Youth Health Care*, AP News (Mar. 10, 2023), https://tinyurl.com/y6vdfxb6. But the Senate Majority Leader, a physician, persuaded his fellow lawmakers to adopt a narrower measure. *See id.* As he explained, "These kids struggle, they have incredible difficulties." *Id.* He "referenced 17 peer-reviewed studies showing a significant decrease in the rates of suicide ideation

[11] West Virginia's law also requires that the "diagnosing medical professionals express in written opinions 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"; that "[t]he minor, the minor's parents . . . and the minor's primary physician agree in writing with the treatment"; and that "[a]ny use of gender altering medication is . . . limited to the lowest titratable dosage necessary." W. Va. Code Ann. § 30-3-20(c)(5)(B)-(D).

and suicide attempts among youth with severe gender dysphoria who have access to medication therapy." *Id.* The Chair of the Senate Health and Human Resources Committee, "another trained physician, . . . said lawmakers would set 'a dangerous precedent' by disregarding medical research in favor of political gain." *Id.*

Nebraska provides another example of a narrower alternative to SB1. Under regulations adopted earlier this year, adolescents must receive at least "40 contact hours of therapeutic treatment" before being prescribed puberty blockers or hormone treatments. 181 Neb. Admin. Code ch. 8, §§ 003(B)(iv), 011(B)(v). A medical practitioner also must determine that "gender nonconformity or gender dysphoria is driving the patient's distress and not other mental or physical health conditions"; "that there is no reasonable expectation of natural resolution of gender nonconformity"; and that "there has been a long-lasting and intense pattern of gender nonconformity or gender dysphoria." *Id.* §§ 003(B)(i), 011(B)(ii). And the regulations prescribe a seven-day waiting period between "the time the prescribing practitioner obtains informed patient consent and the time the [puberty blockers or hormones] are prescribed, administered, or delivered to a patient." *Id.* §§ 010, 015.[12]

Leaders in other States have advocated for similar measures. For example, when he vetoed a ban on gender-affirming care for transgender adolescents, Ohio Governor Mike DeWine explained that "[m]any parents have told me that their child would be dead today if they had not received [gender-affirming] treatment."

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[12] *See* Press Release, *Gov. Pillen Approves LB 574 Regulations on Nonsurgical, Gender Altering Treatments* (Mar. 12, 2024), https://tinyurl.com/y8n3j5bn.

Ohio Governor DeWine, Statement of the Reasons for the Veto of Substitute House Bill 68, at 1 (Dec. 29, 2023), https://tinyurl.com/yxyek2fh. He acknowledged that "there are rare times in the law . . . where the State overrules the medical decisions made by the parents," but he could "think of no example where this is done not only against the decision of the parents, but also against the medical judgment of the treating physician and the treating team of medical experts." *Id.* In lieu of a ban, Governor DeWine proposed narrower restrictions to ensure that minors "receive adequate counseling" before beginning treatment. *Id.* at 2.[13]

II. SB1 VIOLATES THE EQUAL PROTECTION CLAUSE

In refusing to invalidate SB1, the court of appeals did not suggest that the law's categorical ban on gender-affirming care could survive heightened equal protection scrutiny. *See* Pet. App. 48a-50a. That was for good reason: SB1 is far broader than necessary to serve any legitimate medical interests. *Supra* pp. 7-

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[13] *See also* Ark. Governor Hutchinson, *Why I Vetoed My Party's Bill Restricting Health Care for Transgender Youth*, Wash. Post (Apr. 8, 2021), https://tinyurl.com/4v6xkrdw ("I vetoed [a ban on gender-affirming care] because it creates new standards of legislative interference with physicians and parents as they deal with some of the most complex and sensitive matters concerning our youths."); *id.* (describing the proposed ban as "overbroad and extreme"); Letter from La. Governor Edwards to La. House of Representatives Speaker Schexnayder, Veto of House Bill 648 of the 2023 Regular Session 1 (June 29, 2023), https://tinyurl.com/2yskcc4j ("I have . . . recognized that in some instances, such as to curtail the opioid crisis, legitimate limitations, safeguards, or prior authorizations on certain medicines may be necessary. . . . It is unfathomable to think that . . . I would sign into law a bill that categorically denies healthcare for children[.]").

13; *see* Pet. App. 197a-205a. The court of appeals instead reasoned that SB1 is subject to mere rational-basis review. According to the court, the ban neither classifies on the basis of sex, *see id.* at 32a-44a, nor discriminates against transgender individuals in a way that justifies heightened scrutiny, *see id.* at 44a-48a. The court of appeals erred in both respects.

A. The Challenged Law Draws an Impermissible Classification on the Basis of Sex

"'[A]ll gender-based classifications today' warrant 'heightened scrutiny.'" *United States v. Virginia*, 518 U.S. 515, 555 (1996) (*VMI*). Bans on gender-affirming care necessarily classify on the basis of sex: "[W]ithout sex-based classifications, it would be impossible . . . to define whether a puberty-blocking or hormone treatment involved transition from one's sex (prohibited) or was in accordance with one's sex (permitted)." *E.g.*, *K.C.*, 677 F. Supp. 3d at 814. "Consider an adolescent, perhaps age 16, that a physician wishes to treat with testosterone." *Ladapo*, 676 F. Supp. 3d at 1217. "Under the challenged statute, is the treatment legal or illegal? To know the answer, one must know the adolescent's sex." *Id.* "This is a line drawn on the basis of sex, plain and simple." *Id.*; *see also* Pet. App. 162a-175a.

Bans on gender-affirming care also classify on the basis of transgender status, *see infra* pp. 17-19, and "it is impossible to discriminate against a person for being . . . transgender without discriminating . . . based on sex." *Bostock v. Clayton Cnty.*, 590 U.S. 644, 660 (2020). While *Bostock* arose under Title VII, its analysis is highly relevant here. Just as the Court has repeatedly given effect to Title VII's "broad language"—including in ways that the statute's authors would not

have anticipated, *e.g.*, *id.* at 679—the Court has faithfully applied the broad text of the Equal Protection Clause, *see, e.g.*, *J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 135-136 (1994). "Though in some initial drafts the Fourteenth Amendment was written to prohibit discrimination against 'persons because of race, color or previous condition of servitude,' the Amendment . . . [as] ratified contained more comprehensive terms: 'No State shall . . . deny to any person within its jurisdiction the equal protection of the laws.'" *Id.* at 151 (Kennedy, J., concurring in the judgment). Consistent with those broad terms, the Court has "interpret[ed] the equal protection guarantee" to invalidate "unjustified inequality . . . that once passed unnoticed and unchallenged," even in ways the Fourteenth Amendment's drafters might not have predicted. *Sessions v. Morales-Santana*, 582 U.S. 47, 59 (2017) (internal quotation marks and alterations omitted).

In the court of appeals' view, SB1 does not classify on the basis of sex because "no minor [of either sex] may receive puberty blockers or hormones . . . in order to transition from one sex to another." Pet. App. 32a. But the same could be said of the policy at issue in *Bostock*: it barred both men and women from identifying, living, and dressing at work in ways that would enable them to transition from one sex to another. *See, e.g.*, 590 U.S. at 653-654, 662. If a policy that forbids the use of clothing for the purpose of transitioning constitutes a sex classification, the same should be true of a policy that forbids the use of certain drugs for the same purpose.

The court of appeals tried to distinguish *Bostock* on its facts, emphasizing that it involved "employers [who] fired adult employees because their behavior did

not match stereotypes of how adult men or women dress or behave." Pet. App. 41a. But heightened scrutiny applies to "all" sex classifications, *J.E.B.*, 511 U.S. at 136, not just those premised on stereotypes. For example, in *Nguyen v. INS*, 533 U.S. 53, 68 (2001), the Court applied heightened scrutiny to a sex-based classification where "the difference" in treatment did "not result from [a] stereotype."

In any event, SB1 *is* stereotype-based. A sex-based stereotype is a "generalization[]" about a person's "preferences" or "'tendencies'" based on that person's sex. *VMI*, 518 U.S. at 533, 541. Just as it is a generalization to say that a woman will tend to act in "feminine" ways and a man will tend to exhibit "macho" behavior, *see, e.g.*, *Price Waterhouse v. Hopkins*, 490 U.S. 228, 235, 251 (1989), it is a generalization to say that a person will identify with their sex assigned at birth.[14] There can be little doubt that Tennessee relied on that generalization when enacting SB1: the statute declared that the law is designed to "encourag[e] minors to appreciate their sex" assigned at birth. Tenn. Code Ann. § 68-33-101(m); *see id.* § 68-33-102(9). One of the central purposes of heightened

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[14] *See, e.g.*, *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 608 (4th Cir. 2020) ("[D]iscrimination against transgender people constitute[s] sex-based discrimination for purposes of the Equal Protection Clause because such policies punish transgender persons for gender non-conformity."), *cert. denied*, 141 S. Ct. 2878 (2021) (No. 20-1163); *Glenn v. Brumby*, 663 F.3d 1312, 1318-1319 (11th Cir. 2011) (similar); *Whitaker ex rel Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. Of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017) (similar), *cert. dismissed*, 138 S. Ct. 1260 (2018) (No. 17-301); *see also A.C. ex rel. M.C. v. Metro. Sch. Dist. of Martinsville*, 75 F.4th 760, 767-769 (7th Cir. 2023) (reaffirming *Whitaker* after *Bostock*).

equal protection scrutiny is to "take a 'hard look' at generalizations" of that nature. *VMI*, 518 U.S. at 541.

The court of appeals repeatedly suggested that SB1's "concern about potentially irreversible medical procedures" is not sufficiently suspect to justify the application of heightened scrutiny. Pet. App. 42a; *see also id.* at 32a-33a, 34a-36a. But "this conflates . . . the state's *justification* for" the law with the separate question of whether a sex classification exists in the first place. *Brandt*, 47 F.4th at 670 (emphasis added). "One can survive—but cannot avoid—intermediate scrutiny by saying there is a good reason" for enacting a sex classification. *Ladapo*, 676 F. Supp. 3d at 1218. This Court has repeatedly reversed lower courts for making similar mistakes. *See, e.g.*, *Reed v. Town of Gilbert*, 576 U.S. 155, 165-166 (2015); *Johnson v. California*, 543 U.S. 499, 507-509 (2005).

B. SB1 Unconstitutionally Discriminates on the Basis of Transgender Status

Even if SB1's gender-affirming care ban did not qualify as a sex-based classification, it would still trigger heightened scrutiny because it discriminates on the basis of transgender status. "Although SB1 does not use the word 'transgender,' the law plainly proscribes treatment for gender dysphoria." Pet. App. 151a. And "only transgender individuals suffer from gender dysphoria." *Id.* at 151a-152a; *see supra* p. 3. The law thus "expressly and exclusively targets transgender people." *Id.* at 152a. To suggest otherwise would be "like saying that classifying on the basis of gray hair doesn't classify on the basis of age, or that classifying on the basis of wearing a yarmulke doesn't classify on the basis of being Jewish." *Poe*, 2023 WL 8935065, at *12 (citing *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993)).

Transgender individuals are precisely the type of "discrete and insular minorit[y]" who experience "prejudice . . . which tends seriously to curtail the operation of [ordinary] political processes" and which "call[s] for a . . . more searching judicial inquiry." *United States v. Carolene Products Co.*, 304 U.S. 144, 153 n.4 (1938); *cf. City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440-441 (1985). "[T]ransgender individuals historically have been subjected to discrimination on the basis of their gender identity," including through "high rates of violence"; "discrimination in education, . . . housing, and healthcare access"; "high rates of employment discrimination, economic instability, and homelessness"; and "frequent[] . . . harassment" and "physical assault." *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 611-612 (4th Cir. 2020) (internal quotation marks omitted), *cert. denied*, 141 S. Ct. 2878 (2021) (No. 20-1163); *see also, e.g.*, *Ladapo*, 676 F. Supp. 3d at 1223 ("There has long been, and still is, substantial bigotry directed at transgender individuals.").

In holding otherwise, the court of appeals reasoned that transgender status is "[n]ot . . . immutable" and that transgender people are "[n]ot a politically powerless group." Pet. App. 45a-46a (italics omitted). But "gender identity . . . cannot be changed voluntarily." *Id.* at 251a. Nor must a minority be literally "powerless" to justify its recognition as a suspect or quasi-suspect class. *See Cleburne*, 473 U.S. at 440-441. The "position of women in America," for example, had "improved markedly" by the time that the Court first recognized gender-based classifications as quasi-suspect. *Frontiero v. Richardson*, 411 U.S. 677, 685 (1973) (plurality opinion). And while the status of transgender people has improved in some States in recent years, *see, e.g.*, Pet. App. 46a, there has been an "explosion of

anti-trans bills" in many other States. Trans Legislation Tracker, *2024 Anti-Trans Bill Tracker*, https://tinyurl.com/4p9t6a3n (last visited Aug. 28, 2024).[15]

The court of appeals also suggested that treating transgender people as a quasi-suspect class would "remov[e] [certain] policy choices from fifty state legislatures to one Supreme Court." Pet. App. 45a. Not so. Intermediate scrutiny under the Equal Protection Clause would not "make [transgender status] a proscribed classification." *VMI*, 518 U.S. at 533. It would merely ensure that lawmakers have "important governmental objectives" when classifying on the basis of transgender status, and that such classifications "are substantially related to the achievement of those objectives." *Id.* (internal quotation marks omitted). Intermediate scrutiny requires a "fit that is not necessarily perfect, but reasonable." *Bd. of Trustees of State Univ. of N.Y. v. Fox*, 492 U.S. 469, 480 (1989); *see also*, *e.g.*, *Nguyen*, 533 U.S. at 70.

SB1 fails to satisfy that standard. It forces all transgender adolescents in Tennessee to go through puberty against their will—regardless of what they, their parents, and their doctors have decided is medically appropriate and necessary. *Supra* pp. 10-11. As a consequence, many transgender adolescents will be denied the opportunity to live freely and openly—and they will develop physical features that are foreign to their core sense of self. *Supra* pp. 3-4. Too often, the result will be lifelong physical and emotional anguish.

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[15] Transgender people also remain "vastly underrepresented" at "all levels of our State and Federal Government." *Frontiero*, 411 U.S. at 686 n.17. Approximately 50 elected officials at the state and local levels—and none at the federal level—publicly identify as transgender. *See* Out for America, *National Data*, https://tinyurl.com/s2a72fek (last visited Aug. 28, 2024).

Supra pp. 3-4. Tennessee has not carried its burden to justify the infliction of such immense pain on a discrete population of our most vulnerable citizens.

CONCLUSION

The judgment of the court of appeals should be reversed.

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