No. 23-5600, 23-5609

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

L.W., ET AL., *Plaintiffs-Appellees*, &
UNITED STATES OF AMERICA, *Plaintiff/Intervenor-Appellee*,
v.
JONATHAN SKRMETTI, ET AL., *Defendants-Appellants*.

On Appeal from the U.S. District Court for the Middle District of Tennessee
No. 3:23-cv-376

JANE DOE 1, ET AL., *Plaintiffs-Appellees*,
v.
WILLIAM C. THORNBURY, JR., ET AL., *Defendants*, &
COMMONWEALTH OF KENTUCKY, EX REL. ATTORNEY GENERAL DANIEL CAMERON,
Defendant/Intervenor-Appellant.

On Appeal from the U.S. District Court for the Western District of Kentucky
No. 3:23-cv-230

BRIEF OF AMICI CURIAE STATE OF CALIFORNIA AND 19 OTHER STATES SUPPORTING PLAINTIFFS-APPELLEES

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INTERESTS OF AMICI CURIAE

Amici Curiae States of California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington strongly support transgender people's right to live with dignity, be free from discrimination, and have equal access to healthcare.[1] Discrimination and exclusion on the basis of transgender status cause direct economic, physical, and emotional harms to transgender people, including an increased risk of depression, anxiety, substance abuse, and suicide. To prevent these injuries, amici States have adopted laws and policies to combat discrimination against transgender people who seek gender-affirming medical care. These laws and policies adhere to medically accepted standards of care and avoid interfering with the doctor-patient relationship. Amici States' laws and policies result in better health outcomes for our transgender teens, safeguard their physical, emotional, and financial well-being, and preserve the integrity and ethics of the medical profession.

Amici States also share a strong interest in the proper application of the

[1] Amici States submit this amicus brief pursuant to Federal Rule of Appellate Procedure 29(a) in support of Plaintiffs-Appellees and affirmance of the preliminary injunctions.

Equal Protection Clause to protect transgender individuals throughout our nation from unconstitutional discrimination. Kentucky and Tennessee's bans violate equal protection. The challenged laws treat cisgender minors differently from transgender minors, allowing cisgender minors to access certain medications while banning transgender minors from accessing the same. The bans thus single out transgender minors for discriminatory treatment *because of* their gender nonconformity. As the district courts properly concluded, such differential treatment is discrimination based on sex. The lower courts properly reviewed these bans under heightened scrutiny, and correctly concluded that they do not satisfy that standard of review. Transgender minors deserve, and are guaranteed, the equal protection of the law, as are all other persons under the Constitution. This Court should affirm the preliminary injunctions.

ARGUMENT

I. RESTRICTING TRANSGENDER PEOPLE'S ACCESS TO HEALTHCARE SIGNIFICANTLY HARMS TRANSGENDER TEENAGERS

Denying medically necessary care to transgender teens harms their physical, emotional, and psychological health.[2] Many transgender teens suffer from gender

[2] The Tennessee and Kentucky bans not only harm their own residents, but also threaten amici States' residents who travel to Tennessee and Kentucky for school, vacation, and work. Tennessee and Kentucky's laws, for example, could compel transgender youth who receive gender-affirming healthcare in amici States to discontinue their prescribed medications while in Tennessee or Kentucky. Teens

dysphoria: the often debilitating distress and anxiety that can result from incongruence between a person's gender identity and sex at birth.[3] If unaddressed or untreated, gender dysphoria can affect quality of life, trigger decreased social functioning, and prompt self-medication through drugs and alcohol.[4] Gender dysphoria can also be fatal. Among transgender people, suicide attempts are nine times more common than in the overall U.S. population (41% versus 4.6%).[5] The risks are especially high among transgender minors.[6] One study found that 56% of

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traveling to Tennessee and Kentucky, even on a temporary basis, may lack access to gender-affirming medical care if they are hospitalized for an injury or need to refill a prescription. And amici States' residents working, visiting, and studying in Tennessee and Kentucky, like college students and tourists, could be forced to forgo medical care to avoid the bans' penalties.

[3] American Psychiatric Association, *Gender Dysphoria*, in Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2022), https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria (last visited Aug. 1, 2023).

[4] *See* Emily Newfield et al., *Female-to-Male Transgender Quality of Life*, 15(9) Quality of Life Research 1447 (2006), https://www.ncbi.nlm.nih.gov/pubmed/16758113 (observing that transgender men who received transition-related care reported having a higher health-related quality of life than those who had not).

[5] Ann P. Haas et al., Am. Found. For Suicide Prevention & The Williams Inst., Suicide Attempts Among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey 2 (2014), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-GNC-Suicide-Attempts-Jan-2014.pdf.

[6] *See, e.g.*, Ali Zaker-Shahrak et al., Cal. Dep't of Ins., Economic Impact Assessment: Gender Nondiscrimination in Health Insurance 10 (2012), https://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-

transgender youth reported a previous suicide attempt and 86% reported suicidal thoughts.[7]

Access to gender-affirming healthcare and other medical interventions that improve mental health are thus especially important to transgender minors. A 2021 analysis found that, for teens under the age of eighteen, use of gender-affirming hormone therapy was associated with lower odds of recent depression and lower odds of attempting suicide compared to adolescents who wanted, but did not receive, such therapy.[8] Another study reflected that for teenagers and young adults ages thirteen to twenty, receiving gender-affirming care, including puberty blockers and gender-affirming hormones, was associated with 60% lower odds of moderate or severe depression and 73% lower odds of having suicidal thoughts

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Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf ("A recent systematic review of largely American samples gives a suicide attempt rate of approximately one in every three individuals with higher rates found among adolescents and young adults.").

[7] Ashley Austin et al., *Suicidality Among Transgender Youth: Elucidating the Role of Interpersonal Risk Factors*, 37 J. of Interpersonal Violence 2696 (2022), https://journals.sagepub.com/doi/10.1177/0886260520915554.

[8] Amy E. 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, 647–48 (2022), https://doi.org/10.1016/j.jadohealth.2021.10.036.

over a twelve-month follow-up.[9] A survey of over 3,500 transgender adults revealed that individuals who received pubertal suppression during adolescence had nearly 20 percent lower odds of lifetime suicidal thoughts compared to individuals who wanted this treatment but did not receive it.[10] A longitudinal study that followed transgender adolescents from their intake at a gender clinic into young adulthood reported that gender-affirming treatment resulted in significant improvement in global functioning and psychological wellbeing and participants' life satisfaction, quality of life, and subjective happiness were comparable to their cisgender peers.[11] Another study found significant improvement in teens' self-worth after starting hormone therapy.[12] In short, removing discriminatory barriers to healthcare improves health outcomes for our transgender residents, especially teenagers.

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[9] Diana M. 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://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423.

[10] Jack L Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 Pediatrics 1, 5 (2020), https://doi.org/10.1542/peds.2019-1725 (percentage calculated from odds ratio).

[11] *Id.*

[12] Marijn Arnoldussen et al., *Self-Perception of Transgender Adolescents After Gender-Affirming Treatment: A Follow-Up Study Into Young Adulthood*, 9 LGBT Health 238 (2022), https://www.liebertpub.com/doi/epdf/10.1089/lgbt.2020.0494.

Conversely, studies reflect that withholding gender-affirming treatment can have significant negative effects on teens' psychological wellbeing, psychosocial development, and quality of life. Transgender adolescents forced to endure puberty that does not align with their gender identity is "often a source of significant distress."[13] Delaying treatment also imposes harms. A 2020 study reflected that adolescents who begin gender-affirming treatment at later stages of puberty are five times more likely to be diagnosed with depression and four times more likely to have anxiety disorders than adolescents who seek treatment in early puberty.[14]

II. AMICI STATES' LAWS AND POLICIES PROMOTE ACCESS TO GENDER-AFFIRMING MEDICAL CARE BASED ON ESTABLISHED MEDICAL STANDARDS

In light of the adverse consequences that arise when transgender individuals are deprived of access to medically necessary healthcare, many amici States have enacted laws and regulations to ensure that their residents, including transgender

[13] Ximena 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, 480 (2017), https://pubmed.ncbi.nlm.nih.gov/28562420.

[14] Julia C. Sorbara et al., *Mental Health and Timing of Gender-Affirming Care*, 146 Pediatrics 1, 5 (2020), https://publications.aap.org/pediatrics/article/146/4/e20193600/79683/Mental-Health-and-Timing-of-Gender-Affirming-Care.

teenagers, have access to gender-affirming healthcare.[15] These laws promote sound medical practices and increase equity in healthcare. Beyond these general protections, some amici States have issued explicit guidance prohibiting insurers from denying minors treatment for gender dysphoria solely based on age, in recognition of the importance of gender-affirming interventions for this vulnerable population. For instance, Oregon approved puberty suppression coverage for minors after considering "extensive testimony/debate from experts at various public meetings" and "relevant evidence and literature." [16] Washington explicitly allows coverage for puberty suppression and gender-affirming care for those under age twenty. Wash. Admin. Code §§ 182-531-1675(b)(ii), (f). Similarly, New York law requires coverage for medically necessary hormone therapy for individuals who are sixteen years of age and older. N.Y. Comp. Codes R. & Regs. tit. 18 § 505.2(*l*)(2)(i)–(ii).

In contrast to Tennessee and Kentucky's categorical bans on gender-affirming care for minors, amici States' policies also recognize that best medical

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[15] *See generally Equality Maps: Healthcare Law and Policies*, Movement Advancement Project, https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies (last visited Jul. 29, 2023).

[16] *See* Or. Health Auth., Prioritized List: Guideline for Gender Dysphoria 1 (2019), https://www.oregon.gov/oha/HPA/DSI-HERC/FactSheets/Gender-dysphoria.pdf.

practices require an *individualized* assessment to determine whether—and to what extent—gender-affirming care is medically necessary for an individual patient. For example, the District of Columbia has instructed that determinations of "medical necessity" for insurance coverage purposes "must also be guided by providers in communication with individual patients."[17] Washington forbids insurers from "deny[ing] or limit[ing] coverage for gender affirming treatment" when it is "medically necessary" and "prescribed in accordance with accepted standards of care."[18] And California encourages health insurance companies to evaluate coverage criteria for gender-affirming care in order "to avoid needlessly delaying and interfering with medical care recommended by a patient's doctor."[19]

Taken together, these laws and policies reflect amici States' core commitment to preserving the integrity of the medical profession, protecting the equality of all people, regardless of their gender identity, and ensuring that people with gender

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[17] Chester A. McPherson, D.C. Dep't of Ins., Bulletin 13-IB-01-30/15, Prohibition of Discrimination in Health Insurance Based on Gender Identity or Expression 4 (2014), https://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/Bulletin-ProhibitionDiscriminationBasedonGenderIdentityorExpressionv022714.pdf.

[18] Wash. Rev. Code § 48.43.0128(3).

[19] Press Release, Cal. Dep't of Ins., Commissioner Lara Takes Proactive Step to Ensure Transgender Youth Have Access to Gender-Affirming Medical Care for Gender Dysphoria (Dec. 30, 2020), https://www.insurance.ca.gov/0400-news/0100-press-releases/2020/release140-2020.cfm.

dysphoria are not denied medically necessary healthcare.

III. THE BANS VIOLATE THE EQUAL PROTECTION CLAUSE

A. The Bans Discriminate on the Basis of Sex By Prohibiting Only Transgender Youth From Taking Certain Medications

The district courts correctly determined that the Tennessee and Kentucky statutes discriminate based on sex because "the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law." *Doe 1 v. Thornbury*, No. 3:23-CV-230-DJH, 2023 WL 4230481, at *3 (W.D. Ky. June 28, 2023) (quoting *Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022)); *see also L.W. ex rel. Williams v. Skrmetti*, No. 3:23-CV-00376, 2023 WL 4232308, at *10 (M.D. Tenn. June 28, 2023) (the law "prohibits transgender minors—and only transgender minors—from taking transitioning medications due to their gender nonconformity") (quoting *Eknes-Tucker v. Marshall*, 603 F.Supp.3d 1131, 1138 (M.D. Ala. 2022)). The lower courts' conclusions are consistent with the great weight of federal authority also holding that discrimination against transgender individuals is discrimination based on sex.[20]

[20] *See, e.g.*, *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 608 (4th Cir. 2020); *Brandt v. Rutledge*, 47 F.4th 661, 670 (8th Cir. 2022); *K.C. v. Individual Members of Med. Licensing Bd. of Ind.*, 2023 WL 4054086 (S.D. Ind. June 16, 2023); *Doe v. Ladapo*, No. 1:23-cv-00595-JPH-KMB, 2023 WL 3833848 at *8 (N.D. Fla. June 6, 2023); *Eknes-Tucker*, 603 F.Supp.3d at 1147.

In granting Tennessee's request to stay the preliminary injunction pending appeal, this Court expressed its "initial view[]" that the bans do not discriminate on the basis of sex because they apply "to all minors, regardless of their biological birth with male or female sex organs" and do not "prefer one sex to the detriment of the other."[21] In the Court's view, the laws restrict certain "medical procedure[s]," and are "equally applicable to all minors, no matter their sex at birth[.]"[22] In a similar vein, Tennessee asserts that its ban is "sex-neutral" because it offers "no preference for members of one sex over members of the other."[23] And Alabama's amicus brief argues that "what matters are the individual procedures at issue."[24]

But the laws *do* consider sex because they authorize—or prohibit—identical medical procedures based on the *purpose* for which the treatment is being

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[21] *L.W. ex rel. Williams v. Skrmetti*, No. 23-5600, 2023 WL 4410576, at *6, *8 (6th Cir. July 8, 2023).

[22] *Id.* at *6.

[23] Brief of Defendants-Appellants at 31–32, *L.W. v. Skrmetti*, No. 23-5600 (6th Cir. July 24, 2023).

[24] Brief of Amici Curiae Alabama et al., *L.W. v. Skrmetti*, No. 23-5600, 2023 WL 4902009, at *7 (6th Cir. July 24, 2023). Alabama's contention that these are different procedures is undermined by its argument that puberty blockers work exactly the same way regardless of the purpose for which they are being taken. *See id.* ("Puberty blockers work the same way in males and females. Sex has no bearing on their prescription or dosage, whether for treating precocious puberty or for transitioning.").

performed. Tenn. Code § 68-33-103 (barring medical procedures performed "for the purpose of . . . [e]nabling a minor to identify with, or live as, a purported identity inconsistent with the minor's sex"); Ky. Rev. Stat. § 311.372(2) (prohibiting the use of puberty-blockers or hormones "for the purpose of attempting to alter the appearance of, or to validate a minor's perception of, the minor's sex, if that appearance or perception is inconsistent with the minor's sex"). That purpose is directly tied, in explicit statutory terms, to the patient's sex.

These bans cannot be understood as the mere regulation of medical procedures without regard for a patient's sex. They prohibit certain procedures only when the treatment is sought by a teenager whose gender identity does not conform to the teenager's sex at birth. These bans are therefore *not* equally applicable to all minors. Rather, they treat cisgender and transgender minors differently by permitting certain medications for the former while categorically banning the same medications for the latter. *See, e.g., Ladapo*, 2023 WL 3833848, at *9 (N.D. Fl. June 6, 2023) (explaining that to know whether prescribing puberty blockers is legal or illegal, "one must know whether the child is cisgender or transgender. The treatment is legal if the child is cisgender but illegal if the child is transgender because the statute prohibits [puberty blockers] only for transgender children, not for anyone else."). It is beyond dispute that one group—and only one

group—seeks this medical treatment for this purpose: transgender teenagers. *See Skrmetti*, 2023 WL 4232308, at *11 n.18 (SB 1's prohibitions "are directly and exclusively targeted at minors who are transgender."); *see also Thornbury*, 2023 WL 4230481, at *4 ("Regardless of its stated purpose, then, SB 150 would have the effect of enforcing gender conformity."). That discriminates against transgender individuals and constitutes discrimination on the basis of sex.

The district courts' equal protection analysis is consistent with the Supreme Court's decision in *Bostock v. Clayton County.* The high court explained that, in the context of a Title VII claim, "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex." *Bostock v. Clayton Cnty., Georgia*, 140 S.Ct. 1731, 1741 (2020). In other words, "if changing the employee's sex would have yielded a different choice by the employer—a statutory violation has occurred." *Id*. Here, a similar analysis reveals that the challenged laws also impose differential treatment on the basis of sex: changing the minor's sex at birth yields a different result on whether a medication is authorized.

B. The Bans Do Not Satisfy Heightened Scrutiny, Which Amici States' Experience in Regulating the Practice of Medicine Affirms

The district courts also correctly concluded that the laws do not satisfy heightened scrutiny. Tennessee and Kentucky argued that the bans were

substantially related to protecting the integrity of the medical profession and guarding the health of transgender youth from experimental medical procedures. The district courts rejected those assertions based on the extensive record developed below. Judge Hale found that: (1) "there is no evidence" of "any abuse, neglect, or mistake" with respect to providing gender-affirming care that would warrant a total ban; and (2) the ban could not possibly protect "the integrity and ethics of the medical profession" because it would "prevent doctors from acting in accordance with the applicable standard of care." *Thornbury*, 2023 WL 4230481, at *4–5 (internal quotations and brackets removed). Judge Richardson similarly concluded, after reviewing the "voluminous . . . evidentiary record," that "Defendants' allegations of these harms and their prevalence is not supported by the record" and that "it is undisputed that every major medical organization to take a position on this issue . . . agrees that puberty blockers and cross-sex hormone therapy are appropriate and medically necessary treatments for adolescents when clinically indicated." *Skrmetti*, 2023 WL 4232308, at *24, *28, *29.

Amici States' experience supports the district courts' conclusions. Safeguarding access to gender-affirming care has not undermined the integrity of the medical profession. Rather, preexisting state-level safeguards have proven adequate and effective in guarding against improper medical practices. Like

Tennessee and Kentucky, amici States regulate the right to practice medicine through laws and regulations that prohibit abusive, unethical, or medically-improper conduct. *See, e.g.*, Ky. Rev. Stat. § 311.597 (defining "dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof"); Tenn. Code § 63-6-214 (establishing the medical board's power to deny, suspend, or revoke provider licenses in response to unprofessional, dishonorable, or unethical conduct).[25] Violation of the code of conduct set forth in a medical practice act can result in a State's medical board suspending or revoking a provider's medical license. *See, e.g.*, Ky. Rev. Stat. § 311.595; Tenn. Code § 63-6-214.[26] In light of the authority these medical boards already possess, a categorical ban on accepted medical treatment is not substantially related to Tennessee and Kentucky's purported goal of protecting the ethics of the medical profession.

[25] *See, e.g.*, Cal. Bus. & Prof. Code § 2000 et seq.; D.C. Code § 3–1205.14; 225 Il. Comp. Stat. 60/22(A); Mass. Gen. Laws ch. 112, § 5; Md. Code Ann., Health Occ. § 14-101 et seq.; Nev. Rev. Stat. §§ 630.301, 630.306, 630.230; N.Y. Educ. Law § 6530; 63 Pa. Cons. Stat. § 422.1 et seq.; Wash. Rev. Code § 18.71.002 et seq.

[26] *See, e.g.*, Cal. Bus. & Prof. Code § 2220 et seq; D.C. Code § 3–1205.14; 225 Il. Comp. Stat. 60/22(A); Mass. Gen. Laws ch. 112, § 5; Md. Code Ann., Health Occ. § 14-404; Nev. Rev. Stat. § 630.352(4); N.Y. Pub. Health Law § 230-a; 63 Pa. Cons. Stat. § 422.41; Wash. Rev. Code § 18.130.050 et seq.

Amici States' experience also confirms that a categorical ban on gender-affirming care is not substantially related to any concern about the medical risks of receiving such care. Gender affirming care is well-established, evidence-based medical treatment that—like all medical treatments—carries both risks and benefits. The World Professional Association for Transgender Health (WPATH), the Endocrine Society, and other recognized and reputable professional associations endorse evidence-based standards of care for transgender people.[27] A flat ban on such gender-affirming care for teenagers—even when doctors deem them medically necessary—is inconsistent with these medical standards.[28] And any legitimate concerns over such care can be addressed through ordinary regulatory methods. For example, States did not react to the opioid crisis by completely banning the use of opioids and depriving all patients of medications to manage their pain. Instead, States adopted legislation or regulations to curb the amount of opioids that physicians could prescribe and disciplined providers that engaged in

[27] *See* E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health 1 (2022); *see also* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender Incongruent-Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869 (2017).

[28] *See id*.

improper prescribing practices.[29] The record does not support the claim that gender-affirming care must be regulated more stringently; indeed, in marked contrast to the well-documented abuses of the opioid crisis, the record here contains no evidence at all of the supposed abuses that the laws purport to address. *See Thornbury*, 2023 WL 4230481, at *4. Tennessee and Kentucky provide no sound basis for supporting a blanket ban on well-established medical care.

Finally, Tennessee and Kentucky's bans overstep by unnecessarily interfering with the doctor-patient relationship. According to the American Medical Association's Code of Medical Ethics, the relationship between a patient and a physician is based on trust, "which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."[30] Courts have recognized the significance of

[29] Nat'l Conf. of State Legislatures, Prescribing Policies: States Confront Opioid Overdose Epidemic (June 30, 2019), https://web.archive.org/web/20220426122124/https://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx ("State lawmakers are crafting innovative policies . . . to address this public health crisis while also ensuring appropriate access to pain management.").

[30] *Patient-Physician Relationships*, AMA Code of Medical Ethics, https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-physician-relationships (last visited Aug. 1, 2023).

this relationship.[31] And amici States' policies explicitly avoid interfering with the doctor-patient relationship and disrupting decisions rooted in well-accepted medical standards.[32] In short, Tennessee and Kentucky's bans undermine, rather than promote, medical ethics.[33]

C. ALABAMA'S ARGUMENTS ARE FLAWED

Alabama's amicus brief raises two principal arguments in support of Tennessee and Kentucky's laws. Neither is persuasive.

First, Alabama asserts the challenged laws draw classifications based on medical procedure, not sex. As explained above, that view cannot be reconciled

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[31] *See, e.g.*, *Thornbury*, 2023 WL 4230481, at *5 (W.D. Ky. June 28, 2023); *Doe v. Ladapo*, No. 4:23-cv-114-RH-MAF, 2023 WL 3833848, at *13 (N.D. Fla. June 6, 2023) ("Ordinarily it is the patient, in consultation with the doctor, who weighs the risks and benefits and chooses a course of treatment. What is remarkable about the challenged statute and rules is not that they address medical treatments with both risks and benefits but that they arrogate to the state the right to make the decision.").

[32] *See, e.g.*, McPherson, *supra* note 17, at 3–4 (determinations of "medical necessity" for insurance coverage purposes "must also be guided by providers in communication with individual patients."); Press Release, Cal. Dep't of Ins., *supra* note 19 (the State encourages health insurance companies to evaluate coverage criteria for gender-affirming care in order "to avoid needlessly delaying and interfering with medical care recommended by a patient's doctor.").

[33] *See Brandt v. Rutledge*, 551 F.Supp.3d 882, 891 (E.D. Ark. 2021) ("[T]he State's goal of ensuring the ethics of Arkansas healthcare providers is not attained by interfering with the patient-physician relationship, unnecessarily regulating the evidence-based practice of medicine[,] and subjecting physicians who deliver safe, legal, and medically necessary care to civil liability and loss of licensing.").

with the way the laws operate to deny treatment to only transgender individuals, and no one else. *Supra* at Section III.A. Alabama contends that "[i]t does not matter that Kentucky and Tennessee allow these drugs . . . for some purposes but not for transitioning," citing circumstances in which certain States authorize the use of morphine for pain but not assisted suicide, or allow the use of testosterone for Klinefelter Syndrome but not for PTSD. Brief of Amici Curiae Alabama et al., 2023 WL4902009, at *8. But those examples do not categorically bar medical care based on the sex of the patient and thus say nothing at all about whether *these* bans impose a sex-based classification.[34] Nor did they involve medically necessary care.[35] Here, in contrast, Kentucky and Tennessee ban medical treatment based on gender nonconformity, and the treatment denied is medically necessary and consistent with the standards of care for treating gender dysphoria.

Second, Alabama asserts that even if heightened scrutiny applies, the district courts erred by crediting medical expert testimony that gender-affirming treatment is consistent with well-established standards of care. Brief of Amici Curiae

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[34] *See McMain v. Peters*, No. 2:13-CV-01632-AA, 2018 WL 3732660, at *3–4 (D. Or. Aug. 2, 2018) (Plaintiff did not receive testosterone because his levels were only slightly below normal and other medications were more appropriate for treating his mental health issues); *Titus v. Aranas*, No. 3:18-CV-00146-MMD-CLB, 2020 WL 4248678, at *5–6 (D. Nev. June 29, 2020) (Plaintiff did not receive testosterone because his levels were normal so there was no medical need for it).

[35] *Id*.

Alabama et al., 2023 WL 4902009, at *24–29. Alabama dismisses the overwhelming medical consensus that supports gender-affirming care as a treatment option for gender dysphoria, and that opposes categorical bans on medical care like Tennessee's and Kentucky's. *Id*. Instead, Alabama argues that every major medical association in the United States, and WPATH, have political motivations and should be discredited. *Id*. at 29.[36] But Alabama cannot point to *any* American medical association that has endorsed their position.[37] In fact, mainstream medical consensus, and the great weight of federal authority, agree that gender dysphoria is a real, diagnosable, and treatable medical condition—one that harms the physical and mental health of transgender minors and adults alike when left untreated.[38]

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[36] Judge Hale dismissed the purported "ideological takeover of the major medical organizations" as "baseless." *Thornbury*, 2023 WL 4230481, at *5 n.6; *see also Ladapo*, 2023 WL 3833848, at *14 ("[I]t is fanciful to believe that all the many medical associations who have endorsed gender-affirming care, or who have spoken out or joined an amicus brief supporting the plaintiffs in this litigation, have so readily sold their patients down the river. The great weight of medical authority supports these treatments.").

[37] *See Ladapo*, 2023 WL 3833848 at *4 ("At least as shown by this record, not a single reputable medical association has taken a contrary position."); *see also Skrmetti*, 2023 WL 4232308, at *29 ("It is undisputed that 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.").

[38] *See, e.g.*, *Brandt v. Rutledge*, 47 F.4th 661, 671 (8th Cir. 2022) ("According to . . . the British National Institute for Health & Care Excellence,

Alabama also relies on studies from four European countries, some of which have recently limited the availability of gender-affirming care. Brief of Amici Curiae Alabama et al., 2023 WL 4902009, at *20–24. But those European developments in fact support the district courts' analyses: none of these countries categorically banned gender-affirming care like Kentucky and Tennessee have done.[39] Alabama cites no article, study, or recommendation to support its view that

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several studies have shown statistically significant positive effects of hormone treatment on the mental health, suicidality, and quality of life of adolescents with gender dysphoria. None has shown negative effects."); *Brandt v. Rutledge*, No. 4:21-CV-00450 JM, 2023 WL 4073727, at *24 (E.D. Ark. June 20, 2023) ("Delaying gender-affirming medical care when indicated puts patients at risk of worsening anxiety, depression, hospitalization, and suicidality."); *Dekker v. Weida*, No. 4:22-CV-325-RH-MAF, 2023 WL 4102243, at *7 (N.D. Fla. June 21, 2023) ("The overwhelming weight of medical authority supports treatment of transgender patients with GnRH agonists [puberty blockers] and cross-sex hormones in appropriate circumstances."); *Eknes-Tucker*, 603 F.Supp.3d at 1138 (observing that WPATH "recognizes transitioning medications as established medical treatments and publishes a set of guidelines for treating gender dysphoria in minors with these medications . . . [t]he American Medical Association, the American Pediatric Society, the American Psychiatric Association, the Association of American Medical Colleges, and at least eighteen additional major medical associations endorse these guidelines as evidence-based methods for treating gender dysphoria in minors.") (internal citations omitted).

[39] *See Skrmetti*, 2023 WL 4232308, at *27 n.53 ("Defendants' reliance on the practices of European nations is not an apt analogy where none of these countries have gone so far as to ban hormone therapy entirely"); *see also K.C. v. Individual Members of Med. Licensing Bd. of Indiana*, No. 1:23-cv-00595-JPH-KMB, 2023 WL 4054086, at *11 (S.D. Ind. June 16, 2023) ("Most detrimental to Defendants' position is that no European country that has conducted a systematic review responded with a ban on the use of puberty blockers and cross-sex hormone therapy"); *Ladapo*, 2023 WL 3833848, at *14 ("[T]he treatments are available in

gender-affirming healthcare for teenagers is *never* appropriate and does not come close to establishing that both the district courts clearly erred in concluding that "the weight of evidence in the record suggests . . . that treatment for gender dysphoria lowers rates of depression, suicide, and additional mental health issues faced by transgender individuals." *Skrmetti*, 2023 WL 4232308, at *28; *see also Thornbury*, 2023 WL 4230481, at *5. The bans should be overturned.

CONCLUSION

For the foregoing reasons, the preliminary injunctions should be affirmed.

Dated: August 10, 2023

Respectfully submitted,

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appropriate circumstances in all the countries cited by the defendants, including Finland, Sweden, Norway, Great Britain, France, Australia, and New Zealand").

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CORPORATE DISCLOSURE STATEMENT

As governmental parties, amici are not required to file a certificate of interested persons. Fed. R. App. P. 26.1(a).

CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the type-volume limitations set forth in Fed. R. App. P. 29(a)(5) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this document contains 4759 words.

2. I certify that this brief complies with the typeface and type style requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font. Fed. R. App. P. 32(g)(1)

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CERTIFICATE OF SERVICE

I certify that on August 10, 2023, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send notification of such filing to any CM/ECF participants.

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