

Scrutinizing Transgender Healthcare Bans Through Intersex Exceptions

Holning Lau[†] & Barbara Fedders^{††}

ABSTRACT: Major professional medical organizations—for example, the American Academy of Pediatrics, American Medical Association, and Endocrine Society—consider gender-affirming care to be safe and, at times, essential for vulnerable transgender youth. Despite these benefits, 26 states have banned gender-affirming care for minors. Proponents of these bans raise concerns about potential medical harms, the irreversibility of treatments, and the adequacy of informed consent.

Every state ban includes an exception for so-called gender-normalizing surgeries, which are performed on intersex infants to conform their bodies to socially constructed expectations about the male/female binary. The procedures are rarely medically necessary, but proponents of the surgeries contend that they alleviate stigma. Far too often, these procedures result in ongoing pain, loss of sexual sensation, psychological harm, physical scarring, or even sterilization. The irreversibility of these surgeries and the inability of infants to consent are abundantly clear, and research suggests widespread failures to obtain informed consent from parents.

At first blush, the intersex exception in transgender healthcare bans appears to create a stark inconsistency. The very concerns cited to justify the bans—medical harm, irreversibility, and lack of informed consent—are even more pronounced in the context of intersex surgeries. This inconsistency raises the question: Why do the very laws that purport to protect against these factors include exceptions for intersex surgeries?

This Article argues that the intersex exceptions are, in fact, consistent with sentiments behind bans on gender-affirming care: a deep-seated fear of and discomfort with children who do not conform to traditional sex stereotypes. By examining the intersex exceptions, the Article reveals that sex stereotypes, irrational fear, and disgust are foundational motivations underpinning the laws.

[†] Willie Person Mangum Distinguished Professor of Law, University of North Carolina School of Law.

^{††} Reef C. Ivey II Excellence Fund Term Scholar, Associate Professor of Law, University of North Carolina School of Law. We are grateful to Katie Eyer, Suzanne Kim, Craig Konnoth, and Laura Lane-Steele for helpful comments on drafts of this Article. We also thank Erica Schimmel and the staff of UNC School of Law's Kathrine R. Everett Law Library for outstanding research assistance.

The Article further contends that these motivations call into question the bans' constitutionality. As parents of transgender youth challenge these bans in court, with one case—*United States v. Skrmetti*—pending before the Supreme Court, this Article offers a crucial perspective for evaluating the forthcoming Supreme Court ruling and for analyzing subsequent legal developments surrounding gender-affirming care for minors.

INTRODUCTION.....	3
I.BACKGROUND: GENDER-AFFIRMING HEALTHCARE, INTERSEX SURGERIES, AND TRANS YOUTH HEALTHCARE BANS.....	8
A. Gender-Affirming Healthcare.....	9
B. Intersex Surgeries	14
C. Trans Youth Healthcare Bans and Court Challenges	18
II.SEX STEREOTYPES, IRRATIONAL FEAR, AND DISGUST.....	21
A. Sex Stereotypes.....	22
B. Irrational fear	28
C. Disgust.....	31
III. CONSTITUTIONAL IMPLICATIONS	34
A. Equal Protection	35
1. Sex discrimination	35
2. Animus.....	40
3. Unreasonableness aside from animus	45
B. Substantive Due Process.....	46
CONCLUSION.....	49

INTRODUCTION

Leah is a cheerful 12-year-old transgender girl who lives outside Austin, Texas.¹ She loves to skateboard and play soccer.² She began coming out to her family at age 10, first as a gay boy, then as a transgender girl.³ Leah has now socially transitioned—identifying as a girl, using a new name, and wearing dresses.⁴ In her own words: “For so long, I wasn’t being me.”⁵ Leah’s parents’ eyes well up when they recount the mental health toll on Leah prior to her transitioning.⁶ Now, Leah is flourishing.⁷

Leah’s doctor in Texas recommended that she start taking puberty blockers as a form of gender-affirming healthcare.⁸ Her parents need to drive at least 12 hours each way to reach the nearest clinic where she can receive such treatment.⁹ The closest clinic is in New Mexico because Texas has banned doctors from treating minors with gender-affirming healthcare, including puberty blockers, hormone therapy, and surgeries.¹⁰ Leah’s family is still waiting to hear whether the clinic in New Mexico is accepting new patients.¹¹ If it does not have that capacity, Leah’s family will need to travel even farther.

Texas is home to an estimated 30,000 transgender youth.¹² Many of those children’s families are considering moving out of Texas to access gender-

1. This Article’s hypothetical account of Leah is based on two PBS news reports about a transgender girl in Texas pseudonymously referred to as “Leah.” See Laura Barrón-López et al., *Families Face Difficult Decisions as Texas Ban on Youth Gender-Affirming Care Takes Effect*, PBS (Sept. 1, 2023, 5:45 PM) [hereinafter *Families Face Difficult Decisions*], <https://www.pbs.org/newshour/show/families-face-difficult-decisions-as-texas-ban-on-youth-gender-affirming-care-takes-effect> [https://perma.cc/8V5T-FAF4]; Laura Barrón-López, Sam Lane & Tess Conciatori, *Families with Transgender Children Struggle to Navigate Wave of Anti-Trans Politics*, PBS (June 12, 2023, 6:30 PM) [hereinafter *Families with Transgender Children Struggle*], <https://www.pbs.org/newshour/show/families-with-transgender-children-struggle-to-navigate-wave-of-anti-trans-politics> [https://perma.cc/JQT7-JQL3].

2. See *Families with Transgender Children Struggle*, *supra* note 1.

3. See *id.*

4. See *id.*

5. See *id.*

6. See *id.*

7. See *id.*

8. This Article adopts the commonplace usage of the term “gender-affirming healthcare” for referring to transgender people’s transition-related healthcare. Cisgender youth might seek medical treatment to affirm their sense of gender. For example, a cisgender girl may seek breast enhancement surgery to feel more feminine. While such treatment would affirm her gender, it is not encompassed by this Article’s use of the term “gender-affirming healthcare.”

9. In 2022, Governor Greg Abbott ordered Texas’ Department of Family Protective Services to pursue child abuse investigations against parents whose children received gender-affirming healthcare. A court has blocked that order while litigation challenging the order is pending. See Kimberlee Kruesi & Geoff Mulvihill, *LGBTQ+ Advocacy Group Sues Texas AG, Says It Won’t Identify Transgender Families*, AP NEWS (Feb. 29, 2024, 3:51 PM), <https://apnews.com/article/transgender-texas-lawsuit-youth-ede5b126e4f2f47fa179465c364f5549> [https://perma.cc/8FXV-8SQS].

10. See *Families Face Difficult Decisions*, *supra* note 1.

11. See *id.*

12. Jody L. Herman, Andrew R. Flores & Kathryn K. O’Neill, *How Many Adults and Youth Identify as Transgender in the United States?*, WILLIAMS INST. 10 (June 2022),

affirming healthcare.¹³ In deciding where to move, parents face a complicated and rapidly changing map. In 2020, no state banned gender-affirming care for minors.¹⁴ As of August 2024, 26 states have enacted such bans.¹⁵ As a shorthand, we will refer to these laws as “trans youth healthcare bans” or simply “the healthcare bans.” States have adopted these bans despite opposition from parents of transgender children,¹⁶ civil and human rights groups,¹⁷ and major professional organizations in the fields of medicine and psychology, including the American Medical Association, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, American Psychiatric Association, Endocrine Society, and the U.S. and World Professional Associations for Transgender Health.¹⁸

<https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf> (estimating that, in Texas, 29,800 people aged thirteen to seventeen identify as transgender).

13. See Sasha von Oldershausen, “*I Don’t Want to Live in This State of Terror Anymore*”: *Some Families With Trans Children Are Leaving*, TEXAS MONTHLY (July 24, 2023), <https://www.texasmonthly.com/news-politics/trans-families-leaving-texas> [<https://perma.cc/9ESW-4SGP>] (noting that “families with trans children are fleeing” and interviewing a mother who moved with her transgender daughter from Houston, Texas to Los Angeles, California).

14. In 2021, Arkansas became the first state to enact a trans youth healthcare ban. See *Arkansas Save Adolescents from Experimentation (Safe) Act*, ARK. CODE ANN. §§ 20-9-1501 to -1504 (2021).

15. States with bans include Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming. See Holning Lau & Barbara Fedders, *Appendix to “Scrutinizing Transgender Healthcare Bans Through Intersex Exceptions”* [hereinafter *Appendix*], https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4965241 [<https://perma.cc/DD6T-VS4D>].

16. See Lisa Selin Davis, *Transgender Children and Their Parents Struggle to Cope with Restrictive Laws*, CNN (June 22, 2021, 9:22 AM), <https://www.cnn.com/2021/06/14/health/trans-kids-care-state-bans-wellness/index.html> [<https://perma.cc/RA6X-6SZ9>].

17. See, e.g., Kelley Robinson, *LGBTQ+ Americans Under Attack: A Report and Reflection on the 2023 State Legislative Session*, HUM. RTS. CAMPAIGN (June 8, 2023), <https://hrc-prod-requests.s3-us-west-2.amazonaws.com/Anti-LGBTQ-Legislation-Impact-Report.pdf> [<https://perma.cc/243J-V8FM>] (condemning “over 220 . . . [state bills from 2023 that] target the transgender community”); *Transgender People and Healthcare*, ACLU, <https://www.aclu.org/issues/lgbt-rights/transgender-rights/transgender-people-and-health-care> [<https://perma.cc/D8MT-R36E>] (last visited July 26, 2024) (documenting the ACLU’s lobbying and litigation efforts “to eliminate barriers that transgender people face in receiving health care, including treatments specifically related to gender transition and gender affirmation.”).

18. See, e.g., *AMA Strengthens Its Policy on Protecting Access to Gender-Affirming Care*, AM. MED. ASS’N (June 12, 2023), <https://www.endocrine.org/news-and-advocacy/news-room/2023/ama-gender-affirming-care> [<https://perma.cc/B6X3-MCDZ>] (reporting that the American Medical Association’s House of Delegates passed a resolution opposing bans on minors’ access to gender-affirming care; the resolution was sponsored by the Endocrine Society and co-sponsored by the American Academy of Pediatrics, American College of Physicians, and other professional organizations); *Frontline Physicians Oppose Legislation That Interferes in or Criminalizes Patient Care*, AM. PSYCHIATRIC ASS’N (Apr. 2, 2021), <https://www.psychiatry.org/newsroom/news-releases/frontline-physicians-oppose-legislation-that-interferes-in-or-criminalizes-patient-care> [<https://perma.cc/X7K8-ZZ8Q>] (reporting on a position statement against trans youth healthcare bans from the American Psychiatric Association, American Association of Family Physicians, American Academy of Pediatrics, and other professional organizations); *Statement of Opposition to Legislation Banning Access to Gender-Affirming Health Care in the US*, WORLD PRO. ASS’N OF TRANSGENDER HEALTH (Mar. 8, 2023), https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH_WPATH%20Statement%20re_%20GAHC%20march%208%202023.pdf [<https://perma.cc/4QYR-SY92>] (joint policy statement from the U.S. and World Professional Associations for Transgender Health).

Trans youth healthcare bans almost never contain exceptions based on the severity of a transgender child's mental distress.¹⁹ Even if a doctor believes that prescribing puberty blockers is essential to prevent suicidality, the doctor is prohibited from prescribing the treatment.²⁰ The bans do, however, permit doctors to provide the same treatments for purposes unrelated to transgender youth's gender affirmation.²¹ For example, a doctor can provide puberty blockers to a cisgender child who enters puberty too early.²² With respect to gender-affirmation, some states' bans do allow transgender children to continue receiving treatment if they had started treatment before a specified date.²³ The only other exception consistently appearing in trans healthcare bans applies to intersex children.²⁴

The term "intersex" refers to people who were born with sex characteristics that do not comport with binary expectations of female or male bodies.²⁵ Such sex characteristics include a person's anatomy, reproductive organs, chromosomal patterns and/or hormone levels.²⁶ In the 1950s, surgeons in the United States began advocating for surgeries to make intersex children's bodies comport with stereotypical male and female bodies.²⁷ These procedures are rarely medically necessary.²⁸ Instead, they are aimed at conforming intersex children's bodies to societal norms in hopes of reducing their experiences with

19. To the best of our knowledge, West Virginia's ban is the only one to contain an exception based on the severity of gender dysphoria and risk of self-harm. See W. VA. CODE § 30-3-20(C)(5). For a survey of state bans, see *Appendix, supra* note 15. See also Elana Redfield et al., *Prohibiting Gender-Affirming Care for Youth*, WILLIAMS INST. (Mar. 2023), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Youth-Health-Bans-Mar-2023.pdf> [<https://perma.cc/Z7VV-SAUD>] (providing an overview of states' healthcare bans).

20. "More than one-third of transgender high school students attempt suicide in a given year." *Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors*, 134 HARV. L. REV. 2163, 2163 (2021) (citing Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017*, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 70 (2019)).

21. For example, Arkansas's pioneering ban restricts "gender transition procedures" and courts have interpreted that phrase to exclude treatments on cisgender youth. See *Arkansas Save Adolescents from Experimentation (Safe) Act*, ARK. CODE ANN. §§ 20-9-1501 to -1502 (2021); *Brandt v. Rutledge*, 47 F.4th 661, 669-70 (8th Cir. 2022), *aff'g* 551 F. Supp. 3d 882, 891 (E.D. Ark. 2021). See also *Appendix, supra* note 15 (compiling language from 26 states' trans youth healthcare bans).

22. The state bans contain general language limiting their scope to treatments related to transgender youth's gender affirmation. See generally *Appendix, supra* note 15 (compiling language from 26 states' trans youth healthcare bans). Several state bans reinforce their focus on transgender healthcare by stating explicitly that they do not prohibit treatment of "precocious puberty." See *id.*

23. See *Appendix, supra* note 15.

24. See *id.* Some bans contain additional exceptions that are narrowly drawn. For example, Kentucky's ban contains an exception allowing minors to receive care for injuries resulting from gender-transition treatments that they received prior to the ban. KY. REV. STAT. ANN. § 311.372(3)(a)-(c).

25. JULIE A. GREENBERG, INTERSEXUALITY AND THE LAW: WHY SEX MATTERS 1-2 (2012).

26. *Id.*

27. See *id.* at 15-18; Sylvan Fraser, *Constructing the Female Body: Using Female Genital Mutilation Law to Address Genital-Normalizing Surgery on Intersex Children in the United States*, 9 INT'L J. HUM. RTS. HEALTHCARE 62, 63-64 (2016).

28. See Fraser, *supra* note 27, at 63-64.

stigma and social discomfort.²⁹ Health and human rights experts have called for ending medically unnecessary intersex surgeries on young children. These calls have come from entities ranging from the World Health Organization and the American Academy of Family Physicians to the U.N. Office of the High Commissioner for Human Rights.³⁰ Despite mounting criticism of intersex surgeries, trans youth healthcare bans explicitly provide that intersex surgeries shall be permitted by law.³¹ In this Article, we will refer to these exemptions from the bans as the “intersex exceptions.”

This Article provides a sustained focus on intersex exceptions.³² We examine how intersex exceptions ought to shape understandings about trans youth healthcare bans. In doing so, we make two main claims. First, intersex exceptions reveal obscured but foundational sentiments that underlie trans youth healthcare bans. The bans’ proponents contend that the laws are aimed at protecting children against potential medical harm, irreversible treatments, and deprivation of informed consent.³³ Yet the intersex exceptions run counter to these purported goals. In fact, the harms that the bans purportedly address are

29. *See id.*

30. *See United Nations Entities Call on States to Act Urgently to End Violence and Discrimination against Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Adults, Adolescents and Children*, U.N. OFF. HIGH COMM’R HUM. RTS. (Sept. 2015) [hereinafter *U.N. Entities Call on States*], https://www.ohchr.org/sites/default/files/Documents/Issues/Discrimination/Joint_LGBTI_Statement_ENG.PDF [<https://perma.cc/QU7U-5LWZ>] (joint statement from twelve U.N. entities, including the World Health Organization and Office of the High Commissioner for Human Rights, expressing opposition to “unnecessary surgery and treatment on intersex children without their consent”); *Genital Surgeries in Intersex Children*, AM. ACAD. FAM. PHYSICIANS, <https://www.aafp.org/about/policies/all/genital-surgeries.html> [<https://perma.cc/36DA-C4B9>] (last visited July 2024) (position statement adopted by the organization’s Board of Directors in July 2018 and by the Congress of Delegates in 2023).

31. *See also Appendix, supra* note 15 (compiling language from the intersex exceptions in 26 states’ trans youth healthcare bans).

32. This Article builds on previous law review articles that pointed out, but did not examine in great detail, the fact that intersex exceptions are inconsistent with the purported goals of trans youth healthcare bans. *See, e.g.*, Scott Skinner-Thompson, *Trans Animus*, 65 B.C. L. REV 966, 991-92 (2024); Erik Fredericksen, *Protecting Transgender Youth After Bostock: Sex Classification, Sex Stereotypes, and the Future of Equal Protection*, 132 YALE L.J. 1149, 1181-82 (2023). Similar observations have been made in reports apart from law reviews. *See, e.g.*, *Mapping the Intersex Exceptions*, HUM. RTS. WATCH (Oct. 26, 2022), <https://www.hrw.org/feature/2022/10/26/mapping-the-intersex-exceptions> [perma.cc/RD9A-8LDQ]; MOVEMENT ADVANCEMENT PROJECT, LGBTQ POLICY SPOTLIGHT: BANS ON MEDICAL CARE FOR TRANSGENDER PEOPLE 15-16 (2023), <https://www.mapresearch.org/file/MAP-2023-Spotlight-Medical-Bans-report.pdf> [perma.cc/WPB8-QD97]. To the best of our knowledge, this Article is only one of two law review articles that focus closely on intersex exceptions, with the other being a forthcoming article by Ido Katri and Maayan Sudai. The article by Katri and Sudai develops a framework for “normative allyship” between intersex and transgender legal movements; this allyship is based on shared interests in demonstrating the irrationality of trans youth healthcare bans with intersex exceptions and in securing legal protections for minors’ bodily autonomy. Ido Katri & Maayan Sudai, *Intersex, Trans and the Irrationality of Gender Affirming Care Bans*, 134 YALE L. J. (forthcoming 2025) (on file with the authors).

33. *See, e.g.*, HEIDI OVERTON & ALEXANDRA CARO CAMPANA, AM. FIRST POL’Y INST., GENDER TRANSITION MEDICATIONS AND SURGERIES FOR CHILDREN IN THE U.S. (Feb. 2023); SARAH PARSHALL PERRY & THOMAS JIPPING, HERITAGE FOUND., STATES MAY PROTECT MINORS BY BANNING “GENDER-AFFIRMING CARE” (Dec. 2023). *See also infra* notes 140-143 and accompanying text (examining Tennessee’s legislation as an example and noting that it states particular policy goals, which the Attorney General of Tennessee echoed in litigation).

especially pronounced with respect to intersex surgeries.³⁴ It is difficult to understand why intersex exceptions would be included in any law that is truly aimed at addressing concerns about medical harm, irreversibility, and informed consent. We thus contend that other factors motivate trans youth healthcare bans. Specifically, one can infer motivations from the bans' structure, which is characterized by a broad scope and peculiar intersex exception.³⁵ We argue that the bans' structure reveals that sex stereotypes, irrational fear, and disgust are primary motivations.³⁶

Our second claim concerns constitutional analysis. Legislative motives are relevant to constitutional scrutiny. Accordingly, we argue that the three motivating factors that we identify—sex stereotyping, fear, and disgust—should inform constitutional review of trans youth healthcare bans pursuant to both equal protection and substantive due process.³⁷

Numerous lawsuits have challenged the constitutionality of trans youth healthcare bans.³⁸ Federal circuit courts have split on the appropriateness of preliminary injunctions against the bans.³⁹ In the court opinions reported so far,

34. See, e.g., M. Joycelyn Elders, David Satcher & Richard Carmona, *Re-Thinking Genital Surgeries on Intersex Infants*, PALM CTR. (June 2017), <https://www.palmcenter.org/wp-content/uploads/2017/06/Re-Thinking-Genital-Surgeries-1.pdf> [<https://perma.cc/P9EW-HALC>] (joint statement from former U.S. Surgeons General calling for a moratorium on intersex infant surgery due to concerns about medical harm, irreversibility, and informed consent). See also *infra* Section I.B.

35. See *infra* Part II. Regarding the bans' scope, it is worth noting that Arizona's and New Hampshire's bans are considerably narrower than other states' bans because they prohibit surgeries but not puberty blockers or hormone therapy. Georgia's ban covers surgery and hormone therapy but not puberty blockers. See *Appendix, supra* note 15 (comparing the scope of 26 state bans).

36. See *infra* Part II.

37. With respect to equal protection, the intersex exceptions illuminate stereotyping that contravenes the anti-stereotyping principle in sex discrimination cases. See *infra* Section III.A.1 The intersex exceptions also reveal fear and disgust that count against the bans pursuant to equal protection jurisprudence on rational basis review. See *infra* Section III.A.2 Finally, with respect to substantive due process, the fear and disgust revealed by intersex exceptions support construing the healthcare bans as an unreasonable restriction on parental autonomy. See *infra* Section III.B.

38. Constitutional challenges have been brought in federal courts in Alabama, Arkansas, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, and Tennessee. See ELANA REDFIELD, KERITH J. CONRON & CHRISTY MALLORY, WILLIAMS INST., *THE IMPACT OF 2024 ANTI-TRANSGENDER LEGISLATION ON YOUTH 7-8* (2024) (surveying federal court cases on trans youth healthcare bans). In addition, challenges based on state constitutions have been brought in Louisiana, Missouri, Nebraska, North Dakota, Montana, and Texas. See Lois A. Weithorn, *The Intrusive State: Restrictions on Gender-Affirming Healthcare for Minors, Exceptions to the Doctrine of Parental Consent, and Reliance on Science and Medical Expertise*, 75 UC L. J. 713, 802-03 (2024) (surveying state court cases on trans youth healthcare bans).

39. See *Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022) (affirming preliminary injunction), *en banc reh'g denied*, No. 21-2875, 2022 WL 16957734 (8th Cir. 2022); *Eknes-Tucker v. Gov. of Ala.*, 80 F.4th 1205 (11th Cir. 2023) (reversing preliminary injunction), *petition for reh'g en banc* filed Sept. 11, 2023; *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023) (reversing preliminary injunctions), *cert. granted*, *United States v. Skrmetti*, 144 S. Ct. 2679 (2024). In addition, federal district courts in Arkansas and Florida decided cases on the merits, issuing permanent injunctions against trans youth healthcare bans. See *Doe v. Ladapo*, No. 4:23cv114-RH-MAF, 2024 WL 2947123, at *28 (N.D. Fla. June 11, 2024); *Brandt v. Rutledge*, 677 F. Supp. 3d 877 (E.D. Ark. 2023).

intersex exceptions have received only cursory attention.⁴⁰ This Article suggests that this omission is unfortunate because the intersex exceptions reveal legislative motives. One lawsuit has now reached the Supreme Court.⁴¹ In *L.W. v. Skrmetti*, the Sixth Circuit reversed a preliminary injunction that a lower court had imposed on Tennessee's healthcare ban.⁴² Responding to a petition from the U.S. Department of Justice, which joined the case as intervenors, the Supreme Court granted *certiorari*.⁴³ This Article provides a crucial perspective for evaluating the Court's forthcoming ruling and subsequent legal developments, including potential litigation and policy reforms post-*Skrmetti*.

This Article proceeds as follows. Part I provides background on gender-affirming healthcare, intersex surgeries, and trans youth healthcare bans. Part II develops our contention that one can infer from intersex exceptions that trans youth healthcare bans are rooted in sex stereotypes, irrational fear, and disgust. We critique these motivating factors by drawing on literature from liberal theory, critical theory, and social sciences. Part III maps our normative critique onto constitutional claims concerning equal protection and substantive due process. Our Conclusion summarizes this Article's key points, and it comments on the prospect of developing nuanced regulations—instead of outright bans—to enhance informed consent and safeguard against potential risks associated with gender-affirming medical care for minors.

I. BACKGROUND: GENDER-AFFIRMING HEALTHCARE, INTERSEX SURGERIES, AND TRANS YOUTH HEALTHCARE BANS

This Part offers a primer on gender-affirming healthcare for minors, intersex surgeries, and the spate of laws that prohibit trans youth medical care while carving out exceptions for intersex surgeries. This primer shows that the bans are inconsistent in addressing concerns about medical harm, irreversibility, and informed consent. The bans purport to address these concerns by prohibiting

40. *E.g.*, *Skrmetti*, 83 F.4th at 469-70 (noting that Kentucky's and Tennessee's bans contain exceptions for intersex children, referring to them as minors with "congenital conditions" or "sexual developmental disorders"). *See also id.* at 500 (White, J., dissenting) (pointing to the intersex exception in Kentucky's and Tennessee's bans to critique the scope of the bans).

41. *See Skrmetti*, 144 S. Ct. at 2679 (granting *certiorari* to review certain aspects of the Sixth Circuit's decision in *Williams v. Skrmetti*).

42. The Sixth Circuit's decision reversed preliminary injunctions against bans in Tennessee and Kentucky. *Skrmetti*, 83 F.4th at 460.

43. *Skrmetti*, 144 S. Ct. at 2679. The petition was filed by President Biden's Department of Justice. President-elect Trump will assume office after oral arguments in *Skrmetti*. His Department of Justice may eventually file papers to disavow the position taken by the Biden administration. The Supreme Court may dismiss the case in response, but such dismissal seems unlikely. *See* Jimmy Hoover, *Trump's Solicitor General Expected to 'Flip' Prelogar's Positions at Supreme Court*, NAT'L LAW J. (Nov 22, 2024, 07:51 PM), [https://www.law.com/nationallawjournal/2024/11/22/trumps-solicitor-general-expected-to-flip-prelogars-positions-at-supreme-court-\[https://perma.cc/A8R2-M888\]](https://www.law.com/nationallawjournal/2024/11/22/trumps-solicitor-general-expected-to-flip-prelogars-positions-at-supreme-court-[https://perma.cc/A8R2-M888]).

gender-affirming healthcare for transgender youth, yet they allow intersex surgeries, where the same concerns are especially pronounced.

A. Gender-Affirming Healthcare

When a minor's gender identity⁴⁴ conflicts with their birth-assigned sex, shifting the individual's lived experience to align with their internal sense of gender is often essential for well-being.⁴⁵ This process of transition, or gender affirmation, can be entirely non-medical or have a medical component.⁴⁶ Consider the example of Jesse, a young adult who was assigned female at birth but identifies as non-binary⁴⁷ and uses they/them pronouns.⁴⁸ Throughout their childhood and adolescence, Jesse's clothing choices and interests prompted

44. "Gender identity" refers to a person's internal experience of gender, which may or may not correspond with the individual's sex assigned at birth. In this Article, we adopt the growing practice of using the terms "sex" and "gender" interchangeably. We use the phrase "sex assigned at birth" and "birth-assigned sex" to refer specifically to the designation given to an individual based on the individual's biological traits at birth. Some writers distinguish between sex and gender, contending that sex categories are defined by biology while gender categories are social constructs. Others, however, have explained that sex categories are largely socially constructed as well. *See, e.g.*, INTER-AM. COMM'N ON HUM. RTS., VIOLENCE AGAINST LGBTI PERSONS 27-28 (2015); Laurel Westbrook & Kristen Schilt, *Doing Gender: Determining Gender*, 28 GENDER & SOC'Y 32, 53 n.1 (2014).

"Transgender" is an umbrella term referring to individuals whose gender identity does not match their birth-assigned sex. Meanwhile, "cisgender" refers to individuals whose gender identity does match the sex assigned to them at birth. Transgender is an umbrella term because there are different ways in which people's internal feelings of gender may differ from their birth-assigned sex. For example, an individual who was assigned male at birth might later identify as a woman; meanwhile, another individual assigned male at birth might later feel that they do not fit in either category within the man/woman binary. Instead of using the umbrella term "transgender," some communities prefer to use more nuanced terms to describe gender identity. This Article, however, will use the umbrella term to speak generally about the rights of all individuals whose internal sense of gender conflicts with their birth-assigned sex, including both binary and nonbinary transgender persons. "Gender diversity" is a "wide-ranging inclusive term for non-male and non-female identities." Nat Thorne et. al., *The Terminology of Identities Between, Outside, and Beyond the Gender Binary: A Systematic Review*, 29 INT'L J. TRANSGENDERISM 138, 138 (2019).

45. Kareen M. Matouk & Melina Wald, *Gender-Affirming Care Saves Lives*, COLUM. UNIV. DEP'T PSYCHIATRY (Mar. 30, 2022), <https://www.columbiapsychiatry.org/news/gender-affirming-care-saves-lives> [<https://perma.cc/8W36-DDVX>]. Medical professional organizations typically frame their support for gender-affirming care around its utility in helping trans youth address severe mental distress. Some commentators push back against this framing, arguing that an exclusive focus on distress is too limiting; they believe puberty blockers should be made available to a broader set of transgender youth who would benefit from treatment, without necessarily making puberty blockers available "on demand." *See, e.g.*, Danielle M. Wenner & B.R. George, *Not Just a Tragic Compromise: The Positive Case for Adolescent Access to Puberty-Blocking Treatment*, 35 BIOETHICS 925, 928-29 (2021) (querying why psychological distress is the lone gatekeeper for accessing puberty blockers and suggesting this medical intervention might instead "simply increase an adolescent's flourishing, without their having previous psychological distress") (internal citation omitted).

46. Matouk & Wald, *supra* note 45.

47. A recent poll found that 35 percent of Gen Z respondents knew someone who uses gender-neutral pronouns such as "they" or "ze/zim." *Diversity of Nonbinary Youth*, TREVOR PROJECT (July 13, 2021), <https://www.thetrevorproject.org/research-briefs/diversity-of-nonbinary-youth/> [<https://perma.cc/SFK5-5H8S>].

48. This Article's description of Jesse is loosely based on the experiences of Jesse Lueck. *See* TEDx Talks, *Walking Through the World Non-Binary | Jesse Lueck | TEDxRanneySchool*, YOUTUBE (May 9, 2018), <https://www.youtube.com/watch?v=OKJjwTEfaKc>.

people to ask if they wanted to “be a boy.”⁴⁹ Their response: “I don’t want to be a boy. I just want to be treated like one.”⁵⁰ None of Jesse’s peers understood or supported their gender expression.⁵¹ To avoid relentless teasing, Jesse eventually adopted a more stereotypically feminine appearance,⁵² but they began to feel so inauthentic and depressed that they attempted suicide.⁵³ Only after leaving their strict Catholic school did Jesse feel free to wear the clothes and hairstyle of their choosing.⁵⁴ They never sought or obtained medical interventions.⁵⁵ They simply wanted their name and pronouns to be consistently used and respected.⁵⁶ Research suggests that affording such respect is critical to positive mental health outcomes.⁵⁷

For Jesse, gender transition was entirely non-medical. Non-medical transition, far more common than medical transition, may be all that a young person needs.⁵⁸ Non-medical transition can include using a different name and pronouns, wearing different clothing, cutting or growing one’s hair, and shifting to extracurricular activities more congruent with a youth’s gender identity.⁵⁹ It can also include gender-affirming interventions such as psychotherapy and counseling, age-appropriate education about gender and sexuality, and support from family, teachers, and other community members.⁶⁰

For some children, like the transgender girl Leah referred to above, doctors may recommend gender-affirming medical care. When transgender youth enter puberty, the development of secondary sex characteristics that conflict with their gender identity can be “highly traumatic, resulting in ‘depression, anxiety, social withdrawal, cutting and other self-harming behavior, suicidal ideation, suicide attempts, sexual behavioral risks, and substance use.’”⁶¹ Gender-affirming medical care thus aims to align the individual’s physical sex characteristics with

49. *See id.*

50. *See id.*

51. *See id.*

52. *See id.*

53. *See* Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Use: An Endocrinologist’s View*, 17 *NATURE REVIEWS ENDOCRINOLOGY* 581, 584 (2021) (discussing suicidal ideation and suicidal attempts among transgender youth).

54. *See* TEDx Talks, *supra* note 48.

55. *Id.*

56. *Id.*

57. *See Diversity of Nonbinary Youth*, *supra* note 47 (noting study finding that nonbinary youth who report that “no one” respected their pronouns had more than 2.5 times the rate of attempting suicide compared with those reporting that “all or most” people respected their pronouns).

58. Bethany A. Jones et al., *Gender Congruence and Body Satisfaction in Nonbinary Transgender Young People: A Case Control Study*, 20 *INT’L J. TRANSGENDERISM* 263 (2019). *But see* Juanita K. Hodax & Sara DiVall, *Gender-Affirming Endocrine Care for Youth with a Nonbinary Gender Identity*, 14 *THERAPEUTIC ADVANCES ENDOCRINOLOGY METABOLISM* 1 (2023) (suggesting that many providers remain wedded to a gender binary and thus cannot understand gender diverse people who do not wish to transition from male to female).

59. Matouk & Wald, *supra* note 45.

60. *Id.*

61. Weithorn, *supra* note 38, at 742 (quoting Herbert J. Bonifacio & Stephen M. Rosenthal, *Gender Variance and Dysphoria in Children and Adolescents*, 62 *PEDIATRIC CLINICS N. AM.* 1001, 1006 (2015)).

their gender identity.⁶² Such medical care has been endorsed by professional organizations including the American Medical Association, American Academy of Pediatrics (AAP), American Academy of Family Physicians, American College of Physicians, American Psychiatric Association, Endocrine Society, and the U.S. and World Professional Association for Transgender Health (WPATH).⁶³

The Endocrine Society and WPATH have promulgated guidelines, in harmony with principles articulated by the AAP, that stipulate which treatments, if any, are appropriate depending on the child's physical, social, and psychological development.⁶⁴ These guidelines include stringent conditions that doctors must meet to prescribe gender-affirming care, including first diagnosing the child with gender dysphoria⁶⁵ or gender incongruence,⁶⁶ and careful consideration of non-medical interventions.⁶⁷ The guidelines also include requirements for informed consent from the minor along with parental consent or involvement.⁶⁸

There are three main categories of gender-affirming medical care: (1) pubertal suppression through hormone medication (hereinafter "puberty blockers"), (2) hormone replacement treatment for the child to develop secondary sex characteristics aligned with their gender identity (hereinafter

62. *Id.*

63. *See supra* note 18.

64. *See* E. Coleman et al., World Pro. Ass'n for Transgender Health ("WPATH"), *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* 23 INT'L J. TRANSGENDER HEALTH S1, S17, S67-70 (2022) (providing standards of care for transgender healthcare); 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). For discussion on these guidelines, see MEREDITH MCNAMARA ET AL., AN EVIDENCE-BASED CRITIQUE OF "THE CASS REVIEW" ON GENDER-AFFIRMING CARE FOR GENDER DYSPHORIA (2024), https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf [<https://perma.cc/P4U7-U4XE>].

65. According to the American Psychiatric Association, "Gender dysphoria . . . refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 511-20 (5th ed., text rev. 2022). *See also* *What is Gender Dysphoria?*, AM. PSYCHIATRIC ASS'N (July 2022), <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> [<https://perma.cc/2W8W-H3HY>]. The World Professional Association for Transgender Health (WPATH) defines gender dysphoria as "a state of distress or discomfort that may be experienced because a person's gender identity differs from that which is physically and/or socially attributed to their sex assigned at birth." E. Coleman et al., *supra* note 64, at S252.

66. Gender Incongruence is a recognized condition in the 11th edition of the World Health Organization's diagnostic manual, *International Classification of Diseases and Related Health Problems* (ICD-11), which was first published in 2019. *See Gender Incongruence and Transgender Health in the ICD*, WHO, <https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd> [<https://perma.cc/TLN5-4HNK>].

67. E. Coleman et al., *supra* note 64, at S17, S49-51. Some opponents of gender-affirming medical care believe that medical interventions are undertaken cavalierly, but such accusations conflict with the stringent requirements in medical guidelines. *See* Steph M. Schuster & Meredith McNamara, *Troubling Trends in Health Misinformation Related to Gender-Affirming Care* 54 HASTINGS CTR. REP. 53, 54 (2024) (decrying "misinformation about trans identity and the state of the evidence").

68. E. Coleman et al., *supra* note 64, at S47, S57-58.

“hormone therapy”), and (3) surgery. The first medical treatment that healthcare providers consider for transgender youth is the administration of puberty blockers.⁶⁹ These medications delay puberty by suppressing the body’s release of estrogen or testosterone.⁷⁰ For children assigned male at birth, the blockers suppress facial and body hair growth, deepen voices, broaden shoulders, and increase genital size.⁷¹ For those assigned female at birth, puberty blockers limit breast development and stop menstruation.⁷² Puberty blockers pause physical development to give young people time to carefully consider their identity and work with healthcare professionals to determine the extent of transition they need.⁷³ Pausing puberty can also prevent the need for future surgery. For example, if a transgender boy halts the development of breasts, that could prevent the need for future mastectomies.⁷⁴ Puberty blockers are fully reversible in that, once they are stopped, pubertal development restarts along the path of the birth-assigned sex.⁷⁵ Research is mixed, however, on the risk of long-term side effects, including decreased bone density.⁷⁶

Older youths, typically around age 16, may also be eligible to receive hormone therapies if they fulfill certain conditions.⁷⁷ These conditions typically include documentation from a qualified mental health professional stating that the adolescent has experienced a protracted period of gender dysphoria and that potentially complicating social factors have been addressed; evidence that the adolescent has sufficient mental capacity to consent; actual informed consent from the adolescent and their caregiver; and concurrence from a pediatric endocrinologist or other qualified clinician that such treatment is appropriate.⁷⁸ Hormone therapies increase levels of testosterone or estrogen to promote the development of characteristics more closely aligned with the patient’s gender

69. *Puberty Blockers for Transgender and Gender Diverse Youth*, MAYO CLINIC (June 14, 2023), <https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075> [<https://perma.cc/9RE9-VR9C>].

70. *Id.*

71. *Id.*

72. *Id.*

73. See Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS 1, 5 (2018) (policy statement from the American Academy of Pediatrics, published in 2018 and affirmed in 2023).

74. See *Puberty Blockers for Transgender and Gender Diverse Youth*, *supra* note 69.

75. *Id.*

76. See *USPATH and WPATH Respond to NY Times Article “They Paused Puberty, But Is There a Cost?”* Published on November 14, 2022, WPATH (Nov. 22, 2022), <https://www.wpath.org/media/cms/Documents/Public%20Policies/2022/USPATHWPATH%20Statement%20re%20Nov%2014%202022%20NYT%20Article%20Nov%2022%202022.pdf> [<https://perma.cc/FWT6-KRCV>].

77. See Rafferty et al., *supra* note 73, at 6.

78. Caroline Salas-Humara et al., *Gender Affirming Medical Care of Transgender Youth*, 49 CURRENT PROBS. PEDIATRIC ADOLESCENT HEALTH CARE 1, 3 (2019) (citing 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)).

identity.⁷⁹ Such characteristics include increased hair growth and muscle mass for those transitioning toward a male expression of gender, and testicular atrophy and breast development for those doing the reverse.⁸⁰ While stopping hormone-assisted gender transition is rare,⁸¹ the slow pace at which these changes occur lends itself to young people engaging in a deliberative process with their caregivers and physician. Moreover, changes from these treatments are partially reversible, depending on the extent to which hormone therapy has been administered.⁸²

The third category of gender-affirming medical care is surgery. Only in extremely rare cases are gender identity-related surgeries performed on people under eighteen.⁸³ The most common surgery is breast tissue removal, also known as chest masculinization.⁸⁴ Clinical guidelines recommend delaying any gender-affirming genital surgery until adulthood.⁸⁵

As mentioned above, professional organizations have endorsed gender-affirming medical care as safe for transgender minors. These endorsements were based on cross-sectional and longitudinal research suggesting that gender-affirming medical care can lead to improved mental health, including reduction in depression, anxiety, and suicidal ideation.⁸⁶ To be sure, proponents of gender-affirming care acknowledge that, as with any medical intervention, gender-affirming medical care involves some risk of side effects, including the risk of puberty blockers decreasing bone density and affecting fertility.⁸⁷ However, based on the available research, the mainstream medical consensus in the United States is that gender-affirming care should be made available to transgender youth as its benefits often outweigh the risks.⁸⁸

79. *Id.*

80. See McNAMARA ET AL., *supra* note 64.

81. Maria Anna Theodora Catherina van der Loos et al., *Continuation of Gender-Affirming Hormones in Transgender People Starting Puberty Suppression in Adolescence: A Cohort Study in the Netherlands*, 6 LANCET: CHILD & ADOLESCENT HEALTH 869, 875 (2022).

82. *Id.*

83. See Salas-Humara et al., *supra* note 78; Dannie Dai et al., *Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US*, JAMA NETWORK OPEN, June 27, 2024, at 1.

84. Jason D. Wright et al., *National Estimates of Gender Affirming Surgery in the U.S.*, JAMA NETWORK OPEN, Aug. 23, 2023, at 1.

85. Janet Y. Lee & Stephen M. Rosenthal Terhune, *Gender-Affirming Care of Transgender and Gender Diverse Youth: Current Concepts*, 74 ANN. REV. MED. 107, 111 (2023) (citing the guidelines from WPATH and the Endocrine Society).

86. See, e.g., Letter from James L. Madara, Exec. Dir., Am. Med. Ass'n, to the Nat'l Governors Ass'n (Apr. 16, 2021) <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf>; Natalie M. Wittlin et al., *Mental Health of Transgender and Gender Diverse Youth*, 19 ANN. REV. CLINICAL PSYCH. 207, 220 (2023).

87. See Weithorn, *supra* note 38, at 743-44 nn.176-77 and accompanying text (noting that “[g]ender-affirming hormone treatment may cause weight gain, mood, or hematologic and lipid profiles” in addition to potentially affecting bone density and fertility).

88. See *id.* at 737.

Some commentators have questioned the methodology behind the scientific research that supports gender-affirming care for transgender minors, suggesting that the evidence in support of such care is insufficient.⁸⁹ Most notable among such critiques is a report commissioned by the National Health Service of England, written by Dr. Hilary Cass and known as the “Cass Review.”⁹⁰ It is worth emphasizing that even though the Cass Review questioned the robustness of evidence supporting gender-affirming care for transgender minors, it did not support blanket bans of such treatments. The Cass Review called for adding new restrictions to, but not banning, youth access to gender-affirming medical care in the United Kingdom. Indeed, the Cass Review acknowledged that “for some [transgender youth], the best outcome will be transition.”⁹¹ The Cass Review itself has been criticized for adopting a flawed methodology and, therefore, understating the evidentiary support for gender-affirming care.⁹² At the time of this writing, the British Medical Association (BMA) has launched an evaluation of the Cass Review due to “concern about weaknesses in the methodologies used in the [Cass] Review and problems arising from the implementation of some of the recommendations.”⁹³

B. *Intersex Surgeries*

“Intersex” is an umbrella term referring to people born with sex characteristics that do not fit conventional definitions of male or female. Such sex characteristics encompass genitalia, gonads, chromosomes, and/or hormone levels.⁹⁴ Consider the example of Rosie, an intersex child who was featured in the documentary “Gender Revolution: A Journey with Katie Couric.”⁹⁵ Rosie was born with XX chromosomes (typical of a girl).⁹⁶ Due to a congenital condition, Rosie’s body produced more male sex hormones than is typical,

89. See Megan Twohey & Christina Jewett, *They Paused Puberty, but Is There a Cost?*, N.Y. TIMES (Nov. 14, 2022), <https://www.nytimes.com/2022/11/14/health/puberty-blockers-transgender.html> [<https://perma.cc/752Z-HW7Q>] (referencing and summarizing critiques from researchers).

90. See THE CASS REVIEW, INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE (2024), https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf [<https://perma.cc/M8P6-VDT9>].

91. *Id.* at 21.

92. See MCNAMARA ET AL., *supra* note 64.

93. BMA Media Team, *BMA to Undertake an Evaluation of the Cass Review on Gender Identity Services for Children and Young People*, BRITISH MED. ASS’N (July 31, 2024), <https://www.bma.org.uk/bma-media-centre/bma-to-undertake-an-evaluation-of-the-cass-review-on-gender-identity-services-for-children-and-young-people> [<https://perma.cc/TF3M-HRCX>].

94. GREENBERG, *supra* note 25, at 1-2.

95. See Daniella Emanuel, *Raising an Intersex Child: ‘This Is Your Body. ... There’s Nothing to Be Ashamed Of’*, CNN (Apr. 15, 2019, 7:45 AM), <https://www.cnn.com/2019/04/13/health/intersex-child-parenting-eprise/index.html> [<https://perma.cc/T3KA-M9AN>].

96. *Id.*

causing her to be born with what looks like a penis (typical of a boy).⁹⁷ Estimates on the size of the intersex population are as high as roughly 2 percent.⁹⁸ It is estimated that 1 out of every 1000 to 2000 persons is born with conditions that would traditionally be subject to so-called corrective surgeries.⁹⁹ Certain intersex traits, such as Rosie's external genitalia, are apparent at birth.¹⁰⁰ Other times, intersex individuals may not discover until later in life that they have intersex traits such as gonads or chromosomes that do not match their sex assigned at birth.¹⁰¹

When Rosie was born, doctors advised her parents that Rosie should undergo so-called gender normalizing surgery (GNS) while she was still an infant.¹⁰² Specifically, the doctors recommended clitoral reduction (to make Rosie's genitalia resemble a clitoris instead of a penis) and the construction of a vaginal canal.¹⁰³ GNS—also referred to as intersex surgeries—can include clitoral reduction, gonadectomy (removal of testes or ovaries), vaginoplasty, and/or phalloplasty.¹⁰⁴ These surgeries are typically performed when the intersex child is less than eighteen months old, and they are almost always medically unnecessary.¹⁰⁵ Rosie, for example, had no medical need for surgeries.¹⁰⁶ Proponents of these surgeries describe their benefits as social and psychological.¹⁰⁷ They aim to alleviate anxiety and stigma—for the parents and the child—by having the child's body comport with the mainstream conception of gendered bodies.¹⁰⁸

In the 1950s and 1960s, John Money, a psychologist at Johns Hopkins University, played a leading role in making GNS the default standard of care for

97. See Amy Schwabe, *Q&A: How One Milwaukee Couple Is Raising Their 6-Year-Old Intersex Child*, MILWAUKEE J. SENTINEL (Sept. 26, 2016, 6:07 AM), <https://www.jsonline.com/story/life/wisconsin-family/2018/09/26/milwaukee-couple-write-book-raising-intersex-child/973462002> [<https://perma.cc/2ATC-T286>].

98. Melanie Blackness et al., *How Sexually Dimorphic Are We? Review and Synthesis*, 12 AM. J. HUM. BIO. 151, 159-61 (2000).

99. See *id.* at 161; Chanika Phornphutkul et al., *Gender Self-Reassignment in an XY Adolescent Female Born with Ambiguous Genitalia*, 106 PEDIATRICS 135, 136 (2000).

100. See GREENBERG, *supra* note 25, at 1-2.

101. See *id.*

102. See Emanuel, *supra* note 95.

103. Schwabe, *supra* note 97.

104. GREENBERG, *supra* note 25, at 1-2.

105. See *id.* at 21-22 (describing the protocol recommending surgeries on intersex surgery within the first eighteen months of the child's life); Sylvan Fraser, *Constructing the Female Body: Using Female Genital Mutilation Law to Address Genital-Normalizing Surgery on Intersex Children in the United States*, 9 INT'L J. HUM. RTS. HEALTHCARE 41, 63-64 (2016) (noting the practice of performing intersex surgeries before a child reaches eighteen months of age, and noting that surgery is medically necessary only in rare circumstances—for example, to repair a child's urinary tract).

106. Emanuel, *supra* note 95.

107. Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER, L. & JUST. 59, 64-65 (2006).

108. *Id.*

intersex infants.¹⁰⁹ He recommended that intersex babies be assigned either male or female based on surgeries, followed by an upbringing that treats the child accordingly as a boy or girl.¹¹⁰ For years, medical practitioners followed this approach, typically advising parents to never tell intersex children about their surgeries or their intersex status.¹¹¹ The rationale was that intersex individuals must be protected from the mental distress that could come from knowing the truth.¹¹²

Over the years, however, the tide has shifted.¹¹³ The medical literature traditionally referred to intersex individuals as people with “disorders in sexual development” or “DSD.”¹¹⁴ Starting in the 1990s, however, atypical sex characteristics began to be viewed as benign aspects of human diversity.¹¹⁵ Accordingly, a growing literature uses “DSD” to refer to “differences” as opposed to “disorders” of sexual development.¹¹⁶ Indeed, research has yielded scarce evidence of benefits from intersex surgeries.¹¹⁷ Instead, research has demonstrated that intersex surgeries often produce a range of harms that can include sterilization (sometimes triggering the need for lifelong hormone therapy), loss of sexual sensation, physical scarring, ongoing pain, and a host of psychological ailments.¹¹⁸ Surgery also risks assigning a child the “wrong” sex, where the child grows up eventually self-identifying differently from the sex that was surgically imposed: studies suggest that, depending on the intersex condition at issue, the rate of surgically assigning the wrong sex ranges from 5 to 40 percent.¹¹⁹

109. *Id.* at 59-64; Caroline Lowry, *Intersex in 2018: Evaluating the Limitations of Informed Consent in Medical Malpractice Claims as a Vehicle for Gender Justice*, 52 COLUM. J.L. & SOC. PROBS. 321, 326-29 (2018).

110. *See* Tamar-Mattis, *supra* note 107, at 59-64; Lowry, *supra* note 109, at 326-29.

111. This medical approach has been referred to as the “concealment model.” *See* Tamar-Mattis, *supra* note 107, at 64-65.

112. *See id.*

113. *See* Nat Mulkey, Carl G. Streed, Jr. & Barbara M. Chubak, *A Call to Update Standard of Care for Children with Differences in Sex Development*, 23 AMA J. ETHICS 550, 551 (2021).

114. *E.g.*, Peter A. Lee et al., *Consensus Statement on Management of Intersex Disorders*, 118 PEDIATRICS 488, 488 (2006).

115. *See* GREENBERG, *supra* note 25, at 18-25.

116. *E.g.*, Mulkey, Streed & Chubak, *supra* note 113, at 550; *interACT Statement on Intersex Terminology*, INTERACT, <https://interactadvocates.org/interact-statement-on-intersex-terminology> [<https://perma.cc/GBD8-5ZKT>] (last visited July 28, 2024); Amer. Med. Ass’n Bd. of Trustees, *Supporting Autonomy for Patients with Differences of Sex Development (DSD) (Resolution 3-A-16)* (2016), AM. MED. ASS’N, <https://assets.ama-assn.org/sub/meeting/documents/i16-bot-07.pdf> [<https://perma.cc/4V3H-SQRW>].

117. For summaries of the research demonstrating a lack of benefits, see Fraser, *supra* note 105, at 65; Mulkey et al., *supra* note 113, at 552.

118. *See* Fraser, *supra* note 105, at 65; Mulkey et al., *supra* note 113, at 552.

119. HUM. RTS. WATCH & INTERACT, “I WANT TO BE LIKE NATURE MADE ME”: MEDICALLY UNNECESSARY SURGERIES ON INTERSEX CHILDREN IN THE US 58 (2017), https://www.hrw.org/sites/default/files/report_pdf/lgbtintersex0717_web_0.pdf [<https://perma.cc/PSR9-26A9>].

As a result of this shifting tide, the Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology convened a group of international experts that issued a Consensus Statement in 2006, reaffirmed in 2016, encouraging “team decisions” to promote informed consent from parents and to safeguard against medical professionals pressuring parents into pursuing intersex surgeries.¹²⁰ Research from organizations including Human Rights Watch and interACT, however, suggests that informed consent is still lacking in a worrisome number of cases due to pressure from medical professionals.¹²¹ In Rosie’s case, her parents chose not to pursue any surgery, and they decided to raise Rosie as a girl while also referring to her as intersex and encouraging her to embrace gender fluidity.¹²² Rosie’s case, perhaps, is exceptional because her father recalls learning about intersex surgeries as a student and her mother has a medical background as a nurse, thereby equipping them to approach medical decision-making with a greater level of understanding than other parents.¹²³ Still, they reported experiencing enormous pressure from doctors to pursue medically unnecessary surgeries.¹²⁴

Subsequent to the Consensus Statement, several medical professional organizations—including the American Academy of Family Physicians, American Medical Association Board of Trustees, and American Medical Student Association—recognized the harms of GNS and adopted position statements in favor of deferring surgeries until the child is old enough to decide.¹²⁵ Three former U.S. Surgeons General have also issued a joint statement against intersex surgeries.¹²⁶ At the international level, various U.N. entities—including the WHO, human rights treaty bodies, and human rights special rapporteurs—have called for banning medically unnecessary intersex surgeries on young children.¹²⁷

120. Lee et al., *supra* note 114, at 492.

121. HUM. RTS. WATCH & INTERACT, *supra* note 119, at 88-93.

122. Emanuel, *supra* note 95.

123. *Id.*

124. *Id.*

125. See *Genital Surgeries in Intersex Children*, *supra* note 30 (position statement adopted by the American Academy of Family Physicians’ Board of Directors in July 2018 and by the Congress of Delegates in 2023); Amer. Med. Ass’n Bd. of Trustees, *supra* note 116; *AMSA Issues Statement to Defer Gender “Normalizing” Surgeries for Children Born as Intersex*, AMER. MED. STUDENTS ASS’N (Oct. 26, 2017), https://www.amsa.org/press_release/amsa-issues-statement-defer-gender-normalizing-surgeries-children-born-intersex [<https://perma.cc/VNZ3-DZF7>]. *But see* E. Coleman et al., *supra* note 64, at S101 (acknowledging “division within the medical field regarding its management guidelines for early genital surgery” on intersex children).

126. Elders, Satcher & Carmona, *supra* note 34.

127. See *U.N. Entities Call on States*, *supra* note 30 (joint statement from twelve U.N. entities, including the World Health Organization and Office of the High Commissioner for Human Rights, expressing opposition to “unnecessary surgery and treatment on intersex children without their consent”); Press Release, U.N. Off. High Comm’r Hum. Rts., Intersex Awareness Day – Wednesday 26 October (Oct. 24, 2016), <https://www.ohchr.org/en/press-releases/2016/10/intersexawareness-day-wednesday-26-october> [<https://perma.cc/UGG7-2ZTW>] (reporting on a joint statement from numerous U.N. treaty bodies

Mounting calls to ban medically unnecessary intersex surgeries center around several factors. First, there is concern about informed consent.¹²⁸ The patients, being infants and young children (typically under the age of eighteen months), lack the capacity to give consent. Meanwhile, parents often claim that their consent to intersex surgeries was induced by pressure from doctors and the resulting outsized fears.¹²⁹ Second, condemnation of intersex surgeries stems from the fact that such surgeries are irreversible.¹³⁰ Third, research has yielded scarce evidence of benefits to medically unnecessary intersex surgeries.¹³¹ Instead of finding benefits, research has spotlighted a host of harms that intersex surgeries produce.¹³² The following section of this Article will examine how these three categories of harm relate to trans youth healthcare bans.

C. *Trans Youth Healthcare Bans and Court Challenges*

As of July 2024, 23 states have enacted trans youth healthcare bans that encompass all three categories of gender-affirming medical treatments.¹³³ Three additional states have banned a subset of treatments.¹³⁴ The 26 bans subject medical providers to penalties which, depending on the state, could include fines, license revocation, misdemeanor or felony charges, and civil causes of action.¹³⁵ In addition to targeting medical professionals, some bans punish parents and other third parties who assist transgender children in obtaining gender-affirming medical care.¹³⁶

and human rights experts that “urge[d] Governments to prohibit harmful medical practices on intersex children, including unnecessary surgery and treatment without their informed consent, and sterilization”).

128. See, e.g., HUM. RTS. WATCH & INTERACT, *supra* note 119, at 88-93; Elders, Satcher & Carmona, *supra* note 34, at 3.

129. See, e.g., HUM. RTS. WATCH & INTERACT, *supra* note 119, at 88-93.

130. *Id.* at 61-64; Elders, Satcher & Carmona., *supra* note 34, at 3.

131. See, e.g., HUM. RTS. WATCH & INTERACT, *supra* note 119, at 82-86; Elders, Satcher & Carmona., *supra* note 34, at 3.

132. See, e.g., HUM. RTS. WATCH & INTERACT, *supra* note 119, at 82-86; Elders, Satcher & Carmona., *supra* note 34, at 3. *But see* Julie Compton, ‘You Can’t Undo Surgery’: More Parents of Intersex Babies are Rejecting Operations, NBC (Oct. 24, 2018, 4:30 AM), <https://www.nbcnews.com/feature/nbc-out/you-can-t-undo-surgery-more-parents-intersex-babies-are-n923271> (noting that “[s]ome adults who underwent the surgery as children say they’re happy with the results” and citing Jehad Almasri et al., *Genital Reconstructive Surgery in Females with Congenital Adrenal Hyperplasia: A Systematic Review and Meta-Analysis*, 103 J. CLINICAL ENDOCRINOLOGY & METABOLISM 4089 (2018)).

133. For a list of the state bans, see *Appendix*, *supra* note 15. Some of these bans are not in effect due to preliminary or permanent injunctions. The three main categories of gender-affirming medical treatments are puberty blockers, hormone therapy, and surgeries. See *supra* Section I.A.

134. Arizona’s and New Hampshire’s bans only prohibit surgery. Georgia’s ban covers surgery and hormone therapy but not puberty blockers. See *id.* (comparing the scope of 26 state bans).

135. See Weithorn, *supra* note 38, at 782-85; MOVEMENT ADVANCEMENT PROJECT, *supra* note 32, at 13-14.

136. See Weithorn, *supra* note 38, at 785-86; MOVEMENT ADVANCEMENT PROJECT, *supra* note 32, at 14.

Consider Tennessee’s ban, called the “Prohibition on Medical Procedures Performed on Minors Related to Sexual Identity” and commonly referred to as “SB1.”¹³⁷ Enacted in 2023, it is now the focus of the case before the Supreme Court.¹³⁸ SB1 prohibits the administering of puberty blockers, hormone therapy, and surgeries for the purposes of gender transition.¹³⁹ The law is emblematic of trans healthcare bans in stating the purported public health and policy concerns that underlie the law: the cited concerns include the irreversibility of treatments, unclear evidence of the treatments’ benefits, risk of medical harm, and lack of informed consent from patients’ families due to pressure on parents, as well as minors’ inability to provide consent themselves.¹⁴⁰ Jonathan Skrmetti, Attorney General of Tennessee, echoed these concerns in a brief to the Supreme Court.¹⁴¹ He noted that the rate of minors receiving medical treatment for gender dysphoria had grown markedly in recent years, prompting Tennessee to address the risks posed by such treatments.¹⁴² Specifically, he said Tennessee and other states have “enact[ed] laws designed to ensure that potentially irreversible sex-transition interventions of uncertain benefit are not performed on minors who may not be able to fully grasp their lifelong consequences and risks.”¹⁴³

Tennessee’s SB1 has a limited legacy clause, permitting transgender youth who already receive treatment to continue receiving treatments for another year after the law’s effective date.¹⁴⁴ According to SB1, treatments are not prohibited if doctors administer them for purposes unrelated to gender transition.¹⁴⁵ For example, if a cisgender teenage boy experiences low testosterone levels and does not reach puberty at a typical age, a doctor may prescribe him testosterone. However, SB1 prohibits doctors from prescribing testosterone as hormone therapy for the purpose of addressing a transgender person’s gender dysphoria.¹⁴⁶ SB1 also includes an intersex exception, explicitly permitting the treatment of “congenital defects” and defining congenital defects in terms of DSDs.¹⁴⁷

137. See TENN. CODE ANN. §§ 68-33-101 to -109 (2023).

138. See *United States v. Skrmetti*, 144 S. Ct. 2679 (2024) (granting *certiorari* to review certain aspects of the Sixth Circuit’s decision in *Williams v. Skrmetti*).

139. TENN. CODE ANN. §§ 68-33-101 to -104.

140. *Id.* § 68-33-101.

141. Respondents’ Brief in Opposition at 1-5, *United States v. Skrmetti*, 144 S. Ct. 2679 (2024) (Nos. 23-466, 23-477). See also Abbie VanSickle, *Supreme Court Will Hear Challenge to Tennessee Law Banning Transition Care for Minors*, N.Y. TIMES, June 25, 2024, at A19.

142. Respondent’s Brief in Opposition, *supra* note 141 (arguing that “Tennessee did not rush to judgment in its policymaking.”).

143. *Id.* at 2.

144. TENN. CODE ANN. § 68-33-103.

145. See *id.*

146. See *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 481 (6th Cir. 2023) (acknowledging that, according to Tennessee’s ban, “a boy with abnormally low testosterone levels could receive a testosterone booster in adolescence, but a girl could not receive testosterone to transition”), *cert. granted*, *United States v. Skrmetti*, 144 S. Ct. 2679 (2024).

147. TENN. CODE ANN. §§ 68-33-102 to -103.

It is worth emphasizing that, as noted in Section I.B, intersex surgeries raise many of the exact concerns that laws like SB1 purportedly seek to address with respect to transgender youth. Intersex surgeries are undeniably irreversible.¹⁴⁸ They lack informed consent because infants and young children cannot consent to the surgeries, and their parents often face undue pressure to agree to the surgeries.¹⁴⁹ In addition, research suggests that the potential harms—including sterilization, scarring, mental ailments, misassignment of gender, and regret—usually outweigh potential benefits of intersex surgeries.¹⁵⁰ Interestingly, SB1 referenced flaws in Dr. John Money’s research on gender identity in the 1960s to support banning gender-affirming care;¹⁵¹ yet contemporary critics similarly recognize the flaws in Money’s research that galvanized the practice of intersex surgeries.¹⁵² Indeed, SB1 embodies striking inconsistencies in how it addresses the harms of intersex surgeries and the alleged harms of gender-affirming care. The discordance between SB1 and its intersex exception is emblematic of trans youth healthcare bans around the country.¹⁵³

In April 2023, three families and a doctor filed a lawsuit to block Tennessee’s ban.¹⁵⁴ The U.S. Department of Justice joined the case on the side of the plaintiffs.¹⁵⁵ The lawsuit asserted several constitutional arguments based on equal protection and substantive due process.¹⁵⁶ The district court granted a preliminary injunction,¹⁵⁷ but the Sixth Circuit stayed the preliminary injunction in a 2-1 decision.¹⁵⁸ In the same judgment, the Sixth Circuit stayed a preliminary injunction issued by the district court in a case challenging Kentucky’s ban.¹⁵⁹ As noted earlier, the case against Tennessee’s ban is pending before the Supreme Court at the time of this writing.¹⁶⁰ Various federal and state courts have come down differently than the Sixth Circuit, granting preliminary or permanent

148. See, e.g., HUM. RTS. WATCH & INTERACT, *supra* note 119, at 61-64; Elders, Satcher & Carmona, *supra* note 34, at 3.

149. See *supra* notes 121-124, 128-129 and accompanying text.

150. See *supra* notes 118-119, 131 and accompanying text.

151. TENN. CODE ANN. § 68-33-101(f).

152. See *supra* notes 109-111 and accompanying text.

153. See *Appendix*, *supra* note 15.

154. The plaintiffs were Samantha and Brian Williams and their 15-year-old transgender daughter, two other anonymous plaintiff families, and a medical doctor named Susan Lacy. However, the district court held that Dr. Lacy lacked standing. *L.W. ex rel. Williams v. Skrmetti*, 679 F. Supp. 3d 668, 682 (M.D. Tenn. 2023).

155. See Press Release, U.S. Dep’t of Justice, Justice Department Challenges Tennessee Law that Bans Critical, Medically Necessary Care for Transgender Youth (Apr. 26, 2023), <https://www.justice.gov/opa/pr/justice-department-challenges-tennessee-law-bans-critical-medically-necessary-care> [https://perma.cc/KVQ7-CPHB].

156. *Skrmetti*, 679 F. Supp. 3d at 668.

157. *Id.* at 718. The district court decided, however, that plaintiffs did not have standing to challenge the provisions in the Tennessee ban concerning surgeries. *Id.* at 681-82.

158. *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 463 (6th Cir. 2023).

159. *Id.*

160. *United States v. Skrmetti*, 144 S. Ct. 2679 (2024) (granting *certiorari*).

injunctions against trans youth healthcare bans.¹⁶¹ We will examine this spate of litigation and relevant constitutional arguments in greater detail in Part III.

To date, court opinions have made only fleeting references to intersex exceptions. For example, the Sixth Circuit’s majority opinion in *Skrmetti* noted only in passing that SB1 contains an exception for so-called “congenital defects,” without examining the significance of such an exception.¹⁶² Such omissions are misguided. The following two Parts will unpack that significance. At first blush, intersex exceptions seem to be at odds with trans youth healthcare bans because they reflect a striking inconsistency in concerns about irreversibility, informed consent, and potential medical harms. Upon closer examination, however, we can understand that the intersex exceptions are entirely consistent with the healthcare bans because both are motivated by a shared set of factors: sex stereotyping, irrational fears, and disgust. Part II will elaborate on these motivating factors, and Part III will discuss their relevance to constitutional law.

II. SEX STEREOTYPES, IRRATIONAL FEAR, AND DISGUST

The inconsistency between trans youth healthcare bans and their intersex exceptions renders implausible claims that the bans grew mainly from concerns about consent, irreversibility, and medical harm. With this implausibility in mind, one can reason that other motivations were critical.¹⁶³ We contend that entrenched sex stereotypes, irrational fears, and disgust were primary motivating factors.¹⁶⁴ These factors feature prominently in the sociocultural backdrop of the

161. See REDFIELD, CONRON & MALLORY, *supra* note 38; Weithorn, *supra* note 38, at 802-03.

162. *Skrmetti*, 83 F.4th 460 at 495. The dissenting opinion briefly pointed to the intersex exception to critique SB1’s scope. *Id.* at 500 (White, J., dissenting).

163. We make this contention based on logic, not the law; however, it is worth noting that courts have adopted such logic. For example, in employment discrimination cases, courts have found that the implausibility of purported explanations for a defendant’s actions suggests that alternative explanations, such as discriminatory intent, are credible. See, e.g., *Reeves v. Sanderson Plumbing*, 530 U.S. 133, 134 (2000) (holding “[p]roof that the defendant’s explanation is unworthy of credence is simply one form of circumstantial evidence that is probative of intentional discrimination, and it may be quite persuasive”); *Furnco Constr. Corp. v. Waters*, 438 U.S. 567, 577 (1978) (“[W]hen all legitimate reasons for rejecting an applicant have been eliminated as possible reasons for the employer’s actions, it is more likely than not the employer, who we generally assume acts with *some* reason, based his decision on an impermissible consideration.”). Likewise, in constitutional analysis, animus as legislative motive can be inferred from the “utter failure of alternative explanations” for a law. See Dale Carpenter, *The Dead End of Animus Doctrine*, 74 ALA. L. REV. 585, 613 (2023) [hereinafter Carpenter, *Dead End*] (summarizing the Supreme Court’s animus doctrine based on foundational cases from 1973 to 2013).

164. We chose to focus on these three factors because they carry constitutional significance (as we will discuss in Part III) and because there was a gap in legal scholarship concerning these three factors’ significance to trans youth healthcare bans. We do not mean to suggest that these three factors are necessarily the only motivations behind trans youth healthcare bans. Sincerely held religious beliefs, for example, may also play a role; some people of faith view male/female distinctions as inherent and divinely bestowed. See, e.g., Hon. Victoria Kolakowski, *The Role of Religious Objections to Transgender and Nonbinary Inclusion and Equality and/or Gender Identity Protection*, AM. BAR ASS’N (July 5, 2022), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/intersection-of-lgbtq-rights-and-religious-freedom/the-role-of-religious-objections-to-transgender-and-nonbinary-

bans, and they help to explain the bans' structure, which is characterized by a broad scope and peculiar carveout for intersex treatments. Accordingly, one can infer that sex stereotypes, irrational fear, and disgust motivated trans youth healthcare bans.

The following three Sections elaborate on the sociocultural backdrop that informs the inferences we draw from the structure of trans youth healthcare bans. We first examine sex-stereotype thinking, which trans youth healthcare bans reflect and reinforce (Section II.A). Afterwards, we draw from liberal theory, critical theory, and social sciences to discuss how transgender and intersex youth's divergence from sex stereotypes triggers irrational fear (Section II.B) and disgust (Section II.C). We also demonstrate that the healthcare bans comport with such fear and disgust.

It is worth noting that statements from legislators do not paint a full or accurate picture of the factors that motivate lawmaking. Indeed, explicitly stated motivations can be pretextual.¹⁶⁵ Motivations may also be unconscious and therefore unstated.¹⁶⁶ Accordingly, our focus is on the inferences that can be drawn from the structure of trans youth healthcare bans and the sociocultural context in which they emerged.¹⁶⁷

A. Sex Stereotypes

We posit that trans healthcare bans rest on pernicious sex stereotypes. Sex stereotypes are overbroad generalizations about people, resulting from social constructions that are mistaken for facts of nature.¹⁶⁸ In this section, we introduce a two-part schema for understanding sex stereotyping, which we will refer to as first- and second-generation scenarios. While first-generation stereotypes concern the social construction of gender roles and expectations, second-generation stereotypes concern the social construction of biological sex. We demonstrate that these two types of stereotypes are linked, and they both

inclusion-and-equality [<https://perma.cc/5MXL-7GPM>] (summarizing arguments against transgender inclusion stemming from religious convictions). For an illuminating article on religion as a motivating factor behind trans youth healthcare bans, see Anne Alstott et al., "*Demons and Imps*": *Misinformation and Religious Pseudoscience in State Anti-Transgender Laws*, 35 *YALE J. L. & FEMINISM* 223 (2024), which critiques the role of "religious pseudoscience" in state anti-trans legislation.

165. See Skinner-Thompson, *supra* note 32, 979-80 (discussing cases in which courts have found the government's purported legislative goals to be pretextual).

166. The Supreme Court has recognized that unconscious biases exist. See Kenji Yoshino, *Supreme Court 2015: The Court Acknowledges Unconscious Prejudice*, *SLATE* (June 25, 2024), <https://slate.com/news-and-politics/2015/06/supreme-court-2015-the-court-acknowledges-unconscious-prejudice.html> [<https://perma.cc/M6K4-3GP7>] (discussing the Court's acknowledgement of "unconscious prejudice" in the Fair Housing Act case of *Texas Dep't Hous. & Cmty. Affairs v. Inclusive Cmty. Project, Inc.*, 576 U.S. 519, 540 (2015)).

167. We occasionally refer to legislators' statements about the bans, but such statements are not our main focus. See *infra* notes 218-222 and accompanying text.

168. *Schlesinger v. Ballard*, 419 U.S. 498, 508 (1975).

undermine autonomy and dignity. This Section will conclude with an excavation of sex stereotypes that underpin trans youth healthcare bans.

Before discussing transgender and intersex issues further, it is helpful to review how sex stereotypes affect cisgender, dyadic (non-intersex) men and women because they have been the focus of literature on first-generation scenarios.¹⁶⁹ According to first-generation sex stereotypes, a person's birth-assigned sex does and should produce a corresponding set of behaviors and attributes, which we will refer to as gender roles and expectations.¹⁷⁰ For example, males traditionally have been expected to be aggressive¹⁷¹ and serve as breadwinners;¹⁷² females, to be gentle¹⁷³ and serve as caregivers.¹⁷⁴ Scholars have argued that these expectations are incorrect and oppressive: they have shown that it is empirically inaccurate to view a person's gender role as an ineluctable consequence of biology rather than a social construct;¹⁷⁵ in addition, they have explained that strict gender roles undermine autonomy and dignity¹⁷⁶ and allocate power in ways that subordinate women.¹⁷⁷

169. See *infra* notes 170-169 and accompanying text.

170. See, e.g., Mary Anne Case, *Disaggregating Gender from Sex and Sexual Orientation: The Effeminate Man in the Law and Feminist Jurisprudence*, 105 YALE L.J. 1, 10-11 (1995) (noting that “[a]s most feminist theorists use the terminology, ‘sex’ refers to the anatomical and physiological distinctions between men and women; ‘gender,’ by contrast, is used to refer to the cultural overlay on those anatomical and physiological distinctions”).

171. Mary Anne Case, *The Very Stereotype the Law Condemns*, 85 CORNELL L. REV. 1447, 1470 n.118 (2000) (discussing the stereotype of male aggressiveness with respect to employment and military training); Katherine Franke, *What’s Wrong with Sexual Harassment?*, 49 STAN. L. REV. 691, 693 (1997) (arguing that “sexual harassment of a woman by a man is an instance of sexism precisely because the act embodies fundamental gender stereotypes: men as sexual conquerors and women as sexually conquered, men as masculine sexual subjects and women as feminine sexual objects”).

172. Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 995 (describing how in equal protection cases decided in the 1970s, the Court struck down laws premised on the stereotypical male breadwinner/female caregiver model of family roles).

173. See Case, *supra* note 171, at 1470 n.118; Russell K. Robinson, *Perceptual Segregation*, 108 COLUM. L. REV. 1093, 1132 (2008) (“Female attorneys are often presumed to be softer, less aggressive, and burdened in their ability to put work first because of family commitments.”).

174. See Siegel, *supra* note 172, at 995. It is important to note that these dominant sex stereotypes intersect with whiteness. People of color are often ascribed an alternative set of sex stereotypes. For example, Black women are frequently stereotyped as aggressive instead of gentle. See Regina Austin, *Sapphire Bound!*, WIS. L. REV. 539, 539-40 (1989).

175. See Martha Minow, *Foreword: Justice Engendered*, 101 HARV. L. REV. 10, 62 (1987) (noting a “set of symbolic constructions that have simultaneously used men as the norm and denigrated any departure from the norm”).

176. See, e.g., Luke A. Boso, *Dignity, Inequality, and Stereotypes*, 92 WASH. L. REV. 1119, 1138 (2017) (describing anti-stereotyping decisions as “promot[ing] anti-subordination principles by freeing individuals from assigned roles that implicate the inferior or dominant status of [their] group . . . [and] promoting liberty by guarding individuals’ freedom to form and express identities without the government’s weighty hand dictating their behavioral and identitarian gender choices”).

177. See, e.g., Minow, *supra* note 175 at 36 n. 121 (citing Ann C. Scales, *The Emergence of Feminist Jurisprudence: An Essay*, 95 YALE L.J. 1373, 1388 (1986) (“[feminism] sees differences as systematically related to each other, and to other relations, such as exploited and exploiter.”)).

Federal courts have come to reject first-generation sex stereotypes. To be sure, there was a time when the Supreme Court openly embraced them.¹⁷⁸ In *Bradwell v. Illinois*, which upheld the exclusion of women from practicing law, Justice Bradley’s concurring opinion exemplified first-generation stereotyped thinking; he stated: “The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life.”¹⁷⁹ Beginning in the 1970s, however, the Supreme Court struck down, pursuant to constitutional equal protection, several laws that assigned men and women to gender roles in the workforce and at home.¹⁸⁰ For example, the Court invalidated a law that mandated preference for males over females in administering estates,¹⁸¹ as well as alimony statutes requiring husbands to support their ex-wives but not the reverse.¹⁸² These laws embodied stereotyped thinking about different roles for men and women.¹⁸³ Decades later, in 1996, the Supreme Court held that excluding women from admission to the Virginia Military Institute violated equal protection. In its reasoning, the Court reiterated its rejection of “generalizations or tendencies . . . based on ‘fixed notions concerning the roles and abilities of males and females.’”¹⁸⁴

Scholars have explained that transgender individuals are often viewed as extreme violators of gender expectations.¹⁸⁵ Consider, for example, Leah from this Article’s introduction. Leah was assigned male at birth. By wearing dresses, using feminine pronouns, and adopting the name “Leah,” she is transgressing gendered expectations for individuals assigned male at birth.¹⁸⁶ Even if Leah

178. See, e.g., *Muller v. Oregon*, 208 U.S. 412, 421 (1908) (invoking stereotypes while upholding a law that limited the number of hours women were permitted to work).

179. 83 U.S. 130, 140 (1872).

180. Siegel, *supra* note 172, at 995.

181. *Reed v. Reed*, 404 U.S. 71, 72 (1971).

182. *Orr v. Orr*, 99 S. Ct. 1102, 1112 (1979).

183. For additional constitutional cases, see *Frontiero v. Richardson*, 411 U.S. 677 (1973); *Reed v. Reed*, 404 U.S. 71, 72 (1971) and *Stanton v. Stanton* 421 U.S. 7, 7 (1975). The Court has also adopted anti-stereotyping principles in statutory civil rights cases concerning stereotypes about men and women. See *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989) (a Title VII case in which the plurality stated, “[a]s for the legal relevance of sex stereotyping, we are beyond the day when an employer could evaluate employees by assuming or insisting that they matched the stereotype associated with their group”). In *Bostock v. Clayton County*, the Court held that Title VII’s prohibition of sex discrimination encompassed protection against discriminating against transgender people based on gender identity. 590 U.S. 644, 649 (2020). The majority in *Bostock* did not, however, engage with anti-stereotyping legal theories. See Ann McGinley et al., *Feminist Perspectives on Bostock v. Clayton County*, 53 CONN. L. REV. ONLINE 1, 11-13 (2020).

184. *United States v. Virginia*, 518 U.S. 515, 517 (1996) (quoting *Miss. Univ. for Women*, 458 U.S. 718, 725 (1982)).

185. E.g., Naomi Schoenbaum, *The New Law of Gender Nonconformity*, 105 MINN. L. REV. 831, 888-89 (2020).

186. See *supra* notes 164-69 and accompanying text. An increasing number of states have passed laws permitting school staff to ignore transgender students’ name and pronoun requests; these laws may also require parental permission before staff honor transgender students’ name and pronoun requests. See Eesha Pendharkar, *Pronouns for Trans, Nonbinary Students: The States with Laws that Restrict Them in Schools*, EDUC. WEEK (June 14, 2023), <https://www.edweek.org/leadership/pronouns-for-trans->

does not view herself as a gender non-conforming boy (because she identifies as a girl), others might view her this way and cast aspersions as a result.¹⁸⁷ In cases concerning school and workplace discrimination, some courts have held in favor of transgender plaintiffs upon finding that they suffered discrimination due to their non-conformity with gendered expectations.¹⁸⁸

Whereas first-generation stereotypes concern the social construction of gender roles and expectations, second-generation stereotypes concern the social construction of biological sex.¹⁸⁹ A growing body of literature explains that certain aspects of biological sex are socially constructed.¹⁹⁰ To be sure, components of biological sex—gonads, external genitalia, chromosomes, and hormone levels—are characterized by many facts of nature (e.g., the fact that testes produce sperm and ovaries produce eggs). However, human judgment—shaped by culture and social conditioning—also shapes understandings about biological sex.¹⁹¹

Consider, for example, biological sex categorization. Western societies have long categorized people into the male-female binary based on biological sex characteristics, but the decision to have only these two categories is not predetermined by nature.¹⁹² Indeed, many indigenous and non-Western cultures

nonbinary-students-the-states-with-laws-that-restrict-them-in-schools/2023/06 [https://perma.cc/4GNV-4BJH] (discussing trends in state laws).

187. See Schoenbaum, *supra* note 185, at 851.

188. See *e.g.*, *Smith v. Salem*, 378 F.3d 566, 574 (6th Cir. 2004) (concluding that, just as employers who discriminate against women for not wearing dresses or makeup are engaging in sex discrimination, “[i]t follows that employers who discriminate against men because they *do* wear dresses and makeup, or otherwise act femininely, are also engaging in sex discrimination, because the discrimination would not occur but for the victim’s sex”) (emphasis in the original); *Glenn v. Brumby*, 663 F. 3rd 1312, 1317 (11th Cir. 2011) (holding that “discrimination against a transgender individual because of her gender-nonconformity is sex discrimination”). Note, however, that these cases have been criticized for characterizing transgender people as gender-nonconformers in ways that do not match how transgender people often view themselves. See Schoenbaum, *supra* note 185, at 857-62.

189. We use the term “second-generation” because commentary and jurisprudence on this latter category of stereotypes are, generally speaking, more recent and less developed. *Cf.* Laura Lane-Steele, *Sex-Defining Laws and Equal Protection*, 112 CALIF. L. REV. 259, 270-75 (2024) (explaining that the Supreme Court’s canonical sex discrimination cases concerned whether the state is permitted to treat men and women differently, whereas controversies in more recent years concern the state’s definition of who is a man and who is woman).

190. *E.g.*, SUZANNE KESSLER & WENDY MCKENNA, *GENDER: AN ETHNOMETHODOLOGICAL APPROACH* (1978). The Inter-American Commission on Human Rights has adopted this position. See INTER-AM. COMM’N ON HUM. RTS. (IACHR), *VIOLENCE AGAINST LGBTI PERSONS* 27-28 (2015), [hereinafter IACHR] <http://www.oas.org/en/iachr/reports/pdfs/violencelgbtipersons.pdf> [https://perma.cc/HP5Z-Y2VE].

191. See Courtney M. Cahill, *Sex Equality’s Irreconcilable Differences*, 132 YALE L.J. 1065, 1083 (2023) (elaborating upon feminist and queer literature that contends “biological justifications for sex difference and sex discrimination are sex stereotypes because culture always shapes our understanding of biological categories”).

192. Courts have reinforced this understanding of sex binarism. See Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265, 275 (1999) (citing *In Re Anonymous*, 314 N.Y.S. 2d 668, 669 (N.Y. Civ. Ct. 1970), where a family court judge refused to issue a name change to a “transsexual,” stating that “[w]ith respect to gender, a person was either male or female, and no three ways about it”).

have long histories of recognizing more than two sex/gender categories.¹⁹³ Moreover, in Western medical discourse, determining a baby's sex has sometimes hinged on measurement of the baby's external genitalia; if it surpasses a certain length, doctors consider it a penis as opposed to a clitoris and determine the baby a boy.¹⁹⁴ Note that, while a clinically agreed upon size and shape of an infant's genitals affect whether a doctor considers an infant a boy or girl, there is nothing natural or predetermined about that conclusion.¹⁹⁵

Put differently, the idea that everyone must be put into one of two biological sex categories, and then conform to the physical characteristics of that category, is a socially constructed generalization—a stereotype.¹⁹⁶ As scholars such as Suzanne Kessler and Anne Fausto-Sterling have explained, variations in biological sex characteristics are a benign part of human diversity.¹⁹⁷ Yet U.S. surgeons have sought to eliminate these variations and create “normalized” bodies, reinforcing the stereotype that individuals must fit into one of two sex categories. The sex binary is inextricably linked to the idea of binary gender roles because there is a distinct gender role that maps onto each sex. Policymakers have begun to recognize that these binaries are not necessitated by nature—and that enforcing them amounts to the enforcement of sex stereotypes. For example, in 2016, New York City became the first jurisdiction to issue intersex birth certificates.¹⁹⁸ The following year, President Obama's administration promulgated regulations recognizing that “[sex] stereotypes can include the expectation that individuals will consistently identify with only one gender.”¹⁹⁹

Even within the binary, intersex people challenge stereotypes about definitional requirements. Indeed, many intersex individuals identify as male or

193. See, e.g., IACHR, *supra* note 190 at 26.

194. Kishka-Kamari Ford, “First, Do No Harm” – *The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants*, 19 YALE L. & POL'Y REV. 469, 471 (2001). See also Cheryl Chase, *Hermaphrodites with Attitude: Mapping the Emergence of Intersex Political Activism*, 4 GLQ: J. GAY & LESBIAN STUD. 189, 193 (1998) (describing the author's personal experience with having been assigned a sex based on the measurement of external genitalia).

195. Chase, *supra* note 194, at 192-93.

196. Jessica Knouse, *Intersexuality and the Social Construction of Anatomical Sex*, 12 CARDOZO J.L. & GENDER 135, 145-47 (2005).

197. Anne Fausto-Sterling, *The Five Sexes: Why Male and Female are not Enough*, 1993 SCIENCES 20, 21-22. See also SUZANNE KESSLER, LESSONS FROM THE INTERSEXED 7 (1998) (critiquing notion that “genitals are naturally dimorphic”).

198. Susan Scutty, *The Protocol of the Day Was to Lie': NYC Issues First US 'Intersex' Birth Certificate*, CNN (Jan. 2, 2017, 11:03 AM EST), <https://www.cnn.com/2016/12/30/health/intersex-birth-certificate/index.html> [<https://perma.cc/B82T-779E>].

199. 45 C.F.R. § 92.4 (2017) (defining sex stereotypes in Department of Health and Human Services (HHS) regulations interpreting the Affordable Care Act); Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31392 (May 18, 2016) (explaining that prohibited “[s]ex stereotypes can also include a belief that gender can only be binary and thus that individuals cannot have a gender identity other than male or female”).

female, as opposed to non-binary.²⁰⁰ Many intersex advocates suggest that intersex children be provisionally assigned to a binary sex category at birth (but without subjecting the child to intersex surgeries).²⁰¹ In line with that view, Rosie (discussed above) is being raised as a girl even though her parents rejected surgeries that would make Rosie's anatomy conform to expectations about girls' bodies. In doing so, Rosie's parents have challenged the stereotype that so-called "real" females have genitalia that fit the clinical definition of girlhood.

Another second-generation sex stereotype is that a person's biological sex characteristics are fixed at birth and hence inalterable.²⁰² This view helps to explain why people rush to operate on intersex infants before they become older.²⁰³ Because of this view, there is a history of vilifying transgender people—both adults and youth—who modify their bodies to align them with their internal sense of gender.²⁰⁴ While cisgender people modify their physical selves for a host of reasons, ranging from personal expression to addressing health needs, body modifications that transgress sex stereotypes elicit condemnation.²⁰⁵

The opprobrium against changing one's biological sex characteristics is socially constructed.²⁰⁶ In other words, the preference for stable and fixed sex characteristics is based on stereotypes, not on facts of nature. Scholars have critiqued such stereotyped thinking, explaining that expressions of gender identity, including through body modification, are central to individual autonomy.²⁰⁷ Against hegemonic norms of fixed biological sex, expressing

200. Fausto-Sterling, *supra* note 197, at 22 (noting that many intersex people often "slip quietly into society as 'normal' heterosexual males or females").

201. *What is Intersex?*, INTERACT (Jan. 26, 2021), <https://interactadvocates.org/faq/#advice> [<https://perma.cc/ML7M-2BRC>] ("Like any child, an intersex infant can be raised socially as a boy or a girl without unnecessary surgery.").

202. *Boyden v. Conlin* is an example in which a court rejected this second-generation sex stereotype. 341 F. Supp. 3d 979 (2018). The U.S. District Court for the Western District of Wisconsin found that Wisconsin's exclusion of gender-affirming procedures from state employees' health insurance coverage constituted sex discrimination. The opinion stated:

[T]he Exclusion implicates sex stereotyping by limiting the availability of medical transitioning, if not rendering it economically infeasible, thus requiring transgender individuals to maintain the physical characteristics of their natal sex. In other words, the Exclusion entrenches the belief that transgender individuals must preserve the genitalia and other physical attributes of their natal sex

Boyden, 341 F. Supp. at 997. *See also* Cahill, *supra* note 191, at 1115-18 (discussing *Boyden* and related cases).

203. It is worth noting that some surgeries on intersex infants will create a need for follow-up treatments, possibly including lifelong hormone replacement therapy. *See* HUM. RTS. WATCH & INTERACT, *supra* note 119, at 25.

204. *E.g.*, Amy D. Ronner, *Let's Get the "Trans" and "Sex" Out of it and Free Us All*, 16 J. GENDER RACE & JUST. 859, 899-91 (2013) (describing harassment and discrimination of people undergoing medical transition).

205. *Id.*

206. *See, e.g.*, Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 25 (2003) (explaining that the way people understand gender transitions is influenced by cultural forces).

207. *See* Scott Skinner-Thompson, *Identity by Committee*, 57 HARV. C.R.-C.L. L. REV. 657, 678 (2022) (noting the "expressive value of non-normative gender performances").

gender identity through body modification is a radical yet benign assertion of self.²⁰⁸

At first blush, intersex exceptions seem irreconcilable with transgender health care bans if we accept that the goal of the legislation is to address medical harm, irreversibility, and informed consent. However, the intersex exceptions and the bans are congruent when we understand them to be motivated significantly by sex stereotyping.²⁰⁹ In thwarting transgender youths' ability to self-actualize and permitting parents to subject intersex children to medically unnecessary surgeries, the bans reflect and reinforce powerful sex stereotypes. Transgender youth challenge gender expectations based on their birth-assigned sex (first-generation stereotyping). They also challenge cultural understandings about the fixedness of biological sex characteristics (second-generation stereotyping). Intersex infants, too, challenge understandings about biological sex binarism and the definition of biological sex categories (second-generation sex stereotypes). In sum, these healthcare bans and their intersex exceptions adopt, formalize, and enforce sex stereotypes.

B. Irrational fear

Sex stereotypes are so pervasive and deeply entrenched that they form a “psychosocial phenomenon,” eliciting strong feelings, including irrational fears when the stereotypes are transgressed.²¹⁰ Drawing on the works of social theorist Judith Butler, we can understand sex stereotypes as “not just a set of beliefs that we came to adopt in time, but ways of organizing reality that are part of our very formation.”²¹¹ Because sex stereotypes are conflated with reality—with facts of nature—deviations from the stereotypes produce complex anxieties, and irrational “fear of destruction gathers.”²¹²

This fear helps to explain why transgression of sex stereotypes is met with impassioned and outsized responses—in rhetoric as well as in law and public policies. Writing about sexual behavior, Gayle Rubin referred to such outsized

208. *Id.* at 679 (citing A Marquis Bey, *The Trans*-ness of Blackness, the Blackness of Trans*-ness*, 4 TSQ: TRANSGENDER STUD. Q. 275, 277 (2017)). See also Dara Purvis, *Transgender Students and the First Amendment*, 104 B.U. L. REV. 435 (2024) (applying the First Amendment's protection of free expression to gender identity issues); *Doe ex rel. Doe v. Yunits*, No. 001060A., 2000 WL 33162199, at *3 (Mass. Sup. Ct. Oct. 11, 2000) (holding that a transgender girl's “feminine” clothing choices were “not merely a personal preference but a necessary symbol of her very identity” and thus a school ban on her wearing such clothes was unconstitutional).

209. See Brief of the Amicus Curiae interACT: Advocates for Intersex Youth in Support of Petitioners at 4, *United States v. Skrmetti*, 144 S. Ct. 2679 (2004) (No. 23-477) (“[T]he only possible explanation for SB 1's divergent treatment of transgender and intersex minors is that the statute is specifically intended to enforce overbroad expectations about how male and female bodies should develop, appear, and function.”).

210. See JUDITH BUTLER, WHO'S AFRAID OF GENDER 9 (2024).

211. See *id.* at 14 (linking understandings of gender to Louis Althusser's writings on the functions of ideology).

212. See *id.* at 10.

responses as the “fallacy of misplaced scale.”²¹³ Masha Gessen explained that, according to the fallacy of misplaced scale, “sex loomed so large that any sexual transgression, or imagined transgression, might bring extreme punishment.”²¹⁴ A similar misplaced scale attaches to transgender and intersex identities. Trans and intersex children’s transgression of sex stereotypes elicits extreme responses, in terms of both hateful rhetoric and legislative measures such as the healthcare bans that lack nuance and allow intersex surgeries.

As an example of extreme rhetoric, consider the words of Charlie Kirk, a popular conservative commentator and founder of the advocacy group Turning Point USA. Speaking in favor of trans youth healthcare bans, Kirk has questioned the very notion of being transgender: “What does being trans even mean? Does it even—is that even a real thing?”²¹⁵ He likened being a transgender woman to being a “freak with XY chromosomes.”²¹⁶ And he described gender-affirming care as “chop[ping] off” young boys’ genitals,²¹⁷ even though gender-affirming medical care rarely includes surgery and clinical guidelines actually recommend against genital surgeries until patients reach adulthood.²¹⁸ Kirk is not alone in his extreme rhetoric. Other commentators have also stoked fear-based prejudice, as evidenced in many commentators’ references to gender-affirming care as “mutilation.”²¹⁹ Consider also the 2023 Conservative Political Action Conference, where an emblematic speaker proclaimed that “transgenderism must be eradicated.”²²⁰

213. Gayle S. Rubin, *Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality*, in PLEASURE AND DANGER: EXPLORING FEMALE SEXUALITY 267 (Carole Vance ed., 1984).

214. Masha Gessen, *Sex, Consent, and the Dangers of “Misplaced Scale,”* NEW YORKER (Nov. 27, 2017), <https://www.newyorker.com/news/our-columnists/sex-consent-dangers-of-misplaced-scale> [<https://perma.cc/M45C-G9TL>].

215. Charlie Kirk, “*We Must Ban Trans-Affirming Care — the Entire Country. Donald Trump Needs to Run on This Issue,*” MEDIA MATTERS (Apr. 1, 2024), <https://www.mediamatters.org/charlie-kirk/charlie-kirk-we-must-ban-trans-affirming-care-entire-country-donald-trump-needs-run> [<https://perma.cc/RJE3-NZNK>] (providing a transcript and video clip from *The Charlie Kirk Show*).

216. *Id.*

217. *Id.*

218. See *supra* notes 83-85 and accompanying text.

219. HUM. RTS. FIRST, EXTREMISM FACT SHEET, ANTI-TRANS EXTREMISM: THE FAR RIGHT’S NEW STRATEGY TO SPREAD HATE 2 (2023), <https://humanrightsfirst.org/wp-content/uploads/2023/06/FINAL-HRF-Fact-Sheet-Anti-Trans-Extremism-June-2023.pdf> [<https://perma.cc/SAH6-DAKT>] (citing Daniel Trotta, *DeSantis signs Florida ban on transgender treatment for minors*, REUTERS (May 18, 2023, 5:56 AM EDT), <https://www.reuters.com/world/us/desantis-signs-florida-ban-gender-affirming-treatment-transgender-minors-2023-05-17>).

220. Alex Woodward & Gustaf Kilander, *The Eight Most Bizarre Lines from CPAC 2023*, INDEPENDENT (Mar. 4, 2023, 21:17 GMT), <https://www.independent.co.uk/news/world/americas/us-politics/cpac-2023-donald-trump-b2294300.html> [<https://perma.cc/5FA4-A8SM>] (quoting *Daily Wire* journalist Michael Knowles). See also Katie Eyer, *Why the Arkansas Ban on Medical Care for Transgender Kids is Unconstitutional*, REGULATORY REV. (May 4, 2021), <https://www.theregview.org/2021/05/04/eyer-why-arkansas-ban-medical-care-transgender-kids-unconstitutional> [<https://perma.cc/E883-DAPV>] (describing how in debates surrounding the ban in Arkansas, “transgender people have been referred to as an ‘abomination’ and the desire of transgender youth to identify in accordance with their gender identity has been compared to the desire to identify as a cow”). See also Laura Barrón-López et al., *Why Anti-Transgender Political Ads are Dominating the Airwaves this Election*, PBS NEWS (Nov. 2, 2024), <https://www.pbs.org/newshour/show/why-anti->

One can also see the operation of irrational fear in controversies over restroom access. Consider the experiences of Gavin Grimm, the transgender plaintiff in Virginia who challenged his school’s restroom policy.²²¹ Gavin had been shifting from a social gender transition to a medical transition. For seven weeks, Gavin was permitted to use the boys’ bathroom, which he did without incident.²²² However, at some point, parents of children in the school—and then others near and far—began to complain.²²³ The school board responded with a proposed policy that restricted sex-segregated restrooms to cisgender youth and consigned transgender youth (and other “students with gender identity issues”) to separate, solitary facilities.²²⁴ The predator trope—which depicts transgender people as pretending to be another gender to gain access to unsuspecting children in sex-segregated spaces—surfaced in school board meetings. Community members spoke of the need to “protect” students from Gavin, even though only one student had ever complained about Gavin’s use of the boys’ restroom, and that complaint came before additional privacy protections were installed.²²⁵ In Gavin’s case, the Fourth Circuit eventually found the school district’s arguments about protecting other students’ privacy to be grounded in “fantastical fears and unfounded prejudices.”²²⁶

Gavin Grimm’s experiences resulted from “the fallacy of misplaced scale” that attaches to transgender youth’s transgression of sex stereotypes. In the same vein, trans youth healthcare bans should be understood as disproportionate legislation. This legislation does not address medical harm, irreversibility, and informed consent with care and nuance; instead, it is an outsized response grounded in irrational fears.

transgender-political-ads-are-dominating-the-airwaves-this-election [https://perma.cc/W2HJ-ZNNU] (discussing the fact that “Trump’s [2024 presidential] campaign and pro-Trump groups spent an estimated \$95 million on ads, more than 41 percent of which were anti-trans”).

221. See *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 590 (4th Cir. 2020).

222. *Id.*

223. See *id.* at 598.

224. *Id.* at 593.

225. *Id.* at 598-99.

226. *Id.* at 620. Research suggests that trans-inclusive bathroom policies do not increase assaults on cisgender youth. See Jack Turban, *The Science of Trans-Inclusive Bathroom Policies*, PSYCH. TODAY (June 20, 2024), <https://www.psychologytoday.com/us/blog/political-minds/202406/the-science-of-trans-inclusive-bathroom-bills> [https://perma.cc/7FMS-PQ3J] (discussing studies). In Gavin’s case, an amicus brief was filed by school administrators from districts with trans-inclusive bathroom policies. They were collectively responsible for approximately 2.1 million students. According to their brief:

[Their] collective experiences refute the hypothetical concerns . . . that allowing all students to access sex specific facilities and amenities that match their gender identity will lead to general disruption; will violate the privacy or ‘comfort’ of other students; or will lead to the abolition of gender-segregated facilities and activities for all students . . . none of those fears and concerns has materialized in the form of actual problems in their schools.

Brief for School Administrators from Thirty-One States and the District of Columbia as the Amici Curiae Supporting Respondent at 2, *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586 (4th Cir. 2020) (No. 16-273).

Intersexuality also triggers fear and outsized responses. Indeed, there is a long history in the West of treating intersex people as fearsome creatures who are not fully human. Images from the seventeenth century and earlier depicted them as mythical monsters.²²⁷ In more contemporary times, intersex children have been described derisively as “half boy,” “half girl,” or “sexless.”²²⁸ Ambiguous genitalia and chromosomes in infants elicit panic and are treated as an emergency even when interventions are medically unnecessary.²²⁹ As one medical ethicist explained, “Clinicians and parents alike refer to the period after the birth of an infant for whom gender assignment is unclear as a ‘nightmare’ ... Not only does a child with ‘no sex’ occupy a legal and social limbo, but surprise, fear, and confusion often rupture the parents’ anticipated joy at the birth of their child.”²³⁰ Human Rights Watch and interACT have gathered testimonials demonstrating that parents of intersex babies have felt pressured to rush their infants into surgery, as if there were an emergency, even when surgeries were medically unnecessary.²³¹

The panic and fear that surround intersexuality help to explain why intersex exceptions appear in legislation that purports to address potential harms that are acutely present in the context of intersex surgeries—namely, risk of medical harm, irreversibility, and flawed consent. Indeed, irrational fear explains the misplaced scale that characterizes trans youth healthcare bans. The bans are an oversized reaction because they apply even in dire situations, such as when a transgender adolescent seeks puberty blockers, which are largely reversible, to address suicidal ideation.²³² At the same time, the bans are underinclusive both because they do not apply to cisgender youth and because fear of intersexuality has resulted in intersex exceptions.

C. Disgust

A third explanation for bans on gender-affirming care is the powerful emotion of disgust. According to psychologists, disgust is a “[hardwired] automatic affective reaction that evolved to protect us from objects that threaten

227. Nadia Guidotto, *Monsters in the Closet: Biopolitics and Intersexuality*, 4 WAGADU: J. TRANSNAT’L WOMEN’S & GENDER STUD. 48, 57 (2007).

228. *Id.* at 53.

229. See HUM. RTS. WATCH & INTERACT, *supra* note 119 and accompanying text. Indeed, the American Academy of Pediatrics (AAP) has called the birth of intersex children not a medical emergency but a “social emergency.” *Intersex Declared a Human Rights Issue*, INTERSEX SOC’Y N. AM., <https://isna.org/node/841/> [<https://perma.cc/5MDX-5C3A>] (quoting the AAP).

230. HUM. RTS. WATCH & INTERACT, *supra* note 119 (internal citation omitted).

231. *Id.*

232. *Cf. Doe v. Ladapo*, No. 4:23cv114-RH-MAF, 2024 WL 2947123, at *28 (N.D. Fla. June 11, 2024) (“Banning gender-affirming care for minors across the board in all circumstances, rather than appropriately regulating such care, is not sufficiently related to the legitimate state interest in safeguarding health.”).

bodily integrity.”²³³ Scholars have explained that the emotional response of disgust can serve a protective function against perceived harm, activating in people when they are faced with dangerous or unhealthful items, such as animal and human waste or rotting food.²³⁴

In addition to being an affective response, disgust has a cognitive component.²³⁵ For example, one study exposed people to odor from a vial; some participants were told the vial contained cheese while others were told it contained feces.²³⁶ The former group tended to describe the smell as pleasing while the latter group described it as repelling.²³⁷ In this regard, disgust depends on social conditioning.²³⁸ Such conditioning can be intertwined with stereotyping. Scholars have observed that disgust is projected onto people who are stereotyped as inadequate or threatening because they are perceived as violating their own or others’ bodily integrity.²³⁹ A prime example involves gay men.²⁴⁰ Especially in earlier decades, society understood sex between men as misusing the human body in unsanitary ways.²⁴¹ Gay men have been stereotyped as carriers of HIV/AIDS and other communicable diseases.²⁴² Accordingly, social conditioning has, at different points in history, stirred visceral responses of disgust at gay men.²⁴³

Some scholars posit that the disgust response might be useful to lawmaking insofar as it unites a polity to prevent, avoid, and punish things that are “fundamentally important but beyond the comprehension of reason alone.”²⁴⁴ The more prominent view, most forcefully articulated by Martha Nussbaum, is that disgust-based lawmaking should be rejected.²⁴⁵ As Nussbaum and others have argued, emotions such as empathy and compassion can enhance democratic deliberation, but other emotions—including disgust—undermine liberal democracy.²⁴⁶ This is because disgust dehumanizes people, fueling exclusion of

233. Mark Leinauer, *Toxic Sexuality: How Disgust at the Thought of Gay Male Sexuality Threatens the Parental Rights of Gay Male Parents*, 55 ARIZ. ST. L. J. 291, 298 (2023) (internal citations omitted).

234. *Id.*

235. See MARTHA C. NUSSBAUM, HIDING FROM HUMANITY: DISGUST, SHAME, AND THE LAW 87 (2004) (citing the work of Paul Rozin to assert that disgust has a “complex cognitive element”); see also Paul Rozin & April E. Fallon, *A Perspective on Disgust*, 94 PSYCH. REV. 23, 35 (1987).

236. *Id.* at 88.

237. *Id.*

238. Martha C. Nussbaum, *Hiding from Humanity: Replies to Charlton, Haldane, Archard, and Brooks*, 4 J. APPLIED PHIL. 335, 338 (2008).

239. NUSSBAUM, *supra* note 235, at 107-15.

240. See Leinauer, *supra* note 233; MARTHA C. NUSSBAUM, FROM DISGUST TO HUMANITY: SEXUAL ORIENTATION AND CONSTITUTIONAL LAW, 169-70 (2010).

241. Leinauer, *supra* note 233, at 300-01; NUSSBAUM, *supra* note 240, at xii.

242. Leinauer, *supra* note 233, at 333-34; NUSSBAUM, *supra* note 240, at 5-6.

243. Leinauer, *supra* note 233, at 333-36; NUSSBAUM, *supra* note 240, at xiii.

244. Leinauer, *supra* note 233, at 305 (citing Leon R. Kass, *The Wisdom of Repugnance: Why We Should Ban the Cloning of Humans*, 32 VAL. U. L. REV. 679, 686-88 (1997)).

245. NUSSBAUM, *supra* note 235, at 13-14.

246. *Id.* at 7, 13-14.

those who are deemed disgusting and thwarting reason-based consideration of their interests.²⁴⁷

Notwithstanding these powerful normative objections to disgust influencing lawmaking, research suggests that disgust continues to shape major legal issues. One study, for example, examined the role of disgust in attitudes about abortion rights, finding that the “more disgust-sensitive someone was, the more likely she was to oppose the claim that ‘[a] woman should have the right to choose what to do with her body, even if that means getting an abortion.’”²⁴⁸ A separate recent study found evidence that gay men who fathered a child with an ex-wife received unfair treatment from judges in child custody cases, and it linked the unfairness to evidence of judges’ underlying disgust at the thought of gay male sexuality.²⁴⁹

As notions about the human body and bodily integrity are heavily informed by sex stereotypes, and transgender and intersex people transgress these stereotypes, it is perhaps unsurprising that they evoke disgust. Opponents of transgender rights have weaponized disgust, calling transgender people “disgusting,” “filthy,” and “unsafe.”²⁵⁰ Additional evidence of disgust includes a 2020 survey that people with a high degree of pathogen disgust, or fear of disease, were especially likely to oppose transgender people being able to use bathrooms that correspond to their gender identity.²⁵¹ In other words, “the greater one’s general tendency to be concerned with violations of purity, the greater the tendency to support bathroom restrictions. This relationship [of purity concerns] was slightly stronger than conservatism and much stronger than [concerns about] harm.”²⁵²

Philosopher Ellen Feder has interrogated the reactions of doctors facing infants born with intersex conditions, and her conclusion was that doctors’ disgust at atypical sexual anatomy produces shame in parents.²⁵³ While conventional accounts suggest that doctors’ surgical interventions are in response to parents’ expression of fear and concern, doctors may in fact play an active role in producing parents’ sense of shame in the first place. Doctors’ own

247. See NUSSBAUM, *supra* note 235, at xv; Ramón Maiz, *The Political Mind and Its Other: Rethinking the Non-Place of Passions in Modern Political Theory*, in *POLITICS AND EMOTIONS: THE OBAMA PHENOMENON* 29, 64 (Marcos Engelken-Jorge et al. eds., 2011).

248. Courtney Megan Cahill, *Abortion and Disgust*, 48 *HARV. C.R.-C.L. L. REV.* 409, 424 (2013) (citing the study in Yoel Inbar, David A. Pizarro & Paul Bloom, *Conservatives are More Easily Disgusted than Liberals*, 23 *COGNITION & EMOTION* 714, 723 (2008)).

249. Leinauer, *supra* note 233, at 319.

250. See Patrick R. Miller et. al., *Transgender Politics as Body Politics: Effects of Disgust Sensitivity on Transgender Rights Attitudes*, 5 *POL. GROUPS & IDENTITIES* 4, 4 (2017) (describing rhetoric used by opponents of a proposed municipal ordinance outlawing discrimination based on sexual orientation and gender identity).

251. Matthew E. Vanaman & Hanah A. Chapman, *Disgust and Disgust-Driven Moral Concerns Predict Support for Restrictions on Transgender Bathroom Access*, 39 *POL. & LIFE SCIS.* 200, 200 (2020).

252. *Id.* at 206.

253. Ellen K. Feder, *Tilting the Ethical Lens: Shame, Disgust, and the Body in Question*, 26 *HYPATIA* 632, 636-39 (2011).

disgust-based reactions to intersex bodies should be the subject of ethical inquiry.²⁵⁴

Disgust at transgender and intersex youth is perhaps particularly acute given that children are imagined as especially pure, healthy, and full of life.²⁵⁵ Because disgust stems from concerns about bodily integrity, disgust helps explain lawmaking aimed at enforcing conventional understandings of youthful, innocent bodies.

Long-standing disgust toward transgender and intersex people helps to explain the otherwise confounding inconsistency in laws that ban gender-affirming care but allow intersex surgery. Claims that the bans have grown mainly from concerns about consent, irreversibility, and medical harm are unconvincing given that these same issues are even more pronounced with respect to intersex surgeries. Because of this striking inconsistency, one must look elsewhere for an explanation for the bans.²⁵⁶ Sex stereotypes, and the powerful fear and disgust provoked when people transgress sex stereotypes, provide a compelling explanation. The following Part applies this observation in constitutional analysis.

III. CONSTITUTIONAL IMPLICATIONS

The animating themes from Part II carry constitutional significance. Plaintiffs have made several arguments against the constitutionality of trans youth healthcare bans. This Part will examine the ways in which findings of stereotyping, irrational fear, and disgust should inform courts' analysis of equal protection (Section III.A) and substantive due process (Section III.B).²⁵⁷ We will situate our discussion in the context of the current circuit split, with the Eighth Circuit having affirmed a preliminary injunction against a trans youth healthcare ban, and the Sixth and Eleventh Circuits having reversed preliminary injunctions.²⁵⁸ Although our discussion focuses on federal constitutional law,

254. *Id.*

255. These images arguably stem less from children than from adult projections. *Cf.* KATHRYN BOND STOCKTON, *THE QUEER CHILD, OR GROWING SIDEWAYS IN THE TWENTIETH CENTURY* 2-4 (2009) (describing the contrast between conventional understandings of children and children's own imaginations and realities, which include sexual longings and experiences).

256. *See supra* note 163 and accompanying text.

257. Plaintiffs have also asserted claims based on the First Amendment, but those claims are beyond the scope of our Article. *See, e.g.,* *Brandt v. Rutledge*, 47 F.4th 661, 672 (8th Cir. 2022) (deciding that the court need not address plaintiffs' First Amendment claim because it already affirmed the district court's decision on equal protection grounds), *en banc reh'g denied*, No. 21-2875, 2022 WL 16957734 (8th Cir. 2022).

258. *See Brandt*, 47 F.4th at 661; *Eknes-Tucker v. Gov. of Ala.*, 80 F.4th 1205, 1210-11 (11th Cir. 2023) (reversing preliminary injunction), *petition for reh'g en banc* filed Sept. 11, 2023; *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023) (reversing preliminary injunctions), *cert. granted*, *United States v. Skrmetti*, 144 S. Ct. 2679 (2024).

insights from this Part may also be adapted and applied to litigation based on state constitutions.

A. Equal Protection

1. Sex discrimination

Plaintiffs have argued that trans youth healthcare bans violate the Constitution's Equal Protection Clause.²⁵⁹ It is widely understood that there are three standards of review in equal protection cases: strict scrutiny, intermediate scrutiny, and rational basis review.²⁶⁰ Commentators refer to these standards as “tiers” because each standard corresponds with a different level—or tier—of rigor with which the Court reviews impugned laws.²⁶¹ The lowest tier is rational basis review, under which a court will generally uphold a law so long as it is reasonably related to a legitimate government purpose.²⁶² On the other end of the tiered system is strict scrutiny, which is the most rigorous form of review.²⁶³ The Supreme Court has held that laws with race-based classifications are subject to strict scrutiny, requiring that racial classifications be “narrowly tailored” to achieve a “compelling government interest.”²⁶⁴ Because strict scrutiny is very demanding, impugned laws almost always fail strict scrutiny. Sex-based classifications are subject to intermediate scrutiny—not as rigorous as strict scrutiny but not as relaxed as rational basis review. Under intermediate scrutiny, courts require the state to show that sex-based classifications are “substantially related” to an “important government interest.”²⁶⁵ In addition, the Supreme Court has said that the justifications for sex-based classifications must be “exceedingly persuasive.”²⁶⁶ Commentators refer to intermediate scrutiny and strict scrutiny as “heightened” levels of judicial review.²⁶⁷

259. *Brandt*, 47 F.4th at 668; *Eknes-Tucker*, 80 F.4th at 1210; *Skrmetti*, 83 F.4th at 469-70.

260. See ERWIN CHERMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 743-45 (7th ed. 2023).

261. See, e.g., Suzanne B. Goldberg, *Equality Without Tiers*, 77 S. CAL. L. REV. 481, 483 (2004); Kenji Yoshino, *The New Equal Protection*, 124 HARV. L. REV. 747, 755-57 (2011).

262. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 442 (1985).

263. Commentators have called strict scrutiny “fatal in fact” because laws are extremely unlikely to pass such a rigorous test. Gerald Gunther, *The Supreme Court, 1971 Term, Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972); Yoshino, *supra* note 261, at 755 n.61.

264. *E.g.*, *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 227 (1995).

265. *E.g.*, *United States v. Virginia*, 518 U.S. 515, 533 (1996); *Craig v. Boren*, 429 U.S. 190, 197 (1976); see also *Clark v. Jeter*, 486 U.S. 456, 461 (1988) (noting that “intermediate scrutiny” applies to classifications based on sex and illegitimacy).

266. *Kirchberg v. Feenstra*, 450 U.S. 455, 461 (1981) (quoting *Personnel Admin. of Mass. v. Feeney*, 442 U.S. 256, 273 (1979)).

267. See, e.g., Goldberg, *supra* note 261, at 483 n.11 (referring to heightened scrutiny as “all levels of review above rational basis”); Christopher R. Leslie, *Embracing Loving: Trait-Specific Marriage Laws and Heightened Scrutiny*, 99 CORNELL L. REV. 1077, 1084 (2014) (“Both strict and intermediate scrutiny are forms of heightened scrutiny.”). It is worth noting that a finding of race- or sex-based classifications

Circuit Courts have split on whether trans youth healthcare bans embody sex-based classifications. The Eighth Circuit found that Arkansas' ban did indeed distinguish people based on sex—in other words, the law embodied sex-based classifications.²⁶⁸ Arkansas' ban prohibits minors from receiving medical treatments that are intended to change “the individual's biological sex.”²⁶⁹ As the court explained: “under the Act, medical procedures that are permitted for a minor of one sex are prohibited for a minor of another sex. A minor born as a male may be prescribed testosterone or have breast tissue surgically removed, for example, but a minor born as a female is not.”²⁷⁰ In contrast, the Sixth and Eleventh Circuits concluded that the impugned bans do not distinguish between persons on the basis of sex.²⁷¹ In this view, the laws prohibit treating minors for particular conditions—namely, gender dysphoria and related conditions—and such treatment is prohibited regardless of the patient's assigned sex.²⁷² The Sixth Circuit suggested that, even though healthcare bans technically include a sex-based classification, that classification was neutralized—and thus legally irrelevant—because it applies equally to boys and girls.²⁷³ Accordingly, the Sixth Circuit concluded: “the legally relevant classifications [in the impugned bans] turn on presumptively valid age and medical conditions.”²⁷⁴

Scholars have persuasively critiqued the Sixth and Eleventh Circuits' reasoning as contravening established doctrine on how to define and address sex-based classifications.²⁷⁵ While that literature focuses on whether intermediate scrutiny ought to apply, we focus this Article instead on the question of *how to* apply intermediate scrutiny. Assuming *arguendo* that trans youth healthcare bans do encompass sex-based classifications—as the Eighth Circuit concluded—the themes in Part II help guide the application of intermediate scrutiny.

is the main, but not exclusive, way to trigger heightened scrutiny of race- or sex-based discrimination, respectively. A law that does not embody classifications can also trigger heightened scrutiny if there is proof of a discriminatory purpose behind the law. CHEMERINSKY, *supra* note 260, at 783-84.

268. *Brandt v. Rutledge*, 47 F.4th 661, 668, 669-70 (8th Cir. 2022), *en banc reh'g denied*, No. 21-2875, 2022 WL 16957734, (8th Cir. 2022).

269. ARK. CODE ANN. § 20-9-1501(6)(A). *See also id.* § 20-9-1501(1) (defining “biological sex” as the person's sex “at birth, without regard to an individual's psychological, chosen, or subjective experience of gender”).

270. *Brandt*, 47 F.4th at 668.

271. *Eknes-Tucker v. Gov. of Ala.*, 80 F.4th 1205, 1227-28 (11th Cir. 2023), *petition for reh'g en banc* filed Sept. 11, 2023; *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 480-82 (6th Cir. 2023), *cert. granted*, *United States v. Skrmetti*, 144 S. Ct. 2679 (2024).

272. *Eknes-Tucker*, 80 F.4th at 1227-28; *Skrmetti*, 83 F.4th at 480-82.

273. *Skrmetti*, 83 F.4th at 483 (“When laws on their face treat both sexes equally, as these laws do, a challenger must show that the State passed the law because of, not in spite of, any alleged unequal treatment. By contrast, ‘racial classifications’ always receive strict scrutiny ‘even when they may be said to burden or benefit the races equally.’” (citing *Johnson v. California*, 543 U.S. 499, 506, (2005)) (internal citations omitted)).

274. *Skrmetti*, 83 F.4th at 482.

275. *E.g.*, Jessica A. Clarke, *Scrutinizing Sex*, U. CHI. L. REV. (forthcoming 2025); Katie Eyer, *Transgender Equality and Geduldig 2.0*, 55 ARIZ. ST. L.J. 475 (2023).

Recall that according to intermediate scrutiny, a sex discriminatory law must be “substantially related” to “an important government interest.”²⁷⁶ Consider the district court’s and Eighth Circuit’s application of intermediate scrutiny to Arkansas’ healthcare ban in *Brandt v. Rutledge*.²⁷⁷ The district court accepted that protecting children was an important government interest, but it rejected the notion that Arkansas’ ban was substantially related to that governmental goal.²⁷⁸ It found that medical consensus did not support the ban’s underlying position that gender-affirming healthcare is harmful.²⁷⁹ Additionally, the law permitted the same medical procedures to be administered to cisgender youth despite posing similar medical risks across contexts.²⁸⁰ The court found that this line-drawing was not substantially related to protecting children from treatments at issue.²⁸¹ The Eighth Circuit subsequently affirmed the district court’s ruling that Arkansas’s ban discriminated based on sex and could not withstand intermediate scrutiny.²⁸²

As Erik Frederickson has argued, the courts’ analyses in *Brandt* would have been stronger if they had incorporated a discussion of sex stereotypes.²⁸³ In a long line of sex discrimination cases, the Supreme Court has established an anti-stereotyping principle.²⁸⁴ In other words, when sex stereotypes have undergirded state actions, those actions have been struck down for failing intermediate scrutiny. Yet neither the district court nor circuit court in *Brandt* delved deeply into an analysis of sex stereotypes. The district court only mentioned sex stereotypes in passing: “The goal in this context is pretextual because Act 626 allows the same treatments for cisgender minors that are banned for transgender minors as long as the desired results conform with the stereotype of the minor’s biological sex.”²⁸⁵

There are two ways in which sex stereotyping can be relevant doctrinally. Recall that intermediate scrutiny is a means-end test, requiring important government interests (the governmental ends) and a substantial relationship between those interests and the impugned state action (the means).²⁸⁶ As Cary Franklin has pointed out:

276. See *supra* note 265 and accompanying text.

277. *Brandt v. Rutledge*, 47 F.4th 661, 668-70 (8th Cir. 2022), *aff’g* 551 F. Supp. 3d 882, 889-91 (E.D. Ark. 2021), *en banc reh’g denied*, No. 21-2875, 2022 WL 16957734 (8th Cir. 2022).

278. *Brandt*, 551 F. Supp. 3d at 889-91.

279. *Id.*

280. *Id.*

281. *Id.*

282. *Brandt*, 47 F.4th at 668-70.

283. Frederickson, *supra* note 32, at 1187-90.

284. *E.g.*, *Stanton v. Stanton*, 421 U.S. 7, 14 (1975); *Orr v. Orr*, 440 U.S. 268, 269 (1979); *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 725 (1982); *United States v. Virginia*, 518 U.S. 515, 549-50 (1996). See also Cary Franklin, *The Anti-Stereotyping Principle in Constitutional Sex Discrimination Law*, 85 N.Y.U. L. REV. 83, 142-72 (2010) (discussing the evolution of the Supreme Court’s anti-stereotyping principle in constitutional sex discrimination cases).

285. *Brandt*, 551 F. Supp. 3d at 893.

286. See *supra* note 265 and accompanying text.

The anti-stereotyping principle pervades both stages of this inquiry, shaping what constitutes an important interest and what means qualify as sufficiently narrowly tailored to serve this interest. Since this doctrine was introduced in 1976, the Court has never upheld a sex classification after determining that it reflects or reinforces sex stereotypes.²⁸⁷

Indeed, sex stereotypes should inform both stages of reviewing trans youth healthcare bans. First, promoting sex stereotypes cannot constitute an important government interest.²⁸⁸ Part II demonstrated that reinforcement of sex stereotypes appears to be a key motivation for trans youth healthcare bans; the bans thus embody an invalid governmental goal. Second, assuming *arguendo* that the bans' main goals are to prevent medical harm, irreversibility, and flawed consent, trans healthcare bans are not "substantially related" to such goals because the bans' under-inclusiveness is based on sex stereotypes.²⁸⁹ The district court in *Brandt* acknowledged this point by drawing attention to the fact that Arkansas' ban did not apply to cisgender children seeking the same treatments as transgender youth.²⁹⁰ However, it is the intersex exceptions that are particularly striking in terms of under-inclusiveness. As we discussed above, risks of harm are particularly pronounced with respect to intersex surgeries, and yet intersex surgeries are carved out of the ban due to stereotyped understandings of sex. Thus, the sex stereotypes underlying intersex exceptions support invalidating the bans under intermediate scrutiny.

A sex-stereotype focus during intermediate scrutiny would have at least two benefits. The first benefit concerns decisional certainty. A difficulty of applying intermediate scrutiny is that it is a standard rather than a bright-line rule. What counts as an "important" government interest? What constitutes a "substantial relationship"? Intermediate scrutiny arguably embodies messy ambiguity. However, the anti-stereotyping principle provides guideposts for navigating intermediate scrutiny. Upon finding sex stereotypes, a court can be more confident that an impugned state action fails intermediate scrutiny. A second benefit of focusing on stereotyping is its expressive dimension. As Fredericksen has argued: "stereotype-based arguments have significant value beyond their doctrinal impact in courts. They are important for calling out and rebutting claims and preconceptions . . . about transgender identity that underly antitransgender policies."²⁹¹ We would go one step further to say that judicial

287. Franklin, *supra* note 284, at 138 n.296. While Franklin published her article in 2010, to the best of our knowledge, her observation still holds today.

288. *See, e.g., Orr v. Orr*, 440 U.S. 268, 279 (1979) (rejecting the government's goal of reinforcing stereotypical gender roles and, therefore, striking down Alabama's rule that only husbands, and not wives, could be made to pay alimony).

289. Under-inclusiveness based on sex stereotypes has been found to fail heightened scrutiny. *See, e.g., United States v. Virginia*, 518 U.S. 515, 533 (1996).

290. *Brandt*, 551 F. Supp. 3d at 889-91.

291. Fredericksen, *supra* note 32, at 1189.

opinions also present an opportunity to call out and rebut stereotypes about intersex conditions.

A potential difficulty with applying the anti-stereotyping principle is that the Supreme Court’s existing case law has focused on what we have called first-generation sex stereotypes, which concern gender roles assigned to men and women.²⁹² Trans youth healthcare bans tend to implicate second-generation sex stereotypes, which concern the social construction of biological sex. Yet, for the reasons discussed in Part II, first- and second-generation stereotypes are logically linked, and they implicate the same normative concerns. As such, for doctrinal purposes, second-generation sex stereotypes warrant the same scrutiny.

To be sure, the Supreme Court has stated that differential treatment based on “real” differences in biological sex can pass intermediate scrutiny.²⁹³ For example, in *Nguyen v. INS*, the Court upheld an immigration provision stipulating that nonmarital children born abroad to a U.S. citizen have different requirements for obtaining U.S. citizenship depending on whether the parent with U.S. citizenship was their mother or father.²⁹⁴ The Court stated that the law’s disparate treatment of mothers and fathers survived intermediate scrutiny because it was based on biological differences—with mothers being the only ones who undergo pregnancy and childbirth²⁹⁵—as opposed to sex stereotypes.²⁹⁶ *Nguyen* and the doctrine of real differences have been the subject

292. See Franklin, *supra* note 284, at 142-72; see also *supra* Section II.A. It is worth noting that some state courts and lower federal courts have recognized second-generation sex stereotypes. For example, in *Boyd v. Conlin*, the federal district court stated that “the belief that transgender individuals must preserve the genitalia and other physical attributes of their natal sex” is based on sex stereotypes. 341 F. Supp. 3d 979, 997 (2018) (concerning the exclusion of gender-affirming medical procedures from state employees’ health insurance coverage). Some judicial opinions do not explicitly use the term “sex stereotype,” but they nonetheless reflect an interrogation of second-generation sex stereotypes. For example, in *In re Childers-Gray*, the Utah Supreme Court acknowledged that “biological sex” can be defined in various ways; it explained that “‘biological sex’ itself is ambiguous and may mean more than the sex designated by examination at birth.” *In re Childers-Gray*, 487 P.3d 96, 120 (Utah 2021) (concerning the ability of transgender people to change their sex designations on birth certificates).

293. *E.g.*, *Nguyen v. INS*, 533 U.S. 53, 62-64, 73 (2001) (upholding an immigration provision against claims of unconstitutional sex stereotyping because, according to the Court, the law’s disparate treatment of mothers and fathers was based on “basic biological differences,” and the “difference between men and women in relation to the birth process is a real one”). See also *United States v. Virginia*, 518 U.S. 515, 533-34 (1996) (acknowledging that “[p]hysical differences between men and women” can sometimes justify differential treatment based on sex but rejecting such justifications in the instant case).

294. *Nguyen*, 533 U.S. at 58-60.

295. This observation in *Nguyen* sits in tension with the existence of pregnant transgender men, including transgender men who are legally recognized as men. See Cahill, *supra* note 191, at 1094.

296. The Court identified two “important governmental interests” behind the impugned immigration provision: (1) “assuring that a biological parent-child relationship exists” between the child and their citizen parent, and (2) “ensur[ing] that the child and the citizen parent have some demonstrated opportunity or potential to develop . . . [a relationship with] real, everyday ties.” *Nguyen*, 533 U.S. at 62-65. The Court found that the law’s disparate treatment of biological mothers and fathers was substantially related to the two governmental interests, and that the disparate treatment was based on “real” biological differences rather than gender stereotypes. *Id.* at 68-73. In the subsequent case of *Sessions v. Morales-Santana*, 582 U.S. 47 (2017), the Court struck down a separate provision of immigration law for violating equal protection because it found that provision to be based on sex stereotypes.

of much criticism.²⁹⁷ Yet, even accepting that laws based on real differences can survive intermediate scrutiny, the doctrine of real differences does not justify trans youth healthcare bans.

Trans youth healthcare bans are not based on so-called “real” biological differences. The bans reflect and reinforce cultural beliefs about biological sex rather than pre-cultural facts about biological reality. As discussed in Part II, the bans embody socially constructed generalizations about sex being binary and fixed at birth or infancy. Trans youth healthcare bans thus stem impermissibly from sex stereotypes.

2. *Animus*

Even if an impugned ban does not violate intermediate scrutiny, the ban could still violate equal protection if it fails rational basis review. To survive rational basis review, a law must be reasonably related to a legitimate government interest.²⁹⁸ In a series of cases, the Supreme Court has held that laws and other state actions fail rational basis review if they are motivated by animus because animus is not a legitimate government interest.²⁹⁹

Importantly, animus need not be the sole motivating factor behind a law for it to fail.³⁰⁰ In 2020, the Court stated in *Department of Homeland Security v. Regents of the University of California* that “[t]o plead animus, a plaintiff must raise a plausible inference that an ‘invidious discriminatory purpose was a motivating factor’ in the relevant decision”—not necessarily the only factor.³⁰¹ This statement moved the Court away from the 2018 case of *Trump v. Hawaii*, which had suggested that animus must be the sole motivation.³⁰² *Department of Homeland Security v. Regents of the University of California* is, however, consistent with earlier cases that treated animus as impermissible even when it was not the sole motivating factor.³⁰³

297. *E.g.*, Cahill, *supra* note 191 (arguing that the real-differences doctrine cannot be reconciled with recent jurisprudential developments on LGBTQ rights); Kenji Yoshino, *Sex Equality’s Inner Frontier: The Case of Same-Sex Marriage*, 122 YALE L.J.F. 275, 277-78 (2013) (criticizing the reasoning in *Nguyen*).

298. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985).

299. *E.g.*, *id.*; *Dep’t of Agriculture v. Moreno*, 413 U.S. 528, 534 (1973) (holding that “a bare congressional desire to harm a politically unpopular group cannot constitute a legitimate governmental interest”); *Romer v. Evans*, 517 U.S. 620, 632 (1996); *United States v. Windsor*, 570 U.S. 744, 772 (2013). Because judicial inquiry into potential animus is arguably a more searching form of review than rational basis review in other instances, some commentators have called animus review a form of “rational basis review with bite” to distinguish it from traditional rational basis review. *E.g.*, Yoshino, *supra* note 261, at 760-61.

300. *See Carpenter, Dead End, supra* note 163, at 613; Dale Carpenter, *Windsor Productions: Equal Protection from Animus*, 2013 SUP. CT. REV. 193, 245 (2014) [hereinafter *Carpenter, Windsor Products*].

301. 591 U.S. 1, 34 (2020) (quoting *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 266 (1977)).

302. *See Trump v. Hawaii*, 585 U.S. 667, 706; *Carpenter, Dead End, supra* note 163.

303. *See Carpenter, Windsor Products, supra* note 300, at 4 (reading cases as dictating that “the impermissible animus-based purpose need not be the ‘sole’ or ‘dominant’ one. It need only be a

The Supreme Court has considered animus to encompass irrational fears and unthinking prejudice. Consider, for example, *City of Cleburne v. Cleburne Living Center*, which concerned the city's denial of a zoning permit for a proposed group home for housing persons with cognitive disabilities.³⁰⁴ The Court found that the city's decision was a response to neighbors' "fears" and "negative attitudes" that were "unsubstantiated."³⁰⁵ It held that responding to these irrational fears and prejudices was not a legitimate government interest and, therefore, the city's actions could not survive rational basis review.³⁰⁶ The Court has reiterated this premise in subsequent cases. For example, in *Board of Trustees of the University of Alabama v. Garrett*, the Court stated: "[N]egative attitudes or fear, *unsubstantiated by factors which are properly cognizable . . . are not permissible bases*" for governmental decision-making.³⁰⁷ The Court has found that irrational fears and prejudice result in legislation being motivated by a "bare desire to harm" the targeted group.³⁰⁸

As discussed in Part II, trans youth healthcare bans stem from irrational fears and disgust.³⁰⁹ To borrow language from the Supreme Court's description of animus: the disgust we examined amount to "negative attitudes" that are "unsubstantiated."³¹⁰ Indeed, scholars such as Martha Nussbaum and William Araiza have pointed out that laws stemming from disgust are paradigmatic examples of laws embodying unconstitutional animus.³¹¹

Federal courts have looked to various factors as indicia of animus without requiring any one factor in particular.³¹² These factors can be put into two main categories: (1) there may be direct evidence of animus, in the form of statements from lawmakers; and (2) there may be procedural or structural irregularities of impugned state actions, from which animus can be inferred.³¹³ In this Article, we focus on structural indicators of animus because of their relevance to intersex exceptions. The Supreme Court's focus on structure has been evident in at least four cases: *Cleburne v. Cleburne Living Center*, *Romer v. Evans*, *United States v. Windsor*, and *Trump v. Hawaii*.

'motivating factor' or as I propose, a 'material influence'); see also Kevin M. Barry et al., *A Bare Desire to Harm: Transgender People and the Equal Protection Clause*, 57 B.C. L. REV. 507, 545 (2017) ("Once triggered, animus is an evidentiary trump card that discredits other 'legitimate' governmental interests as pretextual.").

304. 473 U.S. 432, 442 (1985).

305. *Id.* at 448.

306. *Id.*

307. 531 U.S. 356, 367 (2001) (internal citations omitted) (quoting *Cleburne*, 473 U.S. at 448).

308. *Cleburne*, 473 U.S. at 447 (quoting *U.S. Dept. of Agric. v. Moreno*, 413 U.S. 528, 534 (1973)).

309. See *supra* Sections II.B-II.C.

310. See *supra* notes 305, 307 and accompanying text.

311. See William D. Araiza, *Disgust and Guns: Conduct Identity, and Second Amendment Animus*, 116 NW. U. L. REV. 1365, 1382 (2022) (citing NUSSBAUM, *supra* note 240, at 150-51 (2010)).

312. See William D. Araiza, *Animus and Its Discontents*, 71 FLA. L. REV. 155, 184 (2019).

313. See Skinner-Thompson, *supra* note 32, at 972-73; Susannah W. Pollvogt, *Unconstitutional Animus*, 81 FORDHAM L. REV. 887, 926-27 (2012).

In each of the four cases, the Court examined the scope of the impugned state action to determine whether animus could be inferred. In *Cleburne*, the city asserted reasons for denying the zoning permit—for example, the fact that the home would sit on a flood plain, questions about assigning legal responsibility for damage caused by residents, and concerns about neighborhood density.³¹⁴ However, the Court found that these reasons could not be squared with the fact that the city had permitted homes for other groups, such as fraternities, nursing homes, boarding houses, and dormitories.³¹⁵ The scope of the city’s permit denial—specifically, what was excluded from denials—was indicative that the city was motivated by irrational fears and prejudice.³¹⁶

Romer and *Windsor* were both gay rights cases. In *Romer*, the Court struck down Amendment 2 to Colorado’s state constitution, which forbade all state and local governmental entities from providing protections against discrimination based on sexual orientation.³¹⁷ The Court inferred animus from the Amendment’s “[s]weeping and comprehensive” scope.³¹⁸ The Amendment lacked any nuance. It banned antidiscrimination protections at all levels of government regardless of the context of the discrimination, be it related to education, employment, housing, insurance, welfare services, and so on.³¹⁹ Because the Amendment enacted “a broad and undifferentiated disability on a single named group,” it was discrimination of “unusual character” and “inexplicable by anything but animus toward the class it affect[ed].”³²⁰ Similarly, in *Windsor*, the Supreme Court inferred animus from the sweeping scope of Section 3 of the Defense of Marriage Act (DOMA), which denied federal recognition of same-sex marriages.³²¹ Drawing on the reasoning in *Romer*, the majority in *Windsor* noted that DOMA made no distinctions between various federal contexts in which marriages are recognized and, instead, DOMA barred federal legal recognition across the board.³²² The Court treated such a sweeping scope as an indication of animus.³²³

In contrast to its decisions in *Cleburne*, *Romer*, and *Windsor*, the Supreme Court rejected claims of animus in *Trump v. Hawaii*, which concerned President Trump’s Executive Order restricting immigration from eight countries—Chad, Iran, Libya, North Korea, Somalia, Syria, Venezuela, and Yemen.³²⁴ Plaintiffs argued, *inter alia*, that the restrictions were unconstitutional because they were

314. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 442 (1985).

315. *Id.*

316. *Id.* at 450.

317. *Romer v. Evans*, 517 U.S. 620, 632 (1996).

318. *Id.* at 627.

319. *Id.* at 629.

320. *Id.* at 632-33.

321. *United States v. Windsor*, 570 U.S. 744, 770-72 (2013).

322. *Id.* at 768.

323. *Id.* at 769-70.

324. *Trump v. Hawaii*, 585 U.S. 667, 706 (2018).

motivated by anti-Muslim animus.³²⁵ The plaintiffs asserted their animus claim in connection with the First Amendment’s Establishment Clause instead of the Fourteenth Amendment’s Equal Protection Clause, but animus analysis is similar in these two doctrinal contexts.³²⁶ The Court invoked the impugned Executive Order’s scope to reject the animus claim.³²⁷ It noted that the Executive Order was not a sweeping restriction on Muslim immigrants.³²⁸ It said that only “8% of the world’s Muslim population” was covered by the Executive Order.³²⁹ Only five—not all—of the countries covered by the executive order were Muslim-majority countries, and all five of those countries had previously been listed by the government as state sponsors of terrorism.³³⁰ The Executive Order also excluded Iraq, “one of the largest predominantly Muslim countries in the [Middle East] region.”³³¹ Moreover, the Executive Order was not an absolute ban on immigration; rather, it imposed additional conditions and vetting processes for immigration from the listed countries.³³² In sum, the Executive Order did not have a scope that was comparable to the sweeping scope that characterized the impugned laws in *Romer* and *Windsor*.

The Supreme Court’s case law is instructive for understanding trans youth healthcare bans. The bans are “unusual” in their sweeping scope. They typically prohibit all gender-affirming medical treatments regardless of details such as the type of treatment, severity of the patient’s circumstances, age of the minor (e.g., whether the patient is seven or seventeen), and the strength of informed consent.³³³ As in *Romer* and *Windsor*, the sweeping and undifferentiating nature of the bans indicates that fear and loathing undergird the bans.³³⁴ At the same time, the intersex exceptions bring to mind the scope of state action in *Cleburne*, in which the city’s permit denial was underinclusive because the city granted zoning permits for group homes that posed similar concerns and risks as the home for the cognitively disabled.³³⁵ Intersex exceptions render healthcare bans underinclusive in addressing purported concerns about medical harm,

325. *Id.* at 701.

326. See Carpenter, *Dead End*, *supra* note 163, at 603-04 (“If the challenge had been rooted in Equal Protection Clause terms, rather than in Establishment Clause religious terms, the animus analysis would not vary.”).

327. *Trump*, 585 U.S. at 706.

328. *Id.*

329. *Id.*

330. *Id.* at 676.

331. *Id.* at 707.

332. *Id.* at 676.

333. See *Appendix*, *supra* note 15.

334. See *supra* Sections II.B-II.C. One might contend that trans youth healthcare bans are not sweeping because they only restrict the healthcare access of transgender minors—not transgender adults. This contention, however, is misguided. The relevant question is whether the bans differentiate among circumstances concerning transgender minors. By way of analogy, the relevant considerations in *Romer* and *Windsor* were whether the impugned laws that restricted the rights of non-heterosexuals differentiated among circumstances concerning non-heterosexuals. The fact that the impugned laws only targeted non-heterosexuals did not prevent the court from concluding that the laws were sweeping and comprehensive.

335. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432 (1985).

irreversibility, and informed consent. Much like the under-inclusiveness at issue in *Cleburne*, the underinclusive nature of intersex exceptions are indicative of animus behind trans youth healthcare bans.

In this Article, we are primarily concerned with the structural indicia of animus due to this Article's overarching focus on intersex exceptions as a structural feature of trans youth healthcare bans. It is worth noting, however, that other writers have argued that lawmakers' statements are direct evidence of animus underlying trans youth healthcare bans.³³⁶ Indeed, in the case of *Doe v. Ladapo*, the district court struck down Florida's trans youth healthcare ban because of the ban's underlying animus, and the court relied primarily on direct evidence of animus.³³⁷ The court did, however, comment that the constitution permits the State of Florida to regulate rather than completely ban gender-affirming care for minors.³³⁸ This statement is perhaps another way of saying that the broad, undifferentiated scope of Florida's ban was tied to animus. The court did not consider the ban's intersex exceptions. Had the court discussed the Florida ban's scope in greater detail, including a discussion of the intersex exception, the court's finding of animus would have been even more robust.

Ladapo is exceptional because, in most other rulings on trans youth healthcare bans, courts have either sidestepped animus analysis or rejected animus claims.³³⁹ In *Skrmetti*, the district court in Tennessee issued a preliminary injunction because it found the ban to be unlikely to satisfy strict scrutiny (as required by the plaintiffs' substantive due process claim) or intermediate scrutiny (as required by plaintiffs' claim of discrimination on the basis of sex or transgender status).³⁴⁰ Because the court found the ban to fail these heightened levels of scrutiny, it had no occasion to discuss whether the ban would fail rational basis review due to animus.³⁴¹ Subsequently, the Sixth Circuit reversed the preliminary injunction, dismissing plaintiffs' animus claim in two paragraphs. In that brief discussion, the court failed to contend with how the intersex exception, coupled with the ban's otherwise broad sweep, reveal irrational fear and disgust.³⁴² The Sixth Circuit stated that "the key problem is

336. *E.g.*, Skinner-Thompson, *supra* note 32, at 1007-17.

337. *Doe v. Ladapo*, No. 4:23cv114-RH-MAF, 2024 WL 2947123, at *15-26 (N.D. Fla. June 11, 2024).

338. *Id.* at *6.

339. *E.g.*, L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 487-88 (6th Cir. 2023), *cert. granted*, United States v. Skrmetti, 144 S. Ct. 2679 (2024) (rejecting animus claim); Eknes-Tucker v. Gov. of Ala., 80 F.4th 1205, 1231 (11th Cir. 2023), *petition for reh'g en banc* filed Sept. 11, 2023 (reversing preliminary injunction and holding that the impugned law survived heightened scrutiny, thereby obviating the need to consider animus or any other aspects of rational basis review).

340. L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 680 (M.D. Tenn. 2023). The district court found that plaintiffs did not have standing to challenge the provisions in the Tennessee ban concerning surgical care. *Id.* at 681-82.

341. *See id.* at 712 n.56.

342. *Skrmetti*, 83 F.4th at 460. In addition, the Sixth Circuit cited *Trump v. Hawaii* to support the contention that animus must be the sole motivation for a law for the law to be unconstitutional. *Id.* at 487-88. After *Trump v. Hawaii*, however, the Supreme Court stated in *DHS v. Regents* that a plaintiff pleading

that a law premised only on animus toward the transgender community would not be limited to those 17 and under.”³⁴³ This reasoning fails to appreciate, however, that irrational fear and disgust can and do exist specifically with respect to transgender and intersex youth, thus supporting the notion that animus undergirds bans specific to youth.³⁴⁴

3. *Unreasonableness aside from animus*

Even if a court does not find animus as a motivating factor, the impugned law could still fail rational basis review.³⁴⁵ For example, in *Eisenstadt v. Baird*, the Court struck down a law that restricted the sale of contraception to married persons.³⁴⁶ The Court found that the law violated equal protection because its discrimination against unmarried persons could not satisfy rational basis review.³⁴⁷ The state had raised legitimate government interests, namely the promotion of health and prevention of fornication.³⁴⁸ The Court concluded, however, that denying unmarried persons access to contraception was not reasonably related to those legitimate government interests.³⁴⁹

One could make a strong argument that, even if a court accepts that safeguarding informed consent, protecting children against potential harm, and postponing irreversible decisions are all legitimate government interests, trans youth health bans with intersex exceptions are not reasonably related to those government goals. The bans are both overinclusive and underinclusive due to irrational judgment. The bans are underinclusive because of their intersex exceptions and because the treatments given as gender-affirming care are not prohibited when they are administered for any other purpose. The bans are also overinclusive because they make no other exceptions for transgender youth even when gender-affirming treatment might be the last resort for addressing dire consequences such as suicidality. A more proportionate response to legitimate government interests would be regulatory safeguards for gender-affirming care

animus need only “raise a plausible inference that an ‘invidious discriminatory purpose was a *motivating factor*’”—not the sole motivating factor. 591 U.S. 1, 31 (2018) (emphasis added). In this regard, *Regents* is consistent with earlier cases that did not require animus to be the sole motivation. See *supra* notes 300-303 and accompanying text.

343. *Skremetti*, 83 F.4th at 487.

344. See *supra* note 255 and accompanying text.

345. See Katie R. Eyer, *Animus Trouble*, 48 STETSON L. REV. 215, 218-26 (2019); Katie R. Eyer, *The Canon of Rational Basis Review*, 93 NOTRE DAME L. REV. 1317, 1335-56 (2018).

346. 405 U.S. 438, 454-55 (1972).

347. *Id.* at 453.

348. *Id.* at 448-49.

349. *Id.* at 449.

as opposed to a blanket ban on treating transgender youth, coupled with an explicit exception for intersex treatments.³⁵⁰

Under rational basis review, under-inclusiveness and over-inclusiveness alone do not necessarily render a law unconstitutional.³⁵¹ For example, under rational basis review, a court will uphold a law that tackles a public policy issue incrementally, resulting in under-inclusiveness.³⁵² In the case of trans youth healthcare bans, however, the root cause of under- and over-inclusiveness is instructive. As demonstrated in Part II, irrational fears and disgust explain the structural design of the healthcare bans. Irrational fears and disgust cloud judgment, producing the over- and under-inclusiveness. As such, assuming *arguendo* that the bans are motivated by legitimate government goals, the healthcare bans do not bear a reasonable relationship to achieving those goals.

It is worth noting that lawmakers can harbor fears and disgust unconsciously.³⁵³ Some commentators have critiqued animus doctrine for failing to capture unconscious biases because animus is often understood as conscious and intentional in nature.³⁵⁴ Linking irrational fear and disgust to the “reasonable relationship” inquiry in rational basis review avoids that problem—even *unconscious* fears and disgust can lead to unreasonable over- and under-inclusiveness.

B. Substantive Due Process

Thus far, we have focused on constitutional challenges based on equal protection. A separate line of attack relies on substantive due process. Plaintiffs have argued that trans youth healthcare bans violate the fundamental right to parental decision-making.³⁵⁵ According to substantive due process doctrine,

350. See *Doe v. Ladapo*, No. 4:23cv114-RH-MAF, 2024 WL 2947123, at *5 (N.D. Fla. June 11, 2024) (“The State of Florida can regulate [gender-affirming medical care] as needed but cannot flatly deny transgender individuals safe and effective medical treatment”).

351. See, e.g., *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (“A legislature must have substantial latitude to establish classifications that roughly approximate the nature of the problem perceived, that accommodate competing concerns both public and private, and that account for limitations on the practical ability of the State to remedy every ill.”).

352. When rational basis review is applicable, the government is free to address problems “one step at a time, addressing itself to the phase of the problem which seems most acute to the legislative mind.” *Williamson v. Lee Optical, Inc.*, 348 U.S. 483, 489 (1955).

353. The Supreme Court has previously recognized the problematic existence of unconscious biases. See Yoshino, *supra* note 166.

354. See William D. Araiza, *Why Bother with Animus?*, 74 ALA. L. REV. 649, 652 (2023) (stating that animus doctrine “can be criticized as deflecting attention away from the systemic or implicit bias scholars have identified as one of the most pressing modern problems of invidious discrimination”). But see Susannah W. Pollvogt, *Windsor, Animus, and the Future of Marriage Equality*, 113 COLUM. L. REV. SIDEBAR 204, 211 (2013) (asserting that the Supreme Court’s majority opinion in *United States v. Windsor* “characterized animus as something akin to unconscious bias as opposed to malicious intent”).

355. See *Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022), *en banc reh’g denied*, No. 21-2875, 2022 WL 16957734 (8th Cir. 2022); *Eckes-Tucker v. Gov. of Ala.*, 80 F.4th 1205 (11th Cir. 2023), *petition for*

substantial restrictions of fundamental rights must survive strict scrutiny.³⁵⁶ As noted previously, strict scrutiny is a more demanding standard of review than intermediate scrutiny and rational basis review.³⁵⁷ Considering how exacting strict scrutiny is, trans youth healthcare bans are extremely unlikely to survive strict scrutiny.³⁵⁸

According to case law that stretches back over a century, parents have a fundamental right to make decisions regarding their children. Indeed, according to the Supreme Court, “the interest of parents in the care, custody, and control of their children . . . is perhaps the oldest of the fundamental liberty interests recognized by this Court.”³⁵⁹ The Supreme Court has recognized the fundamental right to parental decision-making in a range of contexts—for example, in cases concerning a children’s education, healthcare, and visitation with grandparents.³⁶⁰ Courts have split on whether the fundamental right to parental decision-making encompasses a right to seek gender-affirming care for children. District courts have found that trans youth healthcare bans in Alabama, Arkansas, Kentucky, and Tennessee violated fundamental parental rights.³⁶¹ However, the Sixth and Eleventh Circuits reversed the decisions concerning Alabama, Kentucky, and Tennessee; they decided that fundamental parental rights were not implicated.³⁶²

The split among courts stemmed from disagreements on how to define the fundamental right to parental decision-making.³⁶³ The courts that have defined parental rights narrowly drew inspiration from *Dobbs v. Jackson Women’s Health Organization*.³⁶⁴ Reversing fifty years of established precedent, *Dobbs* found that individuals do not have a fundamental right to make decisions about abortion.³⁶⁵ The majority in *Dobbs* applied a strict “history and tradition”

reh’g en banc filed Sept. 11, 2023; L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023), *cert. granted*, United States v. Skrmetti, 144 S. Ct. 2679 (2024).

356. See CHEMERINSKY, *supra* note 260, at 876-77. It is worth noting that restrictions on fundamental rights can also trigger strict scrutiny pursuant to equal protection doctrine if the restriction targets a particular group of people. See *id.* In this Article, we consider the fundamental right to parental decision-making as a substantive due process issue because that is how the circuit courts have been addressing parental rights in healthcare ban cases. See *supra* note 355.

357. See *supra* notes 261-263 and accompanying text.

358. See *supra* note 263 and accompanying text.

359. *Troxel v. Granville*, 530 U.S. 57, 65 (2000).

360. *E.g., id.* (grandparent visitation); *Meyer v. Nebraska*, 262 U.S. 390, 400 (1923) (education); *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 535 (1925) (education); *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972) (education); *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (commitment to mental health facility).

361. *Brandt v. Rutledge*, 677 F. Supp. 3d 877 (E.D. Ark. 2023); L.W. *ex rel.* Williams v. Skrmetti, 679 F. Supp. 3d 668, 680 (M.D. Tenn. 2023); *Doe 1 v. Thornbury*, 679 F. Supp. 3d 576 (W.D. Ky. 2023); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131 (M.D. Ala. 2022).

362. *Eknes-Tucker v. Gov. of Ala.*, 80 F.4th 1205 (11th Cir. 2023), *petition for reh’g en banc* filed Sept. 11, 2023; L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023), *cert. granted*, United States v. Skrmetti, 144 S. Ct. 2679 (2024).

363. See Weithorn, *supra* note 38, at 788-801 (comparing district and circuit court decisions concerning trans youth healthcare bans, focusing on the Sixth, Eighth, and Eleventh Circuits).

364. See *Eknes-Tucker*, 80 F.4th at 219-26; *Skrmetti*, 83 F.4th at 469-75.

365. 597 U.S. 215, 215 (2022).

analysis for determining the existence of fundamental rights.³⁶⁶ Drawing on *Dobbs*, the Sixth and Eleventh Circuits concluded that history and tradition do not support defining parental decision-making rights capaciously enough to encompass decisions regarding gender-affirming medical care for children.³⁶⁷

It is beyond the scope of this Article to offer a comprehensive evaluation of this split among courts. Other commentators have critiqued the Sixth and Eleventh Circuits' approaches from various perspectives, including their reliance on *Dobbs* and their (mis)use of scientific evidence.³⁶⁸ Instead, in this Article, we offer a narrow—but consequential—intervention that builds on our discussion in Part II. Our discussion in Part II is especially relevant to the Sixth Circuit's approach to framing the substantive due process issue.³⁶⁹ The Sixth Circuit stated that history and tradition do not support finding that parents have a fundamental "constitutional right to obtain *reasonably* banned treatments for their children. . . no such tradition exists. The government has the power to *reasonably* limit the use of drugs."³⁷⁰ The Sixth Circuit appears to have carved out "reasonable" medical regulations, such that they cannot be trumped by parental decision-making rights. In effect, the Sixth Circuit's approach subjects all restrictions on youth medical treatments to a reasonableness standard as opposed to strict scrutiny.

Yet, as our discussion in Part II suggested, the medical bans at issue do not seem reasonable. Thus, our analysis casts doubt on the Sixth Circuit's carveout. Indeed, the stereotyping, irrational fear, and disgust that are revealed by the scope of impugned bans suggest that the blanket bans are not reasonable medical regulations. As a result, the Sixth Circuit's circumscription of parental decision-making rights seems misguided. It is worth noting that, although the Supreme Court has granted *certiorari* in the Sixth Circuit's case, the Supreme Court will only be reviewing the Sixth Circuit's rulings with respect to equal protection.³⁷¹ Depending on how narrowly the Supreme Court comes down on the equal protection questions, lower federal courts might continue to grapple with the question of whether the fundamental right to parental decision-making encompasses decisions about gender-affirming care for children.

To be clear, we are not suggesting that restrictions on gender-affirming care for minors can never be squared with fundamental parental rights. Likewise, we are not suggesting that restrictions on intersex surgeries are irreconcilable with fundamental rights. Even if we construe fundamental parental rights broadly,

366. *Id.* at 233-50.

367. See *Eknes-Tucker*, 80 F.4th at 219-26; *Skrmetti*, 83 F.4th at 469-75; Weithorn, *supra* note 38, at 794-801.

368. E.g. Weithorn, *supra* note 38, at 794-801, 803-19.

369. L.W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023), *cert. granted*, United States v. Skrmetti, 144 S. Ct. 2679 (2024).

370. *Id.*

371. *Skrmetti*, 144 S. Ct. at 2679 (grant of *certiorari*).

restrictions on the right could survive strict scrutiny if they are drawn with care and nuance, thus being “narrowly tailored” to achieve the “compelling government interest” of protecting children.³⁷²

CONCLUSION

This Article has examined the structure of trans youth healthcare bans. We interrogated the fact that the bans have a sweeping scope while maintaining exceptions for intersex surgeries. Our analysis suggests that the bans’ underlying motives can be inferred from the bans’ structure and sociocultural backdrop. Specifically, the structure and backdrop suggest that sex stereotyping, irrational fear, and disgust are significant motivating factors.

Additionally, this Article contends that the bans’ underlying factors—sex stereotyping, irrational fear, and disgust—should inform constitutional scrutiny. The Supreme Court’s forthcoming ruling in *United States v. Skrametti* ought to account for these factors. As we have explained, these factors are relevant to several lines of constitutional inquiry, and in each instance, they support finding the bans unconstitutional.

Skrametti will likely not be the last word, and this Article can inform post-*Skrametti* litigation. For example, it is possible for the Supreme Court to hold that the Sixth Circuit erred in deciding that Tennessee’s ban does not discriminate on the basis of sex; the Court could then remand the case to the Sixth Circuit to apply heightened scrutiny accordingly. In that situation, the Sixth Circuit should consider the sex stereotyping that this Article has illuminated. Alternatively, the Supreme Court might affirm the Sixth Circuit’s ruling that sex discrimination doctrine does not apply pursuant to federal constitutional law, but the inquiry would not necessarily end there. Some state constitutions provide more robust sex equality protections than the federal constitution does.³⁷³ Thus, plaintiffs might have stronger sex-discrimination claims when challenging trans youth healthcare bans pursuant to state constitutional law.³⁷⁴ In pending and future challenges based on state-level constitutional law, courts should consider the sex

372. See *supra* note 264 and accompanying text; CHEMERINSKY, *supra* note 260.

373. See Grace Kavinsky, Comment, *An Opportunity for Feminist Constitutional Constitutionalism: Abortion Under State Equal Rights Amendments*, 75 STAN. L. REV. 1209, 1221-22 (2023) (noting that “29 state constitutions have added some form of sex-specific protection and of those, 13 states have constitutional provisions that are virtually identical to the national ERA . . . [and that] claimants have succeeded under state ERAs with arguments that might have failed under the federal Equal Protection Clause”).

374. Cf. Quinn Yeagain, *Litigating Trans Rights in the States*, 85 OHIO ST. L.J. 355, 398 (2024) (surveying state constitution equal protection provisions and their potential usefulness in transgender rights litigation and concluding “[u]nder this big tent, trans advocates can ground their federal Equal Protection arguments in the constitutional language of their state—with a strong chance of a better outcome than in federal court”).

stereotyping this Article unveiled. These possibilities are just two non-exhaustive examples of the judicial proceedings that may ensue post-*Skrmetti*.

Beyond litigation, policymakers could address the problematic structure of trans youth healthcare bans. Indeed, they should consider nuanced alternatives to the current bans. It is beyond the scope of this Article to weigh the pros and cons of potential policies, but for illustration purposes, we will highlight some potential approaches to reform. If policymakers are concerned that parents are not provided with sufficient information about treatment risks and are pressured to make fast decisions, policymakers—including lawmakers and medical boards—can develop heightened disclosure requirements aimed at securing parents' informed consent. Relatedly, policymakers can create strict enforcement mechanisms that penalize doctors who violate disclosure protocols. If policymakers are concerned about the risk-benefit calculus of treatments, they can develop regulations that restrict treatment to minors who present particularly strong cases for treatment instead of banning treatments entirely. Additionally, policymakers should consider reforming access to intersex surgeries. For example, if lawmakers are genuinely concerned about informed consent, medically unnecessary surgeries should be deferred until the child is mature enough to provide meaningful consent. As Ido Katri and Maayan Sudai explain, the transgender and intersex legal movements can work together to advance the bodily autonomy of transgender and intersex youth.³⁷⁵

In sum, this Article has demonstrated that, in light of the otherwise sweeping nature of trans youth healthcare bans, intersex exceptions reveal the bans' motivating factors. These underlying motivations include sex stereotyping, fear, and disgust. We have argued that these biases should be considered in both constitutional scrutiny and policy reform. Accounting for these biases is eminently important to protecting vulnerable youth.

375. A forthcoming article by Ido Katri and Maayan Sudai examines in detail the potential for strengthening allyship between the transgender and intersex legal movements. While recognizing that the two movements' interests have not always aligned, Katri and Sudai map out significant ways in which the transgender and intersex legal movements share core values that center on bodily self-determination. *See generally* Katri & Sudai, *supra* note 32.