

# The Comparator Argument in Trans-Healthcare Ban Cases

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*As states have increasingly restricted gender affirming care for minors across the nation (reinforced by a recent Executive Order by President Trump), and though the Supreme Court ruled on one such state ban, a powerful argument has largely been overlooked. This argument emphasizes the fact that transgender minors are not alone in receiving gender affirming care. Cisgender minors also receive such care for precisely the same reasons as transgender minors—unwanted breast tissue development, undesired hair growth, unusual vocal development, and puberty onset. Indeed, cisgender children receive such care at higher numbers than trans children, and many of the medications used for trans care were developed to provide care to cis individuals.*

*Allowing cisgender children to get care (because their sex assigned at birth aligns with the desired care) and not transgender individuals (because their sex assigned at birth does not align with the desired care) is straightforward sex discrimination. This argument has intuitive appeal, and, as this Article explains, doctrinal importance. Without a showing that cisgender and transgender minors are similarly situated, an equal protection challenge will simply not succeed, as previous Supreme Court cases suggest. Indeed, the Court's oral arguments highlighted this particular argument.*

*Leading up to the argument, however, litigators de-emphasized this comparator argument, focusing on other kinds of claims. They looked primarily to the language of the statute and the causal role that sex assigned at birth plays in limiting care. This Article therefore addresses this gap. It shows the importance of comparator arguments in the sex discrimination space, develops it in detail for future litigation purposes, and calls for further research to render this argument a mainstay in future advocacy.*

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<sup>†</sup> Professor of Law, University of Virginia School of Law. My thanks to Jessica Clarke and Holning Lau for comments, and to Leslie Ashbrook for bluebooking assistance. This Article is based on a brief filed in *United States v. Skrametti*, and was completed before the Supreme Court issued its decision. The views of the author regarding the decision are available at <https://www.scotusblog.com/2025/07/the-use-and-misuse-of-medicine-in-skrametti>. As the Conclusion originally anticipates, the negative outcome in *Skrametti* still leaves room for advocacy in state courts and legislative and administrative bodies, where the comparator argument should be advanced.

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## INTRODUCTION

In the last five years, twenty-seven states have placed restrictions—in many cases, flat bans—on access to gender affirming care for transgender minors.<sup>1</sup> Early in 2025, President Trump issued an Executive Order that similarly seeks to limit such care.<sup>2</sup> In *United States v. Skrametti*, the Supreme Court determined that Tennessee’s ban, SB1, did not the Equal Protection Clause,<sup>3</sup> resolving a wide circuit split on which numerous lower courts have weighed in.<sup>4</sup> *Skrametti* will likely determine the constitutional fate of other such bans as well as the Executive Order.

Arguments challenging these bans on equal protection grounds take several forms. The approach that has received the most airtime in briefs and scholarship is a simple facial approach. In SB1, for example, the main operative provision prohibits providers from administering “a medical procedure” to treat distress arising from “discordance” between “sex” assigned at birth and the minor’s gender “identity.”<sup>5</sup> As the prohibition explicitly turns on the term “sex,” the equality violation is clear on its face. As Justice Kagan put it at oral argument, the law is “utterly and entirely about sex.”<sup>6</sup>

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1. *Bans on Best Practice Medical Care for Transgender Youth*, MOVEMENT ADVANCEMENT PROJECT, [https://www.lgbtmap.org/equality-maps/healthcare\\_youth\\_medical\\_care\\_bans](https://www.lgbtmap.org/equality-maps/healthcare_youth_medical_care_bans) (last visited Feb. 13, 2025). Gender affirming care refers to a range of interventions used to affirm a person’s gender identity. It includes mental health counseling, medication (primarily pubertal suppression and hormone replacement treatment), and surgical intervention, all with the goal of aligning an individual’s physical attributes with their gender identity, or decreasing distress caused by non-alignment. See Craig Konnoth, *The National Termination of Pediatric Gender Affirming Care: A Study in Illegal, Anticipatory Compliance*, 73 UCLA L. REV. DISCOURSE 36, 41–42 (2025). Puberty suppressing medication, known as puberty blockers, suppress the release of sex hormones, which delays puberty, and allows minors and their providers to determine what permanent care (if any) will be sought; such care also reduces future surgical interventions if a child does choose to move forward with care (such as facial feminization or mastectomies). *Id.* at 42. Hormone therapy is generally available only to older youths for developing secondary characteristics associated with their experienced identity. *Id.* Surgery is rarely performed on minors, and almost never involves genital surgery. *Id.* Such care, as explained below, is sought by both transgender individuals (whose gender identity does not align with their sex assigned at birth) and cisgender individuals (whose gender identity does align with their birth assigned sex) as both sets of individuals can develop physical attributes that may not be aligned with their gender identity).

2. Exec. Order No. 14,187, 90 Fed. Reg. 8771, 8771 (Feb. 3, 2025). The Order is more draconian in that it does not allow for grandfathering in of existing patients like many state bans do, and targets care for those under the age of 19, as opposed to 18 as in all states with bans. *Id.*

3. *United States v. Skrametti*, 145 S. Ct. 1816, 1837 (2025).

4. A list of all these cases is available on a spreadsheet on file with author. See generally *Kadel v. Folwell*, 100 F.4th 122 (4th Cir. 2024) (holding that North Carolina’s exclusion of gender-affirming care from state employee health plans violated the Equal Protection Clause); *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022) (affirming preliminary injunction against Arkansas law banning gender-affirming care); *Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205 (11th Cir. 2023) (upholding Alabama’s ban under rational basis review and rejecting the equal protection challenge); *Skrametti*, 145 S. Ct. 1816 (holding that Tennessee’s categorical ban on gender-affirming care for minors violates the Equal Protection Clause).

5. SB1 is codified at TENN. CODE ANN. §§ 68-33-101–109 (2023).

6. Transcript of Oral Argument at 125–26, *Skrametti*, 145 S. Ct. 1816 (No. 23-477) [hereinafter Transcript].

A second argument that has received only passing mentions in the Supreme Court briefing (in a brief I filed),<sup>7</sup> and almost no mentions at the appellate level or in the academic literature, is what I call the “comparator” argument. Unlike the facial approach, the comparator argument does not focus on the *language* of the statute. Rather, it looks to see how individuals who might present similar concerns to the group at issue are *actually* treated.<sup>8</sup> A state actor need never use explicit language referring to a category in order to treat individuals differently based on that category.<sup>9</sup>

And, as it turns out, SB1, like statutes in other states,<sup>10</sup> and the Trump Executive Order,<sup>11</sup> treat minors differently based on their sex assigned at birth. While gender affirming care is commonly referred to as a phenomenon that only transgender people experience, cisgender people seek such care all the time. For example, some cisgender males may experience breast tissue buildup, or atypically high voices.<sup>12</sup> Cisgender females may encounter underdevelopment of breast tissue, facial and body hair growth, and menstruation problems.<sup>13</sup> To alleviate distress caused by nonalignment between the sex with which they identify (which happens to be their birth sex), cisgender people receive medical treatment. Indeed, the evidence suggests that physicians provide gender affirming care for *cisgender* people far more frequently than for *transgender* people, using similar protocols.<sup>14</sup>

A second provision of the statute that received far less airtime than that which explicitly mentions sex, ensures that these cisgender children can receive the same treatment that transgender children cannot. The provision exempts from the ban treatment for “normal development” of the minor’s sex to address “congenital defect precocious puberty, disease, or physical injury.”<sup>15</sup> Statutes

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7. See *infra* notes 78–79, 105, 113. The key exception is a brief that I filed on behalf of several doctors. Brief for Experts on Gender Affirming Care as Amici Curiae Supporting Petitioner and Respondents in Support of Petitioner, *Skrmetti*, 145 S. Ct. 1816 (No. 23-477).

8. This group might be similarly situated or differently situated, but nonetheless present the same concerns. Jessica A. Clarke, *Sex Discrimination Formalism*, 109 VA. L. REV. 1699, 1703–04 (2023).

9. See *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252 (1977) (discussing contextual factors from which racial discrimination can be inferred even without explicit reference to race).

10. Holning Lau & Barbara Fedders, *Appendix to “Scrutinizing Transgender Healthcare Bans Through Intersex Exceptions,”* 36 YALE J.L. & FEMINISM (2024) [hereinafter Lau & Fedders, Appendix], <https://ssrn.com/abstract=4965241>. State bans vary in both form and, to some degree, rationale. States claim that the evidence behind care is faulty, that treatment is risky, that patients do not provide informed consent, and express concerns regarding the lack of reversibility of treatment. See Konnoth, *supra* note 1, at 43. Twenty-three bans cover both surgery and medication; Georgia permits puberty blocker use; Arizona and New Hampshire permit the use of all medication but ban surgery. *Id.* States enforce the bans through civil suit, fines, license revocation, and criminal charges. *Id.* Parents may also be punished. *Id.*

11. Exec. Order No. 14,187, 90 Fed. Reg. 8771, 8771 (Feb. 3, 2025).

12. See *infra* notes 128, 129, 132, 137.

13. See *infra* notes 130, 131, 133, 134, 138, 139.

14. See generally Dannie Dai, Brittany M. Charlton, Elizabeth R. Boskey, Landon D. Hughes, Jaclyn M.W. Hughto, John Orav & Jose F. Figueroa, *Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US*, JAMA NETWORK OPEN, June 2024, at 1 (comparing breast-reduction procedures across cisgender and TGD populations and reporting they are far more common among cisgender patients).

15. See TENN. CODE ANN. §§ 68-33-102(1), 68-33-103(b)(1)(A) (2023).

from other states have similar exemptions.<sup>16</sup> In other words, a cis minor assigned male at birth can receive a treatment that is denied to a trans minor assigned female at birth.

The general sidelining of the comparator approach before the *Skrametti* hearing is all the more notable because it received star billing during the oral argument itself. Or more accurately, the Justices kept raising the question, even as the statute's challengers sought to emphasize the facial approach.

For example, consistent with the briefs, the Solicitor General highlighted the “facial sex classification”—the “sex based line”—in her opening statement.<sup>17</sup> But Justice Thomas (who opened the questioning) almost<sup>18</sup> immediately engaged in a long colloquy regarding whether cisgender and transgender children were comparable for the purposes of taking testosterone.<sup>19</sup> The next set of questions on the discrimination issue zeroed in again on the comparator question:<sup>20</sup> Justice Alito characterized plaintiffs as arguing that a “girl who wants to live like a boy cannot be administered testosterone, but a boy who wants to live like a boy can be administered testosterone.”<sup>21</sup> General Prelogar sought to shift the conversation back to the “facial sex classification.” Justice Alito remained focused on the comparator issue, asking her to imagine a statute that treated cisgender and transgender equally, *without* referring to sex (that is, a situation where only the comparator argument, not the facial argument, applied).<sup>22</sup> But General Prelogar remained adamant: that would be “very different from a law like this” with a clear facial classification.<sup>23</sup> That dynamic—where even liberal Justices raised the comparator question, but the statute's challengers pressed the facial approach—continued for the rest of the argument.<sup>24</sup>

By failing to straightforwardly grapple with the comparator approach, however, the challengers missed an opportunity to explain how SB1 will have no effect for most minors seeking gender affirming care—rather, it only targets

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16. Lau & Fedders, Appendix, *supra* note 10.

17. Transcript, *supra* note 6, at 5.

18. Justice Thomas asked whether the relevant line was based on age rather than sex. *Id.* at 6.

19. *Id.* at 7–9.

20. In between, the Chief Justice and Justice Alito asked questions regarding medical evidence and the appropriateness of deferring to the state rather than on whether discrimination existed in the first place. *Id.* at 9–20.

21. *Id.* at 21.

22. *Id.* at 25 (“Suppose the statute said that puberty blockers may not be prescribed or administered to any minor for the purpose of preventing the onset of puberty prior to the time when puberty generally occurs, okay? That statute makes no reference whatsoever to anybody’s sex. It applies to all minors.”). Prelogar acknowledged that such a law would be “try[ing] to circumvent a facial sex classification.” *Id.*

23. *Id.*

24. *E.g., id.* at 37 (Justice Kagan stating “all of the similar laws that have been passed like this allow this exact same kind of treatment for . . . a person born male who wants to get to puberty [.]”); *id.* at 143 (Justice Jackson raising questions regarding “the similarly situated argument”); *see id.* at 43–45 (General Prelogar making several references to “sex-based line-drawing”). This is not to say that Justices did not ask questions about the facial approach. *See id.* at 66 (Justice Jackson noting “[t]he classification, as far as I can tell, is a line-drawing”).

a small, comparable, disfavored group of minors—those who are transgender—and denies them care.

The Article proceeds as follows. Part I lays out the conceptual and historical background. It explains why it is worthwhile to distinguish among equality arguments, and how the “comparator” argument fits into the universe of equality arguments in legal and statutory analysis. It goes on to show how the comparator argument—along with other arguments—has played out in sex discrimination cases involving transgender people. At the same time, because of the legacy of sex discrimination doctrine—including that of *Dobbs v. Jackson Women’s Health Organization*,<sup>25</sup> comparator arguments have proved difficult to advance in some of these cases. Ironically, it is in these cases that the comparator argument might be the most important.

Part II then lays out the argument I summarize above, along with detailed medical evidence—cisgender and transgender people alike seek gender affirming care, with the former seeking it in higher numbers. By prohibiting only transgender and not cisgender care, SB1 engages in sex discrimination. Part III concludes by addressing objections.

#### I. SITUATING THE COMPARATOR ARGUMENT IN THE GENDER AFFIRMING BAN CASES

This Part offers conceptual and narrative background for the comparator argument with increasing level of specificity. At the highest level of generality, it explains how the comparator argument fits into the broad universe of equality arguments. Next, more specifically, it explains how these arguments, including the comparator argument, have played out in key transgender rights cases involving sex discrimination claims. It finally explains why the comparator argument has proved difficult to advance in trans healthcare cases.

In particular, the comparator argument’s overall weakness in certain areas of sex discrimination doctrine, especially in areas involving healthcare, has made it unattractive to litigants advancing transgender rights in similar contexts. This path dependency is similar to what has played out in other areas of equality law.<sup>26</sup> Ironically, it is in these contexts that the comparator argument can do the most work.

#### A. THE COMPARATOR ARGUMENT IN EQUALITY DOCTRINE—AND IN TRANSGENDER RIGHTS CASES

For the last fifty years, courts and scholars have debated over the values that undergird antidiscrimination law.<sup>27</sup> On one hand, some seek “substantive

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25. 142 S. Ct. 2228, 2245–46 (2022).

26. See generally Craig Konnoth, *Created in Its Image*, 119 YALE L.J. 316 (2009) (discussing analogy-driven equal-protection path dependence).

27. The literature tends to characterize the competing frameworks as anti-subordination versus anticlassification. See Craig Konnoth, *Discrimination Denials: Are Same-Sex Wedding Service Refusals*

equality.” This form of equality is “attuned to context; social, historical, and cultural meanings; [and] systemic and accumulated group-based disadvantages[.]”<sup>28</sup> Behavior that “materially disadvantage[s] and symbolically denigrate[s]” a certain group undermines substantive equality.<sup>29</sup> On the other hand, “formal equality” uses “formal, abstract, logical tests, minimizing consideration of social realities and normative values,” to determine whether discrimination has occurred.<sup>30</sup>

Affirmative action cases help illustrate how these two approaches to equality produce different results depending on the situation. A policy that creates an admissions quota for groups that have experienced historical injustices, such as women or certain racial minorities, violates formal equality principles because of the classification, but because (as many would argue) it seeks to address the historical inequality evident through a consideration of history and context, it vindicates substantive equality.<sup>31</sup> Stripping away the quota does the converse. Progressive scholars tend to support substantive equality approaches.<sup>32</sup>

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*Discriminatory?*, 124 COLUM. L. REV. 2003, 2045 (2024) (“Scholars generally see antidiscrimination law as vindicating three sets of values: antisubordination, antibalkanization, and anticlassification.”); Owen Fiss, *The Accumulation of Disadvantages*, 106 CALIF. L. REV. 1945, 1967 (2018); Reva B. Siegel, *From Colorblindness to Antibalkanization: An Emerging Ground of Decision in Race Equality Cases*, 120 YALE L.J. 1278, 1288 (2011) (“[T]he antisubordination principle is concerned with protecting members of historically disadvantaged groups from the harms of unjust social stratification”). For additional discussion, see LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1514–21 (2d ed. 1988); *id.* at 1520 (“[S]trict judicial scrutiny would be reserved for those government acts that, given their history, context, source, and effect, seem most likely not only to perpetuate subordination but also to reflect a tradition of hostility toward an historically subjugated group, or a pattern of blindness or indifference to the interests of that group.”). In her recent article, Jessica Clarke explains that the anticlassification principle is really part of a family of formal equality approaches, as I explained further below. Jessica A. Clarke, *Sex Discrimination Formalism*, 109 VA. L. REV. 1699, 1703–04 (2023). And the concepts have been known under different monikers in the past. Most notably, see generally Owen M. Fiss, *Groups and the Equal Protection Clause*, 5 PHIL. & PUB. AFFS. 107 (1976) (outlining the “group-disadvantaging principle”).

28. Clarke, *supra* note 27, at 1701–02.

29. Konnoth, *supra* note 27; see also Issa Kohler-Hausmann, *Eddie Murphy and the Dangers of Counterfactual Causal Thinking About Detecting Racial Discrimination*, 113 NW. U. L. REV. 1163, 1172 (2019) (“To identify something as discrimination when it happened because of race or ethnicity is to offer a constitutive claim that explains how an action or practice can be morally objectionable by virtue of the complex of social meanings and relations that constitute the social category.”); Charles R. Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317, 355–56 (1987) (proposing a “cultural meaning” test to “trigger judicial recognition of race-based behavior” by “evaluat[ing] governmental conduct to see if it conveys a symbolic message to which the culture attaches racial significance” and “considering evidence regarding the historical and social context in which the decision was made and effectuated”).

30. Clarke, *supra* note 27, at 1703.

31. See, e.g., Mario L. Barnes & Erwin Chemerinsky, *The Once and Future Equal Protection Doctrine?*, 43 CONN. L. REV. 1059, 1065 (2011).

32. See, e.g., TRIBE, *supra* note 27; Ian Haney-López, *Intentional Blindness*, 87 N.Y.U. L. REV. 1779, 1784 (2012) (“[D]iscriminatory intent doctrine excludes evidence of continued discrimination against non-Whites rooted in history, contemporary practices, and social science. . . . Meanwhile, . . . colorblindness similarly closes courthouse doors to evidence showing that state actors sometimes use race to break down inequality and to foster integration.”); Clarke, *supra* note 27, at 1709–10 (noting that the Court has hobbled disparate impact theory under the Equal Protection Clause).

Scholars continue to do important work in advancing substantive equality arguments, including in the transgender rights space.<sup>33</sup> Yet, for better or for worse,<sup>34</sup> modern doctrine has been increasingly hostile to substantive equality approaches, cleaving ever closer to the dictates of formal equality.<sup>35</sup> Seeking to better untangle the formal equality doctrines that have increasingly directed the Court's doctrine, Professor Jessica Clarke turns to Justice Scalia's opinion in *Oncale v. Sundowner Offshore Services, Inc.*<sup>36</sup> In that case, the Court held that harassment against men by other men violated Title VII's prohibition on sexual harassment, and suggested three ways to think about formal equality.<sup>37</sup>

First, the "but for" test is a causal inquiry that looks into "counterfactuals": that is, the fact finder must determine whether, if the plaintiff were a member of the opposite sex, the harassment would still have occurred.<sup>38</sup>

Next, anticlassification rules (what I refer to above and below as facial discrimination) prohibit line-drawing based on forbidden categories, such as sex. Thus, referencing sex to make a determination regarding a prohibition, benefit, or program constitutes discrimination. As the Court put it in *Bostock v. Clayton County*, the inquiry asks whether a policy can be understood "without using the words man, woman, or sex (or some synonym)."<sup>39</sup> The extent to which the classification plays a *causal* role is irrelevant in determining whether discrimination occurred. Even if the decision would have *been the same* without the prohibited line-drawing, the fact that line-drawing occurred based on the prohibited characteristic renders it unconstitutional under this theory.

Third, "comparator" inquiries examine whether a comparator—that is, someone who is "like" the plaintiff in all relevant respects except for

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33. For example, a substantive approach that focuses on transgender individuals is Laura Lane Steele's *Sex-Defining Laws and Equal Protection*, which explains the motivations and structural forces that undergird the existence of the exceptions. *See generally* Laura Lane-Steele, *Sex-Defining Laws and Equal Protection*, 112 CALIF. L. REV. 259 (2024).

34. As Clarke notes, formalistic reasoning can be "indeterminate, requiring that judges rely on normative and empirical premises . . . , but deny that they are doing so." Clarke, *supra* note 27, at 1706. The value of the tools will depend on the cases, judges, and overall context. *See id.* But Clarke rightly "disput[es] that a wholesale move toward more substantive inquiries of the sort favored by most progressive scholars would achieve those scholars' ultimate aspirations for the law." *Id.* at 1707.

35. *Id.* at 1706. The shift has been decades in the making. *See, e.g.,* Reva Siegel, *Why Equal Protection No Longer Protects: The Evolving Forms of Status-Enforcing State Action*, 49 STAN. L. REV. 1111, 1113 (1997) ("Contemporary equal protection law is premised on a formal and historically static conception of 'discrimination.'"). Clarke offers the following account: "[B]y 'discrimination formalism,' I refer to three features of legal inquiries in the context of defining disparate treatment. First, these inquiries take the forms of rules rather than standards. Second, they are simple, requiring consideration of a small number of elements. And third, they turn on easily discernible facts, eschewing direct investigation into the specific psychological states of discriminators, dynamic social consequences, or expressive meanings." Clarke, *supra* note 27, at 1715. She also notes that while these tests are supposed to discern discriminatory intent, they have taken on "lives of their own." *Id.* at 1716.

36. 523 U.S. 75 (1998).

37. Clarke, *supra* note 27, at 1716–17.

38. *Id.* at 1717–19.

39. 140 S. Ct. 1731, 1746 (2020).

sex . . . was treated more favorably.”<sup>40</sup> This test—the focus of this Article—is different from the preceding ones. It differs from the but-for test in that the but-for test asks a causal, “counterfactual” question—what would the defendant have done if the plaintiff’s sex were different.<sup>41</sup> The comparator test looks at “factual” questions—how a person of a different group that presents similar concerns to the group at issue is actually treated.<sup>42</sup> And unlike facial discrimination, comparators can show discrimination without specific and explicit references to sex. Clarke notes that this test relies heavily on context.<sup>43</sup> What factors play a role in determining whether a comparator is appropriate? Family status (married/single, childless or not)? Religion? Residency? These are hard questions to which there are no clear answers.

In the key Supreme Court case involving transgender individuals, *Bostock*, the Court relies on only the first two of these approaches.<sup>44</sup> *Bostock* held that by prohibiting discrimination based on sex, Title VII of the Civil Rights Act of 1964 also prohibits discrimination based on sexual orientation and gender identity.<sup>45</sup> *Bostock* primarily uses the but-for test—as it says, “sex is necessarily a but-for cause when an employer discriminates against homosexual or transgender employees.”<sup>46</sup> Using classic but-for analysis, the Court posits a counterfactual—that while “a transgender [woman] who was identified as a male at birth” was fired, but “an otherwise identical [woman] who was identified as female at birth” was not.<sup>47</sup> In such a case the transgender woman would have kept her job but-for her sex (assigned at birth).

The Court also uses a facial analysis to rebut counterarguments. The defendants noted that they did not violate the anticlassification norm: “[A]n employer could refuse to hire a gay or transgender individual without ever learning the applicant’s sex,” which means that “the employer’s discrimination against homosexual or transgender persons cannot be sex discrimination.”<sup>48</sup> Justice Gorsuch responded that one could not define the terms “homosexual” or “transgender” “without using the words man, woman, or sex (or some synonym). It can’t be done.”<sup>49</sup>

While *Bostock* engages the first two formal equality arguments, it does not engage in relatively messier, fact-intensive comparator arguments as to whether non-transgender employees were actually retained—there was no dispute on this issue. Many lower courts that have upheld antidiscrimination protections for transgender individuals have similarly ignored comparator arguments, much like

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40. Clarke notes that this is the “default methodology” in Title VII cases. Clarke, *supra* note 27, at 1723.

41. *Id.* at 1704.

42. *Id.*

43. *Id.* at 1723–24.

44. *Bostock*, 140 S. Ct. at 1747.

45. *Id.* at 1754; 42 U.S.C. § 2000e-2.

46. *Bostock*, 140 S. Ct. at 1742.

47. *Id.* at 1741.

48. *Id.* at 1746.

49. *Id.*

the Solicitor General generally invoking the facial approach. For example, in *Brandt v. Rutledge*, the Eighth Circuit invalidated Arkansas’s gender affirming care ban on the grounds that “the minor’s sex at birth determines whether or not the minor can receive certain types of medical care under the law.”<sup>50</sup> And in *Whitaker v. Kenosha Unified School District*, the Seventh Circuit explained that a “School District’s policy” to prohibit transgender boys from using the boys’ bathroom “cannot be stated without referencing sex” and was therefore discriminatory.<sup>51</sup> But many courts invoke both arguments.<sup>52</sup>

## B. THE COMPARATOR ARGUMENT AND PHYSICAL DIFFERENCES

Yet, the comparator argument is important. Indeed, as I argue below, losing on the comparator argument has *always* proved fatal in the trans healthcare ban (and other) cases. Such losses generally turn on the claim that physical differences between men and women mean one cannot compare children assigned male at birth to children assigned female at birth.<sup>53</sup> Legislators can assume that due to these differences, medications will operate differently on their bodies. Understanding the physical differences doctrine is therefore important.

In *United States v. Virginia*, “the most important sex discrimination decision since the 1970s,”<sup>54</sup> Justice Ginsburg, writing for the Court, rejected the claim that Virginia Military Institute’s “adversative method” of training, which includes physical and psychological challenges, would be unsuitable for women.<sup>55</sup> But even as the opinion rejected the state’s generalizations “about the different talents, capacities, or preferences of males and females,” it nonetheless claimed that “[p]hysical differences between men and women . . . are enduring,” and that “[i]nherent differences’ between men and women . . . remain cause for celebration.”<sup>56</sup>

But what physical differences excuse differential treatment? The Court has offered limited guidance. In *Virginia* itself, the “physical standards” that the military institute demanded of its cadets were not a sufficient ground for difference: “some women can meet the [ ] standards.”<sup>57</sup> Explains Professor Cary Franklin, “the only ‘inherent differences’ [the Court] has recognized, since it

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50. 47 F.4th 661, 669 (8th Cir. 2022).

51. 858 F.3d 1034, 1051–52 (7th Cir. 2017) (*abrogated by* Ill. Republican Party v. Pritzker, 973 F.3d 760, 762 (7th Cir. 2020)); *see also* Fain v. Crouch, 618 F. Supp. 3d 313, 327 (S.D.W. Va. 2022), *aff’d sub nom.*, Kadel v. Folwell, 100 F.4th 122, 153 (4th Cir. 2024) (language refers explicitly to sex) (collecting cases).

52. Flack v. Wis. Dep’t of Health Servs., 328 F. Supp. 3d 931, 948–49 (W.D. Wis. 2018) (relying on both arguments, as well as substantive equality arguments).

53. *See infra* Subpart I.C.

54. 518 U.S. 515 (1996); Cary Franklin, *Biological Warfare: Constitutional Conflict Over “Inherent Differences” Between the Sexes*, 2017 SUP. CT. REV. 169, 170 n.6 (2017).

55. *Virginia*, 518 U.S. at 542–43.

56. *Id.* at 516, 533.

57. *Id.* at 525 (quoting lower court).

began to accord heightened scrutiny to sex-based state action, have involved reproductive biology.”<sup>58</sup>

Franklin points to two key cases. In *Michael M. v. Superior Court* in 1981, the Court upheld a statutory rape law that targeted sex only with female minors because “the classification was supported not by mere social convention but by the immutable physiological fact that it is the female exclusively who can become pregnant.”<sup>59</sup> And in 2001, in *Nguyen v Immigration and Naturalization Service*, the Court upheld a law that automatically gave citizenship to the children of unmarried citizen mothers but not fathers: “To fail to acknowledge even our most basic biological differences—such as the fact that a mother must be present at birth but the father need not be—risks making the guarantee of equal protection superficial, and so disserving it.”<sup>60</sup> While the Court agreed that men and women were treated unequally, that inequality was justified by physical differences.

Yet, the scope of activity that implicates “reproductive biology” is changeable, and Franklin seemed optimistic that the Court appeared poised to narrow it. At the beginning of the twentieth century, the Court gave credence to claims that mental and physical labor affected women’s reproductive biology.<sup>61</sup> In more recent cases, she noted, the Court had invalidated abortion prohibitions,<sup>62</sup> and raised questions about discrimination against women “when they are mothers or mothers-to-be.”<sup>63</sup> While courts have used the reasoning of *Nguyen* in parentage cases that allowed the spouse of a mother to gain automatic parentage rights, but not the spouse of the father,<sup>64</sup> in *Pavan v. Smith*, decided in 2017, the Supreme Court hinted at the absurdity of this assumption, as a woman’s spouse need not have a biological link to her child.<sup>65</sup> And that same year, the Court significantly undermined *Nguyen* by holding that a related

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58. Franklin, *supra* note 54, at n.13.

59. 450 U.S. 464, 467 (1981).

60. 533 U.S. 53, 73 (2001).

61. See Craig Konnoth, *Medicalizing Minorities* (Feb. 1, 2026) (unpublished manuscript) (on file with author) (discussing *Muller v. Oregon*, 208 U.S. 412, 422 (1908), which justified labor protection for women to protect the “wellbeing of the race” in part).

62. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 897 (1992).

63. *Nev. Dep’t Hum. Res. v. Hibbs*, 538 U.S. 721, 736 (2003); see also David Fontana & Naomi Schoenbaum, *Unsexed Pregnancy*, 119 COLUM. L. REV. 309, 356 (2019) (“Even though there are physical differences between the sexes when it comes to recovery from childbirth, the [*Hibbs*] Court still carefully scrutinized parental leave policies to ensure that any sex classification was fully supported by this difference and not sex stereotypes.”).

64. Douglas NeJaime, *The Nature of Parenthood*, 126 YALE L.J. 2260 (2017).

65. 137 S. Ct. 2075, 2077 (2017). *Pavan* raised the question of whether same-sex couples could be listed on birth certificates. Arkansas argued that the birth certificate sought to determine biological connections to children for public health purposes; it was not a corollary of marriage recognition. The Supreme Court, however, pointed out that birth certificates required a woman’s husband to be listed as the father, even if she had used a sperm donor, or if someone else was the biological father, and therefore, that the proffered justification failed. *Id.*

immigration provision that also made it harder for the child of a citizen-father to get citizenship than the child of a citizen-mother, was unconstitutional.<sup>66</sup>

Whether or not Franklin's optimism was well placed in 2017, the Court's composition soon changed, and so did the doctrine. In 2022, the Court held in *Dobbs v. Jackson Women's Health Organization* that the Constitution did not protect abortion access.<sup>67</sup> *Dobbs* was based on substantive due process reasoning. But the Court also went out of its way to address the claim that abortion restrictions undermined equality for women: "The regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere pretext[t] designed to effect an invidious discrimination against members of one sex or the other.'"<sup>68</sup> Here, the Court quoted from *Geduldig v. Aiello*—a 1974 case in which the Court had held that pregnancy discrimination did not equal sex discrimination, and which a majority of the Court had not cited with approval for over thirty years.<sup>69</sup>

### C. THE IMPORTANCE OF THE COMPARATOR ARGUMENT

The comparator claim is important because it has proven decisive for the *other* formal equality arguments in cases that raise the question of physical differences. If a court concludes that these differences render sex categories non-comparable in a particular case, then all other formal equality arguments fall.

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66. *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1683 (2017). *Morales-Santana* created a controversy, however, because rather than leveling up and making it just as easy for children of citizen-fathers to get citizenship as those of citizen-mothers, the Court leveled down, and made it just as *hard* for the latter to get citizenship as the former. Kristin A. Collins, *Equality, Sovereignty, and the Family in Morales-Santana*, 131 HARV. L. REV. 170, 208–13 (2017).

67. 142 S. Ct. 2228, 2279 (2022).

68. *Id.* at 2245–46 (quoting *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974)). It bears noting that there is a difference between *Dobbs* in comparison to *Michael M.* and *Nguyen*, but not one that is significant. In the latter cases, courts first "consider whether men and women are 'similarly situated' with regard to the regulation, regardless of any physical sex differences," and then consider whether the physical differences justified the discrimination. Fontana & Schoenbaum, *supra* note 63, at 359. In *Dobbs*, the physical differences make the groups non-comparable in the first place. But this has often been a confusing area of analysis. When investigating whether any discrimination has occurred in the first place, a court may use the justification (physical differences) to find that a group is not similarly situated, and therefore that they cannot be compared—in which case, no equal protection violation has occurred. On the other hand, a court may acknowledge that the groups are comparable and that intermediate scrutiny applies, but then use physical differences to justify the unequal treatment. In other words, physical differences can be used to defeat a discrimination claim at the front end (differences mean the groups are not comparable, so no discrimination has occurred) or the back end (assuming that discrimination has occurred, the differences offer justifications that satisfy intermediate scrutiny). Scholars have written about this feature of the doctrine, and it need not derail us here. It bears noting, however, that the courts I describe have taken the former tack, finding that physical differences render trans- and cisgender minors non-comparable. See Jed Rubenfeld, *Affirmative Action*, 107 YALE L.J. 427, 437 (1997) (describing the connection between asserted interests and invidious group classifications).

69. *Geduldig*, 417 U.S. at 485. Franklin has noted the irony that under *Geduldig*, a key physical difference that defined sex (namely, pregnancy) did not constitute sex discrimination. Franklin, *supra* note 54, at 180. See also *Geduldig*, 417 U.S. at 501 (Brennan, J., dissenting) ("[D]issimilar treatment of men and women, on the basis of physical characteristics inextricably linked to one sex, inevitably constitutes sex discrimination.").

Thus, in *Michael M. and Nguyen*, the sex discrimination at issue violated both the anticlassification rule (both cases involved facial classifications) and the but-for standard (the discrimination was a but-for cause for the injury the plaintiffs suffered).<sup>70</sup> But these but-for and anticlassification rules used to such great effect in *Bostock* dissolved when physical differences rendered men and women non-comparable.

Similarly, the unsuccessful health-ban cases that raise the comparator argument quote the language of *Dobbs* reproduced above (although *Dobbs* does not explicitly reference biological difference) to conclude that because of physical differences, the claims failed. The Sixth Circuit, for example, cited *Dobbs* to explain that the laws in question restricted a “specific course of medical treatment that, by the nature of things, only gender nonconforming individuals may receive.”<sup>71</sup> Similarly, in *Eknes-Tucker v. Governor of Alabama*, the Eleventh Circuit held that “[t]he cross-sex hormone treatments for gender dysphoria are different for males and for females because of biological differences between males and females—females are given testosterone and males are given estrogen.”<sup>72</sup> And, as with the other physical differences cases, a loss on the comparator argument meant a loss on other formal equality arguments. The fact that—according to the court—transgender and cisgender minors are biologically different allows them to ignore the facial classification: notes the Sixth Circuit, “If any reference to sex in a statute dictated heightened review, virtually all abortion laws would require heightened review,”<sup>73</sup> and looked to *Dobbs*, which listed numerous state abortion prohibitions that specified protections and penalties targeted to women.<sup>74</sup>

The comparator argument not only mediates the relationship between other formal equality arguments, but also mediates the relationship between transgender rights cases and sex discrimination doctrine generally. Consider *Grimm v. Gloucester County School Board*, where the Fourth Circuit invalidated school policies that prevented a trans boy from using the boys’ restroom.<sup>75</sup> It would have been hard for the court to hold for Grimm on a facial discrimination ground—sex-segregated bathrooms classify on their face. But by holding that Grimm as a transgender boy was comparable to other cisgender boys, the court

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70. See *supra* notes 59, 60.

71. *Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205, 1229 (11th Cir. 2023).

72. *Id.* at 1228.

73. *L. W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 482 (6th Cir. 2023), *cert. dismissed in part sub nom.*, *Doe v. Kentucky*, 144 S. Ct. 389 (2023), and *cert. granted in part sub nom.*, *United States v. Skrmetti*, 144 S. Ct. 2679 (2024).

74. See *Skrmetti*, 83 F.4th at 482 (citing *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2285–2300 (2022)).

75. 972 F.3d 586, 596 (4th Cir. 2020), *as amended* (Aug. 28, 2020). Jessica Clarke also points to this reading of *Grimm*. Clarke, *supra* note 27, at 1732–35. Laura Lane-Steele identifies two facial sex classifications at issue. First is the sex segregation of bathrooms in general. Second is the way the bathroom rule defines sex. Grimm’s challenge can be understood as an applied challenge to the latter, but the question is why the logic that strikes down one facial definition would not apply to strike down the second. See Laura Lane-Steele, *supra* note 33, at 283.

sidestepped this issue altogether. While “there are other gender-expansive youth who may identify as nonbinary . . . today’s question,” the court noted, “is limited to how school bathroom policies implicate the rights of transgender students who . . . express a binary gender.”<sup>76</sup>

Just as *Grimm* operated within the binary framework of segregated restrooms because of Supreme Court pronouncements on the issue, so too must lower courts operate within the binary framework of segregated biologies. The Court has pronounced that men and women have distinct biology. Given that, as in *Grimm*, the best strategy for lower courts is to situate and compare trans men with cis men, and trans women with cis women.

In short, a cause is only as strong as the legal doctrine that bears it. With *Bostock*, the transgender rights movement hitched its star to a significant degree to sex discrimination doctrine.<sup>77</sup> But as in sex discrimination doctrine, if a court concludes that groups are not comparable because of “physical differences,” other arguments based on but-for and anticlassification doctrine also appear to fail.

#### D. HOW THE COMPARATOR ARGUMENT IS—AND SHOULD BE—TREATED

Given that the comparator argument is the site of strategic importance—and vulnerability—one might imagine that litigants and others would marshal their defenses there, and develop arguments that focus on this argument. That has not proved to be the case.

Take *Skrmetti* for example. After an extensive discussion of the facial and but-for arguments, the petitioners offered a three-sentence analysis (not counting citations) of the comparator argument (including a somewhat puzzling aside regarding intersex minors).<sup>78</sup> The other appellate briefs fare no better. At the Supreme Court, the brief of the United States as Petitioner similarly devoted three sentences to this argument.<sup>79</sup>

Even courts that grant relief to transgender plaintiffs have been similarly tightlipped regarding the comparator argument. The Eighth Circuit in *Brandt v. Rutledge* is representative, curtly noting that the claim that cisgender and transgender people are not comparable “conflates the classifications drawn by the law with the state’s justification for it.”<sup>80</sup> Apart from the Fourth Circuit,

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76. *Grimm*, 972 F.3d at 596.

77. *Bostock v. Clayton County Ga.*, 140 S. Ct. 1731, 1737 (2020).

78. Brief for Plaintiffs-Appellees at 26, *L. W. ex rel. Williams v. Skrmetti*, 83 F.4th 460 (6th Cir. Aug. 11, 2023) (No. 23-5600). It is unclear how intersex individuals fare as comparators, and the brief gives no explanation. A brief filed with the Supreme Court in *Skrmetti* similarly explains that the law allows forced treatment of intersex children—which, to be sure, undermines the state’s claim that the treatments involved are dangerous—but otherwise it is unclear that the Court will conclude that intersex individuals are comparable. Brief for interACT: Advocates for Intersex Youth as Amici Curiae Supporting Petitioner at 3, *Skrmetti*, 145 S. Ct. 1816 (No. 23-477).

79. Brief for Petitioner at 22–23, *Skrmetti*, 145 S. Ct. 1816 (Aug. 27, 2024) (No. 23-477).

80. 47 F.4th 661, 670 (8th Cir. 2022).

discussed below in greater detail,<sup>81</sup> the only courts that discuss the comparator argument have denied relief.<sup>82</sup>

Yet, ceding the ground on the comparator argument may prove fatal. At oral argument, advocates sidestepped the comparator argument, even as the Justices pressed them on that very point. Solicitor General Prelogar’s opening statement highlighted the anticlassification argument.<sup>83</sup> But Justice Thomas, who opened the questioning, raised the comparator issue almost immediately, asking if “physiological difference” meant there was a “difference . . . if a girl takes testosterone or if a boy takes testosterone.”<sup>84</sup> Chief Justice Roberts took up the baton next, similarly explaining that at issue here were “medical” and “technical” assessments of “differen[ce].”<sup>85</sup> Next, Justice Alito chimed in: “[Y]ou say that a . . . girl who wants to live like a boy cannot be administered testosterone, but a boy who wants to live like a boy can be administered testosterone” but “how [should] an equal protection claim [ ] be analyzed when the law in question treats a medical condition or procedure differently based on a characteristic that is associated with just one sex,” an issue he claims was raised in “*Geduldig* in 1974, [and] reaffirmed in *Dobbs* in 2022.”<sup>86</sup>

The Solicitor General, however, kept emphasizing in response that the question was whether there was a classification which those differences could then justify, and emphasized again and again the importance of classifications.<sup>87</sup> Thus, responding to Justice Alito, she notes, “this case isn’t controlled by *Geduldig* and *Dobbs* . . . because, here, we have the facial sex classification.”<sup>88</sup> This caused Justice Alito to push harder by assuming away the facial classification altogether. He asked her to imagine a law that stated that “puberty blockers may not be prescribed or administered to any minor for the purpose of preventing the onset of puberty prior to the time when puberty generally occurs.”<sup>89</sup> He also explained how the comparator argument would have played out in *Geduldig* and *Dobbs*.<sup>90</sup> Thus, he asked the Solicitor General how the comparator argument would play out in this case. When she still pointed to the

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81. See *infra* Subpart.II.C.

82. See *supra* notes 71–74 and accompanying text.

83. Transcript, *supra* note 6, at 5 (“SB1 regulates by drawing sex-based lines and declares that those lines are designed to encourage minors to appreciate their sex.”).

84. *Id.* at 8–9.

85. *Id.* at 12.

86. *Id.* at 21.

87. *Id.* at 12–13, 21–23.

88. *Id.* at 23.

89. *Id.* at 24.

90. “[I]n [*Geduldig*], a man cannot work due to a medical condition that prevents him from working. He gets benefits. A woman cannot work due to a medical condition, pregnancy, that prevents her from working for a period of time. She doesn’t get benefits. . . . [I]n *Dobbs*[.] [a] man who has a medical condition that causes physical and mental distress and pain and limits his daily activities . . . can get a corrective medical procedure. . . . But a woman who has a medical condition that produces similar consequences, namely pregnancy, cannot get an abortion[.] . . . yet there was no equal protection problem in either of those cases.” *Id.* at 26.

facial argument, Justice Barrett later pressed her with a similar hypothetical that assumed away the classification to focus on the comparator issue.<sup>91</sup> Justices Sotomayor, Kagan, and Jackson acknowledged the facial argument at the outset, but similarly also gestured at the comparator argument that preoccupied their conservative colleagues.<sup>92</sup> And the only conservative Justice to ask the ACLU lawyer about sex discrimination theories—Justice Thomas—again focused on the comparator argument.<sup>93</sup>

The best response that the Solicitor General gave was in side-stepping the argument altogether: A determination as to whether men and women have physical differences that make them non-comparable should “be channeled to the heightened scrutiny stage . . . send it back and let the Sixth Circuit grapple with this in the first instance.”<sup>94</sup> But while doctrinally correct, practically this was a dodge—in no other case has the Court ever remanded a physical differences determination to a lower court. In any case, the Sixth Circuit made it abundantly clear that in its opinion, relevant physical differences existed, and that the groups were not comparable.<sup>95</sup>

Indeed, the only full-throated attempt to combat conservative arguments on the comparator issue came from Justices Sotomayor and Jackson in conversation with the Tennessee Solicitor General. Justice Sotomayor asked why a boy (probably meaning a trans girl—who Tennessee would consider a boy) who took “estrogen for . . . unwanted hair” was different from a girl who did the same—“the medical condition is the same.”<sup>96</sup> Justice Jackson similarly explained why a boy or a girl both who “don’t want to grow breasts” should be treated differently.<sup>97</sup> The state’s response—“there has to be some threshold inquiry that recognizes the biological differences between those two”—offered no further explanation.<sup>98</sup> The rest of this Article, then, describes the comparator argument.

## II. CISGENDER GENDER AFFIRMING CARE

The statutes in question—as well as the Trump Executive Order—knock a one-two punch. For example, the Tennessee statute at issue in the Supreme Court, on one hand, prohibits treatment that “enabl[es] a minor to identify with . . . a purported identity *inconsistent* with the minor’s sex” or that addresses “discomfort or distress from a *discordance* between the minor’s sex and asserted

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91. *Id.* at 57.

92. *Id.* at 28–29 (Justice Sotomayor, noting that unlike under Title VII, “under the Equal Protection Clause, we recognize there are inherent differences between the sexes.”); *see also id.* at 37 (Justice Kagan), 68–69 (Justice Jackson) (both making comparator arguments).

93. *Id.* at 95 (detailing the colloquy with the ACLU primarily focused on the state’s interest, and the question of transgender people being a suspect class).

94. *Id.* at 42–43.

95. *See* L. W. *ex rel.* Williams v. Skrmetti, 83 F.4th 460, 482 (6th Cir. 2023).

96. Transcript, *supra* note 6, at 118.

97. *Id.* at 120.

98. *Id.* at 143.

identity.”<sup>99</sup> Under the bill, “sex means a person’s immutable characteristics of the reproductive system that define the individual as male or female, as determined by anatomy and genetics existing at the time of birth.”<sup>100</sup>

On the other hand, it delineates a purported exception that permits the treatment of “a minor’s congenital defect, congenital defect, precocious puberty, disease, or physical injury,” and “physical or chemical abnormality.”<sup>101</sup> But to make sure this exception does not run wild, it notes in the definition section that disease does not include “gender dysphoria, gender identity disorder, gender incongruence, or any mental condition, disorder, disability, or abnormality.”<sup>102</sup> The other 25 statutes that prohibit gender affirming care for minors demonstrate the same structure.<sup>103</sup> This “exception,” however, is the rule of gender affirming care.

In what follows, I first define the comparator in question. I then engage in the comparison and show how it plays out in *Kadel v. Folwell*,<sup>104</sup> the only case in which a court makes the argument in detail.

#### A. SEXUAL CATEGORIES AND COMPARATORS

Judicial decisions, amicus briefs, and recent scholarship have offered different categories as relevant comparators for the purposes of the ban. Those defending the ban suggest that the appropriate comparators are transgender boys and transgender girls. Since both groups are forbidden from accessing care, there is no sex discrimination.<sup>105</sup> Arguments like this one have been made and rejected in cases like *Loving v. Virginia* and *Bostock*.<sup>106</sup> To be sure, it may be appropriate in some circumstances to compare transgender boys to transgender girls—treating those groups unequally may constitute sex discrimination. But that comparison does not exhaust the universe of comparators.<sup>107</sup> Just as an employer who discriminates only against Black people, but not against Asians, still

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99. TENN. CODE ANN. § 68-33-101(b) (2023) (emphasis added).

100. *Id.* § 68-33-102(9).

101. *Id.* § 68-33-103(b)(1)(A).

102. *Id.* § 68-33-103(b)(2).

103. Lau & Fedders, Appendix, *supra* note 10.

104. 100 F.4th 122, 148 (4th Cir. 2024).

105. Brief for Respondents at 3, *United States v. Skrmetti*, 145 S. Ct. 1816 (2024) (No. 23-477).

106. “Nor is it a defense for an employer to say it discriminates against both men and women because of sex. This statute works to protect individuals of both sexes from discrimination, and does so equally. So an employer who fires a woman, Hannah, because she is insufficiently feminine and also fires a man, Bob, for being insufficiently masculine may treat men and women as groups more or less equally. But in *both* cases the employer fires an individual in part because of sex.” *Bostock v. Clayton County Ga.*, 140 S. Ct. 1731, 1741 (2020).

107. *Cf. id.* at 1748 (“[F]or example, when it comes to homosexual employees, male sex and attraction to men are but-for factors that can combine to get them fired. The fact that female sex and attraction to women can *also* get an employee fired does no more than show the same outcome can be achieved through the combination of different factors. In either case, though, sex plays an essential but-for role.”). *Bostock* is engaging in but-for reasoning so it is not directly applicable. But just as multiple causes can underlie but-for reasoning, so can multiple comparators be relevant for comparator-based reasoning.

violates the statute, one might look to see how the statute treats non-transgender groups who obtain analogous forms of care.

Who are those groups? *Kadel* offers “cisgender people” as the relevant comparator—there is discrimination because cisgender minors can get treatment, but trans minors cannot.<sup>108</sup> The only other scholarship focusing on the ban’s exceptions considers *intersex* infants.<sup>109</sup> As these scholars explain, the exceptions allow treatment for intersex infants (without their consent) even while the law withholds treatment from trans minors.<sup>110</sup> These exceptions, they argue, suggest that the legislatures’ purported goals underlying the laws that sound in safety and autonomy are suspect, and that legislators are actually motivated by animus.<sup>111</sup> Petitioners’ Sixth Circuit brief also refers only to intersex minors.<sup>112</sup> And in the Supreme Court, different briefs link the exception to the fate of intersex minors.<sup>113</sup>

Though some may see intersex minors as the appropriate comparator for transgender minors, cisgender individuals who need gender affirming care are the best comparator for the purposes of a formal analysis. Cisgender individuals are those who continue to identify with the sex they were assigned at birth. An intersex individual may also be cisgender if they continue to identify as the sex they were assigned at birth. Inversely, an intersex individual who does not identify with the sex they were assigned at birth would, under this approach, not be understood as cisgender. While I defend this approach in Part III, for the reader to understand what this approach entails, some medical exposition is necessary.

### 1. Defining “Sex”

At the outset, it is important to examine the characteristics that help determine transgender, cisgender, and intersex categories. These terms, in turn, rely on understandings of “sex” and “gender.” Traditional feminist understandings “disaggregate the definition of ‘gender’ from ‘sex’ . . . —the former referring to ‘cultural or attitudinal characteristics distinctive to the sexes, as opposed to their physical characteristics.’”<sup>114</sup> Gendered attributes which

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108. *Kadel v. Folwell*, 100 F.4th 122, 148 (4th Cir. 2024).

109. See e.g., Ido Katri & Maayan Sudai, *Intersex, Trans, and the Irrationality Of Gender-Affirming-Care Bans*, 134 *YALE L.J.* 1521 (2025); Lau & Fedders, *supra* note 10 (manuscript at 28).

110. See e.g., Katri & Sudai, *supra* note 109; Lau & Fedders, *supra* note 10.

111. Katri & Sudai, *supra* note 109, at 1560, 1605; Lau & Fedders, *supra* note 10 (manuscript at 40–45). To be clear, as noted below, these authors do not claim that the groups are similarly situated—rather, that they are differently situated in ways that raise questions about legislative motive.

112. Brief for Plaintiffs-Appellees, *supra* note 78.

113. Brief for Legal Scholars and National Women’s Law Center as Amici Curiae Supporting Petitioner and Respondents Supporting Petitioner, *United States v. Skrmetti*, 83 F.4th 460, at 15 (6th Cir. 2023) (No. 23-477); Brief for interACT, *supra* note 78, at 2.

114. *Bauer v. Lynch*, 812 F.3d 340, 347 (4th Cir. 2016) (citations omitted). Several other courts have indicated a similar understanding. See generally Jessica A. Clarke, *Sex Assigned at Birth*, 122 *COLUM. L. REV.* 1821, 1872–75 (2022) (explaining how the feminist movement helped shape this understanding).

courts have pointed to include “hair styling” and wearing jewelry,<sup>115</sup> dresses, or makeup.<sup>116</sup> Sex includes the supposedly fixed physical characteristics which putatively truly differentiate men and women according to the Court’s doctrine to which the previous Part alludes.<sup>117</sup> In the next Part, this Article interrogates these categories (hence the scare quotes around “defining” and “sex” above). But for the sake of comparison, I take them as given.

Physical characteristics that define sex are themselves subdivided to better understand the categories at issue (intersex, transgender, and cisgender). “Primary” sex characteristics include sex chromosomes (XX associated with femaleness, and XY with maleness);<sup>118</sup> internal and external genitalia (ovaries, vagina, uterus, and clitoris, associated with femaleness; testes, prostate and penis associated with maleness);<sup>119</sup> and the sex hormones themselves (with high levels of estrogen and low levels of testosterone associated with femaleness; and the inverse for males).<sup>120</sup>

Next, there are secondary sex characteristics. Feminine-associated secondary sex characteristics are associated with development in the breast or chest, fat distribution around the hips, and menstruation. Male associated characteristics include increased facial and body hair, Adam’s apples, and deeper voices.<sup>121</sup>

Variation in both primary and secondary characteristics have been observed since ancient Greece, and many of them today have medical diagnoses.<sup>122</sup> Instead of the usual XX or XY sex chromosome,<sup>123</sup> some people might have an extra chromosome—an XXY chromosomal presentation, known

115. *Price Waterhouse v. Hopkins*, 490 U.S. 228, 235, 250, 253 (1989).

116. *Smith v. City of Salem*, 378 F.3d 566, 574 (6th Cir., 2004) (wearing dresses and using make-up for women); *Jespersen v. Harrah’s Operating Co.*, 444 F.3d 1104, 1110 (8th Cir., 2006) (using makeup).

117. *See supra* Part.I.B.

118. Note that various other patterns of chromosomes may be a factor in someone being considered intersex. *See* Brief for interACT, *supra* note 78, at 5.

119. Aditi Bhargava, Arthur P. Arnold, Debra A. Bangasser, Kate M. Denton, Arpana Gupta, Lucinda M. Hilliard Krause, Emeran A. Mayer, Margaret McCarthy, Walter L. Miller, Armin Raznahan & Ragini Verma, *Considering Sex as a Biological Variable in Basic and Clinical Studies: An Endocrine Society Scientific Statement*, 42 ENDOCRINE REVS. 219, 221 (2021).

120. R. Lauletta, M. Sansone, A. Sansone, F. Romanelli & M. Appetecchia, *Gender in Endocrine Diseases: Role of Sex Gonadal Hormones*, 2018 INT. J. ENDOCRINOLOGY, Oct. 2018, at 2, <https://doi.org/10.1155/2018/4847376>.

121. Bhargava et al., *supra* note 119.

122. *See* Sophia M. Connell, *Aristotle and Galen on Sex Difference and Reproduction: A New Approach to an Ancient Rivalry*, 31 STUD. HIST. & PHIL. SCI. 405 *passim* (2000); Mihaela Pavlicev, Anna Nele Herdina & Günter Wagner, *Female Genital Variation Far Exceeds That of Male Genitalia: A Review of Comparative Anatomy of Clitoris and the Female Lower Reproductive Tract in Theria*, 62 INTEGRATIVE & COMPAR. BIOLOGY 581, 582 (2022); Evangelos Spyropoulos, Dimitrios Borousas, Stamatios Mavrikos, Athanasios Dellis, Michael Bourounis & Sotirios Athanasiadis, *Size of External Genital Organs and Somatometric Parameters Among Physically Normal Men Younger than 40 Years Old*, 60 UROLOGY 485, 485 (2002).

123. Humans have twenty-three pairs of chromosomes. Twenty-two of them are unrelated to sex. The twenty-third pair consists of the sex chromosomes involving the pairings I describe. *Turner Syndrome (45 X Syndrome)*, MINN. DEP’T OF HEALTH (Dec. 17, 2024), <https://www.health.state.mn.us/diseases/cy/turner.html>.

as Klinefelter syndrome.<sup>124</sup> Alternatively, individuals with Turner syndrome have one *less* chromosome—instead of an XX or XY pair, they just have an X chromosome.<sup>125</sup> These phenomena can, in turn, result in atypical presentation of genitalia (such as the testes, penis, ovaries, and vagina)<sup>126</sup> as well as secondary sex characteristics (for example, short stature and a lack of menstruation (amenorrhea)).<sup>127</sup>

Diagnoses based on variations in secondary characteristics include those related to atypical increase in breast gland tissue (gynecomastia)<sup>128</sup> in boys,<sup>129</sup> or underdevelopment of breast tissue in girls (breast hypoplasia);<sup>130</sup> hirsutism which involves the growth of dark or coarse hair in typically male-like patterns (such as on the face, thighs, buttocks, chest, back, etc.) on girls;<sup>131</sup> puberphonia, or persistence of high vocal pitch after puberty among male adolescents;<sup>132</sup> menstrual disorders, either because of high bleeding (menorrhagia),<sup>133</sup> or amenorrhea;<sup>134</sup> and precocious puberty, including development of secondary sex characteristics before age eight in individuals assigned female at birth and before age nine in individuals assigned male at birth,<sup>135</sup> among others.<sup>136</sup> Incidence of

124. Evan Los, Stephen W. Leslie, Sandhya J. Kadam & George A. Ford, *Klinefelter Syndrome*, NAT'L LIBR. OF MED. (May 5, 2025), <https://www.ncbi.nlm.nih.gov/books/NBK482314>.

125. *Turner Syndrome (45 X Syndrome)*, *supra* note 123.

126. *Id.* (identifying the genetic and hormonal factors involved in DSD).

127. See Lokesh Sharma & Nidhi Shankar Kikkeri, *Turner Syndrome*, NAT'L LIBR. OF MED. (Nov. 10, 2025), <https://www.ncbi.nlm.nih.gov/books/NBK554621>; Karine Morcel, Laure Camborieux, Programme de Recherches sur les Aplasies Müllériennes & Daniel Guerrier, *Mayer-Rokitansky-Küster-Hauser (MRKH) Syndrome*, 2 ORPHANET J. RARE DISEASES, 2007, at 2, <https://doi.org/10.1186/1750-1172-2-13>.

128. G. A. Kanakis, L. Nordkap, A. K. Bang, A. E. Calogero, G. Bárfai, G. Corona, G. Forti, J. Toppari, D.G. Goulis & N. Jørgensen, *EAA Clinical Practice Guidelines—Gynecomastia Evaluation and Management*, 7 ANDROLOGY 778, 779–80 (2019).

129. Here, I assume cisgender boys.

130. Sebastian Winocour & Valerie Lemaine, *Hypoplastic Breast Anomalies in the Female Adolescent Breast*, 27 SEMINARS PLASTIC SURGEY 42 (2013).

131. See Wissem Hafsi & Jasleen Kaur, *Hirsutism*, NAT'L LIBR. OF MED. (May 3, 2023), <https://www.ncbi.nlm.nih.gov/books/NBK470417>.

132. Vrushali Desai & Prasun Mishra, *Voice Therapy Outcome in Puberphonia*, 2 J. LARYNGOLOGY & VOICE 26, 26 (2012).

133. Intira Sriprasert, Tarita Pakrashi, Thomas Kimble & David F. Archer, *Heavy Menstrual Bleeding Diagnosis and Medical Management*, 2 CONTRACEPTION & REPRODUCTIVE MED., 2017, at 1 n.4, <https://doi.org/10.1186/s40834-017-0047-4>.

134. Gul Nawaz, Alan D. Rogol & Suzanne M. Jenkins, *Amenorrhea*, NAT'L LIBR. OF MED. (Feb. 25, 2024), <https://www.ncbi.nlm.nih.gov/books/NBK482168>.

135. Archana S. Kota, Lokesh Sharma & Sehar Ejaz, *Precocious Puberty*, NAT'L LIBR. OF MED (July 4, 2023), <https://www.ncbi.nlm.nih.gov/books/NBK544313>.

136. Including delayed puberty (ICD 10: E30.0): delayed development of secondary sex characteristics, including a lack of breast development by age thirteen and lack of menstruation by age sixteen in individuals assigned female at birth, and a lack of testicular enlargement by age fourteen in individuals assigned male at birth. Delayed puberty affects approximately five percent of children. Sasha R. Howard & Leo Dunkel, *Delayed Puberty—Phenotypic Diversity, Molecular Genetic Mechanisms, and Recent Discoveries*, 40 ENDOCRINE REVS. 1285, 1285–86 (2019). Additionally, Primary Ovarian Insufficiency, which entails loss of normal ovarian function, results in amenorrhea and decreased estradiol levels, before age forty. Natalia Sopiartz & Paul B. Sparzak, *Primary Ovarian Insufficiency*, NAT'L LIBR. OF MED. (Mar. 6, 2023), <https://www.ncbi.nlm.nih.gov/books/NBK589674>.

some of these conditions is low—but gynecomastia occurs in about fifty percent of males at some point in their lives (though it usually resolves on its own),<sup>137</sup> hypoplasia in about twenty-seven percent of females,<sup>138</sup> and hirsutism in between ten and fifty percent of women.<sup>139</sup> And up to thirty percent of gynecological visits can be attributed to menorrhagia.<sup>140</sup>

## 2. Defining Categories

This exposition in place, we can turn to clarifying the competing comparators that courts and scholars have offered—intersex minors versus cisgender minors.

Intersex individuals are those who experience variations and ambiguity with respect to their *primary* sex characteristics, namely, chromosomes (XXY or X sex chromosomes), genitalia (insufficiently developed or ambiguous), or hormones. These conditions are collectively referred to as differences in sexual development (“DSD”).<sup>141</sup>

When intersex individuals are born, they are often subject to gender normalizing surgeries or intersex surgeries (“GNS”) before they turn 18 months old.<sup>142</sup> These surgeries include clitoral reduction, gonadectomy (removal of testes or ovaries), vaginoplasty, and/or phalloplasty all performed in an attempt to make the intersex child’s genitalia non-ambiguous, such that they resemble as close as possible “normal” male or female genitalia. These surgeries are “are almost always medically unnecessary.”<sup>143</sup> Practitioners claim, however, that the benefits are “social and psychological . . . [and can] alleviate anxiety and stigma—for the parents and the child—by having the child’s body comport with the mainstream conception of gendered bodies.”<sup>144</sup> Many children who are intersex grow up to identify the sex with which they are assigned; many do not.<sup>145</sup>

Many individuals who experience variation in secondary characteristics do so because they are intersex. For example, chromosomal abnormalities like Klinefelter syndrome affects testosterone receptors’ responsiveness and sensitivity, which can affect the development of genitalia, as well as a range of secondary characteristics.<sup>146</sup> Other intersex conditions that affect the

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137. See Kanakis et al., *supra* note 128, at 778–80.

138. Marco Klinger et al., *The Prevalence of Tuberos/Constricted Breast Deformity in Population and in Breast Augmentation and Reduction Mammoplasty Patients*, 40 AESTHETIC PLASTIC SURGERY 492, 492–93 (2016).

139. See Hafsi & Kaur, *supra* note 131.

140. See Sriprasert et al., *supra* note 133, at 1.

141. Lau & Fedders, *supra* note 10 (manuscript at 16).

142. *Id.* (manuscript at 15).

143. *Id.*

144. *Id.*

145. Ramesh Babu & Utsav Shah, *Gender Identity Disorder (GID) in Adolescents and Adults with Differences of Sex Development (DSD): A Systematic Review and Meta-analysis*, 17 J. PEDIATRIC UROLOGY 39, 41 (2021), <https://doi.org/10.1016/j.jpurol.2020.11.017>.

146. Los et al., *supra* note 124.

concentration, and response to various sex hormones can result in a variation in secondary sex characteristics.<sup>147</sup>

But many non-intersex individuals also experience variation in secondary characteristics because these characteristics can vary for reasons that have nothing to do with being intersex. For example, the side effects of common medical interventions can cause variation in secondary sex characteristics: indeed, twenty percent of all gynecomastia cases in men are caused by medications.<sup>148</sup> Drugs that can cause gynecomastia include the hypertension drug spironolactone,<sup>149</sup> Anabolic steroids and androgens (which is used to address muscle loss and delayed puberty), amphetamines (which treat ADHD), antidepressants, digoxin (which is used for heart arrhythmias and issues with blood circulation), calcium channel blockers (used to address blood pressure), chemotherapy drugs, and even over-the-counter heartburn medications can all have a similar effect.<sup>150</sup> And a range of medical conditions ranging from enzyme deficiencies to testicular tumors, end-stage renal disease, and spinal cord disorders can affect sex hormones, which, in turn, can result in gynecomastia.<sup>151</sup>

Women experience hirsutism for similar reasons.<sup>152</sup> Medications that cause hirsutism include those administered for chronic inflammatory conditions, menopause or contraceptives; osteoporosis and breast cancer, alopecia, immunosuppression after organ transplant, endometriosis, low blood sugar, seizures, Wilson's disease, and viral infections, cancer and autoimmune diseases.<sup>153</sup> Medical conditions can similarly affect hormonal pathways, which can then result in hirsutism, and include polycystic ovarian syndrome (PCOS), ovarian and adrenal tumors, Cushing disease/syndrome, hyperprolactinemia, and acromegaly.<sup>154</sup> Hypoplasia (reduced breast growth) can result from radiation and genetic conditions.<sup>155</sup>

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147. Bhargava et al., *supra* note 119, at 221.

148. Ronald S. Swerdloff & Jason C. M. Ng, *Gynecomastia: Etiology, Diagnosis, and Treatment*, NAT'L LIBR. OF MED. (Jan. 6, 2023), <https://www.ncbi.nlm.nih.gov/books/NBK279105>.

149. Glenn D. Braunstein & Bradley D. Anawalt, *Management of Gynecomastia*, UPTODATE (Sep. 27, 2024), <https://www.uptodate.com/contents/management-of-gynecomastia>.

150. Swerdloff & Ng, *supra* note 148.

151. *See id.*; NAT'L LIBR. MED., *Aromatase Excess Syndrome*, MEDLINEPLUS (Apr. 1, 2024), <https://medlineplus.gov/genetics/condition/aromatase-excess-syndrome>.

152. *See, e.g.*, Pankaj Singhania, Aditya Deshpande, Arunava Ghosh, Abhranil Dhar, Pritam Biswas, Rana Bhattacharjee & Subhankar Chowdhury, *Phenytoin-Induced Hypertrichosis and Gingival Hyperplasia*, 2 ANNALS MED. SCI. & RSCH. 87, 87–88 (2002).

153. *See* Hafsi & Kaur, *supra* note 131.

154. *Id.*

155. *See* Deborah P. Merke & Richard J. Auchus, *Clinical Manifestations and Diagnosis of Classic Congenital Adrenal Hyperplasia Due to 21-Hydroxylase Deficiency in Infants and Children*, UPTODATE (June 30, 2025), <https://www.uptodate.com/contents/classic-congenital-adrenal-hyperplasia-due-to-21-hydroxylase-deficiency-in-infants-and-children-clinical-manifestations-and-diagnosis>; Andrea C. Lo et al., *Breast Hypoplasia and Decreased Lactation from Radiation Therapy in Survivors of Pediatric Malignancy: A PENTEC Comprehensive Review*, 119 INT'L J. RADIATION ONCOLOGY, BIOLOGY, PHYSICS 549, 549–59 (2024).

Further, beyond medical conditions and the drugs used to treat them, testicles can be lost as the result of sport accidents,<sup>156</sup> while breast deformities can often be caused by motor accidents.<sup>157</sup> Other biological processes, like pregnancy, menopause, and aging can cause acne, hirsutism, balding, clitoromegaly, and voice deepening.<sup>158</sup>

Thus, many non-intersex individuals *also* experience medically diagnosable variation in presentation of their biological sex. For the purposes of this Article, then, cisgender people are those whose internal gender identity conforms to that of the sex assigned at birth. For non-intersex cisgender individuals, that assignment may occur simply by visual assessment of external anatomy and assignment by a medical professional.<sup>159</sup> For intersex cisgender individuals, that assignment may have occurred after surgery that (luckily) comported with their ultimate internal sense of identity. Both sets of individuals, however, might develop atypical presentation in the secondary characteristics described above—because of DSD, or because of other reasons. This, in turn, requires treatment, which can be compared to those transgender individuals receive.

This is not to say that comparing transgender children and intersex infants is not a productive move for reasons other than engaging in a traditional comparator analysis. For example, Lau and Fedders compare the groups to expose inconsistencies in legislatures' stated motives. As they point out, intersex babies are unable to offer informed consent, intersex surgeries are generally more irreversible than most pediatric gender affirming treatments,<sup>160</sup> and harms such as sterilization are more likely to result from certain intersex surgeries.<sup>161</sup> Thus, they conclude that the legislative motivations behind gender affirming care bans are something other than those the legislature claim, namely, ensuring informed consent, preventing irreversible treatments, and preventing medical harms—and that courts may draw an inference of animus.

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156. Naser Parizad, Navid Faraji & Rasoul Goli, *Orchiectomy After Testicular Trauma in a 45-Year-Old Man: A Case Report*, 48 TRAUMA CASE REPS, 2023, at 1, <https://doi.org/10.1016/j.tcr.2023.100971>.

157. See Horacio F. Mayer, René M. Palacios Huatuco, Mariano F. Ramírez & Ignacio T. Piedra Buena, *Breast Reconstruction After Blunt Breast Trauma: Systematic Review and Case Report Using the Ribeiro Technique*, 50 ARCHIVES PLASTIC SURGERY 550, 550–56 (2023).

158. Christopher Hakim, Vasantha Padmanabhan & Arpita Vyas, *Gestational Hyperandrogenism in Developmental Programming*, 158 ENDOCRINOLOGY 199, 200 (2017); Macarena Alpañés, José M. González-Casbas, Juan Sánchez, Héctor Pián & Héctor F. Escobar-Morreale, *Management of Postmenopausal Virilization*, 97 J. CLINICAL ENDOCRINOLOGY & METABOLISM 2584, 2585–88 (2012).

159. *Assigned Sex at Birth*, BOS. MED. CTR., <https://www.bmc.org/glossary-culture-transformation/assigned-sex-birth>.

160. Lau & Fedders, *supra* note 10 (manuscript at 18–20).

161. *Id.* (manuscript at 19).

## B. MAKING THE COMPARISON

The comparison between transgender individuals and cisgender individuals rests on three grounds. First, the *reasons* for treatments are analogous. Second, the kinds of treatments are similar, if not identical—and third, so are the results.

### 1. Reasons for Treatment

Healthcare bans generally prohibit treatment for gender dysphoria. Such dysphoria is a clinical diagnosis that the Diagnostic and Statistical Manual of the American Psychiatric Association defines as “the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.”<sup>162</sup> The World Professional Association for Transgender Health (“WPATH”) offers a similar definition: “A state of distress or discomfort that may be experienced because a person’s gender identity differs from which is physically and/or socially attributed to their sex assigned at birth.”<sup>163</sup>

Gender dysphoria replaces a previous diagnosis, “gender identity disorder,” which was defined as “an incongruence between assigned sex (i.e., the sex that is recorded on the birth certificate) and gender identity.”<sup>164</sup> This diagnosis was replaced in 2013 to avoid pathologizing all transgender individuals.<sup>165</sup> Transgender individuals who do not feel distress are not diagnosed. Those transgender individuals who are diagnosed with gender dysphoria may receive treatment.

While cisgender care is framed as a biological problem by the statutes, those who seek care do so to address psychological harm. Among cisgender boys, gynecomastia “can be a source of great distress and discomfort especially during” delicate times like adolescence, with more severe gynecomastia causing greater distress.<sup>166</sup> Puberphonia, although rare, is correlated with emotional stress and psychological issues during one’s adolescence.<sup>167</sup> Among cisgender females, breast hypoplasia during adolescence can cause depression, anxiety, low self-esteem, rejection by peers, and even psychosexual dysfunction.<sup>168</sup>

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162. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 511 (5th ed. rev. 2022); see also *What is Gender Dysphoria?*, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> (last visited Nov. 8, 2025).

163. Eli Coleman et al., World Professional Association 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, S252 (2022).

164. See e.g., AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 71 (3d ed. rev. 1987).

165. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 452 (5th ed. 2013); *Kadel v. Folwell*, 100 F.4th 122, 148 (4th Cir. 2024).

166. Ori Berger, Zohar Landau & Ran Talisman, *Gynecomastia: A Systematic Review of Pharmacological Treatments*, 10 FRONTIERS IN PEDIATRICS, Nov. 1, 2022, at 5, <https://doi.org/10.3389/fped.2022.978311>.

167. K. Navin Bharath & M. Kumaresan, *Psycho-Cybernetics of Puberphonia Boys: Few Devastating and Remedy*, 22 J. DENTAL & MED. SCI. 7, 7 (2023), <https://www.iosrjournals.org/iosr-jdms/papers/Vol22-issue12/B2212010713.pdf>.

168. Sebastian Winocour & Valerie Lemaine, *Hypoplastic Breast Anomalies in the Female Adolescent Breast*, 27 SEMINARS IN PLASTIC SURGERY 42 *passim* (2013), <https://pubmed.ncbi.nlm.nih.gov/24872739>.

Hirsutism, especially among cisgender adolescent females with polycystic ovarian syndrome (“PCOS”), creates anxiety and depression, body-image issues, self-esteem issues, and emotional stress.<sup>169</sup> Indeed, some diagnoses like menorrhagia, delayed puberty, and precocious puberty take into account physical, emotional, social, and material quality of life interferences.<sup>170</sup>

While studies on minors are, with reason, in short supply,<sup>171</sup> detailed historical work involving adults shows a similar phenomenon. Health humanities professors Theodore Moses and Jacob Schall explain how breast cancer advocates demanded access to breast reconstruction surgeries after cancer-related mastectomies.<sup>172</sup> Starting in the 1950s, physicians began commenting on “postmastectomy depression” they began seeing in cancer wards.<sup>173</sup> One activist recalls feeling a “void” after her breast was removed. The *New York Times* reported how women would undress in the dark and avoid their husbands.<sup>174</sup> Breast reconstruction “represented the restitution of the loss, the restoration of an ideal or former self which [patients] could experience as their ‘real’ self, not as something artificial or added on, not a new identity but as ‘really me.’”<sup>175</sup> Evidence suggests that both doctors and patients saw the loss as relating to gender presentation. As Moses and Schall note, “[s]ome psychiatrists analogized the loss of a breast to the loss of a penis to convey to a then-majority male profession the psychological effects of losing a ‘badge of femininity.’”<sup>176</sup> One of the most prominent activists in the movement in the 1970s explicitly compared reconstruction to transgender women that she had recently read were successfully obtaining silicone implants. And many of the doctors who engaged in breast reconstruction did so for both cis- and trans-women.<sup>177</sup>

Like many transgender individuals, many cisgender individuals need medical interventions to align their biology with their experienced gender and

169. Michelle G. Lipton, Lorraine Sherr, Jonathan Elford, Malcolm H.A. Rustin & William J. Clayton, *Women Living with Facial Hair: The Psychological & Behavioral Burden*, 61 *J. PSYCHOSOMATIC RSCH.* 161 *passim* (2006); see also T. Cantelmi, E. Lambiase, VR. Unfer, R. Gambioli & V. Unfer, *Inositol Treatment for Psychological Symptoms in Polycystic Ovary Syndrome Women*, 25 *EUR. REV. MED. & PHARM. SCIS.* 2383 *passim* (2021) (discussing varying levels of discomfort described by women with PCOS).

170. Sriprasert et al., *supra* note 133, at 1–2; Jeffrey P. Winer, Justin Parent, Rex Forehand & Nicole Lafko Breslend, *Interactive Effects of Psychological Stress and Early Pubertal Timing on Youth Depression and Anxiety: Contextual Amplification in Family and Peer Environments*, 25 *J. CHILD & FAM. STUD.* 1375 *passim* (2016).

171. INST. OF MED. OF THE NAT’L ACADS.: COMM. ON CLINICAL RSCH. INVOLVING CHILD. BD. ON HEALTH SCIS. POL’Y, *The Necessity and Challenges of Clinical Research Involving Children*, in *ETHICAL CONDUCT OF CLINICAL RESEARCH INVOLVING CHILDREN* 58, 60 (Marilyn J. Field & Richard E. Behrman eds., 2004) [https://www.ncbi.nlm.nih.gov/books/NBK25557/pdf/Bookshelf\\_NBK25557.pdf](https://www.ncbi.nlm.nih.gov/books/NBK25557/pdf/Bookshelf_NBK25557.pdf).

172. Theodore E. Schall & Jacob D. Moses, *Gender-Affirming Care for Cisgender People*, 53 *HASTINGS CTR. RPT.* 15, 17 (2023).

173. *Id.*

174. *Id.*; Dee Wedemeyer, *After Mastectomy: The Options for Breast Reconstruction*, *N.Y. TIMES* (Dec. 9, 1976), <https://www.nytimes.com/1976/12/09/archives/after-mastectomy-the-options-for-breast-reconstruction.html>.

175. Schall & Moses, *supra* note 172, at 18.

176. *Id.* at 17.

177. See *id.* at 20.

seek the same treatments as individuals with gender dysphoria. A subset of treatments offered to align individuals—both cisgender and transgender—with their gender identities are identical. Moreover, every treatment provided for gender dysphoria has an analog in the context of cisgender gender affirming care.

Both cisgender and transgender individuals experience clinical benefits from hormone suppression and hormone replacement. Both cisgender and transgender individuals opt for non-surgical cosmetic treatments to improve their sense of self. Both cisgender and transgender individuals may require mental health treatment. Both groups of individuals seek voice training. And both cisgender and transgender individuals may employ strategies to prevent pregnancy or preserve their reproductive options. In addition to the procedures listed at Appendix B of the amicus brief on which this Article is based, transgender and cisgender adults often receive comparable surgical treatments to affirm their gender identity. In fact, gender affirming treatment for cisgender individuals far outnumbers treatment for transgender individuals.<sup>178</sup>

Though states often compare transgender girls to transgender boys to argue that since both groups are denied treatment, no discrimination has occurred,<sup>179</sup> it makes more sense to make the comparison to *cisgender* children of the same sex. Transgender girls and boys seek different sets of medication, and seek very different physiological outcomes. On the other hand, transgender and cisgender boys, and transgender and cisgender girls seek similar medications for similar outcomes. If states believe that transgender boys and girls are similarly enough situated for comparison, then cisgender and transgender individuals of the same sex are closer—and therefore even more appropriate—comparators.

Finally, just as all trans people do not seek gender affirming care,<sup>180</sup> all women with mastectomies do not seek reconstruction. For example, Comedian Tig Notaro decided to go “flat” after her bout with cancer, and appeared shirtless in public.<sup>181</sup> Notably, many women frame this choice as one relating to how they experience their sexual identity. Famous activist, professor, poet, and Black lesbian feminist intellectual, Audre Lorde rejected attempts to get her to wear prostheses.<sup>182</sup> As she explained in 1980, “I refuse to hide my body simply because it might make a woman-phobic world more comfortable.”<sup>183</sup> As Moses & Schall explain, “Lorde rejected the very concept of breast-reconstruction

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178. *Id.* at 20–21; Dai et al., *supra* note 14, at 2; *see, e.g.*, American Academy of Pediatrics, *Policy Statement: Off-Label Use of Drugs in Children*, 133 PEDIATRICS 563 *passim* (2014).

179. *See* Transcript, *supra* note 6 at 120.

180. William Byne, Dan H. Karasic, Eli Coleman, A. Evan Eyler, Jeremy D. Kidd, Heino F.L. Meyer-Bahlburg, Richard R. Pleak & Jack Pula, *Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists*, 3 TRANSGENDER HEALTH 57, 62 (2018).

181. *See* Schall & Moses, *supra* note 172, at 18.

182. *Id.*

183. *Id.*

surgery, finding the promises and motives of plastic surgeons to be too complicit with sexist gender norms.”<sup>184</sup>

## 2. Comparing Treatments and Effects

Discussing the details of gender affirming treatments and their medical support is both well rehearsed and (therefore) beyond the scope of this Article. Suffice it to say that gender affirming care takes three forms: (1) puberty blockers, which suppress the onset of puberty, (2) hormone therapy, to allow the patient “to develop secondary sex characteristics aligned with their gender identity . . . and (3) surgery.”<sup>185</sup>

Cisgender individuals also receive medical interventions to align their biology with their experienced gender. More importantly, many of the treatments offered to align both cisgender and transgender individuals with their gender identities are identical, as Appendix B to this Article shows in reproducing a table in the brief from the *Skrmetti* case.<sup>186</sup> And beyond these treatments, “similar procedures [provided for gender dysphoria] are done on cisgender people with other diagnoses.”<sup>187</sup> These treatments might include surgical and non-surgical options, including medication from each of the categories mentioned above, mental health counseling, and voice training, among many other approaches. Gender affirming treatment for cisgender individuals is far more common than treatment for transgender individuals.<sup>188</sup>

Individuals with gender dysphoria experience benefits from gender affirming care—as do cisgender patients who seek this care in ways that improve their quality of life, mental health, and psychological functioning.<sup>189</sup> Physiologically, the side effects remain the same. Puberty blockers, no matter the gender identity of the child, can cause bone density loss, leg pain, weight gain, sterile abscesses, mood swings, and headaches.<sup>190</sup> Providers take steps to address these harms for all children receiving this treatment.<sup>191</sup> Debates similarly

184. *Id.*

185. Lau & Fedders, *supra* note 10 (manuscript at 11–12).

186. Brief for Experts on Gender Affirming Care, *supra* note 7.

187. Expert Disclosure Report of Dan H. Karasic, M.D. at 10, *Fain v. Crouch*, No. 3:20-CV-00740 (618 F. Supp. 3d, May 31, 2022), 2022 WL 2764569.

188. See Schall & Moses, *supra* note 172, at 20–21; Dai et al., *supra* note 14, at 2.

189. See, e.g., Luke R. Allen, Laurel B. Watson, Anna M. Egan & Christine N. Moser, *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, 7 CLINICAL PRAC. IN PEDIATRIC PSYCH. 302 *passim* (2019); Lipton et al., *supra* note 169; Berger et al., *supra* note 166.

190. Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha & Guy G. T’Sjoen, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guide*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3882 (2017) [hereinafter *Endocrine Society Guidelines*]; see also Jia Zhu & Yee-Ming Chan, *Adult Consequences of Self-Limited Delayed Puberty*, 139 PEDIATRICS, 2017, at 3–7, <https://doi.org/10.1542/peds.2016-3177>; Chad Terhune, Robin Respaut & Michelle Conlin, *As More Transgender Children Seek Medical Care, Families Confront Many Unknowns*, REUTERS (Oct. 6, 2022, at 11:00 GT), <https://www.reuters.com/investigates/special-report/usa-transyouth-care>.

191. See generally *Endocrine Society Guidelines*, *supra* note 190, at 3881–83 (offering approaches for addressing these harms). Providers have strategies for mitigating these risks for patients, including prescribing

exist regarding the possibility that gender affirming hormonal therapy causes cardiovascular risk, thromboembolism, osteoporosis, cancer, increased triglycerides, and higher cholesterol levels.<sup>192</sup> Yet, cisgender minors use hormonal therapy for *all* the conditions associated with variations in secondary characteristics described above.<sup>193</sup> Finally, those receiving care for gender dysphoria can experience temporary infertility or reduced fertility,<sup>194</sup> but so can those receiving treatment for menstrual disorders or for cancer, as can cisgender men who use testosterone therapy for athletic purposes.<sup>195</sup> Both cisgender and transgender individuals may seek fertility preservation care.<sup>196</sup>

To be sure, gender affirming care can affect patients differently based on their underlying physical condition. Breast reduction surgery for a trans boy means he will lose the ability to breastfeed, but a cis boy who gets this surgery never had this ability and therefore is not losing it. One response is that this is a feature, not a bug, of the treatment. If a cis boy were able to breastfeed he might experience that ability as dysphoric. So might a similarly situated trans boy. But more generally, all patients have unique risk profiles when it comes to treatment—implicating cardiac issues to mental health considerations. Gerrymandering only those risks associated with one characteristic—sex—as

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supplements to maintain bone mineral density, assessing bone mineral density every 1-2 years, testing the volume of Luteinizing Hormone and Follicle-Stimulating Hormone in a patient's blood every 6-12 months, and assessing a patient's anthropometry (i.e., height, weight, and stage of puberty) every 3-6 months. *Id.* at 3880-83.

192. Compare Spyridoula Maraka, Naykky Singh Ospina, Rene Rodriguez-Gutierrez, Caroline J. Davidge-Pitts, Todd B. Nippoldt, Larry J. Prokop & M. Hassan Murad, *Sex Steroids and Cardiovascular Outcomes in Transgender Individuals: A Systematic Review and Meta-Analysis*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3914, 3919 (2017) (concluding that evidence from twenty-nine studies demonstrates an association between sex steroid therapy and an increase in cholesterol, which can increase the risk of cardiovascular disease), with Paul J. Connelly, E. Marie Freel, Colin Perry, John Ewan, Rhian M. Touyz, Gemma Currie & Christian Delles, *Gender Affirming Hormone Therapy, Vascular Health and Cardiovascular Disease in Transgender Adults*, 74 HYPERTENSION 1266, 1268-70 (2019) (highlighting the low-quality evidence in Maraka's meta-analysis, including confounding factors and alternative explanations).

193. See *supra* Subpart.II.A.2.

194. See, e.g., Philip J. Cheng, Alexander W. Pastuszak, Jeremy B. Myers, Isak A. Goodwin & James M. Hotaling, *Fertility Concerns of the Transgender Patient*, 8 TRANSLATIONAL ANDROLOGY & UROLOGY 209 *passim* (2019). As mentioned, before prescribing GnRHAs and HRT, providers are recommended to discuss fertility preservation with youth who want to transition. See *Endocrine Society Guidelines*, *supra* note 190, at 3878 (obligations for discussions on providers).

195. Megan Torve & Keith Hansen, *Preventing Unintended Pregnancies: A Review of Long-Acting Reversible Contraception*, 76 S.D. MED. 132, 135 (2023); Lisa Campo-Engelstein, Sarah Rodriguez & Shauna Gardino, *Saving More Than Lives: A Gendered Analysis of the Importance of Fertility Preservation for Cancer Patients*, in PUBLIC HEALTH METHODOLOGY, ENVIRONMENTAL & SYSTEMS ISSUES 419, 419-432 (Jay Maddock, ed., 2012).

196. See, e.g., Lin Chen, Zirui Dong & Xiaoyan Chen, *Fertility Preservation in Pediatric Healthcare: A Review*, 14 FRONTIERS IN ENDOCRINOLOGY, 2017, at 3-5, <https://doi.org/10.3389/fendo.2023.1147898>; Moira A. Kyweluk, Joyce Reinecke & Diane Chen, *Fertility Preservation Legislation in the United States: Potential Implications for Transgender Individuals*, 6 LGBT HEALTH 331, 331 (2019). In 2024, Tennessee lawmakers referred House Bill 2549 to the House Insurance Subcommittee where it died. This Bill, the Tennessee Strong Families Act, would have required insurance companies to include standard fertility preservation services when an enrollee is diagnosed with a type of cancer that may directly or indirectly cause infertility. See H.B. 2549, 113th Gen. Assemb., Reg. Sess. (Tenn. 2024).

the sole set of side effects to be concerned about itself constitutes sex discrimination.

### C. DOCTRINAL RESULT

If one accepts the claim that transgender and cisgender individuals are comparable, then it is clear that the statutes discriminate by allowing the latter, but not the former, to access gender affirming care. But, as the previous Part ends by observing, the comparator argument in physical differences cases also drives the but-for and facial arguments. In the one appellate case that engages the comparator issue, we see this result.

In *Kadel v. Folwell*, the Fourth Circuit does not separate out the different kinds of formal arguments as I do in the previous Part. But it treats cisgender and transgender individuals as comparators: “[C]isgender people *do* receive coverage for certain gender-affirming surgeries, specifically vaginoplasty (for congenital absence of a vagina), breast reconstruction (post-mastectomy), and breast reduction (for gynecomastia).”<sup>197</sup>

From this comparison, the court derives an anticlassification argument. In pregnancy discrimination cases, “pregnancy is often a reliable indicator of a person’s sex”—but it is not a facial classification.<sup>198</sup> But “determining whether a treatment like reduction mammoplasty constitutes ‘transsexual surgery’ or whether a testosterone supplement is prescribed in connection with a ‘sex change[ ] or modification[ ]’ is impossible—literally cannot be done—without inquiring into a patient’s sex assigned at birth and comparing it to their gender identity.”<sup>199</sup> This inquiry violates facial discrimination principles.

Next, applying *Bostock*, the court uses a but-for argument as well. In addressing an insurance coverage ban, the court explains in the case of a patient seeking a vaginoplasty: Because of the treatment being sought “we know that they were born without a vagina. But . . . [without] know[ing] what sex they were assigned at birth . . . we cannot say whether the Plan or Program will cover the surgery.”<sup>200</sup> In other words, sex becomes a but-for cause of coverage. Thus, the comparator argument drives the outcome with respect to both other formal tests in the Fourth Circuit decision.

### III. OBJECTIONS TO THE COMPARATOR ARGUMENT

Three sets of objections to the comparator argument may arise. Each represents positions that are usually associated with differing political goals and relationships. On the “left,” some might argue that comparators reify fabricated social categories. On the “right,” conservative states defend their bans by claiming that gender dysphoria is a unique diagnosis. And in the “middle,” some

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197. *Kadel v. Folwell*, 100 F.4th 122, 148 (4th Cir. 2024).

198. *Id.* at 147.

199. *Id.*

200. *Id.* at 153–54.

might argue that the intersex category presents a better comparison. I address each argument in turn.

#### A. REIFYING SEXUAL CATEGORIES

In my presentation above, it might appear that I create a base of “primary” biological characteristics, that supports “secondary” biological characteristics, which in turn, support cultural characteristics. I arguably present primary factors as more fixed and biological, at the genetic level, and secondary characteristics as more fluid. After all, cultural factors may determine how facial and body hair should be presented—in some cultures, in some periods, after all, long hair was considered masculine associated, and in any case, can be indeterminate.<sup>201</sup> Similarly, voice pitch and fat distribution hardly present bifurcated presentation around which to organize binarized sex.<sup>202</sup> Sex is usually assigned at birth based on external genitalia.<sup>203</sup>

Queer theory scholars would argue that this construction perpetuates problematic claims about the fixedness of sex.<sup>204</sup> Beyond variation in the characteristics that I demonstrate, the *labeling* of biological characteristics involves cultural mediation.<sup>205</sup> Just as long or short hair *becomes* sexed through cultural norms, so too does genetic matter, through genetic discovery, and sexed association. The decision to organize genetic characteristics around the category of sex, the association of these and associated characteristics with behavioral attributes, and the categorization of deviations from the characteristics as medical abnormalities exhibit some level of cultural mediation.<sup>206</sup> And indeed, some characteristics are ambiguous in their relationship to gender. For example, is a cisgender boy who complains about his height concerned about gender presentation? Boys are more likely to be treated for short stature than girls, but it is unclear how and whether height itself is intrinsically or definitionally associated with maleness.<sup>207</sup> On the flip side, tall children *used* to be treated for

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201. See, e.g., Kursad Unluhizarci, Yilmaz Sahin & Fahrettin Kelestimur, *The Evaluation and Treatment of Hirsute Women*, 1 *WOMEN'S HEALTH* 429, 429–30 (2005).

202. Lyne Chiniara, *Gender Identity*, *MEDSCAPE* (June 26, 2023), <https://emedicine.medscape.com/article/917990-overview>.

203. See *Assigned Sex at Birth*, *supra* note 159.

204. See JUDITH BUTLER, *GENDER TROUBLE: FEMINISM AND THE SUBVERSION OF IDENTITY* 10 (1990).

205. See *id.* at 11 (“This production of sex as the prediscursive ought to be understood as the effect of the apparatus of cultural construction designated by *gender*. How, then, does gender need to be reformulated to encompass the power relations that produce the effect of a prediscursive sex and so conceal that very operation of discursive production?”); *id.* (“Gender ought not to be conceived merely as the cultural inscription of meaning on a pre-given sex . . . ; gender . . . designate[s] the very apparatus of production whereby the sexes themselves are established.”).

206. *Id.*

207. Lokesh Sharma, Deepika Rani, Tanuj Kanchan & Kewal Krishan, *Short Stature*, *NAT'L LIBR. OF MED.* (Mar. 13, 2023), <https://www.ncbi.nlm.nih.gov/books/NBK556031>.

height-related conditions, but no longer, as society increasingly accepts tall height.<sup>208</sup>

And indeed, cisgender children themselves may not consciously associate many of the transformations they seek specifically with sex. While research suggests that children conceptualize sex and gender from a young age,<sup>209</sup> it is unclear *what* they place within that category. A minor male might associate certain genitalia with maleness, but might the distress caused from extra breast tissue arise from potentially being perceived as obese rather than as feminine? How gendered would the *child's* perception of short stature be? This is unclear, and foisting understandings of sex or gender onto the child would be inappropriate.

My response to this claim is a practical one.<sup>210</sup> The fact is that antidiscrimination law—and for that matter, law in general—for better or worse, traffics in categories.<sup>211</sup> Arguments pressing for the dissolution of sex as a category altogether “don’t resonate with conservative jurists.”<sup>212</sup> And indeed, strategies that fully dissolve the *reality* of categories can backfire as activists have found in the case of affirmative action—conservatives today agree that race is socially constructed, but refuse to recognize the lasting effects it nonetheless has on society.<sup>213</sup> Thus, for practical purposes, it is important to rely on arguments that, in turn, rely on sex as a category.

#### B. UNIQUENESS OF GENDER DYSPHORIA

While the preceding objection is hypothetical, in that no one has actually advanced it with respect to arguments involving the healthcare bans, those defending the bans have *actually* argued that care for gender dysphoria cannot be compared to the care received by other minors. For example, relying on arguments made by the state, the Sixth Circuit claimed that gender dysphoria treatment was a “medical procedure that only one sex can undergo.”<sup>214</sup>

Admittedly, as the Fourth Circuit recognized in *Kadel*, there are some unique aspects to gender affirming care for gender dysphoria.<sup>215</sup> Dosage might

208. See V. Sada, G. Puliani, T. Feola, R. Pirchio, R. Pofi, F. Sesti, D. De Alcubierre, M. E. Amodeo, F. D’Aniello, L. Vincenzi, D. Gianfrilli, A. M. Isidori, A. B. Grossman & E. Sbardella, *Tall Stature and Gigantism in Transition Age: Clinical and Genetic Aspects—A Literature Review and Recommendations*, 47 J. ENDOCRINOLOGICAL INVESTIGATION 777, 778 (2024).

209. Anne A. Fast & Kristina R. Olson, *Gender Development in Transgender Preschool Children*, 89 CHILD DEV. 620, 621 (2018).

210. See Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165 *passim* (2020).

211. Laura Grenfell, *Embracing Law’s Categories: Anti-Discrimination Laws and Transgenderism*, 15 YALE J.L. & FEMINISM 51, 52 (2003).

212. Clarke, *supra* note 27, at 1754.

213. Jonathan Kahn, *The Legal Weaponization of Racialized DNA: A New Genetic Politics of Affirmative Action*, 13 GEO. J.L. & MOD. CRITICAL RACE PERSP. 187, 202 (2021).

214. L. W. *ex rel. Williams v. Skrmetti*, 83 F.4th 460, 481 (6th Cir. 2023) (quoting *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2245–46 (2022)).

215. *Kadel v. Folwell*, 100 F.4th 122, 148 (4th Cir. 2024) (“[G]ender-affirming surgeries that are not covered for anyone are surgeries that only transgender people would get.”).

differ from some other treatments, and some side effects, such as fertility loss, might be particular to treatment for this condition.<sup>216</sup> But as Tennessee’s own expert explained in discussing conditions requiring gender affirming care other than gender dysphoria, the “use and outcome” of various treatments “can be very different for different applications.”<sup>217</sup> There is no evidence that variation in treatment for gender dysphoria varies to a significantly greater degree than the variation that any other specific condition might invite—in other words, there is more that links these gender affirming treatments together, including for gender dysphoria, than sets them apart.

Justifications that set gender dysphoria treatment apart rely on the forbidden category—sex—to do so.<sup>218</sup> But this is problematic. As I explain elsewhere, “[i]n determining comparators . . . we can focus on a range of characteristics. . . . But . . . we are forbidden from distinguishing based on certain characteristics [such as sex]. . . . In framing . . . [the] resource at issue then, we cannot manipulate its description in ways that refer to forbidden characteristics.”<sup>219</sup> The one distinguishing factor about gender dysphoria is that the person receiving treatment was assigned the opposite sex at birth. But that is the very category regarding which discrimination is being claimed. To identify that as the distinguishing characteristic is circular, and “gerrymander[s] the nature of the resource based on the characteristics of the group in question to render them dissimilarly situated.”<sup>220</sup>

### C. INTERSEX COMPARATOR

If the first objection was hypothetical and the second one was not, this third objection, much like its political priors,<sup>221</sup> is somewhere in the middle. As described above, lawyers and scholars have linked the exceptions to intersex individuals.<sup>222</sup> Yet, it would be incorrect to conclude that intersex individuals make the better comparator.

First, as a class, intersex individuals is underinclusive of the broader class that receives gender affirming care. As noted above, individuals who are not intersex *also* receive gender affirming care. To separate out intersex people for the purpose of the equal protection analysis from others arguably commits the same error as the Sixth and Eleventh Circuits described in the preceding

216. See *supra* note 69.

217. Expert Declaration of Michael K. Laidlaw, M.D. at 14, *Doe 1 v. Thornbury*, 679 F.Supp.3d 576 (W.D. Ky. 2023) (No. 23-CV-00230).

218. *Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205, 1228 (“[T]he medical procedures that it regulates—puberty blockers and cross-sex hormones as a treatment for gender dysphoria—are themselves sex-based.”); *Skrmetti*, 83 F.4th at 482 (“Testosterone transitions a minor from female to male”).

219. Konnoth, *supra* note 27, at 2059–60.

220. *Id.* In so arguing I reject the Fourth Circuit’s approach. See *Kadel*, 100 F.4th at 142–43 (“There is no caselaw to ground this discussion nor obvious first principles to work from.”).

221. In that, those who make it support gender affirming care and also recognize the practical need for making this argument even if they recognize that sex is a problematic category.

222. See *supra* notes 109–113

objection—it uses sex-defining factors (variation in primary sex characteristics) to identify and define a class.<sup>223</sup>

Second, the treatment that intersex infants receive at the outset is not comparable to the treatment that older minors receive. Intersex treatment is forced rather than voluntarily sought after, at an age when minors do not have a conception of sex, much less the ability to articulate it.<sup>224</sup> Even if they turn out to be cisgender in that they concur with their assigned sex like many transgender individuals who do not seek medical interventions, it is unclear that they would have chosen the particular medical intervention to affirm their gender identity. More comparable is any treatment that an intersex individual might receive when *older* to affirm their identity—either to reverse or address treatment carried out when they were an infant, or for other reasons.

### CONCLUSION

The battle over transgender rights has reached areas—socially and doctrinally—that have proved increasingly fraught. In many areas of life—employment or most public accommodations—*Bostock* dictates the outcome. But in more sensitive areas—bathrooms, healthcare, and even sports teams—the question becomes more complicated both in terms of social norms and doctrine. The physical differences doctrine reflects this sensitivity. Advancing the comparator argument is essential to addressing it.

But the comparator argument is one that is simultaneously straightforward. As I explained in the brief filed at the Supreme Court:

[C]isgender minors are similarly situated to transgender minors. The bodies of cisgender minors with conditions described in this brief do not conform to their internal sense of gender; so too for transgender minors. For some cisgender minors, this creates psychological distress; again, the same is true for some transgender minors. Some cisgender minors seek medication to allow their bodies to conform to their internal sense of gender; and, once more, some transgender minors do the same.<sup>225</sup>

Transgender and cisgender minors—and adults—are similarly situated with respect to gender affirming care. Many transgender and cisgender minors experience changes in their body that have implications for their gender identity and that cause distress. A subset of those individuals may seek medical interventions. Those interventions produce analogous, if not identical, results. Laws that allow one group to receive this care, but ban others from accessing it based on the minor's sex as assigned at birth, are therefore discriminatory.

More importantly, it is essential for movement advocates to highlight this argument. While there is research on transgender minors who seek care, there is a shortage of research on cisgender minors. Such comparative research—that

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223. See Konnoth, *supra* note 27.

224. See Katri & Sudai, *supra* note 109; Lau & Fedders, *supra* note 10.

225. Brief for Experts on Gender Affirming Care, *supra* note 7.

compares numbers of minors receiving care, the purposes of the care, outcomes, and so on, will prove essential in future litigation.

In some ways, it is tempting to rely solely on the facial argument because it seems obvious—the bans mention sex on their face. It is also tempting to rely on *Bostock*-type but-for reasoning, since it is already enshrined in current law. Given the unfavorable outcome in *Skrametti* for the transgender rights community, the comparator argument should be made a central argument in litigation in state courts and work in policy arenas.