

No. 21-2875

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

DYLAN BRANDT, et al.,
Plaintiffs-Appellees,

v.

LESLIE RUTLEDGE,
in her official capacity as the Arkansas Attorney General, et al.,
Defendants-Appellants.

On Appeal from the United States District Court for the
Eastern District of Arkansas
No. 4:21-CV-00450 JM (Hon. James M. Moody, Jr.)

Reply Brief of Defendants-Appellants

LESLIE RUTLEDGE
Arkansas Attorney General

NICHOLAS J. BRONNI
Arkansas Solicitor General

VINCENT M. WAGNER
Deputy Solicitor General

MICHAEL A. CANTRELL
Assistant Solicitor General

KA TINA R. GUEST
Assistant Attorney General

OFFICE OF THE ARKANSAS
ATTORNEY GENERAL
323 Center Street, Suite 200
Little Rock, Arkansas 72201
(501) 682-2007
vincent.wagner@arkansasag.gov

TABLE OF CONTENTS

Table of Contents	i
Table of Authorities	iii
Introduction	1
Argument.....	2
I. Plaintiffs have not proved standing.	2
II. Plaintiffs are unlikely to succeed on the merits of their equal- protection claim.	4
A. The SAFE Act is subject to rational-basis review, not heightened scrutiny.....	5
1. The SAFE Act distinguishes on the basis of age and medical procedure, not transgender status or sex.	5
2. Transgender status is neither a suspect nor quasi-suspect classification.....	10
B. The SAFE Act has a rational basis.....	14
C. The SAFE Act would additionally survive heightened scrutiny.	15
1. Plaintiffs’ effort to rehabilitate the district court’s meager evidentiary analysis highlights its insufficiency.	16
2. The most Plaintiffs have proved is medical uncertainty, which does not invalidate the SAFE Act.	18
III. The parents are not likely to succeed on their substantive-due- process claim.	21
IV. Plaintiffs are not likely to succeed on their free-speech claim.....	24
V. The preliminary injunction is harming Arkansas children and upsetting the status quo.....	27
VI. The Court has jurisdiction to review the denial of the motion to dismiss, because it is inextricably intertwined with the preliminary injunction.	28
Conclusion	30

Certificate of Compliance31
Certificate of Service32

TABLE OF AUTHORITIES

Cases

<i>281 Care Comm. v. Arneson</i> , 766 F.3d 774 (8th Cir. 2014)	27
<i>Abbott v. Perez</i> , 138 S. Ct. 2305 (2018).....	27
<i>Adams v. Sch. Bd. of St. Johns Cnty.</i> , 3 F.4th 1299 (11th Cir. 2021), <i>vacated pending reh’g en banc</i> , 9 F.4th 1369	8
<i>Angelotti Chiropractic, Inc. v. Baker</i> , 791 F.3d 1075 (9th Cir. 2015)	29
<i>Arc of Iowa v. Reynolds</i> , No. 21-3268, — F.4th —, 2022 WL 211215 (8th Cir. Jan. 25, 2022).....	28
<i>Bartnicki v. Vopper</i> , 532 U.S. 514 (2001).....	25
<i>Bell v. Tavistock & Portman NHS Found. Tr.</i> [2021] EWCA (Civ) 1363.....	21
<i>Bohn v. Dakota Cnty.</i> , 772 F.2d 1433 (8th Cir. 1985)	20
<i>Bostock v. Clayton County</i> , 140 S. Ct. 1731 (2020).....	9
<i>Bray v. Alexandria Women’s Health Clinic</i> , 506 U.S. 263 (1993).....	8
<i>Chapman v. United States</i> , 500 U.S. 453 (1991).....	13
<i>Cody v. Hillard</i> , 139 F.3d 1197 (8th Cir. 1998)	17
<i>Comprehensive Health of Planned Parenthood v. Hawley</i> , 903 F.3d 750 (8th Cir. 2018)	18
<i>Craig v. Boren</i> , 429 U.S. 190 (1976).....	7

<i>Does v. Gillespie</i> , 867 F.3d 1034 (8th Cir. 2017)	4
<i>Duffie v. Deere & Co.</i> , 111 F.3d 70 (8th Cir. 1997)	18
<i>Easley v. Cromartie</i> , 532 U.S. 234 (2001).....	18
<i>Eisenstadt v. Baird</i> , 405 U.S. 438 (1972).....	15
<i>FCC v. Beach Commc'ns, Inc.</i> , 508 U.S. 307 (1993).....	14
<i>Frontiero v. Richardson</i> , 411 U.S. 677 (1973).....	12
<i>Gallagher v. City of Clayton</i> , 699 F.3d 1013 (8th Cir. 2012)	12
<i>Geduldig v. Aiello</i> , 417 U.S. 484 (1974).....	8
<i>Gibson v. Collier</i> , 920 F.3d 212 (5th Cir. 2019)	21, 24
<i>Gonzales v. Carhart</i> , 550 U.S. 124 (2007).....	15, 26
<i>Gregory v. Ashcroft</i> , 501 U.S. 452 (1991).....	7
<i>Grimm v. Gloucester Cnty. Sch. Bd.</i> , 972 F.3d 586 (4th Cir. 2020)	11
<i>Heartland Christian Acad. Church v. Waddle</i> , 335 F.3d 684 (8th Cir. 2003)	4
<i>Hennessy-Waller v. Snyder</i> , 529 F. Supp. 3d 1031 (D. Ariz. 2021)	9
<i>Karnoski v. Trump</i> , 926 F.3d 1180 (9th Cir. 2019)	11
<i>Lyng v. Castillo</i> , 477 U.S. 635 (1986).....	11

<i>Marshall v. United States</i> , 414 U.S. 417 (1974).....	21
<i>Mass. Bd. of Ret. v. Murgia</i> , 427 U.S. 307 (1976) (per curiam).....	11
<i>Michael H. v. Gerald D.</i> , 491 U.S. 110 (1989).....	23
<i>Morrissey v. United States</i> , 871 F.3d 1260 (11th Cir. 2017)	22
<i>Nat’l Ass’n of Mfrs. v. Taylor</i> , 582 F.3d 1 (D.C. Cir. 2009).....	27
<i>Nat’l Inst. of Family & Life Advocs. v. Becerra</i> , 138 S. Ct. 2361 (2018).....	25
<i>Newton Cnty. Wildlife Ass’n v. U.S. Forest Serv.</i> , 113 F.3d 110 (8th Cir. 1997)	28
<i>Nyquist v. Mauclet</i> , 432 U.S. 1 (1977).....	13
<i>Org. for Black Struggle v. Ashcroft</i> , 978 F.3d 603 (8th Cir. 2020)	27
<i>Osthus v. Whitesell Corp.</i> , 639 F.3d 841 (8th Cir. 2011)	17
<i>Pediatric Specialty Care, Inc. v. Ark. Dep’t of Hum. Servs.</i> , 293 F.3d 472 (8th Cir. 2002)	4
<i>Pers. Adm’r of Mass. v. Feeney</i> , 442 U.S. 256 (1979).....	8
<i>Pierce v. Soc’y of Sisters</i> , 268 U.S. 510 (1925).....	23
<i>Planned Parenthood of Ark. & E. Okla. v. Jegley</i> , 864 F.3d 953 (8th Cir. 2017)	17
<i>Planned Parenthood of Blue Ridge v. Camblos</i> , 116 F.3d 707 (4th Cir. 1997)	27
<i>Planned Parenthood of Se. Pa. v. Casey</i> , 505 U.S. 833 (1992).....	3, 26

<i>Reno v. ACLU</i> , 521 U.S. 844 (1997).....	15, 26
<i>Romer v. Evans</i> , 517 U.S. 620 (1996).....	15
<i>Schneiderman v. United States</i> , 320 U.S. 118 (1943).....	16
<i>Sorrell v. IMS Health Inc.</i> , 564 U.S. 552 (2011).....	24
<i>United States v. Virginia</i> , 518 U.S. 515 (1996).....	10
<i>Washington v. Glucksberg</i> , 521 U.S. 702 (1997).....	15, 22, 23, 26
<i>Webb ex rel. K.S. v. Smith</i> , 936 F.3d 808 (8th Cir. 2019)	2
<i>Whalen v. Roe</i> , 429 U.S. 589 (1977).....	5, 21
<i>Whole Woman’s Health v. Hellerstedt</i> , 136 S. Ct. 2292 (2016).....	3
<i>Whole Woman’s Health v. Jackson</i> , 142 S. Ct. 522 (2021).....	3
<i>Williams-Yulee v. Fla. Bar</i> , 575 U.S. 433 (2015).....	24
Statutes	
SAFE Act, 2021 Ark. Act 626 (Apr. 6, 2021)	5, 14
Ark. Code Ann. 20-9-1501	2

INTRODUCTION

Conjuring new constitutional rights, the district court cited none of Defendants' extensive evidence documenting the international controversy about performing gender-transition procedures on minors. Indeed, to defend the preliminary injunction, Plaintiffs have identified only a handful of high-level statements that they characterize as findings of fact. So they try to supplement the district court's scant factual analysis. But Plaintiffs' efforts to bolster the district court's order simply highlight how little the district court actually did here. Thus, even taking Plaintiffs' arguments at face value, their response merely underscores why, at a minimum, this Court must vacate the district court's order.

Yet even if the district court had done Plaintiffs' analysis, that wouldn't save the injunction. Rather, it would still rest on multiple legal errors. To start, contrary to Plaintiffs' assertions, the SAFE Act distinguishes only between medical procedures and doesn't draw lines based on status. As such, the SAFE Act falls within Arkansas's broad power to regulate medicine. Likewise, there is no substantive-due-process right to access any medical procedure of one's choosing, without state oversight. Nor for that matter does the First Amendment require Arkansas to leave gender-transition practitioners a loophole that would allow those practitioners to send children out-of-state for barred procedures. This Court should

reverse the preliminary injunction and denial of Defendants’ motion to dismiss, and remand with instructions to dismiss.

ARGUMENT

I. Plaintiffs have not proved standing.

Two categories of standing problems beset Plaintiffs. First, they lack standing to challenge the SAFE Act’s ban on surgical procedures and its private right of action. Second, the practitioners lack standing to assert their patients’ rights.

First up are the standing problems shared by all Plaintiffs. Plaintiffs still do not claim that surgical gender-transition procedures are performed on minors in Arkansas, nor that they seek such surgeries. *See* Defs. Br. 24. Instead, they argue (Br. 26) that because the SAFE Act defines prohibited procedures to include both “medical” and “surgical” procedures, Ark. Code Ann. 20-9-1501(6)(A), they have standing to challenge both aspects of the prohibition. But they cite nothing for the theory that standing to challenge one application of a statute confers automatic standing to challenge its other applications. *Cf. Webb ex rel. K.S. v. Smith*, 936 F.3d 808, 814-15 (8th Cir. 2019) (holding that plaintiffs lacked standing for injunction, despite their standing for damages). Because Plaintiffs neither seek nor perform surgical gender-transition procedures, they lack standing to challenge the Act’s ban of these surgeries.

Equally unsupported is Plaintiffs' theory (Br. 26-27) that the district court could enjoin the SAFE Act's private right of action because it contains a separate government enforcement mechanism. Plaintiffs do not defend the district court's misattribution of this theory to *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). *See* Defs. Br. 25. Nor do Plaintiffs explain how their theory is consistent with the Supreme Court's decision in *Whole Woman's Health v. Jackson*, 142 S. Ct. 522 (2021), which rejected a similar theory. *See, e.g., id.* at 535 (“[T]he petitioners have identified nothing that might allow a federal court to parlay . . . any defendant's enforcement authority[] into an injunction against any and all unnamed private persons who might seek to bring their own S.B. 8 suits.”).

Second, the Plaintiff practitioners lack standing to assert their patients' equal-protection rights. Just like the district court, Plaintiffs largely rely (Br. 27-28) on abortion precedent to support third-party standing here. But the Court has granted abortion practitioners special solicitude to assert the rights of women seeking abortions. *See, e.g., Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2322-23 (2016) (Thomas, J., dissenting).

Beyond inapposite abortion cases, Plaintiffs misread this Court's decisions. One focused on whether the Medicaid Act created a right of action enforceable by doctors—not the broader question whether doctors have third-party standing to assert patients' rights. *See Pediatric Specialty Care, Inc. v. Ark. Dep't of Hum.*

Servs., 293 F.3d 472, 477-78 (8th Cir. 2002) (discussing whether “the provider plaintiffs [we]re intended beneficiaries,” which is required to find right of action); *see also Does v. Gillespie*, 867 F.3d 1034, 1040 n.2 (8th Cir. 2017) (noting tension between *Pediatric Specialty Care* and subsequent Supreme Court precedent). And another chose not to decide whether a school could assert its students’ rights, because the school independently had standing to bring the same claim as the students. *See Heartland Christian Acad. Church v. Waddle*, 335 F.3d 684, 689-90 (8th Cir. 2003). Here, by contrast, the practitioners may only bring a rational-basis claim against the SAFE Act, *see* Defs. Br. 28, so their first-party claim is not the same claim as their patients’ claim. The Court cannot here avoid holding that the practitioners lack third-party standing.

Finally, extending third-party-standing precedent is unwarranted here. Plaintiffs offer no evidence (*see* Br. 28) to support their assertion that individuals are hindered from pursuing their own claims. That assertion is belied by the fact that, in a relatively small State like Arkansas, four families feel free to pursue their individual claims, without using pseudonyms.

II. Plaintiffs are unlikely to succeed on the merits of their equal-protection claim.

The SAFE Act rests on the Arkansas General Assembly’s determination that “[t]he risks of gender transition procedures far outweigh any benefit at this stage of clinical study on these procedures.” SAFE Act, 2021 Ark. Act 626, sec. 2(15)

(Apr. 6, 2021). That determination falls within Arkansas’s well-settled, broad power to regulate the practice of medicine. *See Whalen v. Roe*, 429 U.S. 589, 603 n.30 (1977) (“It is, of course, well settled that the State has broad police powers in regulating the administration of drugs by the health professions.”). As a result, Plaintiffs are not likely to succeed on the merits of their equal-protection claim.

A. The SAFE Act is subject to rational-basis review, not heightened scrutiny.

The SAFE Act distinguishes based on medical procedure and age, not any suspect or quasi-suspect classification. Plaintiffs argue otherwise (Br. 33-34) by conflating different medical procedures. But a girl taking estrogen to ensure her body progresses through puberty, for example, doesn’t undergo the same procedure as a boy taking estrogen to halt puberty and develop feminine secondary sex characteristics. The SAFE Act does not, therefore, discriminate between similarly situated girls and boys, nor between adolescents who do and do not identify as transgender. Plaintiffs do not (Br. 35-39), in any event, justify declaring transgender status to be a new suspect or quasi-suspect classification. The SAFE Act does not trigger heightened equal-protection scrutiny.

1. The SAFE Act distinguishes on the basis of age and medical procedure, not transgender status or sex.

Plaintiffs wrongly equate procedures prohibited by the SAFE Act with other procedures it permits. And they dismiss the Act’s sex-neutral, age-based cutoff.

Instead, they mischaracterize the medical-procedure distinction as transgender-status or sex discrimination.

i. Plaintiffs claim (Br. 10, 33-34) that gender-transition procedures are the same as treatments for conditions like precocious puberty and polycystic ovarian syndrome (PCOS). The record contradicts this claim. Most notably, Dr. Paul Hruz, a professor of pediatric endocrinology at Washington University in St. Louis, explained important differences between gender-transition procedures and those other treatments. *See* App. 360; R. Doc. 45-3, at 25 (comparing gender-transition procedures with PCOS treatments is “inaccurate and misleading”); App. 1033; R. Doc. 55-3, at 3 (comparing use of puberty blockers to transition and to treat precocious puberty “is erroneous”). And highlighting the uniqueness of gender-transition procedures, “[t]he FDA . . . has not approved hormonal therapies for treatment of gender dysphoria.” App. 291; R. Doc. 45-2, at 21. The FDA’s position supports the view that these are different procedures.

Plaintiffs also falsely equate gender-transition procedures with “treatments for individuals with intersex conditions,” Plfs. Br. 32; *accord id.* at 34, conditions that doctors often call “disorders of sexual development,” or “DSDs.” Again, however, the record undercuts Plaintiffs’ claims. Dr. Hruz, who has cared for hundreds of children with DSDs, distinguished gender-transition procedures and DSD treatments. *See* App. 337, 368-69; R. Doc. 45-3, at 2, 33-34. Surgeries performed on

children with DSDs “are generally directed to correcting anatomical defects with clinical significance.” App. 1052; R. Doc. 55-3, at 22. “This would include defects that restrict urinary outflow, increase risk of urinary tract infections, or pose a cancer risk (*e.g.* intraabdominal testes or other dysgenetic gonads containing a Y-chromosome).” *Id.* And contrary to Plaintiffs’ claim (Br. 34, 43) that Arkansas permits sterilizing infants with DSDs, “many if not most patients with DSD[s] have impaired or absent fertility” prior to any medical intervention. App. 1051; R. Doc. 55-3, at 21.

The *nature* of a procedure, therefore, determines whether the SAFE Act prohibits it—not the sex of the child undergoing it. *Contra* Br. 33. Only by ignoring the record could Plaintiffs or the district court claim otherwise.

ii. All gender-transition procedures become permissible once the patient turns 18. *See* Ark. Code Ann. 20-9-1502(a). And Plaintiffs do not dispute that “age is not a suspect classification.” *Gregory v. Ashcroft*, 501 U.S. 452, 470 (1991). Unlike the age classification in *Craig v. Boren*, 429 U.S. 190, 210 (1976), the SAFE Act sets out a uniform age cutoff for all children regardless of sex or transgender status. *See* Br. 34.

iii. Thus, the SAFE Act distinguishes by medical procedure and age. Plaintiffs argue (Br. 29-30) these distinctions are really a proxy for a transgender-status distinction. But the Supreme Court has rejected the uneven-impact analysis

on which Plaintiffs’ transgender-discrimination-by-proxy theory rests. *See Pers. Adm’r of Mass. v. Feeney*, 442 U.S. 256, 271-72 (1979) (“[M]any [laws] affect certain groups unevenly, even though the law itself treats them no differently from all other members of the class described by the law.”). That is why distinctions between “pregnant women and nonpregnant persons” are not sex-based distinctions. *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974); *see Bray v. Alexandria Women’s Health Clinic*, 506 U.S. 263, 271-73 (1993) (same conclusion regarding abortion). Because “nonpregnant persons” can be “members of both sexes,” the Court saw a “lack of identity between” pregnancy and sex. *Geduldig*, 417 U.S. at 496 n.20.

Here, both transgender people and nontransgender people choose not to undergo gender transition. *See, e.g.*, App. 790; R. Doc. 45-21, at 7 (“Not all transgender individuals seek treatment.”). Thus, there is a “lack of identity” between the SAFE Act’s medical-procedure distinction and transgender status. *See Adams v. Sch. Bd. of St. Johns Cnty.*, 3 F.4th 1299, 1331-32 (11th Cir. 2021) (Pryor, C.J., dissenting) (applying *Geduldig* to law that “does not facially classify on the basis of transgender status”), *vacated pending reh’g en banc*, 9 F.4th 1369.¹

¹ En banc argument is scheduled for February 22, 2022. *See Oral Argument Calendar, Adams*, No. 18-13592 (11th Cir. Jan. 11, 2022).

iv. The SAFE Act’s prohibition of gender-transition procedures is not sex discrimination. Nothing in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), proves otherwise. Plaintiffs’ claim that *Bostock*’s reasoning is not “limited to the statutory context,” Br. 31, ignores the Supreme Court’s insistence that it did not “prejudge” any other question in *Bostock*, 140 S. Ct. at 1753. Thus, a district court last year determined *Bostock* did not apply in a case similar to this one. *See Hennesy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1044 (D. Ariz. 2021).

Plaintiffs’ other sex-discrimination arguments (Br. 31-32) rest heavily on their claim that the gender-transition procedures banned by the SAFE Act are the same as others it permits. But that’s simply untrue. A boy receiving testosterone to jumpstart delayed puberty and a girl receiving it to indefinitely halt puberty do not undergo the same procedure. *See, e.g.*, App. 357, 417; R. Doc. 45-3, at 22, 82. Likewise, a girl undergoing a double mastectomy and a boy undergoing surgery to remove abnormal chest tissue have not undergone “comparable surgeries,” whatever Plaintiffs’ witnesses may claim. App. 125; R. Doc. 11-12, at 17; *see* App. 470; R. Doc. 45-4, at 15 (“removing healthy breast tissue from” young women is not equivalent to “the removal of abnormal breast tissue in men”).

Because the procedures banned and permitted by the SAFE Act are not the same, it draws no distinctions between similarly situated girls and boys. Therefore, decisions holding the sexes are similarly situated for purposes of marriage are not

relevant. *See* Br. 32-33. And the medical-procedure distinction at the heart of the SAFE Act defeats Plaintiffs’ novel sex-stereotyping theory of discrimination. *See id.* at 31-32. It is not sex stereotypes that distinguish these procedures. *See, e.g.,* Br. of Med. & Mental Health Prof’ls 27 (Nov. 23, 2021), Doc. ID#5101054 (“For example, in females the course of cross-sex hormones means unusually high doses of testosterone that atroph[y] and chemically degrade[] the sex organs leading to sexual dysfunction and eventual sterility.”). In any event, Plaintiffs cite only an out-of-circuit district court to support their novel theory.

As discussed in Defendants’ opening brief, the Supreme Court has applied heightened equal-protection scrutiny only to laws that disadvantaged members of one sex as compared to similarly situated members of the other sex. *See* Defs. Br. 38-39 (collecting cases). But the SAFE Act prohibits gender-transition procedures for all Arkansans under 18-years-old, regardless of their sex. It therefore draws no “gender-based classification[]” that would “warrant heightened scrutiny.” *United States v. Virginia*, 518 U.S. 515, 555 (1996) (quotation marks omitted).

2. Transgender status is neither a suspect nor quasi-suspect classification.

Because transgender status is not even a quasi-suspect classification, it cannot trigger heightened scrutiny. Plaintiffs’ argument for announcing a new quasi-suspect classification amounts to little more than asking this Court to copy the Fourth Circuit’s reasoning in *Grimm v. Gloucester County School Board*, 972 F.3d

586 (4th Cir. 2020), and to a lesser extent, the Ninth Circuit’s in *Karnoski v. Trump*, 926 F.3d 1180 (9th Cir. 2019). Analyzing the four relevant factors, however—rather than adopting the Fourth Circuit’s analysis wholesale—makes clear that the Court ought not create a new suspect classification here. *See Lyng v. Castillo*, 477 U.S. 635, 638 (1986) (listing four factors).

First, Plaintiffs offer only conclusory assertions about a history of discrimination. Such assertions, even if supported by the record, would prove only that “the treatment of” those who identify as transgender “in this Nation has not been wholly free of discrimination.” *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 313 (1976) (per curiam). That does not establish a quasi-suspect classification. *Id.*

Second, Plaintiffs cannot point to any “distinguishing characteristic[.]” *See Lyng*, 477 U.S. at 638. The term “transgender” is an “umbrella term” for various identities. App. 790; R. Doc. 45-21, at 7; *see* App. 757, 849; R. Docs. 45-19, at 102, 45-22, at 31 (listing identities such as “genderqueer,” “pangender,” “genderless,” and “neutrois”). Plaintiffs claim that the defining characteristic of those identities is “having a gender identity that differs from the[ir] sex designated at birth.” Plfs. Br. 37 (quotation marks omitted) (alteration in original). Yet Plaintiffs do not explain what it means to say that someone who identifies as, for example, “neutrois” does not identify with his or her sex. Nor do they explain the common defining characteristic of someone identifying as “pangender” and another as

“genderqueer,” to take other examples. The potential variation within the term “transgender” is evidence that those covered by this term do not share any common characteristic.

Third, Plaintiffs have not identified a class sharing an “immutable characteristic determined solely by the accident of birth.” *Gallagher v. City of Clayton*, 699 F.3d 1013, 1018 (8th Cir. 2012) (quoting *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973) (plurality op.)). Instead, they argue that they need not prove “immu- tab[ility] in a literal sense.” Br. 37. But they make no effort to square their be- spoke definition of immutability, pulled from an out-of-circuit district court, *see id.* at 38, with this Court’s decisions like *Gallagher*.

Under any definition, however, Plaintiffs cannot show immutability. They do not explain how immutability is consistent with evidence documenting a recent increase in trans-identifications, *see* App. 176-79; R. Doc. 45-1, at 19-22; App. 278-82; R. Doc. 45-2, at 8-12; App. 487; R. Doc. 45-4, at 32; nor the reality that people detransition, *see* App. 894-910; R. Docs. 45-27, 45-28, 45-29; *see also* Br. of Keira Bell et al. 2-3 (Nov. 23, 2021), Entry ID#5101109; nor the consistent finding that most childhood gender-dysphoria cases (80-98%) will desist prior to adulthood, *see* App. 204; R. Doc. 45-1, at 47. On this last point, Plaintiffs claim otherwise (Br. 6 n.6) but cite only a statement that adolescent-onset gender dys- phoria is less well-studied than childhood-onset gender dysphoria. *See* App. 924-

25; R. Doc. 51-1, at 14-15. That statement says nothing of desistance rates. And the record demonstrates that even some renowned gender-transition practitioners have “urged ‘caution’ because ‘some eventually detransition,’” even after adolescent-onset gender dysphoria. App. 1010; R. Doc. 55-1, at 7.

Although Plaintiffs caricature Defendants’ position (Plfs. Br. 38 n.17), they do not address statements from WPATH and others that are inconsistent with immutability. *See, e.g.*, App. 776; R. Doc. 45-20, at 1 (“for some transgender individuals, gender identity may remain somewhat fluid”); App. 788; R. Doc. 45-21, at 5 (describing people who experience “a continuous and rapid involuntary alternation between a male and female identity”). A “fluid” characteristic, subject to “continuous and rapid involuntary alternation,” is not immutable. By contrast, classifications like alienage or legitimacy are neither fluid nor rapidly and continuously changing. *See, e.g., Nyquist v. Mauclet*, 432 U.S. 1, 9 n.11 (1977).

Finally, on political powerlessness, Plaintiffs simply cite (Br. 39 & n.18) a journalist’s tally of the “anti-trans bills” allegedly introduced in 2021. But they offer no details about any of those bills, nor about how their mere introduction demonstrates political powerlessness. *Cf. Chapman v. United States*, 500 U.S. 453, 464 n.4 (1991) (noting “introduction of bills in the Senate,” although “[n]either of the bills was enacted,” making it “questionable whether they even amount

to subsequent legislative history”). Like the other three factors, this last one does not support creating a new suspect classification.

B. The SAFE Act has a rational basis.

The SAFE Act’s procedure and age distinctions survive rational-basis scrutiny. Plaintiffs’ contrary argument (Br. 45-46) mostly amounts to a misapplication of rational-basis review. Under this standard, the SAFE Act “comes to [the Court] bearing a strong presumption of validity.” *FCC v. Beach Commc’ns, Inc.*, 508 U.S. 307, 314 (1993). The Arkansas General Assembly’s “legislative choice is not subject to courtroom fact-finding and may be based on rational speculation unsupported by evidence or empirical data.” *Id.* at 315. Thus, even if the SAFE Act had no legislative findings, Plaintiffs could not—on rational-basis review—rely on their own evidence to undermine the rationality of the SAFE Act. But the Act does have extensive findings. *See* 2021 Ark. Act 626, sec. 2. Outlawing gender-transition procedures performed on minors is a rational response to those legislative findings.

The SAFE Act would survive even the “courtroom fact-finding” that is impermissible on rational-basis review. *Beach Communc’ns*, 508 U.S. at 315. Plaintiffs’ evidentiary arguments rest on the incorrect statement that the Act has banned certain procedures while leaving materially identical procedures untouched. These

arguments fail, because Plaintiffs ignore the evidence distinguishing gender-transition procedures from treatments performed on children with DSDs, *see* App. 1051-52; R. Doc. 55-3, at 21-22; and the evidence of the irreversible damage caused by puberty blockers, *see* App. 1034-35, 1045; *id.*, at 4-5, 15; and mastectomies, App. 463, 470-73; R. Doc. 45-4, at 8, 15-18.

The differences in the banned and permitted procedures separate Arkansas's law from the law in *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972), which limited contraception for the unmarried while allowing it without restriction for the married. And because the SAFE Act distinguishes between medical procedures, it does not, as Plaintiffs claim, "singl[e] out a certain class of citizens for disfavored legal status." *Romer v. Evans*, 517 U.S. 620, 633 (1996). The Act survives rational-basis review.

C. The SAFE Act would additionally survive heightened scrutiny.

Arkansas has an undisputed interest in protecting minors, *see Reno v. ACLU*, 521 U.S. 844, 869 (1997), reinforced by its undisputed interests in protecting the vulnerable, *see Washington v. Glucksberg*, 521 U.S. 702, 731 (1997), and in promoting medical ethics, *see Gonzales v. Carhart*, 550 U.S. 124, 157 (2007). Arkansas determined the risks of gender-transition procedures outweigh the contested evidence that they benefit minors. Prohibiting those procedures for minors based on

that determination is substantially related to Arkansas’s important—indeed, compelling—interests in protecting minors and safeguarding medical ethics.

1. Plaintiffs’ effort to rehabilitate the district court’s meager evidentiary analysis highlights its insufficiency.

The evidence should have led the district court to conclude the SAFE Act survives heightened scrutiny. *See* Defs. Br. 43-48 (summarizing evidence). But the district court’s short evidentiary discussion cited none of that evidence—only material from *amici*. *See* Add. 7-9; R. Doc. 64, at 6-8 & nn.2-6. Plaintiffs try to backfill the evidentiary void in the district court’s reasoning. *See* Br. 40-44. Yet the only “findings of fact” they identify consist of just *three* sentences—none of which cite *any* evidence introduced by either party. *See id.* at 21. As Plaintiffs note, there was “extensive evidence” before the district court. *Id.* at 20. Indeed, the Joint Appendix here is nearly 1200-pages long. The district court’s failure to cite—let alone discuss—any of that evidence unequivocally demonstrates “that the court did not consider the evidence.” *Id.* at 41 n.19.

The district court’s failure to consider the evidence is sufficient to invalidate the preliminary injunction, notwithstanding its misapplication of heightened scrutiny, discussed below, *see infra* pp. 18-21, and previously, *see* Defs. Br. 43-48. Even the statements that Plaintiffs characterize as findings are, in reality, nothing “but the most general conclusions of ultimate fact.” *Schneiderman v. United States*, 320 U.S. 118, 129-30 (1943). A similar failure led this Court to hold that a

preliminary injunction was an abuse of discretion in *Planned Parenthood of Arkansas & Eastern Oklahoma v. Jegley*, 864 F.3d 953 (8th Cir. 2017). There, the district court failed “to make a finding that [Arkansas’s] contract-physician requirement is an undue burden for a large fraction of women seeking medication abortions in Arkansas.” *Id.* at 959. Because the district court had “focused on amorphous groups of women to reach its conclusion,” *id.*, this Court was “left with no concrete district court findings” relevant to the constitutional analysis, *id.* at 960.

Similarly here, the district court made no concrete findings about the risks of gender-transition procedures but only amorphous statements about their alleged benefits—statements based only on submissions by *amici* rather than the parties. *See* Add. 8-9; R. Doc. 64, at 7-8 & nn.4-5. Just like *Jegley*, such a limited factual analysis cannot justify a facial injunction here. *See Osthus v. Whitesell Corp.*, 639 F.3d 841, 845 (8th Cir. 2011) (criticizing injunction that described allegedly unlawful activity “cryptically” and did “not specially find facts”); *Cody v. Hillard*, 139 F.3d 1197, 1200 (8th Cir. 1998) (“[T]he district court’s findings and conclusions [were] simply too cryptic for [this Court] to ascertain whether” the district court had applied the correct legal standard, or “if it did, whether it did so without clear error or abuse of discretion.”). At very least, this Court must vacate and remand for appropriate factfinding. *See Jegley*, 864 F.3d at 960-61; *see also Comprehensive Health of Planned Parenthood v. Hawley*, 903 F.3d 750, 758-59 (8th

Cir. 2018) (vacating and remanding preliminary injunction for lack of necessary findings).

2. The most Plaintiffs have proved is medical uncertainty, which does not invalidate the SAFE Act.

The district court’s insufficient analysis also weakens the deference this Court owes its evidentiary discussion. Insofar as it made any findings, they “become suspect,” because this Court cannot “know what facts the trial court took into consideration in drawing its conclusions.” *Duffie v. Deere & Co.*, 111 F.3d 70, 73 (8th Cir. 1997). And because “the key evidence consisted primarily of documents and expert testimony” in the form of sworn declarations, “[c]redibility evaluations played a minor role.” *Easley v. Cromartie*, 532 U.S. 234, 243 (2001). Given these principles, this Court should reverse, not just vacate, the preliminary injunction.

- i. Continuing to rest on mischaracterizations of the record, Plaintiffs take issue with Arkansas’s focus on the risks of gender-transition procedures. Regarding puberty blockers, *see* Plfs. Br. 8, 43, it is not true that they are fully reversible, *see, e.g.*, App. 1034-35, 1045; R. Doc. 55-3, at 4-5, 15 (discussing permanent effects, particularly on bone density). When a child who is placed on these drugs prior to puberty proceeds to cross-sex hormones, that child will not “undergo[] full gonadal maturation,” with attendant effects on lifetime fertility. App. 1035-36; *id.* at 5-6. And “the vast majority” of children—up to 98%—placed on puberty blockers proceed to cross-sex hormones. App. 1044; *id.* at 14; *see* App.

303; R. Doc. 45-2, at 33. It is at very least an oversimplification to say that puberty blockers do not “have any impact on fertility.” Plfs. Br. 43.

Separately, Plaintiffs miss the point with their repeated assertion that “chest surgery”—*i.e.*, a double mastectomy—does “not affect fertility.” *Id.* at 11, 43. Arkansas has regulated the use of double mastectomies as gender-transition procedures because they permanently destroy healthy organs. An adolescent girl who receives a double mastectomy will never be able to breastfeed, among other life-long consequences, which Plaintiffs never address. *See* App. 463, 472-73; R. Doc. 45-4, at 8, 17-18.

Finally, Plaintiffs repeat their claim (Br. 43) that the continued permissibility of treatments on children with DSDs undermines Arkansas’s interests in the SAFE Act. As Defendants have already detailed, *see supra* pp. 6-7, Plaintiffs’ claim ignores “the major differences between” gender-transition procedures and treatments for DSDs, App. 1051; R. Doc. 55-3, at 21.

ii. Plaintiffs also claim (Br. 39-42) the benefits of these procedures are well-established. Here, again, their claim rests on a one-sided characterization of the record. (The district court simply disregarded the parties’ evidence in favor of statements from *amici*. *See* Add. 8-9; R. Doc. 64, at 7-8.) As an initial matter, Plaintiffs do not acknowledge the fact that the consequences of gender-transition procedures—often consigning a minor to lifetime sterilization—intensify the need

for clear evidence of benefit. *Cf. Bohn v. Dakota Cnty.*, 772 F.2d 1433, 1439 (8th Cir. 1985) (discussing state’s “strong interest in protecting powerless children who have not attained their age of majority”). No such clear evidence exists.

To the contrary, in recent years health officials around the world have become concerned about the weak evidence of benefit. *See* Defs. Br. 11-15. Plaintiffs claim (Br. 14) that gender-transition procedures cause “significant improvement in mental health.” But “the data show[.]” this claim “is a distortion of all of the evidence.” App. 1008; R. Doc. 55-1, at 5; *see, e.g.*, Br. of Medical & Mental Health Prof’ls 16-17 (“those who received puberty blockers were hospitalized more often for suicide attempts than those who did not”). “As far as minors are concerned, there are no medical treatment[s]” used for gender transition “that can be considered evidence-based.” App. 515; R. Doc. 45-5, at 6. Plaintiffs claim (Br. 9) this is also true of other procedures performed on minors, but they point to no other procedures performed on minors with equally weak evidence of benefit that carry such profound consequences.

Plaintiffs also wave away (Br. 11, 44) the reality of post-transition regret. But this documented phenomenon further supports Arkansas’s determination that the purported benefits of gender-transition procedures do not outweigh their consequences for minors. *See* App. 1027-28; R. Doc. 55-2, at 12-13; App. 1036; R. Doc. 55-3, at 6.

All told, the most Plaintiffs’ evidence shows is that “[t]he treatment of children for gender dysphoria is controversial.” *Bell v. Tavistock & Portman NHS Found. Tr.* [2021] EWCA (Civ) 1363 [¶ 3];² *cf. Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019) (“[T]he WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery.”). And “medical uncertainties” like those presented here “afford little basis for judicial responses in absolute terms.” *Marshall v. United States*, 414 U.S. 417, 427 (1974). Given Arkansas’s “broad police powers in regulating the administration of drugs,” *Whalen*, 429 U.S. at 603 n.30, and the “medical and scientific uncertainties” here, the State’s “legislative options must be especially broad,” *Marshall*, 414 U.S. at 427; *see* Br. of Alabama et al. 24-29 (Nov. 23, 2021), Doc. ID#5100949 (detailing States’ power to set medical standards). The SAFE Act falls within that broad power and satisfies heightened scrutiny.

III. The parents are not likely to succeed on their substantive-due-process claim.

One group of parents submitted a brief as *amici curiae* here that documents an ironic reality: Gender-transition practitioners themselves—not the State—often

² <https://www.judiciary.uk/wp-content/uploads/2021/09/Bell-v-Tavistock-judgment-170921.pdf>. In Defendants’ opening brief (at 17 n.4), this URL contains an inadvertent hyphen in “judgment.”

take an adversarial posture towards parents, thereby cutting them out of an adolescent's gender transition. *See, e.g.*, Br. of Yaacov Sheinfeld et al. 10 (Nov. 23, 2021), Entry ID#5101080 (recounting social worker telling father he “did not love his daughter enough” because of concerns about double mastectomy). Prohibiting these procedures for minors supports rather than infringes parents' right to raise their children.

The Supreme Court has “required in substantive-due-process cases a ‘careful description’ of the asserted fundamental liberty interest.” *Glucksberg*, 521 U.S. at 721. Here, the district court announced a fundamental right for parents to choose an experimental gender-transition procedure for their children, despite the State's determination it is unsafe, as long as they have “their adolescent child's consent and their doctor's recommendation.” Add. 11; R. Doc. 64, at 10. Carefully describing the putative right is what *Glucksberg* requires, contrary to Plaintiffs' claim that Defendants “try to narrow the right at stake.” Plfs. Br. 47; *cf., e.g., Morrissey v. United States*, 871 F.3d 1260, 1269 (11th Cir. 2017) (characterizing question as “whether a man has a fundamental right to procreate via an IVF process that necessarily entails the participation of an unrelated third-party egg donor and a gestational surrogate”).

Plaintiffs make little effort to demonstrate that such a right is “deeply rooted.” *Glucksberg*, 521 U.S. at 722. They offer only one paragraph (Br. 47)

with a string cite to inapplicable decisions. Defendants have already distinguished those decisions, to no response. *See* Defs. Br. 49-50. Suffice it to say that none of those decisions are “concrete examples” of the fundamental right Plaintiffs assert. *Glucksberg*, 521 U.S. at 722.

Indeed, many Courts of Appeals’ decisions have rejected a substantive-due-process right of affirmative access to particular medical procedures. *See* Defs. Br. 48 (collecting citations). Rather than discuss those decisions, Plaintiffs strangely claim (Br. 47-48) that even if a minor has no right to access a medical procedure, parents have their own right to access that same procedure on the minor’s behalf.

The decisions Plaintiffs cite stand for no such proposition. In both cases, the Supreme Court declined to decide the exact relationship between a parent’s rights and a child’s rights. *See Michael H. v. Gerald D.*, 491 U.S. 110, 130 (1989) (plurality op.) (per Scalia, J.) (“*We have never had occasion to decide whether a child has a liberty interest, symmetrical with that of her parent, in maintaining her filial relationship. We need not do so here*” (emphasis added)); *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 532, 534-35 (1925) (noting claim based on children’s rights but ruling only on parents’ rights). No person has a substantive-due-process right to access a particular medical procedure. And Plaintiffs’ parental-rights claim “is the obverse of” such a claim, so it should have “fail[ed] for the same reasons.” *Michael H.*, 491 U.S. at 131 (plurality op.).

Regarding strict scrutiny, Plaintiffs rest almost entirely on cross-references. Their only new argument is a footnote attacking the SAFE Act as insufficiently tailored “to individual patients’ needs.” Plfs. Br. 48 n.20. But they cite nothing for the premise that only a law that is “perfectly tailored” to every individual’s needs can satisfy strict scrutiny. *Williams-Yulee v. Fla. Bar*, 575 U.S. 433, 454 (2015); *cf. Gibson*, 920 F.3d at 225 (rejecting claim “that the Eighth Amendment required individualized assessments” of prisoners for surgical transition). “The impossibility of perfect tailoring is especially apparent” here, *Williams-Yulee*, 575 U.S. at 454, when Plaintiffs’ witnesses claim it is impossible to set generalized standards regarding gender-transition procedures, *see* App. 96; R. Doc. 11-11, at 6.

IV. Plaintiffs are not likely to succeed on their free-speech claim.

Closing a potential loophole, the SAFE Act bars Arkansas practitioners from sending children out-of-state for prohibited gender-transition procedures. Sending a child to another practitioner for a prohibited procedure is conduct, not speech. And any burdened speech is only incidental to that conduct.

None of Plaintiffs’ cited decisions (Br. 49-50) considered anything like a practitioner’s referral of a patient to another practitioner to obtain a banned procedure. The law in *Sorrell v. IMS Health Inc.*, 564 U.S. 552 (2011), restricted “the creation and dissemination of information.” *Id.* at 570. The SAFE Act contains no

similar restriction on the creation or dissemination of information but only the conduct of sending children out-of-state to obtain barred procedures.

Bartnicki v. Vopper, 532 U.S. 514 (2001), illustrates the distinction. There, the Court considered a federal statute that, among other things, created criminal prohibitions applying to anyone who “use[s] . . . the contents of illegally intercepted wire or oral communications”; or, “who willfully discloses” such contents “knowing or having reason to know that the information was” illegally obtained. *Id.* at 523-24 (quotation marks omitted). The Court said that “the ‘use’ of the contents” is conduct. *Id.* at 526-27. But the statute’s “naked prohibition against disclosures is fairly characterized as a regulation of pure speech.” *Id.* Regulating when doctors can send a minor to another doctor—with accompanying documentation, of course, *see* App. 687-88; R. Doc. 45-19, at 32-33—for a prohibited gender-transition procedure resembles not a regulation of “pure speech” but of the “use” of illegally obtained information. *See Bartnicki*, 532 U.S. at 527 n.10 (cataloging conduct covered by that ban).

A similar point explains why any speech regulated by the SAFE Act is incidental to its permissible regulation of professional conduct. *See Nat’l Inst. of Family & Life Advoc. v. Becerra*, 138 S. Ct. 2361, 2372 (2018) (*NIFLA*) (“States may regulate professional conduct, even though that conduct incidentally involves

speech.”). Because gender-transition referrals are, by definition, “tied to a procedure,” *id.* at 2373, any speech incidentally impacted is “subject to reasonable licensing and regulation by the State,” *Casey*, 505 U.S. at 884 (joint op.). And contrary to Plaintiffs’ claim (Br. 50), nothing in *Casey* suggested its rationale was limited to informed-consent requirements. Rather, *Casey* highlighted that speech there was implicated “only as part of the practice of medicine,” suggesting this was decisive. 505 U.S. at 884.

Whatever level of scrutiny applies, the SAFE Act survives. Plaintiffs wrongly assert (Br. 51-52) that Arkansas lacks an interest in prohibiting practitioners from avoiding a valid regulation of a medical procedure by sending patients elsewhere. In general, Arkansas has well-settled compelling interests in protecting children from experimental gender-transition procedures and safeguarding medical ethics. *See, e.g., Gonzales*, 550 U.S. at 157; *Reno*, 521 U.S. at 869; *Glucksberg*, 521 U.S. at 731. Allowing practitioners to avoid the SAFE Act’s prohibition by outsourcing the procedure would drastically undermine those interests.

Regarding tailoring, Plaintiffs do not address Defendants’ argument. *See* Defs. Br. 56. Regulating referrals is sufficiently tailored to Arkansas’s compelling interests in banning gender-transition procedures because, without it, practitioners would be free to send children out-of-state to undergo procedures that Arkansas has determined are harmful. *Cf. Nat’l Ass’n of Mfrs. v. Taylor*, 582 F.3d 1, 17

(D.C. Cir. 2009) (finding lobbyist-disclosure statute survived strict scrutiny where it “closed [a] loophole”). Nor do Plaintiffs explain how “counterspeech” would undo an irreversible procedure. *See 281 Care Comm. v. Arneson*, 766 F.3d 774, 793 (8th Cir. 2014).

V. The preliminary injunction is harming Arkansas children and upsetting the status quo.

Reversing the preliminary injunction will end ongoing harm to Arkansas children undergoing irreversible gender-transition procedures. The record and briefs by *amici* contain heart-wrenching stories of adults who came to regret the irreversible damage gender-transition procedures caused to them. *See* Defs. Br. 10-11; Br. of Keira Bell et al. 17 (describing how their procedures were “ultimately ineffective and harmful”). Because of the preliminary injunction, children in Arkansas who would otherwise not undergo gender transition are undergoing the same procedures others have come to regret.

The scope of that harm justifies reversal. Add to it, however, the other injunction factors, including that the “inability to enforce its duly enacted plans clearly inflicts irreparable harm on the State.” *Abbott v. Perez*, 138 S. Ct. 2305, 2324 n.17 (2018); *see Org. for Black Struggle v. Ashcroft*, 978 F.3d 603, 609 (8th Cir. 2020). Additionally, the injunction upsets, rather than preserves, the status quo. *See Planned Parenthood of Blue Ridge v. Camblos*, 116 F.3d 707, 721 (4th Cir. 1997) (Luttig, J., staying injunction in single-judge order).

Finally, this Court’s recent decision in *Arc of Iowa v. Reynolds*, No. 21-3268, — F.4th —, 2022 WL 211215 (8th Cir. Jan. 25, 2022), highlights the impropriety of this facial injunction. *Reynolds* held that “the district court abused its discretion,” because it “did not tailor the present injunction to remedy Plaintiffs’ harms.” *Id.* at *13. Here, as already discussed, *see supra* p. 2, Plaintiffs do not seek surgical procedures, nor even allege that such surgeries are performed in Arkansas. Yet the facial injunction would bar the Act’s application even to surgeries. “This sweeps broader than the relief necessary to remedy Plaintiffs’ injuries”—even taking their allegations at face value—“and is an abuse of discretion.” *Reynolds*, 2022 WL 211215, at *13.

VI. The Court has jurisdiction to review the denial of the motion to dismiss, because it is inextricably intertwined with the preliminary injunction.

The district court denied Defendants’ motion to dismiss, because it concluded that it was “inherent in the Court’s decision to grant the preliminary injunction that the Plaintiffs have stated claims for violations of their Equal Protection, Due Process, and First Amendment rights.” Add. 13; R. Doc. 64, at 12. Therefore, the preliminary-injunction motion and the motion to dismiss are “inextricably intertwined.” *Newton Cnty. Wildlife Ass’n v. U.S. Forest Serv.*, 113 F.3d 110, 116 (8th Cir. 1997).

Plaintiffs are not likely to succeed in establishing new rights under the Equal Protection Clause, substantive due process, and the First Amendment, which requires this Court to reverse the preliminary injunction. That “ruling on the preliminary injunction necessarily resolves the motion to dismiss.” *Angelotti Chiropractic, Inc. v. Baker*, 791 F.3d 1075, 1088 (9th Cir. 2015). Plaintiffs’ only response (Br. 1) is that they think they will succeed on the merits. But this amounts to a concession that the preliminary injunction and motion to dismiss are in fact inextricably intertwined.

CONCLUSION

For these reasons, the district court's order granting a preliminary injunction should be reversed, its order denying Defendants' motion to dismiss should be reversed, and this case should be remanded with instructions to dismiss Plaintiffs' claims with prejudice.

Respectfully submitted,

LESLIE RUTLEDGE
Arkansas Attorney General

NICHOLAS J. BRONNI
Arkansas Solicitor General

VINCENT M. WAGNER
Deputy Solicitor General

MICHAEL A. CANTRELL
Assistant Solicitor General

KA TINA R. GUEST
Assistant Attorney General

OFFICE OF THE ARKANSAS
ATTORNEY GENERAL
323 Center St., Suite 200
Little Rock, Arkansas 72201
(501) 682-2007
vincent.wagner@arkansasag.gov

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B)(ii) because it contains 6,486 words, excluding the parts exempted by Fed. R. App. P. 32(f).

I also certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5)-(6) because it has been prepared in 14-point Times New Roman, using Microsoft Word.

I further certify that this PDF file was scanned for viruses, and no viruses were found on the file.

/s/ Vincent M. Wagner

Vincent M. Wagner

CERTIFICATE OF SERVICE

I certify that on February 3, 2022, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which shall send notification of such filing to any CM/ECF participants.

/s/ Vincent M. Wagner

Vincent M. Wagner