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In the Supreme Court of Ohio

MADELINE MOE, *et al.*, Appellees, v. DAVE YOST, *et al.,* Appellants.	Case No. 2025-0472 On Appeal from the Franklin County Court of Appeals, Tenth Appellate District Case No. 24AP-483

APPELLEES' MEMORANDUM IN RESPONSE TO JURISDICTION

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INTRODUCTION

Plaintiffs-Appellees agree that the constitutionality of H.B. 68 is a substantial constitutional question of public importance and great general interest. Appellants' Memorandum in Support of Jurisdiction, however, mischaracterizes both the issues at stake and the Tenth District's judicious decision addressing those issues. Appellants' Memorandum also contains a number of misstatements of the law and the record. This Memorandum in Response will assist this Court in its consideration of jurisdiction by clarifying the scientific and medical background, the trial testimony, and the law at issue in this case.

BACKGROUND

I. Procedural Background

On March 26, 2024, Plaintiffs filed their Complaint in the Franklin County Court of Common Pleas. On April 16, the court issued a temporary restraining order, which it extended twice. On August 6, 2024, the court issued an opinion and final judgment, making very few findings of fact but denying all of Plaintiffs' claims. Among his few findings, the trial judge agreed that gender affirming medical care is health care, but nonetheless disagreed that it is protected under the Health Care Freedom Amendment (Article I, Section 21 of the Ohio Constitution). Plaintiffs immediately appealed. The Tenth District Court of Appeals expedited the appeal.

On March 18, 2025, the Court of Appeals reversed and remanded for entry of a permanent injunction against enforcement of H.B. 68's provisions banning the use of puberty blockers and hormones "for the purpose of assisting the minor individual with gender transition" because those provisions both violated the Health Care Freedom Amendment ("HCFA") and failed to satisfy strict scrutiny under the Due Course of Law (Article I, Section 16) provision of the Ohio Constitution. The appellate court stated that Plaintiffs' claims under the Single-Subject Rule (Article II, Section 15(D)) and Equal Protection Clause (Article I, Section 2) were moot in light of

the granted relief, and declined to rule on their merits.

II. Factual Background

The evidence at trial overwhelmingly showed that gender affirming medical care is a safe, effective, and evidence-based treatment for adolescents with gender dysphoria. *See, e.g.*, 7.16 Tr.37:10-39:10 (Corathers); 7.16 Tr.167:8-11, 190:6-191:3 (Antommaria).

Gender dysphoria is a serious condition requiring treatment. Gender dysphoria is a diagnosis in the Fifth Edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders for the clinically significant distress arising from a discordance between sex assigned at birth and gender identity. 7.15 Tr.96:23-97:8 (Turban). Untreated gender dysphoria can lead to debilitating distress, depression, impairment of function, substance use, self-injurious behaviors, and even suicidality. 7.15 Tr.99:24-101:19 (Turban).

The Endocrine Society Guideline is the standard of care widely accepted by the medical community across our country. The standard of care for transgender adolescents with gender dysphoria includes the use, where appropriate, of puberty-delaying medication and/or hormone therapy. The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has established a clinical practice guideline for treating gender dysphoria in adolescents, including pubertal suppression and hormone therapy.

Medical care under the Guideline. For *prepubertal* children with gender dysphoria, there are no medical interventions.7.15 Tr.309:4-13 (Corathers). These children may benefit from psychotherapy for support as they navigate possible social transition (e.g., using a new name, clothing or hairstyle). 7.15 Tr.252:3-254:8 (Turban). Experts on both sides agree that if a patient's gender dysphoria persists after the onset of puberty, it is unlikely to desist. 7.15 Tr.169:25-173:4 (Turban); 7.17 Tr.98:13-99:12, 7.18 Tr.38:18-39:6 (Government's expert Cantor).

For youth with gender dysphoria after puberty starts, medical intervention may be

indicated. 7.15 Tr.106:15-107:10 (Turban); 7.15 Tr.305:6-306:7 (Corathers). Prior to any medical intervention, the Guideline requires comprehensive psychosocial assessments, including for any co-occurring mental health conditions or family or social issues. 7.15 Tr.120:21-122:7 (Turban); 7.15 Tr.309:14-310:20 (Corathers). Pubertal suppression may be indicated to temporarily pause pubertal changes to give a young person time to improve or stabilize their mental health, to explore their gender identity, and to pause the development of secondary sex characteristics that would later be difficult or impossible to change. 7.15 Tr.107:24-108:19 (Turban); 7.15 Tr.310:21-312:19 (Corathers). If this treatment is stopped, puberty resumes. 7.15 Tr.313:17-314:13 (Corathers).

For older adolescents who experience gender dysphoria, hormone therapy may be indicated. The Guideline recommends such treatment only if gender incongruence has persisted for years. 7.15 Tr.121:20-122:7 (Turban). The goal is to improve psychological well-being by aligning the body to be consistent with the individual's gender identity. 7.15 Tr.108:21-109:3 (Turban).

Under the Guideline, no medical intervention is provided to minors without the patient and parents being fully informed of the potential risks; a determination that the minor has the emotional and cognitive maturity to understand the risks and appreciate the long-term consequences; the assent of the patient; and the informed consent of the parents. 7.15 Tr.122:8-123:16 (Turban); 7.15 Tr.309:14-310:20 (Corathers); 7.16 Tr.175:10-178:3 (Antommaria).

Gender-affirming medical care isn't novel or unproven. Gender-affirming medical care is not a novel or unproven treatment. Puberty blockers and hormone therapy have been used to treat gender dysphoria since at least the 1990s, and both research and clinical experience demonstrate the safety and efficacy of the care. 7.15 Tr.123:17-124:5, 127:22-134:23 (Turban).

The evidence base for the prevailing clinical guideline is comparable to that for protocols

to treat other pediatric conditions. The protocols for this care were developed by experts in the field using well-accepted processes for reviewing the evidence and developing recommendations. 7.16 Tr.153:1-156:21 (Antommaria). These protocols are comparable to treatment guidelines used in many other areas of medicine, 7.16 Tr.166:16-23, 190:18-23 (Antommaria); 7.15 Tr.304:23-305:5 (Corathers), and rely on the same kinds of cross-sectional and longitudinal studies that are most common in pediatric medicine, where it is rare to have randomized controlled trials, for ethical and practical reasons. 7.16 Tr.157:25-160:24, 161:20-162:20, 171:13-19 (Antommaria). It is undisputed that many other medical treatments for adolescent patients are based on precisely the same type of studies. 7.16 Tr.166:16-23, 190:14-191:3 (Antommaria); 7.15 Tr.304:23-305:5 (Corathers).

Mainstream medical associations oppose complete bans like H.B. 68, as do practitioners who treat patients and conduct research in this area. Pubertal suppression and hormone therapy have been used to treat adolescents since at least the 1990s. 7.16 Tr.52:19-53:2 (Corathers); 7.15 Tr.123:17-124:5 (Turban); 7.16 Tr.152:17-25 (Antommaria). All the major medical and mental health organizations in the United States, including the American Academy of Pediatrics, the American Medical Association, and the American Psychiatric Association, have opposed bans on such care. 7.15 Tr.107:11-23 (Turban).

These treatments are also provided to adolescents with gender dysphoria in countries around the world. While some European countries require that care take place in clinical trials where more data can be collected, none has prohibited pubertal suppression or hormone therapy for minors, as Ohio has done with H.B. 68. 7.16 Tr.187:14-189:11 (Antommaria); 7.15 Tr.168:6-169:8 (Turban); 7.17 Tr.88:4-25 (Cantor).

Physicians who research and provide this care—and even the Government's own

psychiatry expert, Dr. Levine—do not support bans. Plaintiffs' three experts—Dr. Jack Turban from the University of California, San Francisco, as well as Dr. Sarah Corathers and Dr. Armand Antommaria from Cincinnati Children's Hospital—have collectively treated hundreds of patients with gender dysphoria, conducted research, and published peer-reviewed articles and textbook chapters on this care. 7.15 Tr.85:18-86:3, 87:1-88:24, 88:25-89:10, 89:11-91:2, 91:3-15, 293:9-294:2, 294:25-295:14, 296:16-20, 297:9-15; 7.16 Tr. 132:5-133:16, 135:8-18; Trial Exs. 19-21.

At trial, the Government relied on discredited experts with little to no experience in this field, including James Cantor, a pedophilia researcher who trumpets his *lack* of experience in the field of adolescent gender medicine and has *never* treated a person under age 16 (for any condition), 7.17 Tr. 58:9-59:5, 7.18 Tr.26:24-27:4, 32:11-15, 33:16-37:4; and Paul Hruz, an endocrinologist who courts have found unqualified based on his ideological opposition to gender affirming medical care, 7.19 Tr.71:10-72:11, 73:14-75:21. But the Government's psychiatry expert, Dr. Levine, would (absent H.B. 68) continue to make treatment recommendations for transgender adolescent patients on a case-by-case basis. 7.18 Tr.110:16-112:19, 114:19-116:21. That is, the Government's expert with the *most* experience treating adolescents with gender dysphoria *agrees* with treatment in some cases.

The prohibited treatments are effective at reducing gender dysphoria and improving young people's lives. Expert and fact witnesses on both sides agree that some youth can benefit from medically transitioning. 7.18.24 Tr.113:22-114:18 (Government's expert Levine); 7.18 Tr.223:7-11 (Government's witness Reed); 7.15 Tr.129:1-133:23, 199:1-200:5 (Turban); 7.15 Tr.301:14-302:21, 7.16 Tr.14:7-21, 43:16-45:11 (Corathers); 7.16 Tr.262:2-11, 265:17-24, 269:1-271:2 (Moe). Both clinical experience and scientific research demonstrate that gender-affirming medical care improves the lives of the adolescents who need and receive it. 7.15 Tr.129:1-132:14,

133:8-23, 134:16-23 (Turban). The undisputed testimony from Dr. Turban and Dr. Corathers was that among their patients, puberty blockers and hormone therapy greatly relieved their gender dysphoria and enabled them to go from distressed and depressed to thriving teenagers. 7.15 Tr. 129:1-133:23 (Turban); 7.15 Tr.301:14-302:21, 7.16 Tr.14:7-21, 43:16-45:11 (Corathers).

This clinical experience is consistent with peer-reviewed scholarly research showing that these treatments improve the mental health and well-being of adolescents with gender dysphoria: hormone therapy is associated with improvement in a variety of mental health and quality of life outcomes and youth treated with puberty suppression do not see the worsening of mental health that is typically experienced among youth with gender dysphoria as they go through puberty. 7.15 Tr.127:22-133:23 (Turban).

The only lay witnesses with firsthand knowledge of how care was provided in Ohio—the Plaintiffs—testified that transitioning alleviated the Minor Plaintiffs' distress and turned them both into thriving, happy teens. 7.15 Tr.39:3-14, (social transitioning); 7.16 Tr.258:1-10, 253:9-254:2 (social and medical transitioning). The Government did not present any contradictory evidence of care in Ohio. Their brief discusses one witness, a "detransitioner" who traveled to Ohio from California to testify. She had surgery there, which was contrary to the Guideline and standards of care. She is suing her California doctors for malpractice and negligence. 7.19 Tr.116:17-117:8, 120:6-17 (Cole). Surgery is not at issue here, nor did the Government's witness discuss any experience with Ohio medical care.

The prohibited treatments are safe. The Government emphasized the risks from puberty blockers and hormone therapy, but both sides' experts agree that *every* medical treatment poses potential risks. 7.16 Tr.145:16-22 (Antommaria); 7.19 Tr.29:19-30:1 (Government's expert Hruz). And it is undisputed that the risks of the prohibited care are comparable to the risks of other medical

treatments that parents are permitted to obtain for their minor children. 7.16 Tr.167:25-170:4 (Antommaria). Experts on both sides further agree that most of the potential risks associated with puberty blockers and hormone therapy also apply when these very same medications are used for other purposes in minors.[1] For instance, regardless of the reason for which they are used, estrogen and testosterone pose a risk of blood clots, and puberty blockers pose risks related to intracranial pressure. 7.15 Tr.321:3-25, 328:7-25, 7.16 Tr.17:2-20:18 (Corathers); 7.19 Tr.47:7-15, 70:25-71:9 (Government's expert Hruz). Notably, these risks are very rare, particularly when patients are monitored by a doctor. 7.15 Tr.317:25-319:7, 329:16-20, 7.16 Tr.11:17-21 (Corathers). And these risks have not prevented Government's expert Dr. Hruz from providing these same medications for other purposes. 7.19 Tr.70:25-71:9 (Hruz).

The prohibited treatments do not pose a unique risk to fertility, and any such risk can be mitigated. If a patient is treated with puberty blockers and then discontinues treatment, there is no impact on fertility. 7.15 Tr.324:22-325:3 (Corathers). But, just as with other medical treatments minors may undergo,[2] hormone therapy has the potential to impair fertility.[3] It is undisputed, however, that that treatment can be provided in a way that mitigates these risks and ultimately

[1] Pubertal suppression medications (GnRHa) are used to treat other conditions, including central precocious puberty and endometriosis. 7.15 Tr.314:14-315:16 (Corathers). Estrogen is used to treat girls with Turner syndrome and polycystic ovarian syndrome; testosterone is used to treat delayed puberty and hypogonadism in boys. 7.16 Tr.17:2-18:5, 19:11-20:12 (Corathers). Adolescents who are not transgender are sometimes prescribed these medications so that their bodies can better match their gender identities, e.g. cisgender boys may be given testosterone to jumpstart an otherwise delayed puberty and cisgender girls with PCOS may be given estrogen to minimize the development of masculine features. *Id*. at 39:11-41:10.

[2] It is undisputed that there are other medical interventions for minor children that impact fertility, e.g. gonadectomy for infants with differences of sex development. 7.16 Tr.167:25-170:11 (Antommaria).

[3] Hormone therapy alone does not necessarily cause infertility, and adolescents are cautioned that hormone therapy is not contraception. 7.15 Tr.330:4-331:9, 7.16 Tr.12:19-13:16 (Corathers).

preserves fertility. 7.15 Tr.330:4-332:2, 7.16 Tr.12:19-13:20 (Corathers).

While an individual may discontinue treatment at a later point—for many reasons, including satisfaction with the results of prior care, loss of insurance, or harassment—the rate of regret for gender-affirming medical care is very low. 7.15 Tr.177:14-178:12, 182:7-183:11 (Turban).

Experts from both sides agree that the decision whether to provide these treatments to adolescents should be made by parents. Weighing the risks and benefits of medical treatments for their children is something all parents do. And experts from both sides agreed that the decision whether to provide this care to minors should be made by parents after a doctor has fully informed the adolescent and their parents about the potential risks and benefits and the evidence supporting treatment. 7.18 Tr.74:14-24, 95:1-13 (Government's expert Levine); 7.16 Tr.146:8-149:8, 170:12-16, 177:5-178:3 (Antommaria); 7.16 Tr.26:25-30:25 (Corathers); 7.15 Tr.121:5-19 (Turban). That is how medical decision-making and informed consent occurs throughout pediatrics: parents consent on behalf of the minor in consultation with the physician, and the minor participates as appropriate for their maturity. 7.16 Tr.146:24-149:8 (Antommaria); 7.18 Tr.98:7-17 (Government's expert Levine). Indeed, Dr. Levine—the only Government experts with any meaningful experience treating patients with gender dysphoria—has written letters approving hormone therapy for his minor patients and (absent H.B. 68) will continue to make treatment recommendations for such patients going forward on a case-by-case basis. 7.18 Tr.110:16-112:19, 114:19-116:21.

Adolescents for whom this care is clinically indicated will suffer immensely and unnecessarily if this care is withheld until they turn 18. Experts from both sides agreed that there is no evidence-based psychotherapeutic treatment for gender dysphoria. 7.18 Tr.76:15-21 (Government's expert Levine); 7.15 Tr.126:11-25, 136:18-137:3, 137:25-138:2; 200:7-201:143,

210:7-22 (Turban). Thus, if puberty blockers and hormone therapy for adolescents with gender dysphoria are prohibited in Ohio, these patients will be left with no evidence-based treatment option. 7.15 Tr.136:18-137:3, 137:25-138:2; 200:7-201:13 (Turban); 7.15 Tr.302:11-21, 7.16.2 Tr. 52:2-14 (Corathers); 7.16 Tr.178:4-22 (Antommaria).

Harms to adolescents who are unable to receive gender-affirming medical care where it is medically indicated include worsening anxiety, depression, global functioning, and suicidality. 7.15 Tr.207:4-18 (Turban). Waiting until age 18 is not an option: forcing adolescents with gender dysphoria to undergo the physical changes of endogenous puberty will cause them years of unnecessary suffering and leave them with secondary sex characteristics incongruent with their gender identity and difficult or impossible to reverse. 7.15 Tr.207:19-208:10 (Turban).

For Ohio youth currently receiving puberty blockers, the law allows them to continue, but not initiate, hormone therapy. Remaining on blockers until age 18 is not medically appropriate. 7.15 Tr.325:16-326:10 (Corathers). Thus, patients on puberty blockers who cannot continue to hormone therapy would be forced to undergo the changes of endogenous puberty and experience significantly worsening distress as the physical signs of puberty develop incongruent with their gender identity. 7.16 Tr.49:6-52:1 (Corathers); 7.16 Tr.178:4-22 (Antommaria). Withholding care until age 18 from such minors forces doctors to deny patients treatment that can help them, in contravention of their ethical obligations to act in their patients' best interests. 7.16 Tr.52:2-14 (Corathers); 7.16 Tr.178:23-179:14 (Antommaria).

ARGUMENT

I. The Tenth District applied the plain meaning of the Health Care Freedom Amendment's text

The Government argues that the Tenth District should have inserted entirely new limiting language into the HCFA—language that has no foundation in the HCFA's text and would drastically limit its scope. The fact that the Tenth District declined to do so is hardly an error.

Section (B) of the HCFA provides that "No . . . state . . . law shall prohibit the purchase or sale of health care or health insurance." Ohio Const., art. I, § 21(B). That provision is perfectly clear on its own. If the Amendment's drafters and voters had intended to protect only "lawful" health care approved by the legislature, as the Government asserts, then the text could and would easily say so. The fact that it does not is consistent with the HCFA's function as part of the Bill of Rights: to protect the people from legislative overreach, not to facilitate it. *See City of Centerville v. Knab*, 2020-Ohio-5219, ¶ 47 (Kennedy, J., concurring).

Section (D) of the HCFA clarifies that the HCFA's core protections do not "affect any laws calculated to deter fraud or punish wrongdoing in the health care industry." Again, the Tenth District applied a common-sense reading of this text. Especially in conjunction with "fraud," and couched as "in the health care industry," "the term 'wrongdoing' most naturally refers to specific instances of misconduct within the medical profession." App. Op. ¶ 68 (quoting Aug. 22, 2024 Appellants' Br.). Indeed, "wrongdoing in the health care industry" would be a bizarre choice of words to refer to health care itself. Moreover, as the Tenth District rightly noted, the Government's reading of Section (D) would eviscerate Sections (B) and (C). *See* App. Op. ¶ 69 ("Under the state's proposed interpretation, the freedom to choose health care guaranteed by Section 21 is narrowed to nothing more than the right to receive health care subject to the policy preferences of the General

Assembly"). If the HCFA's exception had truly been intended to swallow its core rule, its text would have said so. It does not.

The Government's account of the HCFA's original understanding is an exercise in cherry-picking. As previously noted, the voters knew perfectly well that they were voting to protect their choice of health care from government interference. They knew that not because of the academic commentary or revisionist history that the Government cites, but *because the Amendment's proponents, petition title, and official ballot proponent argument all told them so at the time*. *See* Response to Emergency Motion for Stay Pending Appeal at 13 (collecting sources). The HCFA was indeed partly a reaction to the federal Affordable Care Act, but not in the narrow sense the Government suggests. Its proponents proclaimed that they were "attempting to draw a line in the sand and say that the federal government shouldn't get any further in between doctors and patients."[4] Thus, the Amendment's language expressly protects a right to access not only "health insurance," but "health care" itself.

The Government also misreads the Tenth District's opinion as delegating to "the professional medical community" the authority to determine the scope of the HCFA. It does nothing of the sort. As with any constitutional language, construction of the HCFA's meaning is to be done by courts, using the usual interpretive tools available to them. The Government's hyperbole aside, no one has suggested that just any procedure automatically becomes protected "health care" merely by a litigant or a single doctor declaring it so. "Health care" is a plain language term with a meaning, much like "speech" or a "search." *See, e.g.*, R.C. 2135.01(G) (statutory definition of "health care" predating the HCFA, defining it as "any care, treatment, service, or

[4] Aaron Marshall, Opponents of Issue 3 say amendment would interfere with many Ohio laws, The Plain Dealer (Sept. 2, 2011), https://www.cleveland.com/open/2011/09/opponents_of_issue_3_say_amend.html (accessed May 19, 2025).

procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health"); R.C. 1337.11(G) (similar statutory definition enacted after the HCFA). Future litigation may well require courts to grapple with competing definitions of that term, or competing arguments as to whether a particular procedure qualifies as "health care"—and they may well see fit to consider expert testimony from "the professional medical community," as courts routinely do. The Tenth District certainly did not hold—nor should it have—that trial courts are bound to any one particular medical practitioner's or medical association's opinion of what constitutes "health care." If a litigant or private interest group seeks to impugn proffered medical expertise as "more political than medical," as the Government puts it, then it may certainly attempt to impeach that expertise. Weighing expert opinions is hardly foreign to trial courts. Indeed, ascertaining whether a particular procedure is "health care" is no more difficult or esoteric than determining whether a particular method of execution is "cruel and unusual."

More to the point for this case, the Government's hypothetical protestations are just that: hypothetical. That is because *neither the Government, nor the trial court, nor the Tenth District has ever disagreed that gender-affirming medical care is "health care."* App. Op. ¶ 94. This Court need not wrestle with the precise definition of "health care," because that term's application is undisputed in this case.

Finally, the Government is simply wrong in rhetorically dubbing H.B. 68 a "regulation" rather than a categorical ban or prohibition. A ban need not be universal in order to be a ban. Under H.B. 68, individuals under 18 have no means of obtaining gender-affirming health care in Ohio for as long as they are minors. Thus, H.B. 68 "prohibit[s]" them from purchasing that category of health care, much as minors are said to be "prohibited" from buying alcohol. *See* Ohio Const. art. I § 21; *see* Response to Emergency Motion for Stay Pending Appeal at 12 (collecting similar uses

of the term "prohibit" in statutes). The Government's speed limit analogy is inapposite. A speed limit does not prohibit a person from driving; it merely restricts them from driving *in a certain manner*. H.B. 68 does not merely prescribe how gender-affirming medical care is to be administered to adolescents; it states that it cannot be.

II. The Tenth District correctly ruled that H.B. 68 violates the fundamental right of parents to direct the medical care of their children.

The Tenth District's ruling on the Due Course of Law clause breaks no new ground. H.B. 68 unconstitutionally prevents parents from pursuing medical treatments that they, their adolescent child, and their doctors all agree are medically necessary. Under the Ohio Constitution, parents have a "fundamental liberty interest . . . in the custody, care and control of their children." *In re Guardianship of S.H.*, 2013-Ohio-4380, ¶ 13 (9th Dist.). This interest extends to parents' right to make medical decisions for their children, including, "within reason, whether and what type of medical care the child will receive." *In re I.S.*, 2022-Ohio-3923, ¶ 102 n.8 (8th Dist.). The U.S. Constitution is in accord: Fundamental liberty interests include parents' rights to make decisions "concerning the care, custody, and control their children," based on a "presumption" that "fit parents act in the best interests of their children." *Troxel v. Granville*, 530 U.S. 57, 66, 68 (2000). At a minimum, the right extends to parents' right to "seek and follow medical advice" for their children. *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

Because any restriction on parents' rights in this area "infringe[s] upon a fundamental right," the restriction must satisfy strict scrutiny. *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶ 64. The government cannot "infringe certain 'fundamental' liberty interests at *all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302 (1993); *see also Middleton v. City of Flint*, 92 F.3d 396, 404 (6th Cir. 1996) (where a fundamental right is burdened, government must show a

"compelling state interest," and "that the plan is narrowly tailored to further" that interest). Applying these principles, the Tenth District concluded that "H.B. 68's prescription ban infringes on parents' fundamental right to direct the medical care of their children and authorize treatment for gender dysphoria with puberty blockers and hormone therapy subject to medically accepted standards," and therefore that "strict scrutiny applies." App. Op. at ¶ 104.

The State briefly raises three arguments to challenge this straightforward ruling. First, the State "preserves" the argument that this Court should simply do away with substantive due process entirely. Memo at 14. According to the State, "the due-course clause should be restored to its original meaning—*procedural* rights—without creating new substantive rights." *Id.* The State has provided no basis to take this case to upend a foundational principle of Ohio law. Nor is there one: "Stare decisis is the bedrock of the American judicial system." *Westfield Ins. Co. v. Galatis*, 2003-Ohio-5849 ¶ 1. This Court "depart[s] from precedent" "only with great solemnity and with the assurance that the newly chosen course for the law is a significant improvement over the current course", *id.* — not because certain precedent is inconvenient for the State's current litigating position. Moreover, Respondents are not seeking the creation of "new substantive rights." To the contrary, Respondents are asking the Court to recognize "perhaps the oldest of the fundamental liberty interests recognized by [the] Court." *Troxel*, 530 U.S. at 65.

The State next argues that the fundamental right at interest is parents' specific right "to obtain drugs to transition their children's gender." Memo at 14. As the Tenth District explained, this "framing of the fundamental right would render it largely meaningless." App. Op. ¶ 96. Indeed, "[c]ircumscribing this fundamental right in the manner suggested by the state would obliviate any constitutionally protected right for a parent to seek for their children, without state interference, medical innovations of the 20th and 21st centuries that are accepted as the standard of care by the

relevant medical communities"—treatments such as "noninvasive fetal heart monitoring, penicillin, insulin, organ transplants, the polio vaccine, and congenital corrective heart surgery." *Id.* ¶ 98.

Finally, the State again attempts to eviscerate the scope of parents' fundamental rights by suggesting that their "right is a negative liberty, not a positive liberty to coerce the state to license whatever a parent wants a doctor to do to their children." Memo at 14. But the relevant question for the substantive due process analysis is the existence of state interference: Is the state interfering with parents' authority to direct the upbringing and welfare of their children? *See Bellotti v. Baird*, 443 U.S. 622, 639 n.18 (1979) (discussing the decisions identifying "the existence of a constitutional parental right against undue, adverse interference by the State"). H.B. 68 prevents parents from pursuing medical treatments that they, their adolescent child, and their doctors all agree are medically necessary and that—but for the law at issue—would be available. That is plainly state interference, regardless of whether it results in a parent being forced to take action or being prohibited from taking an action.

CONCLUSION

This Court should accept jurisdiction and, based on the record and law as set forth above, uphold the Tenth District's judgment.

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Respectfully submitted,

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**Motion for permission to appear pro hac vice pending*

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CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was served this 29th day of May, 2025 by email upon the following:

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