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

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INTRODUCTION

The Government is right about this much: This case turns on the question of who decides. The Government's answer is that politicians should decide which medical care is available and who can access that care. But the people of Ohio, through the Constitution and its popularly enacted amendments, decide the basic rights of Ohioans. Those rights, in turn, reserve autonomy and liberty to the people—both to medical patients and to parents and their children. Viewed through the Government's own lens, this case is about a collision between individual rights and the restrictions the legislature has placed on them.

Plaintiffs Madeline Moe, Grace Goe, and their families ("Plaintiffs") challenged H.B. 68 on the grounds that it violates, as relevant here, two separate provisions of the Ohio Bill of Rights: the Health Care Freedom Amendment ("HCFA") and the Due Course of Law Clause. The HCFA enshrines in the Ohio Constitution that individuals, not the General Assembly, decide whether to pursue a particular medical treatment. The text of the HCFA could not be clearer: No state law "shall prohibit the purchase or sale of health care." Ohio Const., art. I, § 21. Here, the trial court determined, and the Government has never disputed, that "[g]ender transition services constitute 'health care.'" A-88 (¶ 17). Thus, H.B. 68 violates the HCFA by prohibiting gender-affirming medical care for minors. The Government's theory—that the HCFA protects health care unless the General Assembly passes a law prohibiting that health care—guts the protections of this provision of the Ohio Bill of Rights.

That alone is sufficient to affirm the decision below, but H.B. 68 also runs afoul of Ohio's Due Course of Law Clause. The right of parents to direct the care of their children is perhaps the most deeply grounded of our fundamental constitutional rights, and the provision of medical care is at the heart of decisions parents make with respect to their children. Gender-affirming medical care has risks; all medical care does. But when a statute deprives parents of the authority to weigh

those risks against the treatment's benefits for their child, the Government must show the statute is narrowly tailored to serve a compelling government interest. H.B. 68 fails that test. Among other issues, the statute is wildly over-inclusive: It imposes a categorical ban on gender-affirming medical care despite the Government's recognition that this care is appropriate for some minors. The Government has nevertheless made no attempt to show that H.B. 68 is narrowly tailored to serve its interest in protecting children.

The Government tries to reset the debate by pointing to "unelected advocacy groups that the court deemed 'experts.'" Opening Br. 1. That is a distraction from the effect of H.B. 68—to siphon power from individual Ohio citizens over their family's health care decisions. The debate over experts has little to do with the HCFA, which makes abundantly clear the General Assembly is prohibited from interfering with an individual's decision to access certain health care. Under the HCFA, it is courts that are tasked with deciding—based on all available information, including expert testimony where appropriate—whether a particular treatment is "health care." With respect to Due Course of Law, it is *parents* that the Government's theory deprives of authority. Before H.B. 68, Ohio's leading medical institutions offered gender-affirming medical care. Parents could then decide, in accordance with rigorous guidelines and treatment criteria, whether that care was appropriate for their child. The Government cannot take that power away from parents by suggesting parents are solely following "unelected experts"—particularly when the Government itself relies on "unelected experts" to justify its position. Rather, the decision lies with parents and any incursion on that familial privacy must withstand strict scrutiny. Contrary to the Government's empty rhetoric, no one is suggesting legal decisionmaking authority should be delegated to medical experts, "unelected" or otherwise.

At bottom, both sides have experts. The question is whether the Government has justified its decision under the applicable level of scrutiny to take away from Ohio citizens, parents specifically, the right to weigh the experts' competing views and come to their own decision. It has not. As Governor DeWine stated in vetoing H.B. 68, the statute rests on the premise "that the State, that the government, knows what is best medically for a child rather than the two people who love that child the most, the parents." The HCFA does not allow this, and the Due Course of Law Clause does not allow this. This Court should affirm the judgment below.

STATEMENT OF THE CASE

I. Gender-affirming medical care is a safe, effective, and evidence-based treatment for adolescents with gender dysphoria.

This case involves gender-affirming medical care, which is a safe, effective, and evidence-based treatment in Ohio and across the United States for adolescents with gender dysphoria. *See, e.g.*, 7.16 Tr.37:10-39:10 (Corathers[1]); 7.16 Tr.167:8-11, 190:6-191:3 (Antommaria[2]). Gender dysphoria is a medical condition recognized by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. A-7 (¶ 9). The condition is "characterized by clinically significant distress resulting from incongruence between a person's gender identity and sex assigned at birth that has persisted for at least six months." *Id.* (¶ 9); *see also* 7.15 Tr.96:23-

[1] Dr. Sarah Corathers is a pediatric and adult endocrinologist, associate professor at Cincinnati Children's Hospital, clinical director of the endocrinology division, and associate chief of staff for the endocrinology subspeciality. 7.15 Tr.293:9-294:2, 294:25-295:14 (Corathers); *see also* Trial Ex. 20 (Corathers CV). In addition to treating about 300 adolescents with gender dysphoria, Dr. Corathers has conducted research and published peer reviewed articles on the treatment of gender dysphoria in adolescents. 7.15 Tr.296:16-20, 297:9-15 (Corathers).

[2] Dr. Armand Antommaria is a pediatric hospitalist, bioethicist, and director of the ethics center at Cincinnati Children's Hospital Medical Center, as well as a professor of pediatrics and surgery at the University of Cincinnati College of Medicine. 7.16 Tr.132:5-133:16; *see also* Trial Ex. 19 (Antommaria CV). Dr. Antommaria works with transgender patients, both at the individual level by conducting clinical ethics consultations and at the policy level through his work with the transgender health clinic at Cincinnati Children's. 7.16 Tr.135:8-18 (Antommaria).

97:8 (Turban[3]) (describing gender dysphoria as "a diagnosis that describes when an individual has a discordance between their gender identity and their sex assigned at birth for a period of at least six months, and that [] discordance creates functional impairment in social, occupational, or other area[s] of functioning"). Untreated, it "can lead to debilitating distress, depression, impairment of function, substance use, self-injurious behaviors, and even suicidality." A-8 (¶ 12); *see also* 7.15 Tr.99:24-101:19.

A. There are longstanding, evidence-based guidelines for diagnosing and treating gender dysphoria.

Like other psychiatric conditions, gender dysphoria is diagnosed through patient clinic interviews and, for minors, information from parents. 7.15 Tr.97:18-99:11, 114:23-115:9, 258:5-13 (Turban); 7.15 Tr.309:14-310:2 (Corathers). As the Government's psychiatry expert, Dr. Levine, explained, a diagnosis of gender dysphoria has inter-relater validity: If one doctor diagnoses a patient with gender dysphoria, another doctor is likely to reach the same conclusion. 7.18 Tr.139:1-140:14 (Levine). Experts for both sides agree that if a patient's gender incongruence persists after the onset of puberty, that incongruence 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); *see also* Opening Br. 26.

As is true with many areas of medicine, there are clinical practice guidelines for treating gender dysphoria. 7.16 Tr.166:16-23, 190:18-23 (Antommaria); *see also* 7.15 Tr.304:23-305:5

[3] Dr. Jack Turban is an assistant professor of child and adolescent psychiatry at the University of California – San Francisco and director of UCSF's gender psychiatry program. 7.15 Tr.85:18-86:3 (Turban); *see also* Trial Ex. 21 (Turban CV). Dr. Turban has extensive experience treating gender dysphoria, including having treated around a hundred minors. 7.15 Tr.87:1-88:24 (Turban). He also teaches child psychiatry fellows, psychiatry residents, and medical students about gender dysphoria, *id.* at 88:25-89:10; conducts research, and publishes widely on the subject of transgender youth, including over 30 peer reviewed articles addressing the mental health of transgender youth and textbooks and textbook chapters on child and adolescent psychiatry generally and gender dysphoria specifically. *Id.* at 89:11-91:2, 91:3-15.

(Corathers). The guidelines issued by the Endocrine Society and the World Professional Association for Transgender Health (WPATH) were each developed by experts in the field using well-accepted methodologies for reviewing the best available evidence and developing treatment recommendations. 7.16 Tr.153:1-156:21 (Antommaria); *see also* 7.15 Tr.105:5-106:14 (Turban); 7.15 Tr.304:17-22 (Corathers). In broad strokes, the treatment at issue in this case has two components. First, puberty suppression medications "reversibly suppress" certain hormones to delay the onset of puberty. A-16 (¶ 26). Second, when appropriate, patients can later access hormone therapy "to induce puberty consistent with a patient's gender identity." A-17 (¶ 27). The availability of specific treatments for gender dysphoria varies depending on the minor's age and specific medical history.

To start, there are no medical interventions for prepubertal children experiencing gender dysphoria. 7.15 Tr.309:4-13 (Corathers). These children may benefit from psychotherapy to explore their gender identity and provide support as they navigate school and possible social transitions (*e.g.*, using a new name or hairstyle to reflect their gender). 7.15 Tr.252:3-254:8 (Turban).

For youth who experience distress after the onset of puberty (*i.e.*, during adolescence), puberty delaying medications may be clinically indicated. 7.15 Tr.106:15-107:10 (Turban); 7.15 Tr.305:6-306:7 (Corathers). Puberty can cause significant distress for youth with gender dysphoria because of the development of secondary sex characteristics that do not match their gender identity. By temporarily pausing pubertal changes, puberty delaying medications give a minor 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). Once treatment stops, puberty resumes. 7.15 Tr.313:17-314:13 (Corathers).

For older adolescents who continue to experience gender dysphoria, hormone therapy may be clinically indicated. The guidelines recommend that such treatment should be provided only if gender incongruence has persisted for "years." 7.15 Tr.121:20-122:7 (Turban). For youth on pubertal suppression, hormone therapy is typically initiated around the time the patient's peers are still experiencing pubertal onset, around age 14. 7.15 Tr.316:12-317:8, 325:4-15 (Corathers).[4] The goal of hormone therapy 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). Transgender male adolescents receiving testosterone will develop masculine secondary sex characteristics such as facial hair and a deeper voice; transgender female adolescents receiving estrogen will develop feminine secondary sex characteristics such as breast development and softened features. 7.15 Tr.327:12-328:6 (Corathers).

Prior to the initiation of either treatment, the guidelines provide for comprehensive psychosocial assessments, including to probe 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). In addition, these treatments are provided to minors only with the assent of the patient and informed consent of the parents *after* the patient and their parents have been fully informed of the potential risks, benefits, and alternatives, and a physician has determined that the minor has the emotional and cognitive maturity to understand the risks and appreciate the long-term consequences of treatment.

[4] Children typically reach the first stages of puberty between the ages of 8 and 14. 7.15 Tr.308:9-309:3 (Corathers).

7.15 Tr.122:8-123:16 (Turban); 7.15 Tr.309:14-310:20 (Corathers); 7.16 Tr.175:10-178:3 (Antommaria).

Puberty delaying medications and hormone therapy have been used to treat adolescents with gender dysphoria since at least the 1990s, and they have been available in Ohio since at least 2009. 7.16 Tr.52:19-53:2 (Corathers); *see also* 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, consider these treatments medically necessary where clinically indicated and have opposed bans on this 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 with nationalized health care services are now requiring that some or all gender-affirming medical care for minors take place in the context of clinical trials where more data can be collected, none of these countries has entirely prohibited pubertal suppression or hormone therapy for minors. 7.16 Tr.187:14-189:11 (Antommaria); *see also* 7.15 Tr.168:6-169:8 (Turban).

Notably, these very treatments are used—and under H.B. 68 remain available—to treat minors with a variety of conditions other than gender dysphoria. Puberty delaying medications, for example, "have been used by pediatric endocrinologists for decades to treat precocious puberty." A-16 (¶ 26); *see also* 7.15 Tr.314:14-315:16 (Corathers) (explaining that puberty delaying medications are used to treat central precocious puberty and endometriosis). Hormone therapy is likewise used to treat a series of other pediatric conditions, including Turner syndrome (when one or both of a female's X chromosomes are missing or partially missing), Klinefelter syndrome (when a male is born with an extra X chromosome), premature ovarian failure,

consequences of cancer treatments, and hypogonadism. A-18 (¶ 28); *see also* 7.16 Tr.17:2-18:5, 19:11-20:12 (Corathers). In addition, 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 polycystic ovary syndrome may be given estrogen to minimize the development of masculine features. 7.16 Tr.39:11-41:10 (Corathers).

B. The undisputed evidence at trial established that these treatments are effective.

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 suppression medications 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 research findings showing that these treatments improve the mental health and well-being of adolescents with gender dysphoria. Studies published in peer-reviewed scholarly journals have found that hormone therapy is associated with improvement in a variety of mental health and quality of life outcomes and that youth treated with puberty suppression do not see the worsening of mental health that is typically experienced among gender dysphoric youth if they go through puberty without treatment. 7.15 Tr.127:22-133:23 (Turban). Thus, it was undisputed at trial that some youth benefit from pubertal suppression and hormone therapy. 7.15 Tr.129:1-133:23, 199:1-200:5 (Turban); 7.15 Tr.301:14-302:21 (Corathers); 7.16 Tr.14:7-21, 43:16-45:11 (Corathers); 7.16 Tr.223:7-11 (Government's witness Reed); 7.18.24 Tr.113:22-114:18 (Levine); *see also* 7.15 Tr.39:13-14 (Goe); 7.16 Tr.262:2-11, 269:1-271:2 (Moe).

Like many pediatric medical treatments, the evidence base for gender-affirming medical care in adolescents relies on cross-sectional and longitudinal studies; in pediatrics, it is rare for there to be a randomized controlled trial, because they are difficult to conduct for ethical and practical reasons. 7.16 Tr.157:25-160:24, 161:20-162:20, 171:13-19 (Antommaria).[5] It was undisputed at trial that doctors must make treatment decisions based on the best available evidence for patients who are currently in need of care. 7.16 Tr.140:5-16, 163:14-164:18, 199:17-200:5 (Antommaria).

Although cross-sectional and longitudinal studies are referred to as "low quality" evidence in the parlance of systems used to grade the quality of medical evidence, 7.15 Tr.127:17-128:25, 131:7-132:8 (Turban); 7.16 Tr.154:3-17 (Antommaria), they still provide a scientifically valid and reliable basis for developing treatment recommendations. 7.16 Tr.143:11-19 (Antommaria). The term "low quality" is used to contrast the available studies with "high quality" evidence, a term that generally refers to randomized controlled clinical trials. *Id.* It was undisputed at trial many other types of medical treatments that adolescent patients and their parents may pursue are based on evidence that is likewise described as "low quality." 7.16 Tr.166:16-23, 190:14-191:3 (Antommaria); *see also* 7.15 Tr.304:23-305:5 (Corathers).[6] And both parties' experts agreed that

[5] As Dr. Antommaria explained, "[a]t this point in time, comparing gender-affirming medical care and mental health care to a placebo and mental health care would not [be] ethical," because the "relevant expert community understands that gender-affirming medical care is more effective than a placebo." 7.16 Tr.159:11-17.

[6] The Government's experts cite to systematic reviews of the body of research, including the Cass Review in the United Kingdom, that they assert show a lack of evidence of efficacy of the prohibited treatments. But those reviews did not offer any new evidence; they just summarized some of the existing research and offered the authors' views on the research. Importantly, they omitted many of the studies in their summaries, with authors of different reviews repeatedly disagreeing about whether a study was worthy of being included. 7.15 Tr.160:8-168:5 (Turban). And in any event, the Cass Review did not recommend a categorical ban on medical treatment. 7.16 Tr.188:19-21 (Antommaria).

it would be beneficial to have more research on the use of puberty suppression medications and hormone therapy to treat adolescents with gender dysphoria—research that is barred under H.B. 68. 7.16 Tr.166:24-167:11 (Antommaria); 7.18 Tr.116:22-118:12 (Government's expert Levine); 7.19 Tr.70:10-17 (Government's expert Hruz).

C. The undisputed evidence at trial established that these treatments are safe.

The parties agreed on much about the risks of gender-affirming medical care. Both sides' experts agreed 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). It was further undisputed that the risks of gender-affirming medical care are comparable to the risks of other medical treatments that parents are permitted to seek and obtain for their minor children. 7.16 Tr.167:25-170:4 (Antommaria). And it was undisputed that most of the potential risks associated with puberty suppression medications and hormone therapy apply equally when these same medications are used to treat other conditions in minors. For example, regardless of the condition they are used to treat, puberty suppression medications may pose risks related to intracranial pressure, and hormone therapy may pose a risk of blood clots. 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). These risks are very rare, particularly when patients are monitored by a doctor. In caring for hundreds of young transgender patients receiving these medications, Dr. Corathers has not seen those side effects. 7.15 Tr.317:25-319:7, 329:16-20, 7.16 Tr.11:17-21 (Corathers). And these risks have not prevented the Government's expert, Dr. Hruz, from providing these same medications to minors for purposes other than the treatment of gender dysphoria. 7.19 Tr.70:25-71:9 (Hruz).

The Government's experts testified that puberty suppression medications can pose a risk to social development and bone health when used to treat gender dysphoria, on the theory that delaying puberty hinders social development and interferes with the rapid accrual of bone

mineralization that occurs during puberty. *See* Opening Br. 6-8. But these asserted concerns are premised on the incorrect assumption that youth treated with puberty suppression medications for gender dysphoria do not start puberty within the time frame of their peers. 7.15 Tr.308:9-309:3, 316:4-317:8, 322:12-323:15; 7.16 Tr.7:14-8:1, 67:14-18 (Corathers); 7.19 Tr.19:18-20:10 (Hruz).

The one potential risk that can, in some cases, differ when these medications are provided to treat gender dysphoria is "a potential risk of decreased fertility potential." 7.16 Tr.12:21-22. Notably, this risk does not exist in all cases of treatment banned under H.B. 68: If a patient is treated with puberty suppression medications and then discontinues treatment, there is no "long-term risk to fertility." 7.15 Tr.324:22-325:3 (Corathers). And for courses of treatment that might result in an impact on fertility, it was undisputed that there are steps that can mitigate those risks or otherwise preserve fertility. 7.15 Tr.330:4-332:2; 7.16 Tr.12:19-13:20 (Corathers).

D. Experts from both parties agreed that parents should weigh the risks of providing gender-affirming medical care against the significant risks from withholding treatment.

The manageable risks from gender-affirming medical care must be weighed against the enormously consequential risks of denying that care. Experts from both sides agreed that, though psychotherapy can be effective in treating comorbidities such as depression and anxiety, there is no evidence-based psychotherapeutic alternative for gender dysphoria. 7.18 Tr.76:6-23 (Government's expert Levine); *see also* 7.15 Tr.126:11-25, 136:18-137:3, 137:25-138:2, 200:7-201:143, 210:7-22 (Turban). Thus, absent puberty suppression medications and hormone therapy, minors with gender dysphoria 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). There is overwhelming evidence that these minors will face a significant risk of harm, including worsening anxiety, depression, impaired global functioning, and suicidality. 7.15 Tr.207:4-18 (Turban). Waiting until they turn 18 is not an option:

Forcing adolescents who are experiencing gender dysphoria to undergo the physical changes that come with endogenous puberty will cause them years of unnecessary suffering, and leave them with secondary sex characteristics that are incongruent with their gender identity and difficult or impossible to reverse 7.15 Tr.207:19-208:10 (Turban).[7]

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); *see also* 7.15 Tr. 121:5-19 (Turban); 7.16 Tr.146:8-149:8, 170:12-16, 177:5-178:3 (Antommaria); 7.16 Tr.26:25-30:25 (Corathers). That is how medical decision-making and informed consent occurs in pediatrics: parents or legal guardians consent on behalf of the patient in consultation with the physician, and the pediatric patient participates to the extent appropriate for their level of development. 7.16 Tr.146:24-149:8 (Antommaria); 7.18 Tr.98:7-17 (Government's expert Levine). Indeed, Dr. Levine—the only one of the Government's experts who has any meaningful experience treating patients with gender dysphoria—has written letters approving hormone therapy for his minor patients and (absent H.B. 68) would 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 (Levine).

[7] As discussed below, for Ohio youth currently receiving puberty suppression medications, the law allows them to continue that treatment but not initiate hormone therapy. *See infra*, p. 13. Remaining on puberty suppression medications until age 18 is neither safe nor medically appropriate. 7.15 Tr.325:16-326:10 (Corathers). Thus, patients on pubertal suppression medication 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 that are incongruent with their gender identity develop. 7.16 Tr.49:6-52:1 (Corathers); 7.16 Tr.178:4-22 (Antommaria).

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).

II. H.B. 68 prohibits gender-affirming medical care.

At issue is the Saving Ohio Adolescents From Experimentation Act ("the Health Care Ban" or "Ban"), contained with House Bill 68. In relevant part, the Health Care Ban prohibits anyone under the age of 18 from accessing gender-affirming medical care, which it refers to as "gender transition services." 2024 Sub.H.B. No. 68. Specifically, physicians are prohibited from prescribing "a cross-sex hormone or puberty-blocking drug for a minor individual for the purpose of assisting the minor individual with gender transition," *id.* (enacting R.C. 3129.02(A)(2)), and further from knowingly engaging in "conduct that aids or abets in" such treatment, *id.* (enacting R.C. 3129.02(A)(3)).[8] The Ban does not apply where a physician has already initiated gender-affirming medical care for a minor who is an Ohio resident, and the physician determines "that terminating the minor individual's prescription for the cross-sex hormone or puberty-blocking drug would cause harm to the minor individual." *Id.* (enacting R.C. 3129.02(B)). The Ban is also limited to care provided for "gender transition services"; it expressly permits physicians to prescribe the same treatment for a variety of other conditions, including, for example, minors "born with a medically verifiable disorder of sex development." *Id.* (enacting R.C. 3129.04). The Attorney General is authorized to "bring an action to enforce compliance" with the Ban's provisions and, any violation of the Health Care Ban "shall be considered unprofessional conduct

[8] The Ban also prohibits performing "gender reassignment surgery on a minor individual," R.C. 3129.02(A)(1), but surgery for gender dysphoria was not available in Ohio, even prior to the passage of H.B. 68. Plaintiffs did not challenge the surgery provision of H.B. 68 and the Tenth District repeatedly declined to address it. *See, e.g.*, A27-28 (¶ 60), A-35 (¶ 78).

and subject to discipline by the applicable professional licensing board." *Id.* (enacting R.C. 3129.05(A), (C)).

H.B. 68 also includes the Save Women's Sports Act, which requires schools to designate sex-segregated sports teams, and mandates that no school, college, university, or interscholastic conference "shall knowingly permit individuals of the male sex to participate on athletic teams or in athletic competitions designated only for participants of the female sex." *Id.* (enacting R.C. 3313.5319). Previous efforts to enact similar, but free-standing, versions of the two individual bills had failed in prior legislative sessions. *See* S.B. No. 132, As Introduced version, 134th General Assembly (Mar. 16, 2021); H.B. No. 454, As Introduced version, 134th General Assembly (Oct. 19, 2021). It was only once the two provisions were combined that the bill cleared the General Assembly. *See* Ohio Legislative Service Commission, Final Analysis of Sub.H.B. No. 68, as passed by the General Assembly (2024), at 9.

On December 29, 2023, Governor Mike DeWine vetoed H.B. 68. As he explained, his veto was ultimately "about protecting human life."[9] "Many parents" told the Governor "that their child would be dead today if they had not received the treatment they received from an Ohio children's hospital."[10] Likewise, many grown adults told the Governor that, "but for this care, they would have taken their lives when they were teenagers."[11] Thus, were he "to sign Substitute House Bill 68 or were Substitute House Bill 68 to become law, Ohio would be saying that the State, that the government, knows what is medically best for a child rather than the two people who love that

[9] Veto Message: Statement of the Reasons for the Veto of Substitute House Bill 68 (Dec. 29, 2023), https://content.govdelivery.com/attachments/OHIOGOVERNOR/2023/12/29/file_attachments/2731770/Signed%20Veto%20Message%20HB%2068.pdf.
[10] *Id.*
[11] *Id.*

child the most, the parents."[12] He continued: "While there are rare times in the law, in other circumstances, where the State overrules the medical decisions made by parents, I can think of no example where this is done not only against the decision of the parents, but also against the medical judgment of the treating physician and the treating team of medical experts."[13]

The General Assembly voted to override Governor DeWine's veto.

III. Plaintiffs challenge H.B. 68 under the Ohio Constitution.

Two Ohio families brought suit to challenge H.B. 68 as unconstitutional.

A. The Goe Family

Gina and Garrett Goe and their four children—Grace Goe and three older brothers—live in a suburb of Columbus. Grace's mother describes Grace as "a delightful, wonderful person. She is warm. She's friendly. She's kind. She has a great group of friends. She is really into arts and crafts." 7.15 Tr.19:16-22. Grace is also academically driven, maintaining straight As entering seventh grade. *Id.*

Grace, a transgender girl, was diagnosed with gender dysphoria approximately seven years before the start of this case. *Id.* at 34:23-35:2, 45:23-46:2. Just prior to starting first grade, Grace began shifting to being "perceived and respected as a girl," including transitioning her pronouns and clothing from masculine to feminine. *Id.* at 38:2-39:2, 40:13-20. Before this transition, Grace "was in distress" and in a "constant state of desperation" to be a recognized as a girl. *Id.* at 45:5-6. She would pray nightly to God to make her a girl and even questioned aloud whether death would allow her to return as one. *Id.* at 27:14-20. Once she socially transitioned, however, Grace blossomed into a thriving, happy, healthy person with strong relationships and many interests. *Id.* at 39:13-14. Only a few people know Grace is transgender—a small group of people who knew

[12] *Id.*
[13] *Id.*

her before her transition—and that is the way she wants to keep it. *Id.* at 46:3-20.

The testimony at trial showed that puberty for Grace "could begin at any time." *Id.* at 51:23-25. The risk of developing masculine physical characteristics "would be devasting" for Grace. *Id.* at 51:23-25, 48:20-49:2. If forced to develop male characteristics, like a deepening voice and facial hair, Grace "would not want to leave the house. She would not feel like herself to be free, to exist in this world as who she is." *Id.* at 55:8-13. Gina and Garrett thus began pursuing the option of puberty suppression medications for Grace. Following a referral from her diagnosing psychiatrist, Grace underwent regular check-ins with an endocrinologist, with whom Grace and her parents have discussed the effects, side effects, and risks of this treatment. *Id.* at 50: 11-51:25. Prior to passage of H.B. 68, the Goes had a plan to discuss potential next steps with Grace's endocrinologist once she found visible signs of puberty in Grace. *Id.* at 53:1-55:13. Gina Goe expected that Grace would proceed with puberty suppression medications. *Id.* ("I would be shocked if she didn't … She knows herself to be a girl[.]").

When Grace learned about H.B. 68, she "laid down and wept" and has been "carrying this looming worry and anxiety." *Id.* at 58:19-59:16. H.B. 68 prevents Grace from receiving the medical care she desperately needs. *Id.* at 56:2-58:18. Her longstanding relationship with her psychiatrist is in doubt, as it is uncertain whether he is able to continue their meetings. *Id.* at 60:4-61:3. H.B. 68's effect leaves the Goe family with an impossible choice. Stopping treatment for Grace would "harm her mentally, emotionally, spiritually, and relationally[.]" *Id.* at 48:23-49:2. But continuing treatment would force Gina to take Grace on periodic multi-day trips to a clinic in Michigan—a substantial "financial burden" that also causes Grace to miss school. *Id.* at 61:9-62:1. The only other options are for the Goes to move out of Ohio or for the family to live separately, options that would impose a massive personal and economic burden. *Id.* at 61:4-63:15.

B. The Moe Family

The Moe family, including Madeline Moe and her older sister, reside in Cincinnati. 7.16 Tr.234:14-25 (Moe). Madeline's father describes her as "a typical 12-year-old," who "enjoys spending time with her friends" and "playing outside." *Id.* at 237:9-11. She is in an accelerated program at one of the country's premier public schools and her goal is to become a lawyer "to defend the innocent and help the people that can't help themselves." *Id.* at 236:16-237:1.

Madeline, a transgender girl, received a diagnosis of gender dysphoria around first grade. Her parents ultimately allowed her to socially "transition into a girl." *Id.* at 254:10-255:24. The year before her transition was the "hardest year" for Madeline and her family. *Id.* at 246:8-11. Madeline frequently expressed sentiments such as, "Why did God make me like this? I wish I could die and just be reborn." *Id.* at 247:23-248:3. On one occasion, Madeline "grabbed a knife out of the drawer and tried to cut herself in the wrist" before her parents succeeded in taking the knife from her. But when Madeline was allowed to be "whoever [she] want[ed] to be," she came "out of her shell." *Id.* at 253:16-19. Madeline went "from a child that had been very distressed and very upset to now being able to express herself as she wanted to be." *Id.* at 258:1-10; *see also id.* at 253:9-254:2. She eventually adopted a feminine name and pronouns. *Id.* Her parents changed her legal name, along with the gender markers on her birth certificate, passports, school records, and medical records. *Id.* at 264:11-15. Since then she has lived and presented herself as a girl. *Id.*

In February of 2023, Madeline received a puberty blocker implant. *Id.* at 265:17-19. The decision was "logical" to her and her parents. *Id.* at 266:15. Madeline's parents concluded that having "facial hair, an Adam's apple, chest hair, big arms, big feet, big muscles" would cause Madeline "to have anxiety, depression, suicidal tendencies." *Id.* at 266:9-24. Both Madeline and her parents were apprised of potential side effects. *Id.* at 267:2-9. Madeline's parents explained

that it was "apparent" to them "that the actual benefits that [they] could see far outweighed any potential side effects." *Id.* Madeline has not "experienced any negative reaction or side effect" since beginning treatment. *Id.* at 267:2-9. Madeline and her parents have also discussed hormone therapy, for which she would be eligible "around age 13 or 14." *Id.* at 267:2-15, 268:16-269:5.

Under H.B. 68, Madeline is unable to begin hormone therapy. Madeline and her family's reaction to the bill's passage was anger and frustration that the "government was not allowing her to live her life." *Id.* at 269:25-270:13, 271:16-18. Without hormone therapy, "it would be devastatingly bad. She would not be able to continue her development into a young woman … To pause or interrupt her development would be devastating to her." *Id.* at 270:21-271:2. The Moes have taken steps to obtain health care for Madeline outside of Ohio, where the waiting list may be over a year to see a physician. *Id.* at 271:19-272:6. Because of H.B. 68, the Moes may be forced to undertake costly and challenging trips back and forth to Illinois. They "don't want to move out of Ohio"; "[e]verything" they have "is in Ohio." But if forced to, they will. *Id.* at 272:23-273:2, 273:3-15.

C. The Tenth District rules the Ban unconstitutional.

On March 26, 2024, Plaintiffs filed a Complaint and Motion for Preliminary Injunction Preceded by Temporary Restraining Order If Necessary in the Franklin County Court of Common Pleas. Plaintiffs' complaint alleged that the Ban violates four separate clauses of the Ohio Constitution: (1) Article II, Section 15(D) (the so-called "single-subject rule"); (2) Article I, Section 21 (the Health Care Freedom Amendment); (3) Article I, Section 2 (Ohio's Equal Protection Clause), and (4) Article I, Section 16 (Ohio's Due Course of Law Clause). A-82.

On April 16, the trial court issued a temporary restraining order, holding that H.B. 68 likely violated the Ohio Constitution's single-subject rule and that Plaintiffs would be irreparably harmed if the Government were permitted to enforce the law during the pendency of the proceedings. *See*

TRO Entry at 11-13. By order issued on April 30, 2024, the trial court extended the TRO through May 20, 2024. It extended the TRO again on May 3, 2024, through the conclusion of the scheduled preliminary injunction hearing and trial.

On July 15-19, 2024, the trial court held a combined hearing on Plaintiffs' preliminary injunction motion and full trial on the merits. On August 6, 2024, the trial court issued an opinion and final judgment on the merits, denying all of Plaintiffs' claims but issuing few findings of fact. A82-93. Among the trial court's sparse factual findings was that "[g]ender transition services constitute 'health care'"—a finding the Government has never directly challenged. A-88 (¶ 17). Plaintiffs filed their Notice of Appeal that same day.

On appeal, the Tenth District reversed the trial court's judgment. After exhaustively cataloguing the evidence in the case, A-5-22, the Tenth District concluded that the trial court had erred with respect to the HCFA and the Due Course of Law Clause. A-25. The Court therefore determined that the remaining two assignments of error, on the single-subject rule and the Equal Protection Clause, were "moot." A-25.

With respect to the HCFA, the Tenth District first determined that "the record supports the trial court's finding that '[g]ender transition services constitute "health care,"' a finding that had "not been challenged or otherwise contested by the state on appeal." A-29. Thus, the court concluded that Plaintiffs' right to obtain gender-affirming medical care was protected by the HCFA's prohibition on laws that "prohibit the purchase or sale of health care or health insurance." A-25 (quoting Article I, Section 21(B)). While recognizing that the HCFA did not "affect any laws calculated to deter fraud or punish wrongdoing in the health care industry," the Court explained that "the term 'wrongdoing' most naturally refers to specific instances of misconduct within the medical profession." A-32 (discussing Article I, Section 21(D)). Thus, this provision could not

be used to justify the ban on gender-affirming medical care. Specifically, it concluded that the General Assembly could not "simply declare any type of health care to be 'wrongdoing' and swallow up the right enshrined in the Ohio Constitution by direct vote of Ohio's citizens." A-35. More broadly, the court rejected the Government's suggestion that the HCFA protected "nothing more than the right to receive health care subject to the policy preferences of the General Assembly." A-33.

As for the Due Course of Law Clause, the court recognized that "[a]mong liberty interests the United States Supreme Court has specifically recognized as protected by the Due Process Clause of the federal constitution is the fundamental right of parents to 'make decisions concerning the care, custody, and control of their children.'" A-39 (quoting *Troxel v. Granville*, 530 U.S. 57, 66 (2000) (plurality op.)). The court therefore determined that the Parent-Plaintiffs in this case "assert a long-recognized and well-established fundamental liberty interest protected by the federal Due Process Clause and Ohio's Due Course of Law Clause." A-43. As a result, H.B. 68 was subject to strict scrutiny—a standard it failed. A52-53. Though the "existence of risks … undoubtedly calls for caution in treating minors with gender dysphoria," the court determined that the risks do not "beget a one-size-fits-all prohibition of widely accepted medical treatments for minor patients and parents who have chosen, in consultation with their doctors and multi-disciplinary team, to treat their children's gender dysphoria diagnosis with puberty suppression medications or hormones in appropriate circumstances and in accordance with the prevailing standards of care." A-52-53.

The Government sought review in this Court, which was granted on July 22, 2025. The Court also stayed the Tenth District's order, thus allowing H.B. 68 to remain in effect.

ARGUMENT

The Tenth District concluded that H.B. 68 violates two separate provisions of the Ohio Bill of Rights: the Health Care Freedom Amendment and the Due Course of Law Clause. Either provision provides an independent basis for affirming the Tenth District's conclusion that H.B. 68 is unconstitutional.[14]

I. H.B. 68 violates the Health Care Freedom Amendment.

The HCFA enshrines in the Ohio Constitution the right to access health care. In relevant part, it provides:

> (B) No federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance.
>
> (C) No federal, state, or local law or rule shall impose a penalty or fine for the sale or purchase of health care or health insurance.

Ohio Const., art. I, § 21. The HCFA has only limited exceptions: It does not affect "laws or rules in effect as of March 19, 2010," "services a health care provider or hospital is required to perform or provide," "terms and conditions of government employment," or "any laws calculated to deter fraud or punish wrongdoing in the health care industry." *Id.*, § 21(D). H.B. 68 bans Ohioans from purchasing a form of health care, and thereby violates both Sections 21(B) and (C).

The Government objects to the Tenth District's ruling on two grounds. In the Government's view, Section 21(B) does not protect the purchase of gender-affirming medical care, on the theory that "Subsection (B)'s right to purchase health care is limited to what the State allows." Opening Br. 36. The Government also maintains that H.B. 68 falls within the exceptions in Section 21(D) on the basis that the provision of gender-affirming medical care is "wrongdoing

[14] If the Court reverses the Tenth District on both Plaintiffs' HCFA and Due Course of Law Claims, then the proper course is to remand this case for the Tenth District to address Plaintiffs' claims based on the Single Subject Rule and the Equal Protection Clause.

in the health care industry." *Id.* Both theories fail. The Government has never challenged the trial court's finding that gender-affirming medical care is health care—nor does it present any basis for having this Court revisit that factual finding. Gender-affirming medical care thus falls squarely within Section 21(B), as well as Section 21(C). As for Section 21(D), the Government makes no attempt to define "wrongdoing in the health care industry," let alone to explain why a standard-of-care treatment offered by Ohio's flagship medical institutions falls into this category.

Whether viewed as a question of "health care" under Sections 21(B) and (C) or "wrongdoing" under Section 21(D), the Government's position is that the HCFA protects only the health care the General Assembly allows it to protect. In other words, no law can prohibit the purchase of health care, unless the law prohibits the purchase of health care. *See* Opening Br. 36. That approach eviscerates the HCFA by protecting individual freedom of choice in health care only so long as the General Assembly has not decided otherwise. The Court should reject the Government's attempt to nullify a provision of the Ohio Bill of Rights through a perverse, atextual reading.

A. Sections 21(B) and (C) protect access to gender-affirming medical care.

1. The text of the HCFA is unambiguous.

"In construing constitutional text that was ratified by direct vote, [the Court] consider[s] how the language would have been understood by voters who adopted the amendment." *City of Centerville v. Knab*, 2020-Ohio-5219, ¶ 22. As with questions of statutory interpretation, the starting point is "the plain language of the text," and "how the words and phrases would be understood by the voters in their normal and ordinary usage." *Id.* (citing *District of Columbia v. Heller*, 554 U.S. 570, 576-577 (2008)). If the text "is plain and unambiguous," the Court applies it "as written," and "no further interpretation is necessary." *Wayt v. DHSC, L.L.C.*, 2018-Ohio-4822, ¶ 15.

The HCFA is unambiguous: It forbids the General Assembly from prohibiting or penalizing "the purchase or sale of health care[.]" Ohio Const., art. I, §§ 21(B)-(C). As the Tenth District explained, while the HCFA does not itself define health care, it has a commonly understood meaning in the Ohio Revised Code—namely, "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental conditions or physical or mental health." *See, e.g.*, R.C. 1337.11(G) (durable power of attorney for health care); R.C. 2135.01(G) (juvenile mental health treatment); *see also* A-29 (¶ 57). Using this definition for guidance, the HCFA dictates that no state law shall prohibit the purchase of "any care, treatment, service, or procedure" to "treat an individual's physical or mental conditions or physical and mental health."

H.B. 68 does exactly that. Gender-affirming medical care involves medications, including puberty suppression medication and hormone therapy, that help lessen or resolve gender dysphoria. *See supra*, pp. 4-8. Gender dysphoria is a medical condition recognized by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. A-7 (¶ 9); *see also supra*, p. 3. Without treatment, it can result in significant harm, including "debilitating distress, depression, impairment of function, substance use, self-injurious behaviors, and even suicidality." A-8 (¶ 12); *see also supra*, pp. 3-4. Thus, these medications are "care, treatment, [or] service" to "treat an individual's physical or mental conditions or physical and mental health," and therefore are properly understood as health care protected by the HCFA.

The text of H.B. 68 in fact confirms that gender-affirming medical care is health care. As relevant here, "'[g]ender transition services' means any medical or surgical service (including physician services, inpatient and outpatient hospital services, or prescription drugs or hormones) provided for the purpose of assisting an individual with gender transition," "including medical services that provide puberty blocking drugs [or] cross-sex hormones." R.C. 3129.01(F). In other

words, H.B. 68 defines the treatments at issue as "medical services" provided for the purpose of treating gender dysphoria, where "medical services" covers care in the category of "physician services" or "prescription drugs or hormones." *Id.* By the statute's own terms, then, "gender transition services" are "service[s]" to "treat an individual's physical or mental conditions or physical or mental health," and therefore qualify as "health care." *See supra*, p. 23.

Against this backdrop, the trial court correctly found that gender-affirming medical care is "health care" for purposes of the HCFA. A-88 (¶ 17) ("Gender transition services constitute 'health care'"). While the trial court ultimately drew the incorrect legal conclusion that gender-affirming medical care should be categorized as "wrongdoing in the health care industry" under Section 21(D), it made no findings to suggest this care falls outside the bounds of Sections 21(B) or (C). A-88 (¶¶ 17-18). The Government never challenged in the trial court whether gender-affirming medical care qualifies as health care, nor did it dispute this finding on appeal before the Tenth District. As the Tenth District explained, "the record supports the trial court's finding that '[g]ender transition services constitute health care,' which has not been challenged or otherwise contested by the state on appeal." A-29 (¶ 57) (internal quotation marks omitted).

In sum, H.B. 68 violates the HCFA by barring health care. H.B. 68 prohibits the prescription of "a cross-sex hormone or puberty-blocking drug for a minor individual" for the purpose of treating gender dysphoria. R.C. 3129.02(A)(2). It further penalizes the prescription of these treatments on threat of "discipline by the applicable professional licensing board." *Id.* 3129.05(A). Thus, H.B. 68 both prohibits access to a specific form of health care and penalizes any medical professional who offers that care—and therefore violates Sections 21(B) and (C) of the HCFA.

2. <u>The Court should reject the Government's attempts to narrow the HCFA.</u>

On appeal before this Court, the Government suggests that gender-affirming medical care

falls outside the purview of "Subsection (B)'s right to purchase health care," Opening Br. 36, but it provides no basis for this assertion. The Government never argues that gender dysphoria is not a physical or mental condition, or that puberty suppression medications and hormone therapy are not a means of treatment for gender-dysphoria. To the contrary, the Government recognizes that gender-affirming medical care is an appropriate treatment for *some* children, but suggests that Plaintiffs just cannot identify "*which* children" are in that category. Opening Br. 27. Nor does the Government ever address, let alone challenge, the trial court's undisputed finding that gender-affirming medical care is health care. *See supra*, p. 19. Rather than attempt to revive a waived challenge to the trial court's finding that gender-affirming medical care is health care, the Government seeks to interpret Sections 21(B) and (C) to exclude gender-affirming medical care without ever grappling with the meaning of "health care." These interpretations share a common thread: They have nothing to do with the text of those provisions.

i. There is no textual basis for the Government's efforts to narrow the HCFA.

To start, the Government briefly suggests that these provisions "are meant to preserve freedom in the market for buying (or refusing to buy) *licensed* health care or insurance." Opening Br. 36 (emphasis added). The Government is exactly correct that the HCFA was intended to preserve the freedom to buy health care, and gender-affirming medical care was indisputably available on the market prior to passage of H.B. 68. *See supra*, p. 7. To the extent the Government is attempting to narrow the scope of the HCFA by adding the word "licensed," that gambit fails. The phrase "licensed health care"—which the Government never defines or otherwise explains—appears nowhere in the text of the HCFA. Moreover, to "license" typically means to grant a legal right to do something. By adding this qualifier, the Government attempts to arrogate much of the authority that Ohio voters expressly transferred to the people. If the General Assembly can

designate certain treatments as "licensed" or "not licensed," then the General Assembly determines which treatments benefit from the protections of the HCFA—entirely sapping the HCFA of force. The Free Exercise Clause, for example, would lose all power if the General Assembly could simply declare that it applies only to "licensed" religions.

The Government's reinterpretation also makes little sense in context. As the concurrence explained below, the "state's reference to 'licensed' health care is a misnomer to the extent it suggests that particular health care procedures, methodologies, and treatments are 'licensed' in Ohio." A-35 (¶ 169, fn.72) (Dorrian, J., concurring in judgment). "Ohio licenses professionals who provide health care," as opposed to licensing "particular procedures, methodologies, and treatments." *Id.* The Tenth District thus properly declined to "add language ('licensed') that does not exist in the constitutional provision." A-28 (¶ 54) (majority op.). Moreover, the Government never actually explains why gender-affirming medical care—a well-established treatment that was available at Ohio's leading medical centers, *see supra*, p. 7—would not fall within the scope of "licensed health care."

The Government separately suggests that Sections (B) and (C) need to be understood against the backdrop of passage of the Affordable Care Act ("ACA"), and should therefore be interpreted solely as measures "to protect Ohioans" from being coerced "into certain healthcare plans" or from being barred from purchasing "fee-for-service care." Opening Br. 36-37. This argument fails on multiple levels.

As a threshold matter, because the language of Sections 21(B) and (C) is unambiguous, it is inappropriate to resort to the "historical context in which [the HCFA] was adopted." Opening Br. 36; *State v. Pariag*, 2013-Ohio-4010, ¶ 10 ("When a statute's language is clear and unambiguous, a court must apply it as written."); *Azar v. Allina Health Servs.*, 587 U.S. 566, 579

(2019) (courts do not allow "ambiguous legislative history to muddy clear" text). The text of the HCFA makes abundantly clear that its protections are not confined to health insurance: The amendment safeguards the purchase "of health care *or* health insurance." Art. I, §§ 21(B)-(C) (emphasis added). As the Tenth District recognized, use of the "disjunctive 'or' to separately reference both 'health care' and 'health insurance'" makes clear that Ohio citizens have "a right to their freedom of choice regarding both." A-28 (¶ 56); *see Cowherd v. Million*, 380 F.3d 909, 913 (6th Cir. 2004) (reciting the "basic principle of statutory construction that terms joined by the disjunctive 'or' must have different meanings"). Finally, the Amendment is titled "Preservation of the freedom *to choose health care* and health care coverage." Art. I, § 21 (emphasis added). Each voter who signed a petition to put the HCFA on the ballot had both the text and the title, and was therefore aware—based on the text alone—that the HCFA preserved the right to choose *health care*, and not just health insurance.[15]

The Government's attempts to tie the text of the HCFA to the ACA are unpersuasive. The Government references Section 21(A)'s protection against coercing an individual "to participate in a health care system," Opening Br. 36, but that reinforces that Section 21(B) provides protection beyond being compelled to purchase health insurance. Section 21(B) would have no purpose if it merely duplicated Section 21(A). *See Elliot v. Durrani*, 2022-Ohio-4190, ¶ 23 (explaining that the Court should "give such interpretation as will give effect to every word and clause," and "avoid that construction which renders a provision meaningless or inoperative" (internal quotations and alterations omitted)). Likewise, the HCFA's application to any "federal, state, or local law" hardly shows that the Amendment was solely a reaction to the ACA. Opening Br. 36. If anything, the

[15] 2010 Issue 3 Initiative Petition, available at https://www.ohiosos.gov/globalassets/ballotboard/2011/2010-05-03initpetition.pdf (accessed Nov. 4, 2025).

inclusion of state and local laws in the text demonstrates that the Amendment's target was *not* limited to the ACA—particularly because the Amendment's application to federal law is largely symbolic in light of the Supremacy Clause. As a leading proponent of the HCFA explained, "[a]t the state level" the HCFA protected against state laws that might "take away Ohioans' freedom to choose their health care or health insurance."[16] "At the federal level," by contrast, the HCFA was merely "intended to strengthen the argument that the" ACA was unconstitutional.[17]

At bottom, the Government's arguments turn on unsupported speculation regarding voters' concerns with the impact of the ACA. But when "construing constitutional text that was ratified by direct vote, [the Court] consider[s] how *the language* would have been understood by the voters who adopted the amendment." *City of Centerville*, 2020-Ohio-5219, at ¶ 22 (emphasis added). Thus, the analysis still turns on the language of the text—not post hoc speculation about the public's understanding of the general purpose of the amendment. The Government provides no basis, and certainly no basis grounded in the text, to impose an interpretation of the HCFA based on its view of the concerns animating the general voting public.

ii. The Government's historical arguments further undermine its interpretation.

Even putting all of that aside, the historical context supports *Plaintiffs*. Both the text of the HCFA and the surrounding messaging demonstrate that voters intended to preserve their freedom of access to health care. As the Government appears to acknowledge, opposition to the ACA turned in significant part on concerns regarding government involvement in health care. The official proponents promised each voter in their "Official Argument" for the provision that Ohioans would

[16] Ed Meese & Jack Painter, *Ohio's battle for health care freedom*, Politico (Nov. 7, 2011), available at https://www.politico.com/story/2011/11/ohios-battle-for-health-care-freedom-067727 (accessed Nov. 4, 2025).
[17] *Id.*

not be "imprisoned, fined, or prosecuted for *choosing* health insurance or *treatment* different from government requirements" (emphasis added).[18] More broadly, much of the messaging focused on curtailing governmental interference in the relationship between physician and patient. HCFA's proponents announced 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."[19] A board member of the HCFA's proponent committee explained that the HCFA was "about freedom—the freedom of Ohioans and others to make some of the most important personal decisions they can make about their choice of health care and how to pay for it."[20] And the HCFA committee's campaign manager declared that "[h]ealth care decisions should be made between patients and doctors. Not politicians and bureaucrats."[21] In short, proponents told voters the HCFA would "allow [them] to have a choice this fall if health care decisions should be made by patients and doctors or politicians in Washington D.C."[22]

Tellingly, proponents also took a broad view of what qualified as "health care," arguing that, under the HCFA, "the state could not 'punish the purchase or sale of *cutting-edge* services,

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[18] 2010 Issue 3 Official Argument For, available at https://www.ohiosos.gov/globalassets/ballotboard/2011/3-argument-for.pdf (accessed Nov. 4, 2025).

[19] Aaron Marshall, *Opponents of Issue 3 say amendment would interfere with many Ohio laws*, The Plain Dealer (Sept. 1, 2011), available at https://www.cleveland.com/open/2011/09/opponents_of_issue_3_say_amend.html (accessed Nov. 4, 2025).

[20] Ed Meese & Jack Painter, *Ohio's battle for health care freedom*, Politico (Nov. 7, 2011), available at https://www.politico.com/story/2011/11/ohios-battle-for-health-care-freedom-067727 (accessed Nov. 4, 2025).

[21] Robert Wang, *Issue 3 low-key, but has long reach*, The Repository (Oct. 30, 2011), available at https://www.cantonrep.com/story/news/politics/elections/issues/2011/10/30/issue-3-low-key-but/42071877007 (accessed Nov. 4, 2025).

[22] Jo Ingles, *Ohio court says anti-Obamacare amendment can be on November ballot*, Reuters (Aug. 12, 2011), available at https://www.reuters.com/article/world/us/ohio-court-says-anti-obamacare-amendment-can-be-on-november-ballot-idUSTRE77B50V/ (accessed Nov. 4, 2025).

procedures, and coverage.'" *See* TRO Entry at 14, fn.11, *Preterm-Cleveland v. Yost*, Hamilton C.P. No. A2203203 (Sept. 12, 2022) (emphasis added) (citing Maurice Thompson, 1851 Center, *Passage of Issue 3 will protect liberty, restrain health care costs, and preserve health care choice and privacy* (Sept. 29, 2011), available at https://www.healthpolicyohio.org/wp-content/uploads/2014/01/1851_issue3essay.pdf.

Finally, the Government points to abortion and medical marijuana to suggest that the HCFA cannot be understood to "have legalized anything claimed as health care." Opening Br. 38 (emphasis omitted). The Government's speculation about the import of the lack of debate on entirely different issues—much like its speculation about voters' understanding of the "real" purpose of the HCFA, *see supra*, pp. 26-28—underscores how little the Government has to say about the text of the Amendment. Moreover, the Government's attempt to undermine the text is doubly attenuated: It is relying not just on cherrypicked historical context, but on cherrypicked historical context that *postdates* the passage of the HCFA. Whether beforehand or—especially—after the fact, "ambiguous … history" cannot "muddy clear" text. *Azar*, 587 U.S. at 579.

Regardless, these examples do not hold up. The Government speculates that abortion "would have been a major point of debate" if "voters understood abortion legalization to be implicated by the Amendment." Opening Br. 38. But when the HCFA was enacted in 2011, abortion *was* legal—and had been for decades. *See Roe v. Wade*, 410 U.S. 113 (1973). It was not until *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), over a decade after passage of the HCFA, that the Amendment became relevant to abortion. As soon as *Dobbs* was issued, the HCFA *was* invoked in challenging the abortion restriction S.B. 23. *See* PI Order at 31-32, *Pre-term Cleveland v. Yost*, Hamilton C.P. No. A2203203 (Oct. 12, 2022). Moreover, the Government contradicts its own point just one page later, citing an article discussing the

contemporaneous debate on whether the HCFA might be used to challenge specific restrictions on late-term abortions. *See* Opening Br. 39.[23]

The HCFA was also irrelevant to medical marijuana, which was illegal under federal law when the HCFA was enacted. It was not until several years later that the federal government issued a memorandum suggesting that it would not enforce the federal ban on marijuana in states that had "enacted laws legalizing marijuana in some form," opening the door to state laws legalizing medical marijuana.[24] And contrary to the Government's theory, the possibility that medical marijuana might be permitted under the HCFA in no way obviates the need for a comprehensive statutory scheme governing its use in the State. Opening Br. 38.

More fundamentally, for both examples, the HCFA protects the purchase of health care—not "anything claimed as health care." *Id.*; *see infra*, pp. 34-35. Plaintiffs have never argued, and the Tenth District did not hold, that a litigant can invoke the HCFA's protections merely by declaring something to be health care. Rather, courts must make a finding, based on appropriate evidence, that particular activity constitutes "health care" under the HCFA. That is precisely what happened here: The trial court made a finding that gender-affirming medical care is health care, and the Government never challenged that finding. *See supra*, p. 19. That case-specific outcome does not mean there are no limits on the term "health care." If the issue arose, the question whether any particular activity is "health care" would need to be litigated on the particular facts of the case.

In short, the Government never disputed that gender-affirming medical care is health care,

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[23] *See* Aaron Marshall, *State Issue 3 won't have a big impact on health care in the short term, experts say*, Cleveland Plain Dealer (Nov. 10, 2011), https://perma.cc/7XH4-6YXM (accessed Nov. 9, 2025).

[24] James M. Cole, U.S. Department of Justice, *Guidance Regarding Marijuana Enforcement* (Aug. 29, 2013), available at https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf (accessed Nov. 9, 2025).

nor does it provide any valid basis for having this Court revisit the trial court's finding. Gender-affirming medical care thus falls squarely within Sections 21(B) and (C).

B. H.B. 68 cannot be justified as a law punishing wrongdoing in the health care industry.

Because gender-affirming medical care is protected by Sections 21(B) and (C), the only remaining question is whether H.B. 68 is properly understood as a "law[] calculated to deter fraud or punish wrongdoing in the health care industry." Ohio Const. art. I, § 21(D). It is not.

1. Section 21(D) applies to misconduct in the health care industry, not medical treatments the General Assembly deems disfavored.

Because the HCFA does not define "wrongdoing," the Tenth District properly began with the "plain and ordinary meaning of the term." A-32 (¶ 67); *see City of Cleveland v. State*, 2019-Ohio-3820, ¶ 17 ("[w]e give undefined words in the Constitution their usual, normal, or customary meaning"). As the Tenth District explained, "wrongdoing" is defined as "evil or improper behavior or action" and "an instance of doing wrong." A-32 (¶ 68) (quoting dictionary definitions). Thus, Section 21(D) preserves laws focused on misconduct—*e.g.*, failure to obtain a patient's informed consent, false billing, or practicing medicine without a license. That makes sense in context: Section 21(D) applies to laws intended to "punish wrongdoing" *or* "deter fraud." Under the canon of noscitur a sociis, "a word gains meaning by the company it keeps," and punishing wrongdoing should therefore be understood as animated by the same underlying concerns as deterring fraud. *State v. Romage*, 2014-Ohio-783, ¶ 13. Both phrases demonstrate that voters were focused on deterring particular acts of misconduct committed in the course of providing treatment, not granting the General Assembly a blank check to determine which treatments should be available for a particular condition.

Moreover, Section 21(D) separately specifies that the HCFA "does not … affect which services a health care provider or hospital is required to perform or provide." Ohio Const. art. I,

§ 21(D). In other words, the HCFA cannot be used to *require* a hospital to provide certain treatments. *See id.* Had the intent of the "wrongdoing" exception been the flipside of this provision—namely, to protect the Legislature's ability to prohibit certain services a hospital would otherwise provide—then Section 21(D) would have used analogous language. It might have stated, for example, that the HCFA does not apply to laws that control "which services a health care provider or hospital is permitted to perform or provide." It would make little sense for Section 21(D) to use the entirely different phrase "wrongdoing in the health care industry" to communicate the HCFA's impact on the "services a health care provider or hospital" is able to provide.

By the same token, it is notable that Section 21(D) applies to laws "calculated to deter fraud or wrongdoing *in the health care industry*" and not, for example, "wrongdoing in the provision of health care" or "wrongdoing in the medical profession." The exception's reference to the "health care industry" confirms that it is targeted toward misconduct in the business of providing health care—for example, false billing, practicing medicine without a license, or violations of the Health Insurance Portability and Accountability Act. A hospital's decision to offer a particular treatment is not naturally described as an act of misconduct "in the health care industry," regardless of whether the Government agrees with the hospital's determination that the treatment should be made available to patients.

2. The Government's interpretation would eviscerate the HCFA.

The Government never offers its own definition of "wrongdoing in the health care industry." Rather, the Government asserts that H.B. 68 did not restrict the General Assembly's "power to identify and prohibit medical procedures that it considers wrongdoing or bad medical practice." Opening Br. 36. In other words, the Government maintains that the General Assembly has total discretion to designate certain medical procedures as "wrongdoing."

The Government's interpretation would destroy the HCFA, a particularly disturbing result given that the HCFA is part of the Ohio Bill of Rights. "[T]he purpose of a bill of rights is to 'protect people from the state.'" *City of Centerville*, 2020-Ohio-5219, at ¶ 47 (Kennedy, J., concurring); *see also City of Cleveland*, 2019-Ohio-3820, at ¶ 16 ("The purpose of our written Constitution is to define and limit the powers of government and secure the rights of the people."). The HCFA would provide no protection at all if the General Assembly had discretion to determine what falls within the Amendment's protections, as the Government contends here. Under the Government's approach, whenever the General Assembly passes a law prohibiting or penalizing a category of health care—thus violating the Amendment's core prohibition in Sections 21(B) and (C)— the Amendment's "wrongdoing" exception is *automatically* met merely *because* the General Assembly passed a law. Section 21(D) would thus override Sections 21(B) and (C) in every circumstance, eviscerating the core protection of the HCFA.

If, as the Government suggests, the right to purchase health care "is limited to what the State allows," Opening Br. 36, then the HCFA provides no check on legislative power. Put differently, if the State already allows for the purchase of certain forms of treatment, there is no need for an amendment protecting the purchase of that treatment. The HCFA's protections are meaningful precisely when the General Assembly might prohibit access to certain forms of treatment—the circumstance the Government would read out of the Amendment. The Court should reject the interpretation that renders "inoperative" the HCFA's core protections. *See League of Women Voters of Ohio v. Ohio Redistricting Comm'n*, 2022-Ohio-65, ¶ 94.

The Government's objections to the Tenth District's interpretation once again ignore the text of the HCFA. The Government repeatedly suggests that Plaintiffs' interpretation assumes the HCFA "legalized anything claimed as health care." Opening Br. 38. That is incorrect. The fact

that gender-affirming medical care qualifies as "health care" in no way means that *anything* qualifies as health care merely by declaring it to be such. "Health care" is a definable term like any other. Indeed, it already has a particular definition that is used repeatedly in the Ohio Revised Code. *See supra*, p. 23. Those sections, which were enacted both before and after the HCFA, are strong evidence not only of the public's understanding of "health care" in the HCFA, but further that the term can be defined clearly. The Government has never challenged the trial court's finding that gender-affirming medical care qualifies as health care, *see supra*, p. 19, but whether anything else qualifies as "health care" would need to be determined on a case-by-case basis. The Tenth District's interpretation hardly means that any "service labeled 'health care' by a willing buyer and a willing seller" must be understood as "health care," or that the court paved the way for, as the Government suggests, "amputation of a healthy body part." Opening Br. 39-40.

Nor is the Government correct that the General Assembly can no longer regulate the medical profession, including "new forms of wrongdoing in the health care industry." Opening Br. 40. It is unclear what the Government means by "new forms of wrongdoing," but novel forms of misconduct—billing malfeasance, unlicensed practice, etc.— fall within Section 21(D)'s exception. To the extent the Government uses "new forms of wrongdoing" to refer to what it views as "debatable treatments," that question will turn on whether a reviewing court finds the treatment to be a form of "health care" under Sections 21(B) and (C). To take one example, the Government is wrong that the Tenth District's decision preordains the outcome of any separate challenge to H.B. 68's surgery provision. Plaintiffs never challenged the surgery provision and surgery for gender dysphoria was not available in Ohio, even prior to the passage of H.B. 68. *See supra*, p. 13 n.8. Thus, there is no factual record in the case regarding the provision of surgery and no fact-finding on this topic related to the definition of "health care."

Finally, while the Government repeatedly objects to the Tenth District's reliance on the consensus of the medical community, the Tenth District's interpretation of the HCFA does not subordinate the General Assembly to the medical community. Rather, voters in Ohio determined that individual Ohioans, not the General Assembly, should have the freedom to decide whether to access certain forms of health care. The Tenth District invoked the medical consensus in explaining that there was no dispute that gender-affirming medical care was properly understood as health care, a finding the Government did not contest below. A-34-35 (¶¶ 73-75). If the General Assembly believes certain conduct does not qualify as health care—female genital mutilation, for example (*see* Opening Br. 33, 40)—then it can make findings to justify a law on that basis, and a court may be tasked with evaluating whether those findings withstand review. As with any other constitutional provision, it is the province of courts to determine whether a particular treatment qualifies as "health care." The trial court made that finding here, and, again, the Government has never attempted to revisit it. *See supra*, p. 19.

Ultimately, H.B. 68 turns on the General Assembly's singling out of puberty suppressing medications and hormone therapy for the treatment of gender dysphoria in adolescents as disfavored. Even putting aside that this view conflicts "with the prevailing consensus of the professional medical community regarding the appropriate standards of care for minors diagnosed with gender dysphoria in the United States," the General Assembly's risk-benefit analysis "has no bearing on [the] analysis under the HCFA." A-35 (¶ 74). Rather, the HCFA has vested the power to decide in the voters, and the Government's unfounded "policy arguments cannot supersede the clear [constitutional] text[.]" *Snodgrass v. Harris*, 2024-Ohio-3130, ¶ 69 (Fischer, J., concurring) (quoting *Universal Health Servs., Inc. v. United States*, 579 U.S. 176, 192 (2016)). This Court should affirm the Tenth District.

II. The Court should affirm the Tenth District's Due Course of Law ruling.

A. There is no basis for overruling Ohio's longstanding recognition that the Due Course of Law Clause protects substantive rights.

The Ohio Constitution guarantees that "every person … shall have remedy by due course of law" "for an injury done him in his land, goods, person, or reputation." Ohio Const., art. I, § 16. For well over a century, this Court has held that this provision protects substantive rights. *See State v. Aalim*, 2017-Ohio-2956, ¶ 15 (citing *Adler v. Whitbeck*, 44 Ohio St. 539, 569 (1887)); *see also State v. Hand*, 2016-Ohio-5504, ¶ 11. The Government recognizes as much, acknowledging "that this Court has long treated Ohio's Due Course of Law Clause as 'the equivalent of the "due process of law" protections in the United States Constitution.'" Opening Br. 17 (quoting *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶ 48)). Opening Br. 17 Thus, this Court has repeatedly explained that "Ohio courts may look to decisions of the United States Supreme Court to give meaning to Ohio's Due Course of Law Clause." *Aalim* at ¶ 15.

While this Court looks to U.S. Supreme Court precedent as a guide, this Court has also repeatedly recognized that the Due Course of Law Clause can and in certain circumstances does provide *greater* protection than its federal due process counterpart. It is well-established that "states have the ability under their own constitutions to grant greater rights than those provided by the federal Constitution." *State v. Bode*, 2015-Ohio-1519, ¶¶ 23-24 (interpreting the Due Course of Law Clause to provide juvenile criminal defendant broader protections than the federal Due Process Clause); *see also Stanton v. State Tax Comm'n*, 114 Ohio St. 658, 671 (1926) (concluding, in case addressing judicial review of administrative action, that Article I, Section 16 is "much broader than the due process clause of the Fourteenth Federal Amendment"). And this Court has repeatedly "reaffirm[ed] that," as "the ultimate arbiter of the meaning of the Ohio Constitution," the Court "can and will interpret [the state] Constitution to afford greater rights to [Ohio] citizens"

when "prudent and not inconsistent with the intent of the framers." *State v. Mole*, 2016-Ohio-5124, ¶¶ 20-21.

The Government should decline the Government's invitation to overturn well over a century of precedent and hold that the Due Course of Law Clause no longer protects substantive rights. Opening Br. 21. "The doctrine of stare decisis is designed to provide continuity and predictability in our legal system." *Westfield Ins. Co. v. Galatis*, 2003-Ohio-5849, ¶ 43. It is therefore "of fundamental importance to the rule of law." *Id.* at ¶ 44. Thus, this Court has specified that it will overrule its prior precedents only where "(1) the decision was wrongly decided at that time, or changes in circumstances no longer justify continued adherence to the decision, (2) the decision defies practical workability, and (3) abandoning the precedent would not create an undue hardship for those who have relied upon it." *Id.* at ¶ 48. The Government's request fails all three requirements.

First, this Court correctly decided well over a century ago that the Due Course of Law Clause contains both substantive and procedural components. The Government attempts to excise the substantive component by suggesting the Clause concerns "an individual's right to access the court system and to seek a remedy." *Stolz v. J&B Steel Erectors*, 2018-Ohio-5088, ¶ 12. But the Government fails to explain why the right "to seek a remedy" does not encompass protections akin to substantive due process. As the Government's own cited sources recognize, "due course of law" was used at the Founding "to refer to legal procedure more broadly." Rema & Solum, *The Original Meaning of "Due Process of Law" in the Fifth Amendment*, 108 Va.L.Rev. 448, 501-502 (2022). "Due process of law," by contrast, referred more narrowly to "legal process in the technical sense." *Id.* at 452; *see also id.* at 461 (explaining that "'due process of law' refers to legal process in the sense in which the word 'process' is used in the phrase 'service of process'"). The Government

asserts that Due Course of Law is necessarily narrower than the scope of the Due Process Clause, but it provides no support for that assertion, nor does it explain why, for example, a guarantee not to "deny … right or justice to anyone" is limited to procedural rights. Opening Br. 19 (quoting the Magna Carta: Clause 40, *The Magna Carta Project*, available at https://bit.ly/4pX4gzL (accessed Dec. 1, 2025)). Moreover, while the Government cites (at 21) a series of cases recognizing that comparable due course of law provisions do not impose a "limitation upon the legislature," these cases hold that due course of law does not affirmatively require the legislature to protect certain rights—by, for example, eliminating the statute of limitations on medical malpractice claims. *See Harrison v. Schrader*, 569 S.W.2d 822, 827-828 (Tenn. 1978). They have little bearing here.

Second, the status quo is entirely workable. *Galatis* at ¶ 48. As this Court has explained, "decisions of the United States Supreme Court … give meaning to Ohio's Due Course of Law Clause." *Aalim*, 2017-Ohio-2956, at ¶ 15. Thus, the "workability" required to "retain the 'substantive' aspect of the Due Course of Law Clause" is merely to follow U.S. Supreme Court precedent as the floor and consider whether the Ohio Constitution provides any greater protections—a task this Court is certainly able to manage. The Government makes no argument to the contrary.

Finally, the Government turns the reliance analysis on its head by advising that "[i]f the voters want a substantive-review clause, they can add one." Opening Br. 21. That would be a surprise to voters, who have enjoyed a substantive-review clause since at least 1887. *See supra*, p. 37. The Government's approach would lead to a sea change in Ohio constitutional law, as the State Constitution would no longer protect any number of recognized fundamental rights. *E.g.*, *Hand*, 2016-Ohio-5504, at ¶¶ 21-38 (use of a juvenile adjudication to enhance the sentence for a substantive offense violates Article I, Section 16); *Stanton*, 114 Ohio St. at 683-684 (the Ohio

Constitution protects a right of judicial review in administrative proceedings).

"Overruling precedent is never a small matter." *Kimble v. Marvel Entm't*, 576 U.S. 446, 455 (2015). "To reverse course" requires "a 'special justification'—over and above the belief 'that the precedent was wrongly decided.'" *Id.* at 455-456 (quoting *Halliburton Co. v. Erica P. John Fund, Inc.*, 573 U.S. 258, 266 (2014)). The Government has nothing of the sort here. Rather, it cavalierly suggests undoing Ohio's protection for substantive rights because "misuse of the doctrine" has purportedly "caused ongoing mischief." Opening Br. 21. This vague reference in no way justifies abandoning a deeply ingrained line of precedent. Adherence to previous rulings "permits society to presume that bedrock principles are founded in the law rather than in the proclivities of individuals, and thereby contribute[] to the integrity of our constitutional system of government, both in appearance and in fact." *State v. Hubbard*, 2021-Ohio-3710, ¶ 44 (quoting *Vasquez v. Hillery*, 474 U.S. 254, 265-266 (1986)). The Court should not accept the Government's ill-conceived invitation to subvert the integrity of that system.

B. H.B. 68 violates the Ohio Due Course of Law Clause.

H.B. 68 violates Article I, Section 16 of the Ohio Constitution by infringing the parent Plaintiffs' fundamental right to seek appropriate medical care for their children. It is therefore subject to strict scrutiny—a standard it does not satisfy. *See Harrold v. Collier*, 2005-Ohio-5334, ¶ 39 ("[S]tatute that infringes on a fundamental right is unconstitutional unless the statute is narrowly tailored to promote a compelling government interest.").

1. <u>Parents have a fundamental liberty interest in directing the medical care of their children.</u>

"[T]he interest of parents in the care, custody, and control of their children … is perhaps the oldest of the fundamental liberty interests." *Troxel v. Granville*, 530 U.S. 57, 65 (2000) (plurality op.). A "long line of cases" has recognized that the "'liberty' specially protected by the

Due Process Clause includes the right[] … to direct the education and upbringing of one's children." *Washington v. Glucksberg*, 521 U.S. 702, 719 (1997) (citing *Meyer v. Nebraska*, 262 U.S. 390 (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925)); *see also Santosky v. Kramer*, 455 U.S. 745, 753 (1982) (emphasizing "[t]he fundamental liberty interest of natural parents in the care, custody, and management of their child"). This Court has also recognized this interest under the Ohio Constitution, which likewise protects parents' "fundamental liberty interest … in the custody, care and control of their children." *In re S.H.*, 2013-Ohio-4380, ¶ 13. And because "the Ohio Constitution is a document of independent force," the Court need "not presume that the rights afforded" under the U.S. Supreme Court's precedents "are the only rights or are the same rights as those afforded under the Ohio Constitution." *State v. Hackett*, 2020-Ohio-6699, ¶ 26 (Fischer, J., concurring) ("In some circumstances, rights afforded to people under the Ohio Constitution are greater than those afforded to a person under the United States Constitution.").

The scope of parents' fundamental rights extends to parents' right "to recognize symptoms of illness and to seek and follow medical advice" for their children. *Parham v. J.R.*, 442 U.S. 584, 602, 604 (1979) (parents "retain plenary authority to seek" certain medical "care for their children, subject to a physician's independent examination and medical judgment"); *see also In re I.S.*, 2022-Ohio-3923, ¶ 102, fn.8 (8th Dist.) (recognizing that parents' right to make medical decisions for their children includes, "within reason, whether and what type of medical care the child will receive"). In *Parham*, the U.S. Supreme Court considered the process required to involuntarily commit a minor for treatment for a mental illness. 442 U.S. at 588. While the decision ultimately turned on principles of procedural due process, the Court first considered the scope of parental authority with respect to a child's medical care. *Id.* at 603. As the Court explained, "[s]imply

because the decision of a parent … involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state." *Id.* (noting that the "same characterizations can be made for a tonsillectomy, appendectomy, or other medical procedure"). Rather, "[p]arents can and must make those judgments" surrounding a minor's "need for medical care or treatment." *Id.*; *see also Kanuszewski v. Mich. Dep't of Health & Human Servs.*, 927 F.3d 396, 418-419 (6th Cir. 2019) ("Parents possess a fundamental right to make decisions concerning the medical care of their children."). And the parental interest should grow only stronger where, as here, the parent shares the child's interests in pursuing a particular course of medical care. *Cf. Santosky*, 455 U.S. at 760-761.

The Government attempts to avoid this well-established tradition by narrowing the right at issue from parents' right to direct their child's medical care to parents' right to access gender-affirming medical care for their child. *See* Opening Br. 22-23. While the Government acknowledges parents' role in their child's medical care, the Government maintains that "parents have had the right to choose options among those on a menu of lawful health care, but the State has always set the menu." Opening Br. 22. This approach fails multiple times over.

To start, the Government's unduly narrow framing of the constitutional right cannot be squared with courts' prior treatment of the scope of parental rights. *See* Opening Br. 22-23. According to the Government, Plaintiffs' claim fails because "gender transition for minors" is not "objectively, deeply rooted in this Nation's history and tradition." *Aalim*, 2017-Ohio-2956, at ¶ 16. But the starting point for the analysis has always been the general "liberty of parents and guardians to direct the upbringing and education of children under their control." *Pierce*, 268 U.S. at 534-535; *see also Meyer*, 262 U.S. at 399 (emphasizing the fundamental right "of the individual to … bring up children"). In the educational context the Court has considered whether a state could

constitutionally limit parents' choices in education broadly. *See, e.g.*, *Pierce*, 268 U.S. at 534-535. The Court did *not* evaluate whether, for example, there was a deeply rooted tradition of teaching German, *Meyer*, 262 U.S. at 400-401, or permitting a Catholic education, *Pierce*, 268 U.S. at 534-535. This Court has taken the same approach. In *Harrold v. Collier*, 2005-Ohio-5334, for example, the Court explained that, because "parents have a fundamental liberty interest in the care, custody, and management of their children," it was required to review "Ohio's nonparental-visitation statutes under the strict-scrutiny standard." *Id.* at ¶ 40. The Court did not consider whether there was a deeply rooted right for non-parental visitation. *See id.* The Government's approach here is irreconcilable with these precedents. *See State v. Loe*, 692 S.W.3d 215, 271 (Tex. 2024) (Lehrmann, J., dissenting) (explaining that the right to direct a child's care, as "articulated" throughout "history," "has *always* been defined broadly").

Moreover, the Government is wrong that gender-affirming care is not "on the menu." These exact treatments *are* available—just not for Plaintiffs. The Government does not prohibit minors from taking precisely the same medications for other conditions. *See supra*, pp. 7-8. Thus, the Government did not remove these treatments from the menu in Ohio generally, or even from the menu for Ohio minors specifically. It removed them from the menu *only* for certain minors, including Plaintiffs here. As a result, the relevant analysis for purposes of the Due Course of Law Clause is not whether a particular treatment is available, but rather whether the state can interfere with parents' decision that an otherwise available medical treatment is appropriate for their child. That decision falls in the heartland of the well-established liberty right for parents to direct the "care and nurture of the child." *Prince*, 321 U.S. at 166.

At bottom, the fundamental failing of the State's approach is that it allows the State to end run strict scrutiny. There are, of course, limits to the scope of parental authority. *See Parham*, 442

U.S. at 603 (noting that "a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized"). The function of the strict scrutiny analysis is to find those limits. *See S. Bay United Pentecostal Church v. Newsom*, 141 S. Ct. 716, 718 (2021) (statement of Gorsuch, J.) ("The whole point of strict scrutiny is to test the government's assertions …"). "But a state cannot simply deem a treatment harmful to children without support in reality and thereby deprive parents of the right to make medical decisions on their children's behalf." *Williams ex rel. L.W. v. Skrmetti*, 83 F.4th 460, 511 (6th Cir. 2023) (White, J., dissenting).

That is precisely what the Government attempts to do here. In its view, the Government can decide that certain treatments should no longer be available, and in so doing declare that there is no fundamental right to that treatment. Opening Br. 22 (arguing that the state "has always set the menu" of available health care options). If there is no fundamental right to a treatment, then the state's decision is subject to rational-basis review. *See id.* And under rational-basis review, there is a less searching evaluation of whether the state properly removed the treatment from the menu in the first place. *See id.* Thus, the Government has managed to sidestep strict scrutiny through its own declaration that there is no fundamental right at play. That approach is squarely incompatible with the entire purpose of the tiers of review, which is to identify *when* the state's decision is appropriately entitled to deference. "It has never been enough for the State to insist on deference" in matters involving public health, and it should not be enough to do here. *S. Bay United*, 141 S. Ct. at 718 (Gorsuch, J., statement).

2. H.B. 68 does not satisfy strict scrutiny.

The Government failed to meet its burden at trial to demonstrate that the Ban survives strict scrutiny. The Government's asserted interests revolve around "protecting children from harmful

effects." Opening Br. 25. While protecting children can constitute a compelling government interest, the undisputed facts—supported by the testimony of the *Government's* experts—show the Ban is not narrowly tailored to further that interest. Rather, the Ban is "both underinclusive and overinclusive," and therefore cannot be sustained even assuming the Government has identified a compelling interests. *First Nat'l Bank of Bos. v. Bellotti*, 435 U.S. 765, 793-794 (1978); *see also Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 216 (2023) (deeming admissions program unconstitutional where it was both "underinclusive" and "overbroad" to solve the problems identified).

i. The undisputed facts show that the Ban is overinclusive.

The Government acknowledges that gender-affirming medical care is appropriate for some minors. Dr. Levine—the only one of the Government's experts with meaningful experience related to the treatment of gender dysphoria—testified that he has approved hormone therapy for some minor patients and, absent H.B. 68, would continue to do so on a case-by-case basis. 7.18 Tr.110:16-112:19, 114:19-116:21 (Levine) ("Q. Okay. Going forward, whether you would approve hormone therapy for other minors would be a decision that you would make on a case-by-case basis, correct? A. Yes."). He further agreed that the decision whether to provide gender-affirming medical care to minors with gender dysphoria should be made by parents, in consultation with their children's doctors and after being informed of the potential risks—precisely how this decision was made prior to the Ban. 7.18 Tr.74:14-24 (Levine) ("The parents and the child, the family itself has to make the decision about what to do next."); *see also id.*, 95:1-13 ("I think it's a decision the family has to make after they weigh the pros and cons, after they hear about the – the information that is known about adults with transgender identities and what is not known about the subject."). Thus, the Government's own evidence demonstrated that gender-affirming medical care is appropriate for some minors, and that the ultimate decision whether to proceed with gender

affirming care should be made by families.

The Government acknowledges that gender-affirming medical care is sometimes appropriate, but maintains that a categorical ban is nevertheless warranted because "Plaintiffs cannot identify *which* children might turn out to be Ohio's future Chloe Coles, who are left to rebuild shattered childhoods and, later, adult lives." Opening Br. 27. Because the Government purportedly cannot identify which minors "will someday experience deep regret" for undergoing this treatment, it believes "the State can thus reasonably conclude that *no* child, regardless of the amount of education or screening, can truly understand the scope of what he or she is deciding." *Id.* at 28. But that is exactly why it is parents, and not the legislature, that is tasked with the right and responsibility to decide the best course of action for their minor adolescent diagnosed with gender dysphoria. It would be an enormous intrusion on not only parental rights, but personal liberty generally, for the legislature to abrogate individual decision-making anytime there was a remote chance of regret.

As a threshold matter, Ms. Cole's deeply unfortunate circumstances involved, by her own account, alleged malpractice in California. Indeed, Ms. Cole has a lawsuit pending against her doctors in California for medical negligence and failure to follow standards of care when administering hormone therapy. *See* 7.19 Tr.120:6-17. Her prescribing endocrinologist was not the first she had approached; the first had declined to prescribe hormone therapy. *Id.* 120:18-121:19. Thus, the Government's evidence for banning an entire course of treatment turns in significant part on a single, out-of-state case of medical malpractice.

More fundamentally, there is *no* evidence to support the Government's assertion that it is unable to identify which minors should appropriately receive gender-affirming medical care. As Plaintiffs' experts testified, the clinical practice guidelines recommend, among other steps, a

comprehensive biopsychosocial evaluation, "years" of gender incongruity, and a rigorous informed consent process that advises patients and parents of the potential risks and benefits, including fertility risks. *See* 7.15 Tr.106:15-107:23, 112:2-115:24, 118:7-124:5, 195:22-196:19 (Turban); 7.16 Tr.36:23-39:1 (Corathers); 7.16 Tr.170:5-11, 180:3-15 (Antommaria); *see also supra*, pp. 6-7. The Government presented no contrary evidence that these recommendations are ineffective in identifying the subset of minors for whom gender affirming care may be appropriate. In particular, while the Government did not dispute "that those who *begin* dysphoria prepuberty, *and* still are dysphoric after puberty, are unlikely to desist," it nevertheless argued that this "subset misses those whose dysphoria resolves before, or at the onset of, puberty." Opening Br. 26. But *no* medical intervention is provided to youth before the onset of puberty. *See* 7.15 Tr.309:4-13 (Corathers); *supra*, p. 5. Thus, the youth the Government identifies are simply not candidates for gender-affirming medical care—and the Government's concern with this population cannot justify a ban on gender-affirming medical care. *See id.* Nor can the Government justify the Ban based on minors "who do not first express dysphoria until adolescence." Opening Br. 26. The Government's cited evidence suggests that gender dysphoria *may* desist in *pre*pubescent children, 7.17 Tr.98:14-18 (Cantor); it in no way supports the Government's suggestion that gender dysphoria will desist in minors who experience gender dysphoria during puberty.

The Government also failed to present any evidence that there has been a departure from this approach in Ohio. The only evidence about the provision of gender-affirming medical care for adolescents in Ohio was Dr. Corathers' testimony about how care is provided at Cincinnati Children's Hospital, 7.15 Tr.295:3-10, 296:5-20, 7.16 Tr.23:7-39:1 (Corathers), and the testimony of Michael Moe and Gina Goe about their daughters' treatment. 7.16 Tr.254:3-13, 265:14-267:25 (Moe); 7.15 Tr.31:10-34:24 (Goe). That undisputed testimony showed that providers in Ohio

followed the rigorous process outlined above. Again, the testimony of a single witness who received inappropriate treatment outside of Ohio does not justify the Government's conclusion that it had no choice but to ban gender-affirming medical care for all minors. *See supra*, p. 46.[25]

The Government has also failed to show that "a limit on *all minors* is the only way to meet Ohio's interest." *Id.* at 29 (emphasis added). Indeed, the Government made no attempt to "even argue on appeal that it has no less restrictive means than a categorical ban to advance its interest." A-53 (¶ 114). While generally summarizing "its experts' concerns about the effectiveness of medicalized transition for minors and absence of reliable evidence on whether gender dysphoria will resolve without lifechanging medical interventions," the Government never explained why the "purported uncertainty expressed by some medical experts" was sufficient to justify H.B. 68, as opposed to "more tailored alternatives to a categorical ban." *Id.* That is fatal under strict scrutiny. *See Loe*, 692 S.W.3d at 272 (Lehrmann, J., dissenting) (ban on gender-affirming care failed to survive strict scrutiny where the legislature had "decided unilaterally, and categorically, that medical treatment for minors with gender dysphoria is off the table as a therapeutic option without any consideration for the individual needs of any unique child").

Finally, the Ban is separately over-inclusive because the Government fails to differentiate the different risks from different treatments. The Government points to the risks of puberty suppressing medications and hormone therapy, but puberty suppressing medications are fully reversible. *See supra*, pp. 5-6, 11. Because it was undisputed that puberty suppression medications

[25] Even if there were evidence that some doctors in Ohio provided substandard treatment—evidence the Government never presented here—that practice could be rooted out through employer-level discipline, action by the state medical licensing board, or medical malpractice suits. 7.16 Tr.180:16-183:4 (Antommaria). The possibility that there may be some doctors who might not follow the prescribed guidelines does not justify banning medical care for minors who need it. *Id*. at Tr.181:20-23.

pose no risk to fertility, the Government's concern with the risk to minors' fertility cannot justify a ban on these puberty suppression medications specifically. The Government asserts that most minors who start on puberty suppression medications will "eventually move to" hormone therapy, Opening Br. 26, but that does not justify banning puberty suppression medications in addition to hormone therapy.

ii. The undisputed facts show that the Ban is under-inclusive.

At the same time, the Ban is significantly under-inclusive. The medications at issue are banned only when used for gender-affirming medical care, but they carry largely the same risks regardless of the condition they are treating. *See supra*, pp. 10-11. The Government fails to explain why parents are able to weigh the risks and benefits of these medications for other conditions, but not for gender dysphoria. Similarly, a series of other medications come with similar risks and potential side effects, and yet the General Assembly does not prohibit parents from weighing the risks and benefits to decide whether to proceed with treatment. *E.g.*, 7.16 Tr.167:25-170:16 (Antommaria). To the contrary, it is not uncommon "for adolescent patients and their parents to make decisions to undergo treatments with comparable risks." *Id.* at 168:22-24. In short, the "singl[ing] out" of gender-affirming medical care "for special treatment undermines" the Government's assertion that it must override parental preferences here. *Bellotti*, 435 U.S. at 793.

3. <u>The Ban does not satisfy rational basis review.</u>

If the Court concludes that strict scrutiny does not apply, the gaping disconnect between the scope of the Ban and the asserted justifications nevertheless demonstrates that the Ban does not survive any level of scrutiny. Even in a case "calling for the most deferential of standards" of review, courts nevertheless "insist on knowing the relation between the" statute "and the object to be attained." *Romer v. Evans*, 517 U.S. 620, 632 (1996). And when the law's scope is "so far removed from [the asserted] justifications that … it [is] impossible to credit them," the law fails

even rational basis review. *Id.* at 635.

That is the case here: The ban on gender-affirming medical care for minors makes "no sense in light of how" Ohio treats medical care provided for purposes other than "gender transition." *Bd. of Tr. of Univ. of Ala. v. Garrett*, 531 U.S. 356, 366, fn.4 (2001) (citation omitted). While the Supreme Court determined in *United States v. Skrmetti*, 605 U.S. 495 (2025), that a Tennessee law banning gender-affirming medical care survived rational basis review based on a preliminary injunction record, the Court there was not faced with "a startling lack of evidence" between the statute and the Government's stated goals. *Brandt ex rel. Brandt v. Griffin*, 147 F.4th 867, 891 (8th Cir. 2025) (Kelly, J. concurring in part and dissenting in part) (suggesting that a challenge to Arkansas' ban on gender-affirming medical care should be remanded for the trial court to assess whether it survived rational basis review). Here, the undisputed facts after a merits trial demonstrated that the State banned gender-affirming medical care despite recognizing that the treatment *is* appropriate for some minors. Moreover, the record reveals no justification for allowing parents to weigh the risks and benefits of these same medications for other treatments, but not for gender dysphoria. *See supra*, pp. 4-13. Against this backdrop, the law's "sheer breadth is so discontinuous with the reasons offered for it that" it cannot be upheld any under any standard of review. *Romer*, 517 U.S. at 632. Thus, even if the Court concludes that rational-basis review applies, it should still find the Ban unconstitutional under the Due Course of Law Clause.

CONCLUSION

For the reasons outlined above, Plaintiffs respectfully request that the Court affirm the judgment of the Tenth District. If the Court reverses the Tenth District's determination on both the HCFA and the Due Course of Law Clause, Plaintiffs respectfully request that the Court remand the case to the Tenth District to address Plaintiffs' two remaining claims.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on December 9, 2025, the foregoing was electronically filed via the Court's e-filing system. I further certify that a copy of the foregoing was served by email upon the following:

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