In the
Supreme Court of Ohio

MADELINE MOE, ET AL.,	:	Case No. 2025-0472
	:	
Appellees,	:	On appeal from the Franklin County
	:	Court of Appeals,
v.	:	Tenth Appellate District
	:	
DAVE YOST, ET AL.,	:	Court of Appeals
	:	Case No. 24AP-483
Appellants.	:	

MEMORANDUM IN SUPPORT OF JURISDICTION OF STATE APPELLANTS

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INTRODUCTION

The People of Ohio, through their representatives, acted to protect Ohio's children from a pressing trend: the growing use of powerful drugs to medically "transition" the gender of children. The issue evokes strong views, but this Court need not decide among them. That is because Ohio tasks the General Assembly with reconciling competing sides of urgent public policy questions. It did just that when it enacted a law regulating the healthcare industry in the classical liberal tradition—offering children special protections, while leaving adults generally free to order their own lives without affecting the rights of others. Ohio thus extended the commonsense insight that children cannot fully consent to becoming patients for life, any more than they can consent to marriage before adulthood. *See* R.C. 3101.02. But a court held that Ohio may not do so, because, it said, Ohio's Constitution created a right for parents to transition their children. *Moe v. Yost,* 2025-Ohio-914 (10th Dist.) ("App.Op.").

That wrong decision cries out for review. Whether this law is constitutional is a question of public and great general interest. The Tenth District's ruling leaves Ohio children unprotected from the great harms the state demonstrated at a five-day trial. The disputed drug treatments sterilize children's developing bodies, make them patients for life, and inflict often irreversible damage. And all this for questionable benefits. The Tenth District also overturned the will of the people, twice-expressed through a supermajority of Ohio's legislature. That, too, is alone reason for review.

Both of the Tenth District's novel legal theories—that parents have had a "fundamental right" under "substantive due process" to transition their children since 1802, and that Ohio's 2011 Health Care Freedom Amendment also creates such a right—

are further reasons for review. Both theories break new ground and threaten more laws. The Court should grant jurisdiction to allow the State to make its case for protecting children. Our children deserve nothing less.

STATEMENT

I. Ohio acted to protect minors from drug-based and surgical "gender transitions."

In January 2024, the Ohio General Assembly enacted a law addressing the social issues created by a recent trend: minors identifying as "transgender," or their parents identifying them as a gender other than their sex. The Assembly heard testimony much like what the trial court later heard, including testimony about the health risks of medical interventions designed to physically alter children to align their bodies with new identities. It also heard testimony from those whose lives had been deeply affected by transition procedures. The Assembly then enacted H.B. 68—overcoming the Governor's veto to do so. That statute addressed three primary places this trend intersects with the State's compelling interest in protecting children and families: parental rights, scholastic sports, and the health-care industry.

At issue here, several provisions aim at "Saving Ohio Adolescents from Experimentation" by regulating different aspects of the health care industry. Specifically, these provisions prohibit licensed medical professionals from performing various forms of medical "gender transition services" upon minors. R.C. 3129.01(F) (defining such services); *see* R.C. 3129.02(A) (barring action). The prohibited services include "gender reassignment surgery," R.C. 3129.02(A)(1), "prescrib[ing] a cross-sex hormone," R.C. 3129.02(A)(2), or prescribing "puberty-blocking drug[s]," *id.* Other

provisions govern mental-health professionals in counseling regarding gender dysphoria or transition, R.C. 3129.03, and bar Ohio's Medicaid program from paying for minors to transition, R.C. 3129.06. The law grandfathered in ongoing treatment; doctors may indefinitely continue any course of medication that they began by the law's effective date. R.C. 3129.02(B). Other provisions, not at issue in this appeal (unless Plaintiffs cross-appeal, as explained below), are designed to preserve girls' and women's sports teams for those born female, R.C. 3313.5320(B), and protect parents' custodial rights, R.C. 3109.054. The law's effective date was April 24, 2024, but it was initially restrained by the trial court. It went into effect on August 6, 2024.

II. After plaintiffs sued, Ohio showed at trial that drug-based transitions entail risks that outweigh the alleged benefits for minors.

Plaintiffs sued to challenge the law on March 26, 2024. *See* Compl. Plaintiffs are two families, using the pseudonyms "Goe" and "Moe." The Parent Plaintiffs identify both Minor Plaintiffs as "transgender," with each "designated as male" at birth and now having a "female gender identity." Compl. ¶¶96, 108. Plaintiffs raised four counts under the Ohio Constitution. *See* Ohio Const. art. II, §15(D); art, I, §21; art. I, §2; art. I, §16. (The counts and Tenth District's disposition of them are summarized below in Part III). The named defendants are the State of Ohio, Attorney General Dave Yost, and the Medical Board (together, "State Defendants" or the "State").

The trial court held a five-day trial. No one disputed that recent years have seen a surge in identified "gender dysphoria" in youth, accompanied by increased use of medical interventions on children through puberty blockers, hormone injections, and surgery. Dr. James Cantor testified to the lack of scientific evidence supporting the

injection of pubertal-suppression drugs and cross-sex hormones on minors with gender dysphoria. Tr. 7/17 85:4–118:20; 119:24–133:3. Dr. Stephen Levine explained the psychiatric risks, alleged benefits, and uncertainty surrounding such treatment. Tr. 7/18 81:7–103:25. Dr. Paul Hruz testified about the lifelong hormonal effects of such drugs. Tr. 7/19 29:19–51:17. All questioned the advisability of gender transition in minors generally. Tr. 7/17 93:10–94:22, 99:16–100:2; Tr. 7/19 63:17-64:13.

Plaintiffs' experts characterized the use of puberty blockers and cross-sex hormones as safe and effective. See Tr. 7/15 131:7–132:14 (Turban); Tr. 7/16 37:10-38:18 (Corathers), 167:8–11 (Antommaria). They explained that they typically rely on guidelines by groups known as the Endocrine Society and the World Professional Association for Transgender Health (WPATH). *See* Tr. 7/15 105:1–106:14 (Turban), 304:17–22 (Corathers); Tr. 7/16 153:1–9 (Antommaria).

Drs. Cantor and Levine disputed whether the WPATH and Endocrine Society guidelines were developed using well-accepted evidentiary review processes. Tr. 7/17 133:4–135:13, 141:1–145:20, 146:1–150:4; Tr. 7/18 62:1–63:17. For example, Dr. Cantor said, "in medical ethics, we don't decide if something is safe" because "[t]here's no such thing as a zero-risk medical intervention. All we can ever do is decide whether the potential risks are worth the potential benefits." Tr. 7/18 20:19–25.

Dr. Cantor explained that puberty blockers and cross-sex hormones stunt a child's typical puberty. Puberty blockers result in keeping "a prepubescent child in a prepubescent body" past a normal age, so the child retains "the body of [a] 9- or 10-year-old" until "roughly age 14"—well into the years that their peers have teenaged bodies.

Tr. 7/17 127:4–10. Blockers prevent development of "a sex drive and crushes," leading to lifelong sexual dysfunction. Tr. 7/17 128:6–22. While some literature says "puberty will kick in" if a child stops using blockers, there is no "evidence that it's reversible." Tr. 7/17 129:17–18; 130:8-13. And "upwards of 98 percent" of those who start blockers will continue to the next step: cross-sex hormones. Tr. 7/18 7:13–19.

Cross-sex hormones—estrogen to boys, testosterone to girls—steer the child's body away from features that typically align with natal sex, and toward features of the opposite sex. Tr. 7/19 38:7-20 (Levine). Those hormones entail significant risks, including a risk of infertility so great that when children begin such hormone treatment (typically at ages 13 to 15), Plaintiffs' own expert testified that doctors "counsel patients ... essentially assuming that [hormone treatment] will cause infertility." Tr. 7/15 249:23-24 (Turban); *see* Tr. 7/17 126:3–12 (Cantor). Both puberty blockers and hormone treatment raise a significant risk of low bone density and osteoporosis. Tr. 7/17 125:24-126:1; Tr. 7/19 31:18–32:3. Cross-sex estrogen also increases the risk of blood clots, as plaintiffs' expert admitted. Tr. 7/15 248:22–249:1 (Turban).

But without medical intervention, gender dysphoria—the diagnosable mental illness associated with significant distress caused by incongruence between gender identity and natal sex, *id.* 96:22–97:8—can and often does resolve on its own, Tr. 7/17 98:13-99:5 (Cantor). While a transgender identity is often genuinely felt, a child with such an identity before puberty can and often will desist from that identity after puberty takes its natural course. In multiple studies of prepubescent children with gender dysphoria, about 80 percent of those who did not begin transitioning "cease to feel

gender dysphoric over the course of puberty." Tr. 7/17 98:14–20.

Multiple systemic reviews have assessed the risks against the benefits of gender transitions; all concluded that treating youth with gender dysphoria by injecting puberty blockers and hormones carries greater risks than benefits. Tr. 7/17 80:5–11 (Cantor). Dr. Cantor explained that "[e]very systematic review that has been conducted, they've been unanimous. They've all come to the same conclusion: We don't have evidence of benefit outweighing the much more solid and objective evidence of risk." Tr. 7/17 86:22–87:1*; see also id.* 86:4–9. That consensus was then augmented by the Cass Review, a comprehensive review commissioned by the United Kingdom's National Health Service. Tr. 7/17 85:4–25.

While expert testimony established significant safety concerns, lay testimony established the personal consequences for those who experience these risks. Chloe Cole, a "detransitioner," explained the consequences of her transition. Tr. 7/19 108:16–114:25. She began puberty blockers at 13, testosterone injections after that, and surgical removal of her breasts. She testified to deep regret and depression; her younger self did not fully appreciate the lifetime effects she still endures, such as knowing she will never be able to nurse a child.

III. The trial court upheld the law, but the appeals court reversed on two grounds.

The trial court ruled for the State on all four counts. Com. Pl. Op. 12 (Aug 6, 2024). The law has been in effect since August 6, 2024. (Plaintiffs asked for an injunction pending appeal, but the motion was constructively denied. *See* Motion of Appellants to Restore and/or Grant Injunction Pending Appeal (Aug. 7, 2024).)

The appeals court reversed in part. It held that Ohio's limits on puberty blockers and cross-sex hormones violated "parents' right to substantive due process," App.Op. ¶121, under the Due Course of Law clause, and violated the Health Care Freedom Amendment ("HCFA"), *id.* ¶76. The court specified that its ruling applied only to Ohio's limits on drug-based interventions, not limits on surgical procedures (which Plaintiffs said they did not challenge). *Id.* ¶¶47, 125.

The court did not reach Plaintiffs' equal-protection or one-subject claims, *id.* ¶125, but the court's explanation of the one-subject claim seems to have partly resolved that claim by rejecting it to the extent that Plaintiffs sought to enjoin the sports, custody, or surgical provisions. That is because the Plaintiffs' one-subject claim aimed to enjoin all provisions, *i.e.*, including the surgical, sports, and custody provisions. *See* Compl. at 32 (prayer); Appellants' Br. at 43–44. The court said that Plaintiffs "have not claimed they would be adversely affected by enforcement of H.B. 68's sports or custody provisions," and did not independently attack the surgical provisions. App.Op. ¶47. In describing the one-subject claim as moot, *id.* ¶123, the court implicitly treated that claim as now limited to only the drug provisions. Thus, only a cross-appeal could broaden the judgment.

This Court granted a stay pending appeal. *See 04/29/2025 Case Announcements, 2025-Ohio-1483.*

THIS CASE PRESENTS A SUBSTANTIAL CONSTITUTIONAL QUESTION OF PUBLIC AND GREAT GENERAL INTEREST

This case cries out for review. First, the decision below invalidates a major law, leaving children unprotected. Second and third, the appeals court adopted radical constitutional views that empower judges and delegate regulatory power to industry.

I. The Court should review a decision that invalidates a significant Ohio law and leaves children unprotected from often irreversible harms.

The international debate over medically transitioning children's gender is one of the most important of our time. This case involves a landmark law that takes a side in that debate. Indeed, a supermajority of Ohio's legislature adopted the challenged law—*twice*—because of the public's overwhelming general interest in protecting children and families from irreversible damage. Ohio is hardly alone: 26 States have adopted similar laws. *See* Annette Choi, *26 states have passed laws restricting gender-affirming care for trans youth*, CNN (Dec. 3, 2024), https://perma.cc/C52C-SAFY. The U.S. Supreme Court is reviewing two such laws. *L.W. v. Skrmetti,* 83 F.4th 460 (6th Cir. 2023), *cert. granted, United States v. Skrmetti,* 144 S. Ct. 2679 (2024).

These state laws join a worldwide trend. Nation after nation now limit such drugs for minors because of growing evidence that such procedures risk serious harm to children. As Dr. Cantor testified, "[e]very systematic review that has been conducted, they've been unanimous. They've all come to the same conclusion: We don't have evidence of benefit outweighing the much more solid and objective evidence of risk." Tr. 7/17 86:22–87:1. Among those reviews is the United Kingdom's Cass Review, which led to new restrictions in the U.K. on giving these drugs to children. *See* Final Report, Cass Review, https://perma.cc/V67Q-X8QP. Much of Europe, and now Brazil, have

likewise pulled back. Gabriela Galvin, *The UK is the latest country to ban puberty blockers for trans kids. Why is Europe restricting them?*, Euro News (Dec. 13, 2024), https://perma.cc/5EPK-AQZM; *Brazil prohibits hormone therapy for transgender minors, Buenos Aires Times* (Apr. 16, 2025), https://perma.cc/UY9R-ZGKJ.

Those free nations have acted for the same reason Ohio did: chemical and surgical transitions have devastating effects on children. As the State showed at trial, these interventions make children drug-dependent patients for life, with resulting health problems on top of lifelong sterility and sexual dysfunction. *See* above at 4–6. Children do not fully appreciate those lifetime implications at twelve or fifteen. Moreover, most children's dysphoria dissipates without drug-based transition, and proponents' claimed improvements in outcomes have not been borne out by the evidence. *Id.* It is a radical thing to claim that Ohio is constitutionally barred from protecting children in this way. This Court should review the merits of such a bold claim.

II. The Tenth District's radical due-course-of-law holding warrants review.

The Tenth District held that Ohio's limits on chemical-transition procedures for children violate the Ohio Constitution's guarantee that everyone "shall have remedy by due course of law," art. I, §16, because Ohio's law "facially violates Ohio parents' right to substantive due process." App.Op. ¶121. Three reasons support review.

First, the entire enterprise of "substantive due process" deserves review. To be sure, this Court has long treated the Due Course of Law Clause as "the equivalent of the 'due process of law' protections in the United States Constitution." *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶48. But as an original matter, that clause

created no substantive rights; it simply entitled injured parties to seek redress. *See State v. Aalim*, 2017-Ohio-2956, ¶¶40, 45–48 (DeWine, J., concurring). The Court should review whether to restore that original understanding, or, instead, to limit this procedural clause's "substantive" scope to what the Court has already adopted, and to stop inventing new "rights."

Second, the Tenth District's decision is novel and expansive. It concluded that Ohio's law must satisfy strict scrutiny because a "parent's right to direct the medical care of their children is a fundamental constitutional right." App.Op. ¶107. But claims cannot be assessed at that abstract level; courts must look at the *specific* form of care at issue, using a "careful description of the asserted fundamental liberty interest." *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997) (quotation omitted). After all, the U.S. Supreme Court *rejected* a substantive due process right to assisted suicide in *Glucksberg* and a substantive-due-process right to abortion in *Dobbs v. Jackson Women's Health Org.,* 597 U.S. 215 (2022). Neither case hovered at the abstract level of "health care," but asked if a specific procedure was protected. The Tenth District thus departed from this Court's standard that fundamental rights are only those that are "objectively, deeply rooted in this Nation's history and tradition and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Aalim*, 2017-Ohio-2956, ¶16 (quotation and ellipses omitted). Ohio and America have no "deeply rooted" "history and tradition" of giving children drugs to transition their gender away from natal sex.

Third, the Tenth District's view empowers judges at the expense of the people

and their representatives in the political branches. If rights can be evaluated abstractly, judges may sit above policymakers at every turn. And if a claimed right may stand under the broad umbrella of "medical care," without regard to the specific drug or procedure, then *every* health care regulation faces strict scrutiny. This approach has been rightly rejected. *See Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 703, 706 (D.C. Cir. 2007) (en banc) (concluding that neither parents nor children have constitutional rights to use drugs that the FDA has not approved). Notably, although Plaintiffs disclaim a challenge to the limit on surgical transitions, neither they nor the Tenth District offer any *legal* distinction between an asserted parental right to transition their children with syringes, and an asserted parental right to transition their children with scalpels. The Tenth District's reasoning thus creates a right to surgical interventions on children, too.

Beyond the definition of "fundamental right," the other aspects of the court's opinion—from denigrating the State's compelling interest in protecting children to its tailoring analysis—likewise veered off course; each has questionable roots and broad effects. In sum, the entire due-course-of-law analysis warrants this Court's review.

III. The Tenth District's radical reading of the Health Care Freedom Amendment ignores the constitutional text and delegates state power to the private healthcare establishment.

The Tenth District's Health Care Freedom Amendment ruling requires review. That Amendment, adopted in 2011, was directed at resisting the then-new federal Affordable Care Act. *See State ex rel. Ohio Liberty Council v. Brunner,* 2010-Ohio-1845, ¶64. It also aimed to bar Ohio from adopting its own state-level mandate to buy health insurance. That was an important barrier against a state policy trend at

the time. Such a law had been adopted in Massachusetts; its architect was then the leading and eventual Republican Party presidential nominee. And five years earlier, a 2006 major-party candidate for Ohio governor had proposed that Ohio adopt the Massachusetts model, too. *See* Policy Statements, Blackwell-Raga for Governor, https://tinyurl.com/4mhw7vnk. But that Amendment was textually careful not to displace the State's traditional power to regulate the practice of medicine; it does not "affect any laws calculated to deter fraud or punish wrongdoing in the health care industry." Ohio Const., art. I, §21(D). Ohio voters thus retained the General Assembly's lawmaking power to regulate health care. Voters did not, in 2011, create a right to chemically transition children—anymore than Ohio did in 1802.

In context, the text of Part (B) protects the right to purchase *lawful* health care, as shown not only by Part (D), but also by the text of Parts (A) and (C). Part (A) bars the State from compelling participation in a health care system, and Part (C) bars any "penalty or fine for the sale or purchase of health care." That text confirms that the Amendment preserves freedom to buy what is lawfully available, including through fee-for-service, which individual insurance mandates would swallow. Or, as one supporter put it, "it protects the right of individuals to purchase … lawful medical services." Ilya Shapiro, *On the Ohio Health Care Freedom Act and Its Relationship to Obamacare*, Cato Institute (Feb. 15, 2011), https://perma.cc/B6SJ-9TL6. Voters understood that meaning. *See City of Centerville v. Knab*, 2020-Ohio-5219, ¶22.

The Tenth District's ruling rejects that original understanding of the text. It held that the HCFA deprived the State of its traditional power to define the scope of the

accepted practice of medicine. App.Op. ¶¶66, 69. Even the Tenth District rightly rejected the broadest misreading of the Amendment, namely, that Ohioans now have "the right to receive ***any*** treatment alleged to be 'health care,'" *id.* ¶73, or whatever one willing doctor and one willing patient will try, or that the State may limit only "conduct that was already unlawful" when the Amendment was enacted, *id.* ¶66 n.31 (quoting Appellants' Br. at 53). But the reading that the appeals court *did* adopt is still untethered from the text, and still guts the Assembly's power to protect Ohioans.

The Tenth District adopted, as a *constitutional* line, what it described as the "prevailing standards of care accepted by the professional medical community." *Id.* In other words, the Amendment prevents the General Assembly from ever countermanding the "professional medical community" consensus (whatever a court thinks that may be). That misreading amounts to a permanent delegation of power from the State to the healthcare industry establishment. It also gives courts a standardless commission to choose *which* groups count as the "professional medical community," and *what* level of agreement amounts to "prevailing." Does one look to the American Medical Association, or to a specialized group, if they point in different directions? What if the chosen group is split 50-50, or 70-30? Or, what if the group is more political than medical? *See* IWF Amicus in Support of Jur. at 11–12.

The court also adopted an illusory limiting principle when it held the General Assembly may still "appropriately ***regulate*** the practice of medicine," but may not "categorically ban" what doctors recommend. App.Op. ¶73. But that "regulate" vs. "ban" dichotomy falters. After all, this law *is* a regulation: it does not ban cross-sex

hormones, but limits their use to adults, those over 18 years old. The problem with calling that temporal regulation a "ban" is that *every* regulation can be defined as a "ban" in the regulated situation. A speed limit of 65 is no longer a regulation of how fast to drive; it is a "ban" on driving 66. That maneuver, too, calls for review.

ARGUMENT

State Appellants' Proposition of Law No. 1:

The Due Course of Law Clause does not create a parental right to obtain drug-based "gender transitions" for a child.

For starters, Ohio preserves the argument that the due-course clause should be restored to its original meaning—*procedural* rights—without creating new substantive rights. *See Aalim*, 2017-Ohio-2956, ¶¶40, 45–48 (DeWine, J., concurring). Even under current precedent, strict scrutiny is reserved for "fundamental rights," which are "objectively, deeply rooted in this Nation's history and tradition and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Aalim*, 2017-Ohio-2956, ¶16 (quotation and ellipsis omitted). Parents do not have a "fundamental right" to obtain drugs to transition their children's gender because Ohio has no history or tradition of protecting any such right. *See id.* And whatever fundamental rights parents may have to reject unwanted educational or medical interventions on their children, that right is a negative liberty, not a positive liberty to coerce the state to license whatever a parent wants a doctor to do to their children. Rational-basis review thus applies here, *see Stolz v. J & B Steel Erectors, Inc.*, 2018-Ohio-5088, ¶14, and Ohio's regulation is rational: drug-based transitions risk many lifelong harms without countervailing benefits.

State Appellants' Proposition of Law No. 2:

The Health Care Freedom Amendment does not create a parental right to obtain drug-based "gender transitions" for a child.

The HCFA did not create the "right" alleged here. While the Amendment prevents the State from adopting either an individual mandate to compel insurance coverage or a ban on fee-for-service arrangements, it preserves the General Assembly's traditional power to regulate the practice of medicine. *See* Ohio Const., art. I, §21(D). In other words, the General Assembly still defines what is acceptable medical practice and what is "wrongdoing." The contrary view eviscerates a core police power in Ohio. "[T]he guarantees of the Ohio Constitution are subject to a reasonable, nonarbitrary exercise of the police power of the state … when exercised in the interest of public health, safety, morals, or welfare." *Wymsylo v. Bartec, Inc.,* 2012-Ohio-2187, ¶50. And the Tenth District's reliance on the "professional medical community" is both atextual and unworkable; Ohio's voters did not delegate State power to the medical establishment consensus, as divined by judges. The only tenable view is the original one: the Amendment restricts the State from socializing medicine or banning private insurance, but preserves the State's traditional power to regulate the health care industry. The People, through their representatives, have decided that chemically transitioning a child is wrongdoing. That is squarely within their power.

CONCLUSION

The Court should accept jurisdiction and reverse the Tenth District's judgment.

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