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.	:	

REPLY BRIEF OF STATE APPELLANTS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases **Page(s)**

Statutes and Constitutional Provisions

INTRODUCTION

This appeal is about Ohio's law limiting medical gender "transitioning" of children. Other provisions of that same law bar biological males from participating in female school sports. Though the sports provisions are not at issue here, Plaintiffs nevertheless engage the State in dodgeball before this Court, by dodging key issues. That may be a good strategy in dodgeball, where dodging is the goal, but not so much before this Court.

Plaintiffs' Due Course of Law argument dodges the requirement to show not only a "history and tradition" of a claimed fundamental right, but also a "careful description of the asserted fundamental liberty interest." *State v. Aalim*, 2017-Ohio-2956, ¶16 (quoting *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997)). They also duck addressing the multiple cases rejecting near-identical due-process claims to other States' similar laws. They either ignore cases entirely or cite such cases' *dissents* without discussing the holdings. *E.g.,* Moe Br.44 (citing dissent in *L.W. v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023), *aff'd, United States v. Skrmetti*, 605 U.S. 495 (2025)).

When it comes to the Health Care Freedom Amendment, Plaintiffs likewise dodge defining their view. They only oppose the correct view: that the HCFA covers commercial transactions in health care, both as to insurance and as to direct purchase or sale of health-care services, but does not limit the State's traditional power to define what is legal health care. State Br.35–41. Plaintiffs say that they disclaim the "Wild West" view of entirely gutting state power. But their textual reading leads to that conclusion. And though they insist that they do not challenge the State's prohibition on *surgical* gender transitions, their views would legalize even those surgeries.

Plaintiffs also hedge against reliance on "experts" to avoid the extreme consequences of a no-limits position. But they cannot dodge it: the appeals court invoked "experts"—or the "consensus of the medical community"—to define the scope of Ohioans' rights. *Moe v. Yost*, 2025-Ohio-914, ¶101 (10th Dist.) ("App.Op."). Plaintiffs may maintain that "no one is suggesting" reliance on experts, Moe Br.2, but the lower court plainly did so. And the more Plaintiffs run away from "experts" as their touchstone, the less they provide any concrete explanation of what legal test achieves their moderate consequentialism. They say that courts can judge cases based on "appropriate evidence"—but that evidence turns out to be so-called "experts" who, in this case, have been exposed as political activists that put ideology above sound medicine.

The Court should reject all those dodges and reject these claims. Our Constitution allows the People's representatives to protect children from risky procedures.

ARGUMENT

Ohio's laws against medical transitioning for minors do not violate the Due Course of Law Clause or the Health Care Freedom Amendment. Plaintiffs' responses do not show otherwise. Indeed, they largely ignore key caselaw, and they likewise fail to meaningfully address the implications of their views. Ohio's laws validly protect children from questionable medical interventions that risk permanent effects.

I. Ohio's age minimum for medical gender transitions does not violate Ohio's Due Course of Law Clause.

Ohio's Due Course of Law Clause provides that everyone "shall have remedy by due course of law." Ohio Const., art. I, §16. The appeals court found that this clause, which protects procedural rights in courts, also harbors a "substantive due process"

right for parents to override State regulation of medical care to direct their children's medical gender transitions. The Court should revisit whether "substantive due process" exists, but even if it does, nothing about Ohio's law here violates the clause. No fair reading of Ohio's or the nation's "history and tradition" creates a fundamental right to medical gender transitions for children. And Ohio's interests justify setting an age minimum for such treatment. None of Plaintiffs' responses overcomes that.

A. The Court should revisit "substantive due process" under Ohio's Due Course Clause, and *stare decisis* factors do not justify keeping this mistaken doctrine.

This Court has long held that Ohio's Due Course of Law Clause is "the equivalent of the 'due process of law' protections in the United States Constitution." *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶48. That has meant creating a "substantive" component to the clause, despite the original understanding that the clause merely granted a procedural right to seek redress in court, not substantive rights. *See Aalim*, 2017-Ohio-2956 at ¶¶40, 45–48 (DeWine, J., concurring). The State has already urged the Court to rectify this error in *Paganini v. The Cataract Eye Center of Cleveland,* No. 2025-0386 (argument Feb. 10, 2026).

Plaintiffs, not surprisingly, appeal to *stare decisis* to preserve substantive due process—but they do not meaningfully engage the State's arguments about the clause's proper original meaning. Moe Br.37–40. The State showed extensively that the clause has been misread, State Br.17–21, but Plaintiffs ignore most of that, saying that the State "provides no support for that assertion," Moe Br.39. Their discussion of due course versus "due process" as covering "legal procedure more broadly" does not get them all the way to *substance,* as opposed to scope of procedure. Moe Br.38

(quotation omitted). In any case, the merits do not warrant more discussion here, both because there is little to reply to, and because the Court will presumably decide the issue in *Paganini*, which is ahead of this case on the calendar.

As to *stare decisis*, what Plaintiffs do say is wrong. First, they say that the current approach is workable because the Court can follow federal precedent and adjust for Ohio law if needed. Moe Br.39. Their federal-baseline point is ironic, as on the *precise* issue here—a substantive-due-process claim regarding medical gender transitions for children—Plaintiffs ignore the federal cases against them, either relying on *dissents* in those cases or ignoring them entirely. *See, e.g.,* Moe Br.44 (citing dissent in *L.W. v. Skrmetti*, 83 F.4th 460 (6th Cir. 2023), *aff'd, United States v. Skrmetti*, 605 U.S. 495 (2025)); Moe Br.50 (citing dissent (with partial concurrence) in *Brandt v. Griffin*, 147 F.4th 867 (8th Cir. 2025)); *see also Poe v. Drummond,* 149 F.4th 1107 (10th Cir. 2025) (cited in State brief but not in Moe's brief). Plaintiffs likewise do not meaningfully engage with the U.S. Supreme Court's *Skrmetti* holding that such laws have a rational basis (as against equal protection claims), relying only on the *Brandt* dissent to dismiss *Skrmetti*. So Plaintiffs' appeal to following federal law as a "workable" solution, even if helps them as to *stare decisis*, dooms them on the merits.

More important, though, is that both federal and Ohio litigation show that current doctrine is unworkable. While courts have set down guidelines, such as *Glucksberg*'s "history and tradition" test and its requirement of a "careful description" of a right, litigation has shown that such standards—especially in enforcing the careful-description rule—are manipulable and prone to enabling policy preferences over law.

Second, Plaintiffs' appeal to reliance interests hurts rather than helps them. They cite two cases as showing reliance on substantive-due-process rights, but neither justifies reliance interests. Moe Br.39–40 (citing *State v. Hand*, 2016-Ohio-5504, ¶¶21–38, and *Stanton v. State Tax Comm'n*, 114 Ohio St. 658, 683–84 (1926)). For one thing, criminals cannot rely on wiping clean their juvenile-delinquency history, as any reliance interest arising from *Hand*, a criminal case about considering prior juvenile adjudications in adult sentencing, suggests. At any rate, this Court will soon review whether *Hand* was even correct. *State v. Morrell,* Case No. 2025-1277. For another, *Stanton,* which involved procedures for appealing a tax commission's rulings, is neither about substantive due process (it is a procedural-due-process case), 114 Ohio St. 658 at syl., nor about any reliance interest because *Stanton* rejected the due-process claim there, so no one ever relied on it. *See id.* at 675.

Perhaps Plaintiffs meant to refer not to reliance on specific outcomes, but on the general availability of Due Course claims. But that is even worse. Reliance interests involve particular legal rules, around which parties order their affairs. No one orders their affairs around the *general* existence of substantive-due-process doctrine—no one can reasonably violate a law, for example, on the hopes that a litigation attack will succeed. If anything, the existence of the doctrine makes it harder to rely on *any* law, as all laws might be upset any day, or held in limbo for years, based on unpredictable judicial preferences. That is a reason to jettison this doctrine, not to keep it.

B. Ohio's law does not violate the Due Course of Law Clause.

Even if the Due Course of Law Clause retains a "substantive" aspect, it is not violated here. First, the clause does not create a "fundamental right" of parents to

direct their children's medical gender transitions, nor does any right to control their children's health care overcome the State's authority to regulate what counts as legal health care. Second, under any standard, the law here is valid, as the State's interests in protecting children from these risky procedures meet any balancing test.

Against this, Plaintiffs' responses are unavailing. They dodge the relevant test and precedent about the proper level of specificity of a claimed right. And they dodge the on-point precedent about *this* claim and add other mistakes as well.

1. No fundamental right exists here, as Ohio does not have a deeply rooted history and tradition of medical gender transitions.

First, both this Court and the U.S. Supreme Court have held that fundamental rights are 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." *State v. Aalim*, 2017-Ohio-2956, ¶16 (quoting *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997) (further quotation omitted)). The claimed right must have a "careful description," with "concrete examples"—not an abstract description, which is vulnerable to allowing "subjective elements" to govern judicial review. *Id.*

Aalim's application of the test demonstrates this. There, the claimed right was to an "amenability hearing" in juvenile-court proceedings. That claim was "disposed of in short order," because "Ohio's Due Course of Law Clause and the federal Due Process Clause both predate the creation of juvenile courts in Ohio and throughout the United States," so "these provisions cannot have created a substantive right to a

specific juvenile-court proceeding." *Id.* at ¶17. The Court did not telescope out to general principles of procedure, or how youth or adults were treated in regular courts in 1851. The *specific* application did not exist then, so the claim was a non-starter. Applying that test here is equally simple, as of course the idea of medically altering a child's gender would have shocked the 1851 framers.

Plaintiffs do not even attempt to meet the *Aalim/Glucksberg* standard of "careful description," and indeed, they do not even cite it. Their sole citation to *Gluckbserg,* Moe Br.40–41, is to that case's acknowledgement of the very different protected rights in children's *education,* while they ignore the test and its application in *Glucksberg* itself. *Glucksberg* rejected a claim to assisted suicide, as the Court looked to the *particular* procedure sought. *See Glucksberg*, 521 U.S. at 722–23. Had the Court generalized out to "health care" or obtaining medication generally, that plaintiff would have won. Similarly, Plaintiffs cite *Aalim* for the principle that the Court has held that some substantive rights are protected, Moe Br.37, for the idea of looking to federal caselaw, *id.* at 39, and for the *State's* proper statement of the "history and tradition" test. But they ignore that test's key aspect—the "careful description" rule.

Plaintiffs insist, despite *Aalim*'s and *Glucksberg*'s teaching, that "the starting point for the analysis has always been the *general*" interest of parents to "'direct the upbringing and education of children.'" Moe Br.42 (quoting *Pierce v. Soc. of Sisters*, 268 U.S. 510, 534–35 (1925) and citing *Meyer v. Nebraska*, 262 U.S. 390, 399, 401–03 (1923)) (emphasis added). But that level of generality is so broad as to be meaningless. *Meyer* established a parental right to teach children German. If that right was

so broad as to cover medical gender transitions, it is hard to see why the Court had reason to further debate cases such as *Pierce,* with the similar right to educate children in private, religious schools. Plaintiffs cite other cases far afield from this one, such as *Troxel v. Granville,* 530 U.S. 57, 66 (2000), regarding custody and visitation, and *Santosky v. Kramer*, 455 U.S. 745, 753 (1982), regarding termination of parental rights. *Santosky* is also irrelevant because it concerns *procedural* due process. So, too, is *Parham,* which does involve health care, but only in a procedural context, as the State already addressed. State Br.31–32 (citing *Parham v. J. R.*, 442 U.S. 584 (1979)). Not only are their cited cases far from this one, but also, plaintiffs fail to acknowledge that such an expansive "right to control children's lives" would equally allow parents to overcome the ban on gender-transition surgery, rendering their claim not to challenge that provision hollow.

Plaintiffs also fail to respond to specific rejections of health-care claims for adults to obtain themselves, including *Glucksberg* and *Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 703, 706 (D.C. Cir. 2007) (*en banc*). As the State noted, basing a right to override State health-care laws on *parental* rights implies that parents could demand for their children what the parents could not even demand for themselves as adult consumers. State Br.24. Plaintiffs do not respond to that point. Nor can they; under their theory, parents could choose for their children, under a broad "health care" umbrella, all the procedures that courts have said are not a right for even adults, whether using drugs not approved by the U.S. FDA (*Abigail Alliance*), or obtaining assisted suicide (*Glucksberg*).

In attempting to shift the focus to an overbroad "parental right" at the *Meyer/Pierce* level, Plaintiffs also studiously avoid the more precise point that multiple federal and state courts have applied the substantive-due-process test to this *precise* context—medical gender transitions for children—and have rejected the claim. The State extensively discussed Judge Sutton's substantive-due-process analysis in the Sixth Circuit's decision in *L.W. v. Skrmetti*. Plaintiffs do not acknowledge that holding or grapple with that analysis—despite acknowledging the need to look to federal law. Moe Br.39. Instead, plaintiffs cite an array of *dissents*—beginning with the dissent in *L.W. v. Skrmetti*—cementing the weakness in their position in federal and state courts alike. Moe Br.43, 44, 50 (citing dissents in *State v. Loe*, 692 S.W.3d 215, 271 (Texas S.Ct.); *L.W. v. Skrmetti*; and *Brandt v. Griffin*, 147 F.4th 867 (8th Cir. 2025)). Similarly, Plaintiffs ignore the Tenth Circuit's decision in *Poe v. Drummond*, 149 F.4th 1107 (10th Cir. 2025), which the State cited along with the Sixth and Eighth Circuit rejections of near-identical due-process claims. State Br.23.

Even if the Court telescopes out partly from this specific context, any right of "directing children's health care" still exists—parents may choose *among* legal options, but cannot override the State's power to define legal medical care. As the Sixth Circuit explained, "[t]his country does not have a 'deeply rooted' tradition of preventing governments from regulating the medical profession in general or certain treatments in particular, whether for adults or their children." *L.W.,* 83 F.4th at 473. Such state regulations carry a "strong presumption of validity," and they validly "limit parental freedom," even regarding "medical treatment." *Id.* (quotations and citation omitted).

In sum, the proper test is the "careful description" test, and under that test, no "fundamental right" exists here.

2. Ohio's interests justify its minimum-age requirement for medical gender transitions under any standard.

Because no fundamental right exists here, Ohio need only show that the challenged laws are "rationally related to a legitimate government interest," with "substantial deference to the General Assembly's predictive judgment." *Stolz v. J&B Steel Erectors*, 2018-Ohio-5088, ¶19 (quotation omitted). Plaintiffs offer only a token response on rational basis—denying that there is any here, Moe Br.49–50—while devoting most of their words to insisting that the State fails a plainly inapplicable strict-scrutiny test, Moe Br.44–49. On either approach, Plaintiffs are mistaken.

Rational Basis. First, the State showed many rational bases to enact these limits, including protecting children from both known harmful effects and known and unknown risks, with those downsides notably measured against questionable benefits, all in the overarching context of children's inability to fully appreciate those risks. State Br.25–29. The State cited not only the evidence given over a five-day trial here, but also the U.S. Supreme Court's acknowledgment of a rational basis for such laws (which, true, was against an equal-protection claim, but with the same rational-basis test). *Id.* at 27. The State also noted the growth of jurisdictions—sister States and other nations—banning or greatly limiting such treatments for children. *Id.* at 28.

Against all this, Plaintiffs say little, and what they say is wrong. First, their rational-basis discussion dismisses the U.S. Supreme Court's *Skrmetti* decision only by asserting that Ohio's evidence is lacking, and that Tennessee's was not—relying on

the Eighth Circuit dissent for the point. Moe Br.50. That is doubly wrong: If the evidence is good enough for Tennessee, it is good enough for Ohio, and on rational-basis review, legislation "may be based on rational speculation unsupported by evidence or empirical data." *F.C.C. v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993). Ohio's experts provided more than enough evidence to meet rational-basis review.

Second, Plaintiffs mistakenly argue that Ohio's law fails rational basis because the limit applies only to such medications for purposes of gender transitions, while allowing the same medications for children for other conditions. The U.S. Supreme Court's *Skrmetti* decision rejected that precise point, saying that Tennessee could rationally find that the risks outweighed the benefits for *this purpose,* but not for other purposes. The Court specifically said that it might be "true, as the plaintiffs contend, that puberty blockers and hormones carry comparable risks for minors no matter the purposes for which they are administered." *Id.* at 524. Nevertheless, said the Court, "it may also be true, as Tennessee determined, that those drugs carry greater risks when administered to treat gender dysphoria" than for other purposes. *Id.* That reasoning is no less true under due process than under equal protection.

Finally, Plaintiffs' rational-basis argument insists wrongly, and repeatedly, that the State "recogniz[ed] that the treatment *is* appropriate for some minors." Moe Br.50; *see id.* at 45, 46. Plaintiffs appear to base that claim on two points. First, the State, in saying that it would be rational to limit treatments, cited the harrowing story of Chloe Cole, a detransitioner who testified at trial about her regrets, the failure of "experts" to explain the risks, and the suffering from her surgery as a minor.

State Br.27. In that context, the State noted that even Plaintiffs could not say "which children might turn out to be Ohio's future Chloe Coles." *Id.* But Ohio law does not protect only those children who may, like Cole, ultimately express regret for undergoing an irreversible medical procedure. Ohio law protects *all* children from such risky procedures, regardless of whether they publicly express regrets. Second, Plaintiffs cite one of the State's several witnesses, Dr. Levine, who acknowledged that in some cases, he personally had left such decisions to families, without advocating against *or for* medical transition for children. Moe Br.45. But he never said that Ohio's law was wrong, and even if he would draw a narrower limit than Ohio's General Assembly did, Ohio's willingness to sponsor a witness with a slight variation in opinion does not show a rational-basis shortcoming.

Although Plaintiffs' specific rational-basis discussion does not go into detail in challenging the State's many enumerated concerns—such as lost fertility for life, risk of reduced bone density, and more—they do implicitly challenge them in their fact statement, but those challenges do not defeat rational basis. For example, they do not deny that cross-sex hormones can destroy fertility, and implicitly concede it. They say only (1) that puberty blockers alone do not cause infertility, which could bounce back if the child does not go on to cross-sex hormones, Moe Br.11, and (2) that as to lost fertility from cross-sex hormones, there are "steps that can mitigate those risks or otherwise preserve fertility," *id.* Those blithe reassurances omit key details: as to the "puberty-blockers only" point, Plaintiffs omit that virtually all children who use blockers do go on to cross-sex hormones. The State's expert, Dr. Cantor, said that

"upwards of 98 percent" of children on puberty blockers go on to cross-sex hormones, Tr. 7/18 7:13–19 (Dr. Cantor), while Plaintiffs' expert, Dr. Turban, conceded that at about 95 percent was accurate, Tr. 7/15 235:22–236:4 (Dr. Turban). As to "mitigat[ing]" lost fertility by "preserv[ing] fertility, the testimony that Plaintiffs cite shows only one option: having an adolescent "freeze" sperm or eggs for potential future use. Tr. 7/15 330:4-332:2; Tr. 7/16 12:19-13:20 (Dr. Corathers). Surely it satisfies rational basis for the State to be concerned that such processes are not the same as natural fertility and that children might not appreciate that difference. In sum, the State easily satisfies rational basis.

Strict Scrutiny. Even if the Court somehow reaches strict scrutiny—which is, again, impossible under the *Aalim/Glucksberg* test for fundamental rights, looking to a "careful description" and "history and tradition"—the State prevails. Plaintiffs concede that "protecting children can constitute a compelling government interest," Moe Br.45, and put all of their eggs in the basket of tailoring, saying Ohio's law is both over- and under-inclusive. They are wrong.

First, Plaintiffs' "overinclusiveness" argument is largely premised upon the mistaken claim that the State conceded that "some" children should undergo medical gender transitions because they may not come to regret it, debunked *above at* 12. Without that mistaken assumption, that part of the overinclusiveness claim collapses. Likewise, in insisting that procedural rules are a better fit, Moe Br.46–48, Plaintiffs assume that Ohio's interest is in limiting only *some* childhood gender transitions. That is wrong, and such a "tailoring" argument is really about re-defining

the State's interest to one that Plaintiffs prefer, rather than about *how* to meet *Ohio's* established interest. Plaintiffs also say that the State fails to adequately distinguish the harms of puberty blockers from those of cross-sex hormones. Moe Br.48–49. But as noted above, 95 to 98 percent of children on blockers go on to hormones. Further, if the hormone ban is upheld, as it should be, then the supposed benefits of blockers evaporate, as "buying time" to consider hormones goes away.

Second, Plaintiffs' underinclusiveness argument rests on a mistaken premise: that because the medications can also have side effects when used for other purposes, it is inconsistent to limit them only for gender-transition purposes. Moe Br.49. But as explained above—and as *Skrmetti* explained—a medical "treatment" is an interaction between an underlying condition and the medicine or surgery or other process used to address it, so the "same" medication amounts to a different treatment when used for a different purpose. All medical assessment—and legislative assessment of medical treatment—is about balancing risks *and* benefits, so a given risk carries different relative weight as against a different purpose. Compare a surgical example: Ohio can reasonably decide that it was wrong to cut off Chloe Cole's healthy breasts to look like a boy, while it would have been reasonable to perform a mastectomy if she had breast cancer. Medications, too, have context-specific balancing of risks and benefits.

All told, Plaintiffs' Due Course claim fails, whether the Court looks at claimed tailoring concerns, rational basis, or an alleged fundamental right—or excises the wayward doctrine of substantive due process from Ohio's Due Course of Law Clause.

II. Ohio's age minimum for medical gender transitions does not violate the Health Care Freedom Amendment.

Just as Ohio's age minimum for medical gender transitions does not violate the Due Course of Law Clause, so, too, it does not violate Ohio's Health Care Freedom Amendment. As the State explained, the HCFA addresses the commerce of providing health care, covering both insurance and any other "purchase or sale" of health care. Ohio Const., art. I, §21(B). It was adopted in response to the federal Affordable Care Act, which also involved how health care or insurance could be bought and sold. The HCFA did nothing to limit the State's traditional power to define what is legal to provide as legitimate health care. Indeed, not only does the "purchase or sale" language of Part (B) leave that traditional state authority untouched, but the HCFA reinforced the State's authority with belt and suspenders in Part (D), by preserving state authority to address "wrongdoing." State Br.35–36. Plaintiffs' responses do not overcome that showing, and indeed, properly understood, their responses further confirm why they are wrong.

A. A "no limits" reading of the HCFA is unreasonable because it guts state protections, and Plaintiffs' attempt to find an *ad hoc* "middle ground" has no textual basis and devolves to expert control.

While the State's view is correct standing alone on both the HCFA's text and context, and while Plaintiffs' contrary view is incorrect standing alone, the big picture is best understood by comparing the three possible views of the HCFA. The State's view is that the State retains its power to define legitimate "health care," and to regulate or ban procedures, even if some or many doctors disagree. One alternate view is the "unlimited" view, by which the State can no longer limit *any* procedure that some

health-care provider wishes to provide and that a would-be patient desires. The second alternate view is that the State retains power over some procedures but not others, with the balls and strikes called by courts using some standard. But that second alternate view raises the question: *What* middle ground does the HCFA support? Despite initially distancing themselves from an experts-decide approach, Plaintiffs find middle ground in "expert" consensus—that is, that the "prevailing standard of care accepted by a consensus of the medical community" defines the HCFA's scope. App.Op.¶101. The two alternate readings differ greatly; each has different flaws.

Plaintiffs' primary dodges—though there are others as well—are (1) their seeming—but unclear—inconsistent invocation of both wrong options, and (2) as to the "middle ground" option, their refusal to identify what standard applies, other than the Tenth District's "expert consensus" view. For example, Plaintiffs' discussion of the HCFA's text regarding the "purchase or sale of health care" seems to suggest the no-limit option. *See* Moe Br.22–28. After all, as the State pointed out, nothing in the text invites any middle ground, or reliance on "expert consensus" or any standard. In other words, the State admits that the "no limits view" is the second-best reading after the State's own—but that extreme view carries extreme consequences. It cuts off new state laws to address new problems, and it would invalidate several laws enacted since the HCFA. *See* State Br.39–41.

Plaintiffs, perhaps recognizing the implications of the no-limits view, disclaim any such view, Moe Br.31—but are cagey on how any such limits survive. They say that courts should decide, "based on appropriate evidence," whether a given activity

"constitutes 'health care' under the HCFA." *Id.* But what is that "appropriate evidence" for courts to look to?

The Tenth District expressly relied on "expert" consensus, looking to the "prevailing standard of care accepted by a consensus of the medical community." App.Op.¶101. It left no doubt which experts it leaned on—not only Plaintiffs' expert witnesses, as the appeals court identified the "World Professional Association of Transgender Health" or "WPATH," which it called "the leading association of medical professionals treating transgender individuals," and "the Endocrine Society," a similar group, as its guideposts. App.Op.¶13. The court explained that "[g]iven their scientific expertise on the subject, these organizations are considered the standard-bearers in gender-affirming care." *Id.* at ¶14.

Surprisingly, Plaintiffs insist that "no one is suggesting that legal decisionmaking should be delegated to medical experts," Moe Br.2, when experts are the heart of the appeals court's reasoning. While the court did not literally substitute medical groups for the court to render judgment, the court's adoption of "what experts say" as a benchmark is a functional delegation, unwarranted by the HCFA.

Again, Plaintiffs never identify concretely what the "appropriate evidence" would be for distinguishing valid and invalid HCFA claims, other than "expert" views. Despite disclaiming it, Plaintiffs' brief relies repeatedly on "experts" as the deciding factor. Moe Br.3–13. Plaintiffs repeatedly note the Governor's veto statement, Moe Br. 3, 15–16, which acknowledges that the State can override parental choice, but suggests it should not do so as against "medical experts." Moe Br.15–16 (quoting veto

statement). Plaintiffs should simply embrace their position rather than dodge it: they are the ones "suggesting" that experts are the real deciders.

Further, Plaintiffs do not respond at all to the exposure of WPATH—the acknowledged central hub of expertise, according to the Tenth District, and to Plaintiffs until now—as a political advocacy group that put its ideological goals above medical evidence in putting out its guidelines. *See* State Br.33, 44; *see* Amicus Br. of Alabama and 24 Other States at 5–24; Amicus Br. of IWF and CCV at 3–16.

B. Plaintiffs' remaining arguments do not disturb the State's showing that the HCFA preserves state authority to define legal health care.

While their inconsistency is their biggest flaw, Plaintiffs are wrong on several other points regarding the HCFA's true meaning, which is about the health-care market in light of the federal ACA, not about legislative power to define allowable health care. For example, Plaintiffs try to dismiss the federal ACA context by saying that the State's "attempts to tie the text of the HCFA to the ACA are unpersuasive." Moe Br.27. But this Court has already recognized that the "primary impetus of [the HCFA] is the portion of the Patient Protection and Affordable Care Act that requires" purchase of health care insurance through federally approved channels. *State ex rel. Ohio Liberty Council v. Brunner*, 2010-Ohio-1845, ¶64. The timing proves it: the HCFA's text specifically grandfathers in Ohio laws enacted a year and a half *before* its enactment—March 19, 2010—the Friday before the ACA's March 21 passage and March 23 signature. *Id.* at ¶2 (citing Ohio Const. art. I, §21(D)).

That context shows that the "purchase or sale" language involves regulating the *market* for health care, not defining what goes on the market. That is shown by both

the affirmative language regarding the "purchase or sale" and by the reservation for "wrongdoing." As the State noted, not only does Part (D)'s "wrongdoing" reservation work together with Part (B)'s limiting "purchase or sale" language, but the State's view is also reinforced by Parts (A) and (C). State Br.36.

Plaintiffs also mistakenly seek to invoke comments by the HCFA's proponents. They claim that an editorial by Ed Meese supports their view, Moe Br.28 n.16, but that article supports the State, as shown by Mr. Meese's *own amicus in this case. See* Juris. Amicus of Hon. Ed Meese. Plaintiffs also cite statements by HCFA author Maurice Thompson, Moe Br.30, but as the State showed, Mr. Thompson also noted that the State could define easily the scope of health care after passage, State Br.39.

For all their mistakes, Plaintiffs get some things partly right. They rightly note that the HCFA does not define "health care," and they point to statutes that do define it. Moe Br.23 (citing, e.g., R.C. 1337.11(G) and R.C. 2135.01(G)). But that points in the State's favor. The lack of definition in HCFA—which does, by contrast, define "health care system," *see* Ohio Const., art. I, §21(E)(2)—shows that defining health care was left to the General Assembly while the HCFA targeted only the health-care *markets*. And Plaintiffs' invocation of other statutory definitions confirms the point. What they miss, though, is that the General Assembly may *amend* such definitions as they think appropriate, and that is exactly what it did here: It declared that gender-transition services for children are not a valid form of "health care" in Ohio.

Finally, Plaintiffs try two "gotchas" regarding use of the term "health care," but both fail. They say that even the challenged laws endorse the idea that the proscribed

practices are "health care," because it defines them as "medical services." Moe Br.23–24. That is no concession, but shows that the relevant line is not between so-called "health care" and "not health care," but between "health care allowed in Ohio" and "health care or medical services *not* allowed in Ohio, even if some or many doctors desire it." Likewise, the trial court's description of "health care" is not a second "gotcha" (nor was it a "factfinding"), and the State did not concede the whole case by allegedly "not challenging" the labeling. What matters is not the label, but whether it is legal in Ohio, and whether the General Assembly can regulate it.

Return to surgery on minors. Again, Plaintiffs disclaim any challenge to the law's limits on surgery for minors. But, just as with their argument under the Due Course Clause, *above at* 8, their arguments here would entitle them to override the surgery law. If the HCFA protects "health care" practices approved by a "consensus" defined by WPATH, as the Tenth District found, that view *does* encompass surgery. Indeed, one of the many exposures of WPATH's ideology-first approach was that an earlier draft of the guidelines would have endorsed age minimums, but WPATH accepted political appointees' pressure to remove those limits, including for surgery. That means surgery is on the table, Plaintiffs' protestations notwithstanding.

For all these reasons, and those in the State's opening brief, the Court should uphold Ohio's laws, and allow the People, through their representatives, to protect Ohio's children from these risky procedures.

CONCLUSION

The Court should reverse the Tenth District's judgment.

Respectfully Submitted,

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