

No. 24-90, 24-99

**In the
Supreme Court of the United States**

DALE FOLWELL, State Treasurer of North Carolina, *et al.*,
Petitioners,

v.

MAXWELL KADEL, *et al.*,
Respondents.

BILL CROUCH, Secretary of W.V. Department of Health
and Human Resources, *et al.*,
Petitioners,

v.

SHAUNTAE ANDERSON, *et al.*,
Respondents.

*On Petitions for Writs of Certiorari to the
U.S. Court of Appeals for the Fourth Circuit*

**Brief of Missouri and 23 other States
in support of North Carolina and West Virginia**

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**INTEREST OF *AMICI* STATES AND
SUMMARY OF ARGUMENT**

The States of Missouri, Alabama, Alaska, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Montana, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Virginia, and Wyoming submit this brief to explain their strong interest in preserving the democratic prerogative of States to make decisions “in areas fraught with medical and scientific uncertainties.” *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228, 2268 (2022) (quoting *Marshall v. United States*, 414 U.S. 417, 427 (1974)); *see also Gonzales v. Carhart*, 550 U.S. 124, 163 (2007) (States have “wide discretion” to regulate “in areas where there is medical and scientific uncertainty”). Making policy decisions in an area of scientific uncertainty is a core, sovereign, democratic function.¹

The Fourth Circuit’s decision threatens this democratic prerogative. Right in the very first sentence, the court errs—badly—in a way that taints the rest of its analysis. It concludes that gender transition interventions (such as puberty blockers, cross-sex hormones, and irreversible surgeries) are “medically necessary.” To the contrary, just a few weeks before the Fourth Circuit’s decision, a four-year, four-hundred-page, comprehensive review conducted by the United Kingdom’s National Health Service concluded that

¹ On August 6, 2024, counsel for Missouri timely informed all parties of the intent to file this amicus brief. *See* Rule 37.2.

the evidence for gender transition interventions is “remarkably weak,” with “no good evidence on the long-term outcomes of interventions.” *The Cass Review: Independent Review of Gender Identity Services for Children and Young People* 13 (Apr. 10, 2024).² In line with these findings, the United Kingdom has restricted the use of these interventions, joining other countries—like Finland, Norway, and Sweden—that have recently declared these interventions to be “experimental,” “lacking” in evidentiary support, and entailing “risks [that] ... are likely to outweigh the expected benefits.” *Infra* Part I.A.

Organizations on this side of the pond have likewise expressed concern about these interventions. The U.S. Department of Health and Human Services did so three years ago. And even the organizations proffered by the plaintiffs and favorably cited by the Fourth Circuit—such as WPATH and the Endocrine Society—muster only half-hearted recommendations, not the full-throated endorsement the Fourth Circuit suggests. The Endocrine Society admits its relevant recommendations are “weak recommendations” because the quality of evidence is “low” or “very low,” and WPATH admits that the model it advocates is unproven and that it merely “is *hoped* that future research will explore the effectiveness of this model.” *Infra* Part I.B.

In light of the medical uncertainty acknowledged in the international medical community, *Amici* States

² https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf

have taken a variety of approaches to the issue. Some decline to pay for these chemical and surgical interventions through state-funded healthcare programs. As of last month, 25 States—having compared the known, irreversible side-effects to the unknown, speculative benefits—have gone further and passed laws prohibiting these interventions in certain circumstances. And some States, like Missouri, have passed laws barring interventions only temporarily (Missouri’s moratorium on hormonal interventions sunsets in three years)—until policymakers obtain the benefit of more scientific studies. Still other States have allowed these interventions—but only after individuals have first been provided adequate counseling care and psychological support.

In light of this Court’s precedent recognizing that States have wide authority in areas of medical uncertainty, this Court should permit the States appropriate latitude to respond to these scientifically unsettled issues.

ARGUMENT

I. Medical authorities across the globe have recently concluded that gender-transition interventions lack evidence of safety and efficacy.

The science surrounding gender transition interventions is new and unsettled. As the Fourth Circuit acknowledged in a footnote, “gender dysphoria” as a psychiatric condition was not recognized until 2013, “which ‘reflected a significant shift in medical understanding.’” *Kadel v. Folwell*, 100 F.4th 122, 136 n.5 (CA4 2024) (quoting *Williams v. Kincaid*, 45 F.4th

759, 767–69 (CA4 2022)). The World Health Organization classified transgender identity as a mental health disorder until just five years ago. BBC, *Transgender No Longer Recognised as ‘Disorder’ by WHO* (May 29, 2019).³ These recent, enormous changes make the Fourth Circuit’s core presumption—that these interventions are proven safe and effective—as perplexing as it is demonstrably erroneous.

A. The international medical community has increasingly concluded that these interventions lack scientific support.

There is a growing, robust, international consensus that when it comes to these interventions, “the evidence is lacking.” *What America Has Got Wrong About Gender Medicine*, *The Economist* (Apr. 5, 2023).⁴ Countries across Europe—the United Kingdom, France, Finland, Norway, and Sweden, among others—“have raised the alarm,” expressing concern that the harms “outweigh the benefits.” *Ibid.* Finland recently described these interventions in minors as “experimental” and said “treatment should seldom proceed beyond talking therapy”—*i.e.*, counseling. *The Evidence to Support Medicalised Gender Transi-*

³ <https://www.bbc.com/news/health-48448804>

⁴ <https://www.economist.com/leaders/2023/04/05/what-america-has-got-wrong-about-gender-medicine>

tions in Adolescents is Worryingly Weak, The Economist (Apr. 5, 2023).⁵ As the publication recently known as the British Medical Journal summarized it, “European countries have issued guidance to limit medical intervention in minors” and are instead “prioritising psychological care” such as counseling. Jennifer Block, *Gender Dysphoria in Young People Is Rising—And So Is Professional Disagreement*, BMJ, 1 (Feb. 23, 2023).⁶

United Kingdom. The United Kingdom’s recently released, four-year, four-hundred-page, comprehensive overview of the science best illustrates this trend. Unlike plaintiffs’ witnesses—who have financial and reputational interests in challenging West Virginia’s and North Carolina’s policies—the head of the United Kingdom’s Cass Review was chosen because she had “no prior involvement or fixed views in this area” and thus was unlikely to be swayed by financial or reputational interest.⁷

The Cass Review was led by Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health. The review commissioned at least nine studies—“systematic reviews,” the gold standard

⁵ <https://www.economist.com/briefing/2023/04/05/the-evidence-to-support-medicalised-gender-transitions-in-adolescents-is-worryingly-weak>

⁶ <https://www.bmj.com/content/bmj/380/bmj.p382.full.pdf>

⁷ <https://cass.independent-review.uk/nice-evidence-reviews/>

study in evidence-based medicine.⁸ After four years of study, and on the basis of these reviews, Dr. Cass’s team concluded that the evidence for gender transition interventions is “remarkably weak,” that there is “no good evidence on the long-term outcomes of interventions,” that doctors ordinarily are supposed to be “cautious” but that “[q]uite the reverse happened” here, that the evidence “had already been shown to be weak” in 2020, and that in 2024 “there continues to be a lack of high-quality evidence in this area.” Cass Review 13, 20.

For example, with respect to puberty blockers, the Review found “no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes, which without a control group could be due to placebo effect or concomitant psychological support.” *Id.*, at 179.

On cross-sex hormones, the review determined that the existing studies were so weak that “[n]o conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility.” *Id.*, at 184.

The Cass Review thus recommended restricting medicalized interventions—for example, by focusing on “provid[ing] assessment and psychological support” rather than rushing to chemical and surgical intervention. *Id.*, at 36.

⁸ Available at <https://cass.independent-review.uk/nice-evidence-reviews> and <https://adc.bmj.com/pages/gender-identity-service-series>.

Consistent with the Cass Review, the United Kingdom has restricted availability of these interventions. Puberty blockers, for example, are permitted only in a formal research protocol—none of which exists yet. Aimee Woodmass, *UK High Court Rules Ban on Puberty Blockers Is Lawful*, JuristNews (July 31, 2024).⁹ While the Cass Review did not recommend prohibiting cross-sex hormones entirely, it did stress “extreme caution” and said that hormones should be tried only as a “tertiary” intervention if others fail. Cass Review 35–36.

Sweden. Similarly, Sweden’s health authority issued guidelines concluding that, at least for minors, “the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits.” *Care of Children and Adolescents with Gender Dysphoria*, Socialstyrelsen: The National Board of Health and Welfare (2022).¹⁰

After the Swedish health authority made these determinations in 2022, a major study in Sweden reinforced the conclusions. Ludvigsson, et al., *A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research*, *Acta Paediatrica* (Apr. 17, 2023).¹¹ That study concluded there was a “current lack of evidence for hormonal therapy improving gender dysphoria”

⁹ <https://www.jurist.org/news/2024/07/uk-high-court-rules-ban-on-puberty-blockers-is-lawful/>

¹⁰ <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf>

¹¹ <https://doi.org/10.1111/apa.16791>

and thus the interventions “should be considered experimental,” concluded this “absence of long-term studies is worrying because many individuals start treatment as minors and CSHT is lifelong,” and concluded that better research is “urgently needed.” *Id.*, at 2280, 2288, 2290.

Finland. Likewise, Finland’s health authority recently reviewed the data and concluded that (at least for minors), these interventions are “an experimental practice,” that “there are no medical treatment[s] that can be considered evidence-based,” that surgical treatments should be taken off the table entirely, and that hormonal intervention should be used (if at all) only as a last resort. *Recommendation of the Council for Choices in Health Care in Finland: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors*, PALKO/COHERE Finland (2020).¹²

B. Domestic authorities likewise agree that the science is unsettled.

The Fourth Circuit’s assumption that these interventions are medically established is especially faulty in light of the domestic organizations—including some favorably cited by the plaintiffs—that recognize the limitations.

Start first with the U.S. Department of Health and Human Services. One of its subagencies, the U.S.

¹² Certified translation available at <https://ago.mo.gov/wp-content/uploads/Finland-Guidelines-for-Minors-certified-translation.pdf>

Agency for Healthcare Research and Quality, recently concluded (with respect to minors), “There is a lack of current evidence-based guidance for the care of children and adolescents who identify as transgender, particularly regarding the benefits and harms of pubertal suppression, medical affirmation with hormone therapy, and surgical affirmation.” *Topic Brief: Treatments for Gender Dysphoria in Transgender Youth*, AHRQ, Nom. No. 0928, at 2 (2021).¹³

Then there are the organizations touted by plaintiffs and credited by the Fourth Circuit: the self-described advocacy organization WPATH and the Endocrine Society. But even these organizations have conceded that there are major gaps in the science: “America’s professional bodies acknowledge the science is low quality.” The Economist, *What America Has Got Wrong About Gender Medicine*.¹⁴

For example, the Endocrine Society has recommended using puberty blockers and cross-sex hormones for minors, but the relevant recommendations are highly limited and filled with qualifications: the organization offers only “weak recommendations” because the quality of the evidence is “low” or “very low.” Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. Clinical Endocrinology & Metabolism 3869, at 3871–72

¹³ <https://effectivehealthcare.ahrq.gov/system/files/docs/topic-brief-gender-dysphoria.pdf>

¹⁴ <https://www.economist.com/leaders/2023/04/05/what-america-has-got-wrong-about-gender-medicine>

(Nov. 2017).¹⁵ Similarly, WPATH advocates what it calls a “gender-affirming care” model, and found only “scant, low-quality evidence” to support its recommendations. The Economist, *The Evidence to Support Medicalised Gender Transitions in Adolescents Is Worryingly Weak*.¹⁶ In its most recent guidelines, WPATH even admits that its model is unproven, and that “it is *hoped* that future research will explore the effectiveness of this model.” WPATH, *Standard of Care 8*, at S33 (2022) (emphasis added).¹⁷

In hindsight, the Fourth Circuit’s reliance on WPATH was especially silly for reasons that go beyond WPATH’s own statements. Recent documents produced in discovery reveal that WPATH has long been suppressing scientific research that undercuts WPATH’s preferred conclusions.

WPATH hired a team from Johns Hopkins University to conduct “dozens” of systematic evidence reviews for WPATH to use in crafting its new guidelines. See ECF 100, U.S. Dep’t of Health and Human Services’ Response to Motions to Seal, Dkt. *Voe v. Mansfield*, No. 1:23-cv-864, at *9–12 (M.D.N.C. May 13,

¹⁵ <https://academic.oup.com/jcem/article/102/11/3869/4157558>

¹⁶ <https://www.economist.com/briefing/2023/04/05/the-evidence-to-support-medicalised-gender-transitions-in-adolescents-is-worryingly-weak>

¹⁷ <https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644>

2024).¹⁸ But then WPATH interfered with publication of the science when the results came back negative. As the Johns Hopkins team lead privately reported to HHS—in documents that have since been made public—WPATH began “trying to restrict our ability to publish” after “we found little to no evidence” supporting these interventions. *Ibid.* Summarizing these documents, *The Economist* reported that WPATH “expressed a desire to control the results” and said Johns Hopkins could not release results “without WPATH approval,” which would only be given if WPATH believed the results did not “negatively affect” WPATH’s advocacy. *Research into Trans Medicine Has Been Manipulated*, *The Economist* (June 27, 2024).¹⁹

These suppression attempts have become so bad that prominent practitioners in the field are starting to speak out. Dr. Erica Anderson, who identifies as transgender and is a prominent clinical psychologist in San Francisco, has expressed concern that activists regularly hamper medical development by silencing critics. As Anderson said, “The pressure by activist medical and mental health providers, along with some national LGBT organizations to silence the voices of detransitioners and sabotage the discussion around what is occurring in the field is unconscionable.” Ed-

¹⁸ Available at <https://ago.mo.gov/wp-content/uploads/Voe-v-Mansfield-USDC-MDNC.pdf>.

¹⁹ <https://www.economist.com/united-states/2024/06/27/research-into-trans-medicine-has-been-manipulated>

wards-Leeper & Anderson, *The Mental Health Establishment Is Failing Trans Kids*, Washington Post (Nov. 24, 2021).²⁰

A New York Times report also reveals that WPATH bowed to political pressure to change its guidelines—pressure from the Biden administration. Azeen Ghorayshi, *Biden Officials Pushed to Remove Age Limits for Trans Surgery, Documents Show*, NY Times (June 25, 2024).²¹ “U.S. health officials lobbied to remove age minimums for surgery in minors because of concerns over political fallout.” *Ibid.* WPATH complied—over the dissent of members who said “we should be basing this on science and expert consensus,” not political pressure. *Ibid.*

Even more shocking, acting on the advice of “social justice lawyers,” some WPATH authors intentionally chose *not* to seek evidence reviews so they would not have to report the results, which were expected to be negative. As one author explained: “Our concerns, echoed by the social justice lawyers we spoke with, is that evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits.” ECF 619, *Boe*

²⁰ <https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/>

²¹ <https://www.nytimes.com/2024/06/25/health/transgender-minors-surgeries.html>

v. *Marshall*, 2:22-cv-184-LCB (M.D. Ala. May 27, 2024)²² (quoting Ex. 174, ECF 560-24 at 2).

II. States need flexibility to make the calls about coverage—especially in contexts involving medical uncertainty.

As the petitioners in both cases rightly point out, States have limited resources. Missouri, for example, spends 24% of its general funds just on Medicaid. *Medicaid Expenditures as a Percent of Total State Expenditures by Fund*, KFF (formerly Kaiser Family Foundation) (last visited Aug. 7, 2024).²³ That number does not include administrative costs for Medicaid, *ibid.*, nor non-Medicaid healthcare funding (such as funding for state employees). And it of course does not cover the thousands of other things States must fund, such as road services and education.

Limited resources necessarily means States must make tough calls about what to cover. If, for example, a State has enough funds to cover only one of two different procedures, the State must triage and decide which procedure will lead to the best health outcomes overall. It may choose, for example, to focus resources on procedures that increase life longevity by years rather than expensive procedures that modestly decrease pain for a short time—even though both procedures are independently worthwhile.

²² <https://www.courtlistener.com/docket/63252064/619/boe-v-marshall/>

²³ <https://www.kff.org/medicaid/state-indicator/medicaid-expenditures-as-a-percent-of-total-state-expenditures-by-fund/>

Absent federal preemption, these are policy decisions that the States are entitled to make. “Medicaid ... is designed to advance cooperative federalism.” *Wisc. Dep’t of Health and Fam. Services v. Blumer*, 534 U.S. 473, 495 (2002). Apart from federally established floors, the program generally “leave[s] to States the decision” about what to cover. *See id.*, at 497.

States regularly exercise this discretion. For example, Missouri Medicaid covers pacemakers, but not ones with plutonium batteries because of the attendant risks of those pacemakers. Missouri Medicaid Ambulatory Surgical Center Provider Manual at 13 (2024).²⁴ Similarly, Missouri does not cover vein punctures for blood draws, “routine foot care,” orthotic splints, testing for specific antibodies, or transportation to a medical facility—even though physicians might determine that all those services are medically necessary. *Ibid.*

The ability of States to make these judgment calls is always necessary, but it is especially necessary in the context of gender transition interventions given the emerging international consensus that these interventions lack scientific support. While the intended benefits of these interventions remain speculative, the risks are severe and typically “well understood.” Cass Review Interim Report at 35 (Feb.

²⁴ <https://mydss.mo.gov/media/pdf/ambulatory-surgical-center-provider-manual>

2022).²⁵ “These include increased cardiovascular risk, osteoporosis, and hormone-dependent cancers.” *Id.*, at 36. Fertility is also hampered. *Ibid.* Some interventions impede fertility; others render a person completely and irrevocably infertile.

Other risks are less well understood because of lack of testing but are still extraordinary. These can include the concern that interventions in fact “alter[]” a person’s gender identity, “permanently disrupt[]” “brain maturation,” and decrease bone density (leading to increased risk of fractures). Cass Review 178. Surgeries in particular are known to have especially high complication rates and low evidence of efficacy. *See, e.g., Wang, et al., Outcomes Following Gender Affirming Phalloplasty: A Systematic Review and Meta-Analysis*, 10 *Sexual Medicine Reviews* 499 (2022) (reporting complication rates of 76.5% and noting that “current evidence” of surgical “outcomes is weak”).

In contrast, counseling care is recognized to be effective and is free from any of these side effects. Counseling care (sometimes called “talk therapy” or “psychotherapy”) has been “highly recommended” by WPATH and other groups. *E.g., WPATH, Standard of Care 7*, at 28 (2012).²⁶ That is because it can “greatly facilitate the resolution of gender dysphoria”; indeed, through this care, many “individuals integrate

²⁵ <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf>

²⁶ https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf

their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body.” *Id.*, at 8, 25.

In other words, a method of treatment with *no* physical side effects has been recognized—even by prominent proponents of chemical and surgical intervention—as an effective clinical response to gender dysphoria. It is thus no surprise that “European countries have issued guidance to limit medical intervention” in certain cohorts and instead are “prioritising psychological care.” Jennifer Block 1.²⁷

The States ought to be able to do the same. Faced with limited resources and a context where States must compare one treatment (counseling care) that is well established and has no downsides against a different procedure that has extraordinary side effects and is widely recognized in the European medical community to be experimental, the States’ “options must be especially broad.” *Marshall*, 414 U.S., at 427. States should not be forced to pay for hotly disputed interventions just because they are supported by a self-described advocacy group with a troubling record of trying to suppress evidence.

The Fourth Circuit’s contrary conclusion that States have *no* discretion is not just contrary to law; it threatens the ability of States to make the tough decisions with which they are democratically entrusted. The Fourth Circuit’s sharply split decision undermines federalism and should be quickly reversed.

²⁷ <https://www.bmj.com/content/bmj/380/bmj.p382.full.pdf>

CONCLUSION

The Court should grant the petitions for writs of certiorari.

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