IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT
FRANKLIN COUNTY, OHIO

MADELINE MOE, *et al.* Plaintiffs-Appellants, v. DAVID YOST, *et al.* Defendants-Appellees.	Case No. 24AP-483 On appeal from the Franklin County Court of Common Pleas, Case No. 24-cv-002481

BRIEF OF APPELLANTS

Freda J. Levenson (45916)
Counsel of Record
Amy Gilbert (100887)
ACLU OF OHIO FOUNDATION
4506 Chester Avenue
Cleveland, Ohio 44103
(614) 586-1972
flevenson@acluohio.org
agilbert@acluohio.org

David J. Carey (88787)
Carlen Zhang-D'Souza (93079)
ACLU OF OHIO FOUNDATION

Dave Yost (0056290)
OHIO ATTORNEY GENERAL

T. Elliot Gaiser (0096145)
SOLICITOR GENERAL
Counsel of Record
Erik Clark (0078732)
DEPUTY ATTORNEY GENERAL
Stephen P. Carney (0063460)
DEPUTY SOLICITOR GENERAL
Amanda Narog (0093954)
ASSISTANT ATTORNEY GENERAL
30 East Broad Street

1108 City Park Ave., Ste. 203
Columbus, Ohio 43206
(614) 586-1972
dcarey@acluohio.org
czhangdsouza@acluohio.org

Chase Strangio*
Harper Seldin*
Leslie Cooper*
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, Floor 18
New York, NY 10004
(212) 549-2500
cstrangio@aclu.org
hseldin@aclu.org
lcooper@aclu.org

Miranda Hooker*
Jordan Bock*
Goodwin Procter LLP
100 Northern Avenue
Boston, MA 02210
(617) 570-1000
mhooker@goodwinlaw.com
jbock@goodwinlaw.com

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

Counsel for Appellants

17th Floor
Columbus, Ohio 43215
(614) 466-8980
thomas.gaiser@ohioago.gov

Counsel for Appellees

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Assignment of Error No. 2: The trial court erred in entering judgment for the Government on Appellants' claim under Article I, Section 21 of the Ohio Constitution (the "Health Care Freedom Amendment," or "HCFA"), as H.B. 68 unlawfully "prohibit[s]" and/or "impose[s] a penalty … for" the sale or purchase of gender-affirming medical care.

Assignment of Error No. 3: The trial court erred in entering judgment for the Government on Appellants' claim under Article I, Section 2 of the Ohio Constitution (the equal protection clause), as H.B. 68 facially classifies on the basis of sex, and the Government has failed to demonstrate that H.B. 68 is narrowly tailored to serve a compelling state interest.

Assignment of Error No. 4: The trial court erred in entering judgment for the Government on Appellants' claim under Article I, Section 16 of the Ohio Constitution (the due course of law clause), as H.B. 68 infringes on the fundamental right of parents to seek appropriate medical care for their children, and the Government has failed to demonstrate that H.B. 68 is narrowly tailored to serve a compelling state interest.

ISSUES PRESENTED FOR REVIEW

1. Under the Ohio Constitution's single-subject rule, may a bill unnaturally combine two unrelated laws, regulate multiple entirely distinct aspects of individuals' lives, serve multiple inconsistent and opposing purposes, and contain a title that expressly identifies at least two unconnected subjects?

(Issue 1 pertains to Assignment of Error No. 1.)

2. Does a legislative enactment violate the Health Care Freedom Amendment when it expressly "prohibit[s] the purchase or sale of health care" and "impose[s] a penalty … for the sale or purchase of health care"?
3. Should Ohio courts nullify the Health Care Freedom Amendment by assuming that any "health care" that is "prohibit[ed]" or "penal[ized]" by the Ohio General Assembly is necessarily "wrongdoing … in the health care industry," and thereby exempt from the Amendment?

(Issues 2 and 3 pertain to Assignment of Error No. 2.)

4. Does a legislative enactment violate the equal protection clause of

the Ohio Constitution when it facially classifies on the basis of sex and is not narrowly tailored to serve a compelling interest?

(Issue 4 pertains to Assignment of Error No. 3.)

5. Does a legislative enactment infringe on the fundamental parenting right of the Ohio Constitution when it abrogates parents' ability to make decisions about the type of medical care their child will receive, and the displacement of parental decision-making with governmental decision-making is not narrowly tailored to a compelling government interest?

(Issue 5 pertains to Assignment of Error No. 4.)

6. Can a law survive strict scrutiny where the Government has failed to demonstrate that the law is narrowly tailored to serve a compelling interest?

(Issue 6 pertains to Assignment of Error Nos. 3 and 4.)

INTRODUCTION

Appellants Madeline Moe and Grace Goe are twelve-year-old transgender girls who, alongside and supported by their parents, have brought this action to challenge the constitutionality of House Bill 68 ("H.B. 68"). H.B. 68 artificially packages together two unrelated Acts of the General Assembly, each with a separate range of prohibitions and impositions. To Madeline and Grace, H.B. 68 spells the denial of critical medical treatment for a serious health condition that, if left untreated, can cause severe harm. Specifically, H.B. 68 bans gender-affirming medical care (which it dubs "gender transition services") for those under age 18. The banned care consists of several widely accepted and evidence-based medical interventions for the treatment of gender dysphoria in adolescents. Appellants are not directing a challenge toward those parts of H.B. 68 that prohibit surgical procedures.

H.B. 68's Health Care Ban is directly targeted at—indeed, is *limited to*—transgender adolescents, and that is who will suffer as it takes effect. Appellants are cases in point. Before Madeline Moe was able to live her life as a girl, she was in a persistent state of misery. When she was in first

grade, she frequently stated that she wished she could die and be reborn as a girl and, ultimately, attempted to cut her wrists with a kitchen knife. Once she was allowed to live as she knew herself to be, she immediately improved. Today, because she is receiving puberty delaying medication that is preventing her from experiencing the distress of seeing her body masculinize—treatment prohibited by H.B. 68—she is thriving.

Grace Goe is hoping for a similar story. Like Madeline, she suffered considerable distress as a result of gender dysphoria, but showed immediate and marked improvement upon being allowed to live as herself. She has now lived as a girl for most of her life; she and her parents are seeking the same medical care for her that Madeline has obtained. For both Madeline and Grace, the prospect of being unable to access gender-affirming medical care would be devastating. That possibility threatens to push them and their families out of Ohio altogether.

Appellants have brought four constitutional challenges to H.B. 68, each of which is entirely independent of the others:

First, H.B. 68 violates the Ohio Constitution's single-subject rule. It is, quite literally, two laws of separate origin hastily jammed together:

the Health Care Ban, and a Sports Prohibition aimed at excluding transgender women and girls from women's and girls' collegiate and interscholastic sports. These two acts have no common subject matter or cognizable joint purpose: one purports to "protect" transgender adolescents by denying them medical care, while the other restricts adult and youth sports participation. This claim requires no factual showing and should be resolved in Appellants' favor as a matter of law.

Second, H.B. 68 violates the Health Care Freedom Amendment (HCFA) to the Ohio Bill of Rights, which expressly precludes the General Assembly from prohibiting or penalizing the purchase or sale of "health care." The Government does not dispute that gender-affirming care is "health care," nor that H.B. 68 prohibits or penalizes it. Instead, it asks this Court to construe the HCFA to have no enforceable meaning. Again, this claim should be resolved in Appellants' favor as a matter of law.

Third, H.B. 68 violates the Ohio Constitution's equal protection clause. It expressly imposes classifications on the bases of sex, incongruence between sex designated at birth and gender identity, and government preference for gender conformity. These classifications must

be tested under strict scrutiny, but the Government failed to meet its burden at trial to demonstrate that the Health Care Ban is narrowly tailored to serve a compelling state interest. Even the Government's own experts agree that the Ban is not as narrowly tailored as they believe it should be.

Fourth and finally, H.B. 68 infringes on the fundamental parenting right guaranteed by the due course of law clause. It does so by substituting the General Assembly's judgment for that of fit parents: banning wholesale a category of health care that is otherwise available for them to choose for their children. Again, the Government has failed to show a basis for the law to withstand strict scrutiny.

As discussed below, the trial court committed several critical errors in its analysis of these claims, and indeed, appears to have failed to engage with the ample expert evidence before it. Its judgment should be reversed.

STATEMENT OF THE CASE AND FACTS

I. The Enactment of H.B. 68

A. H.B. 68 Prohibits Gender-Affirming Medical Care and Restricts Sports Participation

H.B. 68's title "references two subjects: Saving Ohio Adolescents

from Experimentation and Saving Women's Sports":

> To enact [multiple sections] of the Revised Code to enact the Saving Ohio Adolescents from Experimentation (SAFE) Act regarding gender transition services for minors, and to enact the Save Women's Sports Act to require schools, state institutions of higher education, and private colleges to designate separate single-sex sports teams and sports for each sex.

2024 Sub.H.B. No. 68; *see* TRO Entry at 11–12.

In relevant part, the first bill contained in H.B. 68, called the SAFE Act (the "Health Care Ban" or "Ban"), prohibits physicians from providing gender-affirming health care—which it dubs "gender transition services"—to patients under the age of 18. That prohibition forbids physicians 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)), or from knowingly engaging in "conduct that aids or abets in" such treatment. *Id.* (enacting R.C. 3129.02(A)(3)). The Ban contains a limited exemption for continuation of current Ohio residents' preexisting care. *Id.* (enacting R.C. 3129.02(B)). The Attorney General is authorized to "bring an action to enforce compliance" with the Health Care Ban, and the State

Medical Board is instructed that any violation of the Health Care Ban "shall be considered unprofessional conduct and subject to discipline[.]" *Id.* (enacting R.C. 3129.05(A), 3129.05(C)).

The second bill in H.B. 68, called the Save Women's Sports Act (the "Sports Prohibition"), requires that schools 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). This portion of the bill is not subject to enforcement by the Attorney General or the State Medical Board. Instead, H.B. 68 creates private rights of action for damages and injunctive relief for "[a]ny participant who is deprived of an athletic opportunity," "[a]ny participant who is subject to retaliation or other adverse action," or "[a]ny school or school district that suffers any direct or indirect harm" as a result of a violation. *Id.* (enacting R.C. 3313.5139(E)(1)-(3)).

B. H.B. 68 Combines Two Bills That Had Previously Failed

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 (March 16, 2021); H.B. No. 454, As Introduced version, 134th General Assembly (October 19, 2021). When H.B. 68 was first introduced, it consisted solely of the Health Care Ban, with no mention of interscholastic sports. *See generally* H.B. No. 68, As Introduced version, 135th General Assembly (February 27, 2023). A separate bill introduced earlier that month, House Bill 6, contained what would become the Sports Prohibition. *See* H.B. No. 6, As Introduced version, 135th General Assembly (February 15, 2023).

Four months later, on June 14, 2023, the contents of H.B. 6 were rolled into H.B. 68 as a second "Act" within that bill. *See* Saving Ohio Adolescents from Experimentation Act: hearing on H.B. 68 before the H. Comm. on Public Health Policy, 2023 Leg., 135th Sess. Once the Acts were combined, the bill cleared the Ohio House within a week. *See* Ohio Legislative Service Commission, Final Analysis of Sub.H.B. No. 68, as passed by the General Assembly (2024), at 9.

C. H.B. 68's Two Acts Are Structurally Distinct

The Health Care Ban and the Sports Prohibition have no overlap in

title, substance, or enforcement mechanisms. Each has its own set of statutory definitions, and neither uses any terms defined in the other Act. *See* 2024 Sub.H.B. No. 68 (enacting R.C. 3129.01, containing definitions for the Health Care Ban, and R.C. 3345.562, containing separate definitions for the Sports Prohibition). Each amends a different title of the Revised Code—the Health Care Ban amends Title 31 (domestic relations and children), while the Sports Prohibition amends Title 33 (education).

Each Act also has its own enforcement mechanism. The Health Care Ban authorizes the Attorney General to bring an "action to enforce compliance," and some violations "shall be … subject to discipline by the applicable professional licensing board." *See id.* (enacting R.C. 3129.05). The Sports Prohibition, meanwhile, is enforced solely by private actions for damages or injunctive relief. *See id.* (enacting R.C. 3345.562).

Moreover, the General Assembly's findings in Section 2 of the bill pertain only to the Health Care Ban, with no mention of sports. *See id.*

II. The Nature of Gender-Affirming Care for Adolescents with Gender Dysphoria

The evidence presented at trial overwhelmingly showed that gender-

affirming medical care is a safe, effective, and well-accepted treatment in Ohio and across the United States for the treatment of 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]).

A. Gender Dysphoria Is a Serious Condition Requiring Treatment

Gender dysphoria is "a diagnosis that describes when an individual has a discordance between their gender identity and their sex assigned at

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[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 endocrinologist subspeciality of the hospital. 7.15 Tr.293:9-294:2, 294:25-295:14 (Corathers). As set forth among her other qualifications and experience on her CV, *see* Trial Exhibit 20, Dr. Corathers has treated about 300 individuals with gender dysphoria, 7.15 Tr.296:16-20 (Corathers), and has conducted research and published peer reviewed articles on the treatment of gender dysphoria in adolescents. *Id* at 297:9-15.

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

birth for a period of at least six months, and that [] discordance creates functional impairment in social, occupational, or other area[s] of functioning." 7.15 Tr.96:23-97:8 (Turban[3]).

Gender dysphoria is diagnosed the same way that other psychiatric conditions are: patient clinical interviews and, for minors, information from parents as well. 7.15 Tr.97:18-99:11, 114:23-115:9, 258:5-13 (Turban); 7.15 Tr.309:14-310:2 (Corathers). Defendants' psychiatry expert, Dr. Levine, agreed and further testified as to the validity and reliability of the diagnosis of gender dysphoria, noting that it has inter-relator validity, meaning that if one doctor diagnoses a patient with gender dysphoria, another doctor is likely to reach the same conclusion. 7.18

[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). Among his other qualifications and experience, *see* Trial Exhibit 21, Dr. Turban treats adults and minors with gender dysphoria, including around a hundred youth, 7.15 Tr.87:1-88:24 (Turban); teaches child psychiatry fellows, psychiatry residents, and medical students about gender dysphoria, *id.* at 88:25-89:10; conducts research and has published between 30 and 40 peer reviewed articles about the mental health of transgender youth, *id.* at 89:11-91:2; and has written textbooks and chapters on child and adolescent psychiatry generally and gender dysphoria specifically. *Id.* at 91:3-15.

Tr.139:1-140:14 (Levine).

Experts on both sides also agree that if a patient's gender incongruence persists after onset of puberty, that incongruence is unlikely to naturally 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). When untreated, individuals with gender dysphoria can experience depression, anxiety, self-harm—including harm to the secondary sex characteristics that cause distress—and suicidality. 7.15 Tr.99:24-101:19 (Turban).

B. The Widely Accepted Protocols for Treating Adolescents with Gender Dysphoria Include Pubertal Suppression and Hormone Therapy When Medically Indicated

The medical profession's generally accepted guidelines for treating gender dysphoria are issued by the Endocrine Society and the World Professional Association for Transgender Health (WPATH). 7.15 Tr.105:5-106:14 (Turban); 7.15 Tr.304:17-22 (Corathers); 7.16 Tr.153:1-9 (Antommaria). These guidelines were developed by experts in the field using well-accepted processes for reviewing the evidence and developing recommendations. 7.16 Tr.153:1-156:21 (Antommaria). These guidelines are comparable to treatment guidelines used in many other areas of

medicine. 7.16 Tr.166:16-23, 190:18-23 (Antommaria); 7.15 Tr.304:23-305:5 (Corathers).

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 to support them as they navigate school and possible social transition (e.g. using a new name or clothing or hairstyle that 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), medical interventions such as puberty delaying medications and hormone therapy may be indicated. 7.15 Tr.106:15-107:10 (Turban); 7.15 Tr.305:6-306:7 (Corathers). Prior to the initiation of any medical interventions for adolescents, both guidelines provide for comprehensive psychosocial assessments, including 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).

Because of the distress that pubertal changes can cause youth with gender dysphoria, the goal of pubertal suppression is to temporarily pause

pubertal changes to give a young person time to improve or stabilize their mental health, to explore their gender identity, and to prevent the development of secondary sex characteristics that would later be difficult or impossible to change. 7.15 Tr.107:24-108:19 (Turban); 7.15 Tr.310:21-312:19 (Corathers). If treatment is stopped, puberty resumes. 7.15 Tr.313:17-314:13 (Corathers).

For older adolescents who continue to experience gender dysphoria, hormone therapy may be indicated. The guidelines recommend that such treatment should only be provided 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 that 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

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

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).

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

Pubertal suppression and hormone therapy have been used to treat adolescents with gender dysphoria since at least the 1990s, and available in Ohio since at least 2009. 7.16 Tr.52:19-53:2 (Corathers); 7.15 Tr.123:17-124:5 (Turban); 7.16 Tr.152:17-25 (Antommaria). All the major medical and mental health organizations in the United States, including the American Academy of Pediatrics, the American Medical Association and the American Psychiatric Association, consider these

treatments appropriate and medically necessary care and have opposed bans on such care. 7.15 Tr.107:11-23 (Turban).

These treatments are also provided to adolescents with gender dysphoria in countries around the world. While some European countries with nationalized healthcare 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 and hormone therapy for minors. 7.16 Tr.187:14-189:11 (Antommaria); 7.15 Tr.168:6-169:8 (Turban); 7.17 Tr.88:4-25 (Cantor).

C. The Prohibited Treatments Are Effective

Experts and fact witnesses on both sides agree that some youth can benefit from medically transitioning. 7.18.24 Tr.113:22-114:18 (Levine); 7.16 Tr.223:7-11 (Reed); 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.262:2-11, 265:17-24, 269:1-271:2 (Moe).

Both clinical experience and scientific research demonstrate that gender-affirming medical care improves the lives of the adolescents who

need and receive it. 7.15 Tr.129:1-132:14, 133:8-23, 134:16-23 (Turban). The undisputed testimony from Dr. Turban and Dr. Corathers was that among their patients, puberty blockers and hormone therapy greatly relieved their gender dysphoria and enabled them to go from distressed and depressed to thriving teenagers. 7.15 Tr. 129:1-133:23 (Turban); 7.15 Tr.,301:14-302:21, 7.16 Tr.14:7-21, 43:16-45:11 (Corathers).

This clinical experience is consistent with 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 as they go through puberty. 7.15 Tr.127:22-133:23 (Turban).

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 these are difficult to conduct for ethical and

practical reasons. 7.16 Tr.157:25-160:24, 161:20-162:20, 171:13-19 (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), that does not mean that they are without scientific value or unreliable for purposes of developing treatment recommendations, but rather, to contrast such studies with "high quality" evidence, which generally refers to randomized controlled clinical trials. 7.16 Tr.143:11-19 (Antommaria). It was undisputed that many other types of medical treatments that adolescent patients and their parents may pursue are based on "low quality" evidence. 7.16 Tr.166:16-23, 190:14-191:3 (Antommaria); 7.15 Tr.304:23-305:5 (Corathers).[5]

[5] The Government's experts cite to systematic reviews of the body of research, including reviews from the U.K. known as the Cass Review, 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 about the research. Importantly, they omitted many of the studies in their summaries, with authors of different reviews disagreeing more than half of the time about whether a study was worthy of being included. 7.15 Tr.160:8-168:5 (Turban).

It was also undisputed 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). Both parties' experts agree it would be beneficial to have more research on the use of puberty blockers and hormone therapy to treat adolescents with gender dysphoria. 7.16 Tr.166:24-167:11 (Antommaria); 7.19 Tr.70:10-17 (Government's expert Hruz); 7.18 Tr.116:22-118:12 (Government's expert Levine). H.B. 68 would forbid such research.

D. The Prohibited Treatments Are Safe

Experts from both sides 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). And it was 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).

Experts on both sides further agree that most of the potential risks associated with puberty blockers and hormone therapy also apply when

these very same medications are used for other purposes in minors.[6] For instance, regardless of the reason for which they are used, estrogen and testosterone pose a risk of blood clots, and puberty blockers pose risks related to intracranial pressure. 7.15 Tr.321:3-25, 328:7-25, 7.16 Tr.17:2-20:18 (Corathers); 7.19 Tr.47:7-15, 70:25-71:9 (Government's expert Hruz). Notably, these risks are very rare, particularly when patients are monitored by a doctor: in her practice of 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 for purposes

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

other than the treatment of gender dysphoria. 7.19 Tr.70:25-71:9 (Hruz).[7]

The one potential risk that can, in some cases, differ when these medications are provided to treat gender dysphoria is the possible impairment of fertility. This is not the case with all of the banned treatments, e.g. if a patient is treated with puberty blockers and then discontinues treatment, there is no impact on fertility. 7.15 Tr.324:22-325:3 (Corathers). But, like other medical treatments minors may undergo,[8] some gender-affirming medical treatments have the potential to impair fertility.[9] However, it was undisputed that treatment can be

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[7]The Government's experts also assert that there is a risk to social development and bone health associated with providing puberty blockers as treatment for gender dysphoria, asserting that delaying puberty past normally-timed puberty hinders social development and interferes with the rapid accrual of bone mineralization that occurs during puberty. But these asserted concerns are premised on the erroneous assumption that youth treated with puberty blockers 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).

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

[9] Hormone therapy alone does not necessarily cause infertility, and adolescents are cautioned that hormone therapy is not contraception. 7.15

provided in a way that preserves fertility and mitigates fertility risks. 7.15 Tr.330:4-332:2, 7.16 Tr.12:19-13:20 (Corathers).

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

E. Experts from Both Sides Agreed That the Decision About Whether to Provide Gender-Affirming Medical Care for Adolescents Should Be Made by Their Parents

Weighing the risks and benefits of medical treatments for their children is something all parents do. And experts from both sides agreed that the decision whether to provide this care to minors should be made by parents after a doctor has fully informed the adolescent and their parents about the potential risks and benefits and the evidence supporting treatment. 7.18 Tr.74:14-24, 95:1-13 (Government's expert Levine); 7.16 Tr.146:8-149:8, 170:12-16, 177:5-178:3 (Antommaria); 7.16 Tr.26:25-30:25 (Corathers); 7.15 Tr.121:5-19 (Turban). As a general matter, that is

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Tr.330:4-331:9, 7.16 Tr.12:19-13:16 (Corathers).

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) will continue to make treatment recommendations for such patients going forward on a case-by-case basis. 7.18 Tr.110:16-112:19, 114:19-116:21 (Levine).

F. Adolescents for Whom Gender-Affirming Medical Care Is Clinically Indicated Will Suffer Immensely, and Unnecessarily, if These Treatments Are Withheld Until They Turn 18

The well-accepted protocols for treating adolescents with gender dysphoria include pubertal suppression and hormone therapy; when these interventions are clinically indicated, there is no evidence-based alternative. Experts from both sides agreed that there is no evidence-based

psychotherapeutic treatment for gender dysphoria (though psychotherapy can be effective in treating comorbidities such as depression and anxiety). 7.18 Tr.76:15-21 (Government's expert Levine); 7.15 Tr.126:11-25, 136:18-137:3, 137:25-138:2; 200:7-201:143, 210:7-22 (Turban). Thus, if puberty blockers and hormone therapy for adolescents with gender dysphoria are prohibited in Ohio, these patients will be left with no evidence-based treatment option. 7.15 Tr.136:18-137:3, 137:25-138:2; 200:7-201:13 (Turban); 7.15 Tr.302:11-21, 7.16.2 Tr. 52:2-14 (Corathers); 7.16 Tr.178:4-22 (Antommaria).

Harms to adolescents who are unable to receive gender-affirming medical care where it is medically indicated include worsening anxiety, depression, global functioning, and suicidality. 7.15 Tr.207:4-18 (Turban). Waiting until adolescents 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 will 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).

For Ohio youth currently receiving puberty blockers, the law allows them to continue that treatment but not initiate hormone therapy. Remaining on blockers until age 18 is not medically appropriate or safe. 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).[10]

III. Appellants Are Suffering Direct and Significant Injuries as a Result of H.B. 68

A. Grace Goe and Her Family Will Suffer Harm as a Result of H.B. 68

Gina, Garrett and their four children—Grace and her three older brothers—live in a suburb of Columbus. 7.15 Tr.18:8-24, 19:4-14 (Goe).

[10]In addition to harming patients, withholding care until age 18 from those minors for whom care is medically indicated forces doctors to deny patients treatment that can help them, in contravention of their ethical obligations to act in their patients' best interests. 7.16 Tr.52:2-14 (Corathers); 7.16 Tr.178:23-179:14 (Antommaria).

Her 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. She loves baking. This summer, she launched her own bracelet-weaving business and has been selling her bracelets to people in [her] community." *Id.* at 19:16-22. She is going into seventh grade as a straight-A student. *Id.* at 19:25-20:3.

Grace, a transgender girl, was diagnosed with gender dysphoria some six years ago. *Id.* at 34:23-35:2, 45:23-46:2. In the summer before first grade, Grace socially transitioned from masculine to feminine in her name, pronouns, and choice of clothing, and generally shifted to being "perceived and respected as a girl[.]" *Id.* at 38:2-39:2, 40:13-20. Before Grace's transition "[s]he was in distress. She was just coming to us in a constant state of desperation" to be recognized as a girl, praying nightly for God to make her one, and, causing alarm for her parents, even wondering aloud whether death would allow her to return as one. *Id.* at 27:14-21, 45:1-6. Once she was able to live as who she knew herself to be, "[h]er distress ceased and melted away almost instantaneously." *Id.* at 39:13-14. She blossomed into a "thriving, happy, healthy person," and

now enjoys strong family relationships, friends, and a wide array of interests and hobbies. *Id.* at 45:1-6, 19:15-22, 26:8-27:21. Grace has lived as a girl ever since. *Id.* at 45:7-22. Only a select few of Grace's friends, family, and acquaintances—largely those who knew her before her transition—know she is transgender, "and that's the way she wants to keep it." *Id.* at 46:3-20.

Puberty for Grace "could begin at any time." *Id.* at 51:23-25. For her to develop masculine physical characteristics "would be devastating[.]" *Id.* at 51:23-25, 48:20-49:2; *see also id.* at 58:19-59:16 (Grace "laid down and wept" upon learning of H.B. 68, and has been "carrying this looming worry and anxiety" ever since). "She 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. This impending concern prompted Gina and Garrett to prepare for Grace to receive puberty blockers. Following a referral from her diagnosing psychiatrist, Grace undergoes 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. As soon as Grace's endocrinologist finds visible signs of puberty in Grace,

the Goes and their doctors will discuss the matter again, but ultimately Gina has every expectation that Grace will need to proceed with puberty blockers. *Id.* at 53:1-55:13 ("I would be shocked if she didn't … She knows herself to be a girl[.]").

H.B. 68 would keep Grace from receiving medical care she will imminently need. *Id.* at 56:2-58:18. Even her longstanding relationship with her psychiatrist is in doubt; it is uncertain whether he will be able to continue their meetings. *Id.* at 60:4-61:3. If H.B. 68 takes effect, it will leave the Goe family facing an impossible choice. Forgoing treatment for Grace would "harm her mentally, emotionally, spiritually, and relationally[.]" *Id.* at 48:23-49:2. Gina may be forced to take her on periodic multi-day trips to a clinic in Michigan, a substantial "financial burden" that would cause Grace to miss school. *Id.* at 61:9-62:1. Alternatively, the Goes may need to move away from Ohio, again at considerable personal and economic burden. Or H.B. 68 could effectively split the Goe family apart, with Grace and Gina living with a relative in California while Garrett and Grace's brothers remain behind, where Garrett has a job and the boys have settled lives. *Id.* at 61:4-63:15 (seeking

an option that "would cause the least trauma on each individual person.").

B. Madeline Moe and Her Family Will Suffer Harm as a Result of H.B. 68

The Moes are longtime Cincinnati residents, with Madeline and her older sister having lived there for their whole lives. 7.16 Tr. 234:14-25 (Moe). Madeline's father describes her as "a typical 12-year-old. She enjoys spending time with her friends, playing outside. [...] She likes watching TV, watching movies with us. She likes walking the dog with me. She likes playing Wordle [...] those little New York Times games." *Id.* at 237:9-16. She attends an accelerated program in one of the nation's top public schools, and aspires to be a lawyer, "to defend the innocent and help the people that can't help themselves." *Id.* at 236:16-237:1.

Madeline is transgender. *Id.* at 237:19-21, 239:16-17. She was diagnosed with gender dysphoria around first grade, and eventually her parents allowed her socially "to transition into a girl." *Id.* at 254:10-255:24. The year prior to her social transition was "definitely the hardest year ... for Madeline and for our family." *Id.* at 246:8-11. Madeline was frequently "saying things like, 'Why did God make me like this? I wish I

could die and just be reborn.'" *Id.* at 247:23-248:3. One day, while saying similar things, she "grabbed a knife out of the drawer and tried to cut herself in the wrist" until her parents managed to get the knife away from her. *Id.* at 249:24-250:23. During a vacation to Mexico, her family realized that when Madeline was allowed to present herself as "whoever you want to be," she "just really, really [came] out of her shell[.]" *Id.* at 253:9-254:2. Once she was able to live as a girl, "[i]t was beautiful. It was like we got our kid back. She had gone 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; 253:9-254:2. Soon after, she began to use a feminine name and pronouns. *Id.* at 255:22-257:5, 258:25-259:2. Her parents changed her legal name, as well as the gender markers on her birth certificate, passports, school records, and medical records. *Id.* at 264:9-15. She has continuously lived and presented herself as a girl for the past five years. *Id.* at 258:17-24.

In February of 2023, Madeline received a puberty blocker implant. *Id.* at 265:17-19. The choice was "logical" to her and her parents. 266:9-24. "[T]o have facial hair, an Adam's apple, chest hair, big arms, big feet,

big muscles [...] would cause her to have anxiety, depression, suicidal tendencies." *Id.* at 266:4-24. She and her parents were informed of potential side effects; she has experienced none. *Id.* at 267:2-15. She will need a new implant around February of 2025. *Id.* at 267:19-268:15. Madeline and her parents have also considered hormone therapy, for which she would be eligible "around age 13 or 14." *Id.* at 268:16-269:5.

Madeline's family knows that under H.B. 68, she will be unable to begin hormone therapy. *Id.* at 269:25-270:13; 271:16-18 ("her reaction was same as ours, anger, frustration, being upset that the government was not allowing to live her life."). Absent 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 made efforts to secure health care for Madeline outside of Ohio—in Chicago—where she is currently on an 18-month waiting list to see a physician. *Id.* at 271:19-272:6. Were H.B. 68 to go into effect, the Moes would be forced to make expensive and difficult trips back and forth. *Id.* at 272:2-22. Alternatively, they "don't want to move out of Ohio, but we will if we have to." *Id.* at

272:23-273:2; 273:3-15 ("Everything we have is in Ohio. It always has been. And I always thought it would be. … [I]f the burden becomes too much, then we will have to [move]. We'll be forced to.").

IV. Procedural Background

On March 26, 2024, Appellants filed a Complaint and Motion for Preliminary Injunction Preceded by Temporary Restraining Order If Necessary in the Franklin County Court of Common Pleas. 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 Appellants 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 Appellants' 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 Appellants' claims, but issuing very few findings of fact. Appellants filed their Notice of Appeal that same day.

On August 7, 2024, Appellants filed a Motion for Injunction Pending Appeal with this Court. The Government opposed on August 9, and on August 12, filed a Motion to Expedite. This Court granted the Motion to Expedite on August 14.

SUMMARY OF THE ARGUMENT

H.B. 68 violates the Ohio Constitution in four independent respects, reflected in the four Assignments of Error.

Assignment of Error No. 1: H.B. 68 violates the single-subject rule contained in Article II, Section 15(D). As its title openly states, it is a combination of two legislative Acts. One of those Acts restricts access to widely accepted medical care in the name of "protecting" adolescents. The other Act prohibits transgender women and girls from participating on women's or girls' sports teams. This combination of subjects is impermissible—and indeed, is the product of flagrant logrolling, the very maneuver that the single-subject rule exists to prevent.

Assignment of Error No. 2: H.B. 68 violates Article I, Section 21,

the Health Care Freedom Amendment (HCFA), which protects from laws that would prohibit or penalize the sale or purchase of "health care." The Government and its experts have never disputed that H.B. 68 does precisely that: prohibits and/or penalizes the sale or purchase of gender-affirming medical care, which is "health care" by any plausible definition. Instead, the Government asks this Court to ignore the HCFA's plain text, inserting phantom language that would allow the HCFA's limited exceptions to cancel out its core meaning. This Court should not allow the Ohio Bill of Rights to be manipulated in that fashion.

Assignment of Error No. 3: H.B. 68 imposes a sex-based classification that fails strict scrutiny. Specifically, H.B. 68 classifies based on sex in three independent ways: (1) it classifies based on an adolescent's sex designated at birth; (2) it classifies based on the incongruence between a person's gender identity and their sex designated at birth; and (3) it conditions treatment based on the government's preference that an adolescent live and identify with their sex designated at birth. Under the Ohio Constitution, sex-based classifications are subject to strict scrutiny, and can only be upheld if the Government proves that

they are narrowly tailored to serve a compelling government interest. The undisputed facts are sufficient to show that the Government failed to meet that demanding burden.

Assignment of Error No. 4: Ohio's due course of law clause grants parents a fundamental liberty interest in the care of their children, including the right to make medical decisions for their children. H.B. 68 tramples on this fundamental liberty interest and upends the well-established presumption that parents act in the best interests of their children. This is impermissible absent a showing by the Government that H.B. 68 is narrowly tailored to serve a compelling government interest—again, the undisputed facts show that the Government have failed to meet that burden.

ARGUMENT

I. Standard of Review

This Court reviews a trial court's "application of the law … de novo." *Harris v. Sunsong Holdings, Inc.*, 2021-Ohio-1213 ¶ 9 (2nd Dist.); *St. Mary's v. Auglaize Cty. Bd. of Commrs.*, 2007-Ohio-5026 ¶ 38 ("questions of law are subject to de novo review on appeal"); *Nationwide*

Mut. Fire Ins. Co. v. Guman Bros. Farm, 73 Ohio St. 3d 107, 108 (1995) ("questions of law are reviewed by a court *de novo*."). While this Court is "bound to accept the trial court's findings of fact which are supported by competent, credible evidence, [it] must independently determine as a matter of law, without deference to the trial court's conclusions, whether the findings of fact satisfy the appropriate legal standard." *State v. Brant*, 2001-Ohio-3994 at 4-5 (10th Dist.) (quoting *State v. Goins*, 98AP-266 (10th Dist. Oct. 22, 1998); *see also Daily Servs., LLC v. Transglobal, Inc.*, 2023-Ohio-2462, at ¶ 48 (noting that the appellate court will "freely review application of the law to the facts").

II. Assignment of Error No. 1: Appellants Are Entitled to Judgment As a Matter of Law Under the Single-Subject Rule

A. The Single-Subject Rule Prohibits Unnatural Combinations of Subjects

Article II, Section 15(D) of the Ohio Constitution provides: "No bill shall contain more than one subject, which shall be clearly expressed in its title." This rule "disallow[s] unnatural combinations of provisions in acts, *i.e.*, those dealing with more than one subject[.]" *In re Nowak*, 2004-Ohio-6777, ¶ 71 (quoting *State ex rel. Dix v. Celeste*, 11 Ohio St.3d 141,

143 (1984)). The rule exists to prevent "logrolling," defined as:

> [T]he practice of several minorities combining their several proposals as different provisions of a single bill and thus consolidating their votes so that a majority is obtained for the omnibus bill where perhaps no single proposal of each minority could have obtained majority approval separately.

State v. Bloomer, 2009-Ohio-2462, ¶ 47 (quoting *Dix* at 142–43). The result is a "more orderly and fair legislative process," *Dix* at 143, and clearer legislative accountability.

Courts do not allow the government to define a "subject" at an extreme level of abstraction; indeed, that would defeat the purpose of the rule. *See, e.g.*, *State ex rel. Hinkle v. Franklin Cty. Bd. of Elections*, 62 Ohio St.3d 145, 148 (1991); *Linndale v. State*, 2014-Ohio-4024, ¶ 18 (10th Dist.); *State ex rel. Ohio Acad. of Trial Lawyers v. Sheward*, 86 Ohio St.3d 451, 498 (1999) ("we are not obliged to accept that any ingenious comprehensive form of expression constitutes a legitimate subject"). In *Hinkle*, for example, the bill made changes to elected judiciary structure, but also revised a law that regulated local option elections. *Hinkle* at 148. The Supreme Court rejected the government's argument that the bill encompassed "election matters," remarking that it

was "akin to saying that securities laws and drug trafficking penalties have sales in common[.]" *Id.* Similarly, this Court in *Linndale* found a "blatant disunity" of subject matter where a bill made changes to judiciary structure, but also prohibited texting and driving. It rejected the government's argument that these provisions both modified the "authority, scope, and jurisdiction" of courts. *Linndale* at ¶ 18; *see also, e.g.*, *Akron Metro. Hous. Auth. Bd. of Trustees v. State*, 2008-Ohio-2836, ¶ 21 (10th Dist.) ("modifying local authority" was too broad a concept to connect zoning regulations with school extracurricular activities).

B. H.B. 68's Text, Structure, and History Exhibit All the Hallmarks of Logrolling

H.B. 68's title brazenly defies the constitutional requirement that a bill's "one subject ... be clearly expressed in its title[.]" It describes H.B. 68 as comprising two distinct Acts, governing two unrelated subject matters: the "Saving Ohio Adolescents from Experimentation (SAFE) Act regarding gender transition services for minors, *and* … the Save Women's Sports Act to require schools, state institutions of higher education, and private colleges to designate separate single-sex teams and sports for each

sex." 2024 Sub.H.B. No. 68 (emphasis added).

Adolescent health care and interscholastic sports are distinct subjects pertaining to two wholly separate spheres of life. Nowhere did the General Assembly identify any common thread connecting them. The Health Care Ban restricts physicians' ability to provide certain treatments to adolescent patients—an issue that has no relation either to schools or to athletics. The Sports Prohibition dictates the operation of schools' and universities' athletic programs, which, likewise, has nothing to do with adolescent health care. Merging the two is an "unnatural combination[]" of distinct subjects into a single bill, and a blatant display of the "disunity of subject matter" that is the "polestar in assessing a violation of the one-subject rule." *Nowak*, 2004-Ohio-6777, at ¶ 71, ¶ 59.

The analysis could simply stop there, with nothing more needed. "[T]he one-subject provision does not require evidence of fraud or logrolling beyond the unnatural combinations themselves." *Id.* at ¶ 71. Nonetheless, such evidence may provide relevant context, and it is worth noting that H.B. 68's history and structure display it in spades.

First, each of H.B. 68's two Acts had previously failed to pass as a

standalone bill in prior legislative sessions and stalled again in 2023. They passed only once combined. *See supra* SOC Section I.B; TRO Entry at 12.

Second, the bill's siloed structure betrays its history. Neither Act makes any reference to the other. Each Act has its own means of enforcement—one by official state action, one by private lawsuit. They are, in short, two freestanding laws stapled together. *Supra* SOC Section I.

Third, the General Assembly's findings in Section 2 of the bill pertain solely to the Health Care Ban, with no connection to sports. That is to say, the justification of the Health Care Ban has no overlap with the justification of the Sports Prohibition. *Supra* SOC Section I.C.

C. The Government and the Trial Court Have Identified No Cognizable "Subject" That Is "Clearly Expressed" In the Bill's Title

At no stage of this litigation has the Government—or for that matter, the trial court—identified any common subject matter that is "clearly expressed in [H.B. 68's] title." Ohio Const. art. II, § 15(D); *see generally, e.g.*, *Byrd v. State*, 679 S.W. 3d 492, 495 (Mo. 2023) (under an identical

single-subject rule, noting that "the bill's title serves as the touchstone for the constitutional analysis"). Instead, the Government has relied purely on post hoc characterizations, attempting to retrofit H.B. 68's two Acts with a common purpose. It is even more telling that the Government and the trial court cannot agree on H.B. 68's purported "subject."

At the outset, the Government claimed that the Health Care Ban and Sports Prohibition share a purpose of protecting children. Even setting aside whether H.B. 68 could ever be said to "protect" children by denying them health care for a serious condition, that argument fails on the face of the law. The Sports Prohibition extends to adults in collegiate athletics.

Elsewhere, the Government has argued that both Acts responded to what they term an "increasingly pressing social trend" that warranted "protect[ion]": Ohioans being transgender. The trial court correctly rejected that reasoning at first. *See* TRO Entry at 11–12. It later reversed itself, with no explanation of what warranted its reversal. *See* Judgment Entry at 7 (identifying a "common purpose" of "regulation of transgender individuals," "[n]o matter how abhorrent that may be to some").

The trial court was right the first time. It is undisputed that H.B. 68's

two Acts impose two distinct sets of restrictions on two unrelated aspects of people's lives: health care and athletics. Ohio courts have never recognized multiple disparate areas of regulation as a single "subject" based not on a common activity, position, status, occupation, possession, interest, or geographic locale—but rather, solely based on the fact that the law will tend to impact a demographic group in two unrelated aspects of their lives. Indeed, even targeting "businesses" is not a sufficiently coherent subject matter to connect unrelated spheres of regulation. *City of Toledo v. State*, 2018-Ohio-4534, ¶¶ 17-19 (6th Dist.) (rejecting the argument that a bill "standardiz[ed] the manner in which businesses are regulated" because the bill governed disparate activities across several substantive areas of law). The outcome can hardly be any different when the purported target—which, again, is identified nowhere in the bill's title—is not a category of entity, but a category of people.

To find otherwise would invite absurdly tenuous connections in legislation. Indeed, in the Government's telling, if the state became concerned by a "growing trend" of Jewish Ohioans, the legislature could simultaneously enact school dress codes banning the wearing of

yarmulkes, food safety laws restricting the sale of Kosher products in grocery stores, and statewide fire codes prohibiting lighting of menorahs in public libraries, all unified under the purported purpose of "regulation of [Jewish] individuals." That is not—and cannot be—how courts apply the single-subject rule.

During the course of this appeal, the Government has argued that H.B. 68 "protect[s] children and youth affected by the rise of gender transition medical interventions and a greater share of young Ohioans who wish to live their lives aligned with their transgender identity." Opp. to Motion for Injunction at 17. That is a compound subject, not a single subject; the first half has to do with the Health Care Ban, the second half with the Sports Prohibition.

In its most recent briefing, the Government also argues that H.B. 68 regulates transgender adolescents in the same way that the Americans with Disabilities Act regulates people with disabilities. That comparison fails on multiple fronts. For one thing, the ADA is a federal law that is not limited by Ohio's single-subject rule. For another, H.B. 68's component purposes do not align in the manner that protective laws like the ADA do.

The ADA does indeed apply to people with a certain characteristic—those with a disability—but it advances a uniform purpose: to *protect them* in multiple different aspects of their lives. That is not the case with H.B. 68, even in the Government's own telling. The Health Care Ban purports to "protect" transgender adolescents by denying them medical care,[11] but even the Government does not claim that the Sports Prohibition shares the purpose of "protecting" transgender children. Instead, the Sports Prohibition's purpose is not to protect transgender girls and women, but to *exclude* them from girls' and women's sports teams.

In other words, even adopting the Government's own narrative, H.B. 68's Health Care Ban supposedly exists to protect transgender people, while the Sports Prohibition purports to protect others *from* them. That is not a shared subject matter.

D. The Appropriate Remedy Is Invalidation *In Toto*

Where there is no "primary" subject in a bill that violates the single-subject rule, the entire bill is invalid. *See State ex rel. Ohio Academy of*

[11] Appellants, of course, strenuously dispute that the Health Care Ban actually "protects" anyone at all.

Trial Lawyers v. Sheward, 86 Ohio St.3d 451, 500 (1999) (where attempting to carve out a primary subject "would constitute a legislative exercise wholly beyond the province of this court," the appropriate remedy is invalidation in toto rather than severance); *City of Toledo* at ¶ 30 (similar). H.B. 68 is not susceptible to severing any one offending portion, as no "primary" subject of the bill is discernible; the Health Care Ban and the Sports Prohibition are coequal.

Appellants need not establish standing on every single portion of the bill. *See Preterm-Cleveland v. Kasich*, 2018-Ohio-441, ¶ 30. They have demonstrated standing to challenge the Health Care Ban. *See generally* Motion for Injunction pp. 5–14, Judgment Entry at 2–3. But, as the Health Care Ban is no more "primary" to H.B. 68 than the Sports Prohibition, it is"not possible to save any provisions of the bill." *City of Toledo* at ¶ 31.

III. Assignment of Error No. 2: Appellants Have Demonstrated a Right to Relief on Their Claim Under the Health Care Freedom Amendment (HCFA)

Article I, Section 21 of the Ohio Constitution, the Health Care Freedom Amendment ("HCFA"), was enacted through a citizen-led ballot initiative in 2011. 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.

The HCFA contains only limited exemptions: laws that were already "in effect as of March 19, 2010," laws affecting which services a health care provider is "required to" provide, the "terms and conditions of government employment," or "laws calculated to deter fraud or punish wrongdoing in the health care industry." Ohio Const., art. I, § 21(D).

By banning Ohioans from purchasing a specific category of medical treatment, H.B. 68 violates both Section 21(B) and 21(C). None of the exemptions in Section 21(D) apply.

A. The Health Care Freedom Amendment protects Ohioans' right to make their own individual health care decisions

"In construing constitutional text that was ratified by direct vote, we consider how the language would have been understood by the voters who adopted the amendment." *City of Centerville v. Knab*, 2020-Ohio-5219, ¶ 22. Courts are to "begin[] with the plain language of the text," and consider "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)).

The primary command of the HCFA is simple, direct, and unambiguous. It forbids the General Assembly from prohibiting or penalizing "the purchase or sale of health care[.]" Ohio Const., art. I, § 21(B)–(C). "Health care" is distinct from health insurance or insurance coverage, as evidenced by the HCFA's repeated use of the disjunctive phrase "health care or health insurance." *See Cowherd v. Million*, 380 F.3d 909, 913 (6th Cir. 2004) ("[I]t is a basic principle of statutory construction that terms joined by the disjunctive 'or' must have different meanings because otherwise the statute or provision would be redundant."); *see also State ex rel. Liberty Council v. Brunner*, 2010-Ohio-1845, ¶ 57 (noting the then-prospective amendment's "general object or purpose of preserving freedom of choice in health care *and* health-care coverage") (emphasis added).

Thus, by its plain text, the HCFA not only protects an individual's ability to select health insurance coverage, but also ensures constitutional protection for an individual's right to select—and a provider's right to

provide—particular health care services, procedures, and treatments.

The background and circumstances of the HCFA's adoption only bolster this conclusion. *See City of Centerville at* ¶ 22 (a court may "review the history of the amendment and the circumstances surrounding its adoption, the reason and necessity of the amendment, the goal the amendment seeks to achieve, and the remedy it seeks to provide to assist the court in its analysis"). The HCFA was enacted against the backdrop of a nationwide debate over the federal Affordable Care Act ("ACA"). The HCFA was itself an effort to reject or undercut portions of the ACA, based on perceived governmental interference in the relationship between physician and patient.[12] Its proponents announced that they were "attempting to draw a line in the sand and say that the federal government

[12] *See generally, e.g.*, *Opponents of health care law continue petition drive*, WFMJ21 (June 25, 2010) https://www.wfmj.com/story/12709736/opponents-of-health-care-law-continue-petition-drive (accessed Aug. 7, 2024); *Obama health care foes score big court win*, CBS News (Aug. 12, 2011), available at https://www.cbsnews.com/news/obama-health-care-foes-score-big-court-win/ (accessed Aug. 7, 2024).

shouldn't get any further in between doctors and patients."[13] A board member of the HCFA's proponent committee wrote in a national publication 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."[14] Likewise, the committee's campaign manager declared that "[h]ealth care decisions should be made between patients and doctors. Not politicians and bureaucrats."[15] He added that the amendment would "allow voters to have a choice this fall if health care decisions should be made by patients and doctors or politicians in Washington D.C."[16]

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[13] 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 Aug. 7, 2024).

[14] 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 Aug. 7, 2024).

[15] 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 Aug. 7, 2024).

[16] Jo Ingles, *Ohio court says anti-Obamacare amendment can be on*

Even further, HCFA proponents specifically intended the amendment to protect against efforts to penalize or punish disfavored forms of health care. As the Hamilton County Court of Common Pleas noted, in the only case applying the HCFA before this one:

> Proponents of the HCFA argued that its passage would not 'further overcrowd our prisons with those who pursue alternative medicine' and that under its provisions the state could not '*punish the purchase or sale of cutting-edge services, procedures, and coverage*.'

See TRO Entry at 14 n.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*, available at https://www.healthpolicyohio.org/wp-content/uploads/2[redacted]_issue3essay.pdf (Sept. 29, 2011)).

B. H.B. 68 cannot be reconciled with the HCFA's core prohibition

As a matter of plain text, it cannot be disputed that the Health Care

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November ballot, Reuters (Aug. 12, 2011), available at https://www.reuters.com/article/us-ohio-obamacare/ohio-court-says-anti-obamacare-amendment-can-be-on-november-ballot-idUSTRE77B50V20110812/ (accessed Aug. 7, 2024).

Ban violates the HCFA's primary directive. Gender-affirming health care is "health care" within any reasonable understanding of that term; the Government and its experts have never disputed this point, and the trial court agreed. *See* Final Judgment at 7.

Similarly, the Government cannot dispute—and again, the trial court agreed—that H.B. 68 "imposes a penalty upon medical providers" who provide gender-affirming health care. *Id.* It is thus beyond question that H.B. 68 violates the core prohibitions of Article I, Section 21(B) and (C).

C. The Government's Interpretation of the "Fraud and Wrongdoing in the Health Care Industry" Exception Would Nullify the HCFA

The HCFA includes only very few specified exceptions: most saliently, the HCFA does not apply to "laws calculated to deter fraud or punish wrongdoing in the health care industry." Ohio Const. art. I, § 21(D). That exception does not apply here.

H.B. 68 does not categorically define any particular medical intervention as "fraud" or "wrongdoing," and the legislative findings are silent on those points. There also is no specific intervention—pharmaceutical or surgical—that the Health Care Ban categorically

proscribes for all purposes and all patients (or even all minors) in the State of Ohio. Rather, it prohibits a specific subset of patients—transgender adolescents with gender dysphoria—from purchasing health care to treat their medical diagnosis, while allowing all other Ohioans, of any age, to purchase those same interventions. And, the Ban still allows physicians to continue providing gender-affirming health care to adolescent Ohio residents who are already receiving it, as well as to all adults. *See* 2024 Sub.H.B. No. 68 (enacting R.C. 3129.02(B)).

Moreover, the HCFA's "fraud or … wrongdoing in the health care industry" exception *cannot* encompass a wholesale ban like H.B. 68 without nullifying the core protection of the HCFA. The trial court erred in finding otherwise. As it stated in its final judgment:

> Notwithstanding the forgoing [sic], the Health Care Freedom Amendment unequivocally provides that its provisions do not affect laws calculated to punish wrongdoing in the health care industry. Art. 1, §21(D).
>
> The State of Ohio has legislated that a medical provider's provision of gender affirming care constitutes 'wrongdoing.' Again, the remedy for those who object to the State of Ohio's determination of wrongdoing cannot be found within the judicial system but is instead with their vote.

Final Judgment at 7–8. That reading is both wrong and unsustainable.

First, the trial court's reasoning would allow the HCFA's exception to fully swallow the rule. Under its logic, in any instance where the General Assembly passed a law prohibiting or penalizing a category of health care—thus facially violating the Amendment's core prohibition in Sections 21(B) and (C)—then the Amendment's "wrongdoing" exception would *automatically* be met, merely *because* the legislature passed a law. Subsection (D) would cancel out subsections (B) and (C), reducing the Amendment to a nullity. Courts may not void whole provisions of the Constitution in this manner. *League of Women Voters of Ohio v. Ohio Redistricting Comm'n*, 2022-Ohio-65, ¶ 94 ("we should avoid any construction that makes a [constitutional] provision meaningless or inoperative") (internal citation and quotation marks omitted).

To be sure, the HCFA does not expressly define Section 21(D)'s term "wrongdoing," but that term must be reconciled with the rest of the Amendment in a coherent manner. *Id.*; *see also, e.g.*, *City of Cincinnati v. Correll*, 141 Ohio St. 535, 538 (1943) ("The Constitution must be read and construed in its entirety so as to harmonize and give force and effect

to all its provisions."). Section 21(D) provides that the HCFA does not "affect any laws calculated to deter fraud or punish wrongdoing in the health care industry." Read in context—in conjunction with "fraud" and "in the health care industry"—the term "wrongdoing" most naturally refers to specific instances of misconduct within the medical profession: for example, negligence, malpractice, failure to obtain a patient's informed consent, false billing, practicing medicine without a license, or other actions committed in the course of providing care.

Alternatively, "wrongdoing" could refer to conduct that was already unlawful at the time the HCFA was enacted. That is how the Hamilton County Court of Common Pleas construed it. *See* TRO Entry, *Preterm-Cleveland v. Yost*, Hamilton C.P. No. A2203203 (Sept. 12, 2022). That definition also cannot save the Health Care Ban; gender-affirming medical care was available in Ohio at the time the HCFA was enacted in 2011, *see supra* SOC Section II.B (testimony by Dr. Corathers that this health care was available by at least 2009), and was not unlawful.

In either event, "wrongdoing" cannot be taken out of context to encompass banning an entire category of health care, without disregarding

the rest of the HCFA.

Second, the trial court's reading grants an absurd and dangerous power to the Ohio General Assembly: the power to redefine words in the Ohio Constitution. In the trial court's reading, the HCFA protects only whatever the legislature decides it protects, because anything the legislature deemed "wrongdoing" would not be protected by the HCFA.

That is backwards. The legislature is subject to the plain meaning of the Constitution's text, not the other way around. *City of Cleveland v. State*, 2019-Ohio-3820, ¶ 17 ("[w]e give undefined words in the Constitution their usual, normal, or customary meaning"). Moreover, "the 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* at ¶ 16 ("The purpose of our written Constitution is to define and limit the powers of government and secure the rights of the people."). That purpose would be defeated if the legislature could remove or modify its own limitations at will.

Consider how that approach, if applied elsewhere, would undercut even the most basic constitutional protections. The First Amendment to

the U.S. Constitution provides that "Congress shall make no law … prohibiting the free exercise" of "religion." Applying the trial court's approach—giving legislatures, rather than courts, the power to determine the scope and meaning of constitutional text—the Free Exercise Clause might protect only the free exercise of whatever Congress chose to recognize as a "valid" religion. In that view, Congress could prohibit a particular religion altogether, and yet not violate the First Amendment. By the same token, the "wrongdoing" exception cannot mean that the state may pick and choose what health care is protected under the HCFA.

D. The Government's Slippery-Slope Argument Fails

The Government's hyperbolic warnings of "shocking implications" to a plain-text reading of the HCFA are also unavailing. *See* Opp. to Motion for Injunction at 26.

The HCFA extends protections to "health care." Importantly, neither the Government, nor its experts, ever disputed that gender-affirming care is "health care." Even H.B. 68's text acknowledges that much. 2024 Sub.H.B. No. 68 (enacting R.C. 3129.01(F)) ("'Gender transition services' means any medical or surgical service…"). Upon hearing

extensive expert evidence from both sides, the trial court agreed. *See* Final Judgment at 7. Just as with any constitutional protection, there will exist difficult or borderline cases, or matters that are more obviously outside the HCFA's scope. But by the Government's own concession, gender-affirming care is not one of them.

But the fact that gender-affirming care qualifies as "health care" certainly does not imply that *anything* would qualify—just as, for example, not just anything is "speech" subject to the First Amendment's protection or a "search" subject to the Fourth Amendment's warrant requirement. "Health care" is a plain language term that can be defined, with definable limits. *See, e.g.*, R.C. 2135.01(G) (statute enacted in 2003 before the HCFA, defining "health care" as "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health"); R.C. 1337.11(G) (statute enacted in 2013 after the HCFA, employing a similar definition). There are any number of actions or procedures that have no medical purpose or value for diagnosis or treatment, are not countenanced by the medical profession, and could not meet any definition of "health care."

The Government has pointed to several inapposite items that—contrary to the Government's overblown warnings—would *not* be protected by a plain-text reading of the HCFA. *See* Opp. to Motion for Injunction. To respond briefly to the Government's list: female genital mutilation is not a medical treatment, and if it were, Ohio's existing statutory ban would exempt it anyway; the HCFA has no role in that. *See* R.C. 2903.32(C) (exempting "a procedure performed for medical purposes"). Sale of controlled substances between "a willing buyer and seller" for recreational use is also not "health care."[17] The HCFA expressly exempts any "laws or rules in effect as of March 19, 2010," *see* Ohio Const. art. I, § 21(D), and so would have no effect on Ohio's assisted suicide ban, or its rules restricting the use of anabolic steroids for athletic enhancement, or the use of cocaine hydrochloride—*even if* those things met the definition of "health care," which is dubious in many circumstances. *See* R.C. 3795.02 (ban on assisted suicide, enacted in

[17] There are any number of prohibited narcotics or other substances that are banned or restricted by federal law, whether or not they have potential medical applications. Under basic principles of federal supremacy, the HCFA has no effect on federal restrictions.

2003); OAC 4731-11-03 (rules restricting steroids and cocaine hydrochloride, versions of which were in effect as early as 1986).

Continuing down the Government's list of exaggerated warnings: it claims that applying the HCFA will lead to "electroshock therapy for minors." That is a non sequitur; the Government has not pointed to any ban on such a procedure.[18] Although the Government cites a regulation relating to electroconvulsive therapy (ECT), that regulation merely governs certain state psychiatric hospitals' ability *to make referrals* to an outside facility for ECT. Unlike H.B. 68, the regulation does not prohibit a type of health care, and so is unaffected by the HCFA. *See* OAC 5122-3-03. Furthermore, versions of that regulation predate the HCFA's effective date. *See id.*; art. I, § 21(D).

Moreover, as noted previously, nothing in the HCFA immunizes physicians from liability for negligence, malpractice, and similar

[18] Cleveland Clinic "is among a limited number of medical centers offering ECT for adolescent patients." *See* Joseph Austerman, D.O., *ECT for Adolescents Doesn't Deserve Its Bad Rap*, available at https://my.clevelandclinic.org/health/treatments/9302-ect-electroconvulsive-therapy (accessed August 21, 2024);

malfeasance. Unlike H.B. 68's prohibition on an entire category of care, regulation of such acts would generally qualify as punishing "wrongdoing in the health care industry." *See* art. I, § 21(D). The Government paints an apocalyptic picture of "amputation of a healthy body part" and "lobotomies-for-payment," but any unwarranted procedure would often constitute (at minimum) negligence, malpractice, and/or the unlicensed practice of medicine. The Government has identified no express statutory ban on lobotomies, "for payment" or otherwise (nor are Appellants aware of one), but certainly they will often—if not always—fall outside the realm of accepted standards of care. A physician who fails to exercise ordinary skill and care in diagnosing and treating a patient would still be liable for their misconduct. *See, e.g.*, *Estate of Hall v. Akron Gen. Med. Ctr.*, 2010-Ohio-1041, ¶ 21 (medical malpractice plaintiff may recover upon demonstrating an injury that "was the direct and proximate result of the physician's failure to use ordinary skill, care, and diligence").

This Court need not resolve every scenario in advance, nor must it devise a universal definition of "health care" or "wrongdoing" that would resolve any outlandish hypothetical the Government can concoct. That is

because, again, this is not an edge case that tests the boundaries of those terms. *See State ex rel. Parisi v. Dayton Bar Ass'n Certified Grievance Committee*, 2019-Ohio-5157, ¶ 48 (noting "the cardinal principle of judicial restraint—if it is not necessary to decide more, it is necessary not to decide more") (internal citation omitted). The operative question under the HCFA is not whether this Court endorses gender-affirming care or any other form of health care, either generally or in a particular patient's case. *See, e.g.*, *District of Columbia v. Heller*, 554 U.S. 570, 636 (2008) ("what is not debatable is that it is not the role of this Court" to ignore constitutional text). The only questions are whether gender-affirming care is "health care" at all, and whether H.B. 68 prohibits or penalizes it. The Government has already conceded these points.

IV. Assignment of Error No. 3: Equal Protection

H.B. 68 imposes a sex-based classification that fails strict scrutiny. By prohibiting treatment if and only if that treatment is deemed to facilitate a "gender transition"—defined as the "social, legal, or physical changes" involved in allowing someone to identify as a gender "different from" the patient's biological sex—H.B. 68 classifies on the basis of sex

in at least three distinct ways. Sex is a suspect classification under Ohio law, and the Government therefore has the burden to show that H.B. 68 is narrowly tailored to advance a compelling governmental interest. The Government has failed to meet this burden.

A. H.B. 68 Classifies Based on Sex

H.B. 68 classifies based on sex in three independent ways: (1) it classifies based on an adolescent's sex designated at birth; (2) it classifies based on the incongruence between a person's gender identity and their sex designated at birth; and (3) it conditions treatment based on the government's preferences about an adolescent's sex—namely, that they live and identify with their sex identified at birth. These classifications underscore that H.B. 68 was passed "because of"—and not "in spite of"—the effect it has on the ability of transgender adolescents to live in accordance with their gender identity. *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 279 (1979).

1. H.B. 68 classifies based on sex designated at birth

Whether individual adolescents may access a particular medical intervention under H.B. 68 depends on their sex designated at birth. Per

the Act, the treatments prohibited by H.B. 68 are prohibited if and only if they are used for "gender transition," defined by the Act as the "process in which an individual goes from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex." R.C. 3129.01(E). The law therefore defines the prohibited procedures based on the patient's sex assigned at birth. Put slightly differently, whether an adolescent can access certain treatment depends entirely on whether the adolescent was designated male or at female at birth. The law speaks in explicit sex-based terms precisely to communicate that the treatments are prohibited when an adolescent of one sex intends to transition to a different sex. Because the law's prohibitions "cannot be stated without referencing sex," they are "inherently based upon a sex-based classification." *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017), *cert. dismissed*, 138 S. Ct. 1260 (2018).

It makes no difference that H.B. 68 bans gender-affirming care for adolescents of both sexes; the application of H.B. 68 to any one adolescent turns on sex. A sex classification does not become less of a sex

classification because it applies equally to men as a group and women as a group. The Supreme Court squarely rejected that approach in *J.E.B. v. Alabama*, when it held that sex-based peremptory challenges violate the Equal Protection Clause even though "the system as a whole [wa]s evenhanded," in the sense that men and women were equally likely to be struck based on their sex. 511 U.S. 127, 159-60 (1994) (Scalia, J., dissenting). So too here: a law that classifies based on sex cannot escape strict scrutiny by targeting both sexes. *See Powers v. Ohio*, 499 U.S. 400, 410 (1991) ("classifications do not become legitimate on the assumption that all persons suffer them in equal degree").

2. H.B. 68 classifies based on the incongruence between a person's sex designated at birth and their gender identity

H.B. 68 separately classifies based on whether an adolescent is seeking to alter features that are "typical" of their sex assigned at birth or instill features that "resemble a sex different" from their birth sex. As the Supreme Court has recognized, when the government "penalizes a person identified as male at birth for traits or actions that it tolerates in [a person] identified as female at birth," then "sex plays an unmistakable" role in the

classification. *Bostock v. Clayton Cnty.*, 590 U.S. 644, 660 (2020) (explaining that "transgender status [is] inextricably bound up with sex"). That is precisely the case here: Under H.B. 68, whether any medication or intervention is prohibited depends on whether the treatment is deemed consistent with the minor's sex designated at birth. Indeed, H.B. 68 expressly defines "gender transition services" based on whether they "alter or remove" features "that are typical for the individual's biological sex," or create "characteristics that resemble a sex different from the individual's birth." R.C. 3109.054(F) (specifying that this provision applies to "*cross-sex* hormones") (emphasis added). By drawing a line based on the incongruence between a person's sex designated at birth and gender identity, the Ban "unavoidably discriminates against persons with one sex identified at birth and another today." *Bostock*, 590 U.S. at 669.

3. H.B. 68 imposes a government preference for gender conformity

Whether treatment is available under H.B. 68 turns on whether it will confirm an adolescent's sex at birth: treatment is available if it will lead to conformity with sex assigned at birth—and not available if it will

not. Indeed, H.B. 68 specifically allows treatment for intersex conditions, also described as differences or disorders of sex or sexual development, thus allowing parents to consent to any treatment—pharmaceutical or surgical—that will confirm their child's "biological sex." R.C. 3129.04. H.B. 68 therefore imposes a "form of sex stereotyping where an individual is required effectively maintain [their] natal sex characteristics." *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018); *cf. Kadel v. Fowell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020) (rule discriminates based on sex if it "tethers [people] to sex stereotypes which, as a matter of medical necessity, they seek to reject").

B. Sex-Based Classifications Are Subject to Strict Scrutiny Under Ohio Law

"The United States Constitution provides a floor for individual rights and civil liberties, but state constitutions are free to accord greater protections." *State v. Broom*, 2016-Ohio-1028, ¶ 55. The Ohio Constitution does so here. Under the Fourteenth Amendment to the U.S. Constitution, "heightened scrutiny" applies to gender-based classifications, including those that purport to classify based on physical

differences between the sexes. *See United States v. Virginia*, 518 U.S. 515, 555 (1996); *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 n.9 (1982). Under the Ohio Constitution, however, sex is a suspect class. *See Adamsky v. Buckeye Loc. Sch. Dist.*, 73 Ohio St.3d 360, 362 (1995) ("[A] suspect class … has been traditionally defined as one involving race, national origin, religion, or sex."); *In re A.W.*, 2015-Ohio-3463, ¶ 23 ("Suspect classes include race, sex, religion, and national origin[.]"), *aff'd in part, appeal dismissed in part on other grounds*, 2016-Ohio-5455, *reconsideration denied*, 2016-Ohio-7455 (Table).

Because sex is a suspect class, "strict scrutiny applies." *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶ 64. To survive strict scrutiny, H.B. 68 must be narrowly tailored to serve a compelling state interest. *Groch v. Gen. Motors Corp.*, 2008-Ohio-546, ¶ 155; *see also Rowitz v. McClain*, 2019-Ohio-5438, ¶ 19 (10th Dist.). Strict scrutiny places a "heavy" burden on the Government—a burden it cannot satisfy here. *See Crowe v. Owens Corning Fiberglass*, 8th Dist. Cuyahoga No. 73206, 1998 WL 767622, *4 (Oct. 29, 1998), *aff'd*, 1999-Ohio-16 (Mem.).

C. The State Cannot Satisfy Strict Scrutiny

The Government failed to meet its burden at trial to demonstrate that the Health Care Ban is narrowly tailored to serve a compelling government interest. Appellants agree as a general matter that protecting children can constitute a compelling government interest, but the undisputed facts—and indeed, the testimony of the Government's own experts—show that the Ban is not narrowly tailored to further that interest.

The trial court erroneously concluded that rational basis review applied. As a result, it did not engage with almost any of the scientific evidence in its findings of fact. However, *even relying on undisputed facts alone*, the record demonstrates that the Government failed to meet its burden under strict scrutiny.

1. <u>The undisputed facts show that the Ban is not narrowly tailored to further the Government's asserted interest in protecting children</u>

The Ban prohibits medical providers from providing puberty blockers and hormone therapy to minors when these treatments are provided for purposes of gender transition. It forbids the provision of this medical care in every such case, regardless of the individual

circumstances. But the undisputed facts demonstrate that the law is not narrowly tailored to further the Government's asserted interest in protecting the well-being of children.

First, the Government's own expert, 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 make such decisions for minor patients going forward on a case-by-case basis. 7.18 Tr.110:16-112:19, 114:19-116:21 (Levine). That the Government's expert does not support banning care and recognizes that it can be appropriate for some minors refutes any suggestion that a categorical ban is what is required to protect children.

Dr. Levine further agrees that the decision about 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. 7.18 Tr.74:14-24, 95:1-13. It was undisputed that apart from the Ban, this is how medical decisions are made for minors. *See supra* SOC Section II.E. That the Government's

own expert agrees that this medical decision, like other medical decisions for children, should be left to informed parents refutes the Government's position that there is something unique about this care that warrants wresting this particular medical decision from parents who, in all other cases, are trusted to make the decision to provide otherwise available medical care to their children.

Additionally, experts on both sides agree that it would be beneficial to youth to have more clinical research studies on the treatment of adolescents with gender dysphoria. *See supra* SOC Section II.C. But the Ban does not permit this research that the Government's experts favor because it prohibits this care in all circumstances, with no exceptions. In this additional respect, it is beyond dispute that the law is overinclusive.

2. The Government has failed to show that any of their asserted rationales justify singling out this care for prohibition

The Government has failed to show that any of the specific rationales they offered justify the Ban under strict scrutiny.

Assertion that the banned treatments are ineffective and risky

The General Assembly claims that there is a lack of evidence of efficacy of the prohibited care and that these treatments carry risks. *See* 2024 Sub.H.B. No. 68 (Sec. 2(F)-(H)). But it was undisputed that the quality of evidence supporting this medical care—cross-sectional and longitudinal studies—is no different than the quality of evidence supporting much of pediatric care. *See supra* SOC Section II.C. It was also undisputed that all medical care carries risks, and that the risks associated with this care are comparable to the risks of other medical care parents can obtain for their children. *See supra* SOC Section II.D. The Government failed to show that the Ban is narrowly tailored to ensure that youth are provided with treatment supported by a particular level of evidence or protected against medical care that carries certain risks.

The Ban is extraordinarily over and underinclusive with respect to these interests. Indeed, the very medications banned when used for gender-affirming medical care pose almost all of the same risks cited by the Government when used for other purposes that are permitted. *See supra* SOC Section II.D. Moreover, each of the treatments that is banned

carries different potential risks, and the Government failed to show that banning all of them is narrowly tailored to achieving its interest protecting against risks. For example, the potential risk to fertility from hormone therapy does not explain why puberty blockers are prohibited: it was undisputed that, on their own, pubertal suppressors pose zero risk to fertility. Similarly, the risks of surgery have no bearing on the risks of either pubertal suppression or hormone therapy—or on this case.[19]

In sum, there is such a disconnect between these asserted interests and what the Ban actually targets that it fails strict scrutiny. And indeed, the Government's assertion that gender-affirming medical care is somehow uniquely ineffective and risky is inconsistent with the fact that H.B. 68 allows current patients to continue undergoing that care. *See supra* SOC I.A (exemption for ongoing treatment).

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[19] *See* 2024 Sub.H.B. No. 68 (Sec. 2(E), (I)-(L), (N)). Banning GnRHa and hormone therapy because of concerns about surgical risks and outcomes is not narrow tailoring. Appellants do not challenge the surgical ban contained in H.B. 68. 7.15.24 Tr. 7:10-14 (Opening Statement).

Assertion that youth will outgrow gender incongruence and, thus, treatment is unnecessary

The General Assembly asserts in its legislative findings that youth affected by the Ban are likely to outgrow gender incongruence and, thus, there is no need to provide puberty blockers or hormone therapy to minors with gender dysphoria. *See, e.g.*, H.B. 68 (Sec. 2(C)). But experts from both sides agree that if a patient's gender incongruence persists after onset of puberty, that incongruence is unlikely to naturally desist. 7.17 Tr.98:13-20 (Government's expert Cantor); 7.15 Tr.169:25-173:4 (Turban). In other words, youth for whom the banned treatments might be indicated are not likely to "outgrow" gender incongruence. Because no medical interventions are provided to any youth before the onset of puberty, 7.15 Tr.309:4-13 (Corathers), the persistence or desistence of transgender identity among prepubertal children is irrelevant to whether to provide medical treatment to pubertal adolescents.

Assertion that psychotherapy is an alternative appropriate treatment

The Government's experts assert that psychotherapy alone should be provided to adolescents with gender dysphoria. But it is undisputed

that while psychotherapy can be important to treat co-occurring conditions, there are no evidence-based psychotherapy treatments for gender dysphoria, 7.18 Tr.76:15-16 (Government's expert Levine); 7.15 Tr.126:11-25, 136:18-137:3, 137:25-138:2; 200:7-201:13, 210:7-22 (Turban). In other words, the Government's experts admit that their proposed alternative is speculative.

Assertion that gender-affirming medical care is being provided without appropriate assessment and informed consent.

The Government devoted much of the trial to trying to demonstrate that some doctors, somewhere, have at some point departed from the WPATH Standards of Care and Endocrine Society Guidelines by providing puberty blockers, hormone therapy, or surgery "on demand," without engaging in what those clinical practice guidelines recommend: among other things, a comprehensive biopsychosocial evaluation; only providing hormone therapy if gender incongruity has been present "for years"; and a rigorous informed consent process that advises patients and parents of the potential risks and benefits (including fertility risks). 7.15 Tr.106:15-107:23, 112:2-115:24, 118:7-124:5, 195:22-196:19 (Turban);

309:4-310:20; 7.16 Tr.36:23-39:1 (Corathers), 170:5-11, 180:3-15 (Antommaria).

The Government did not present any direct evidence that such departure from the guidelines is an issue in Ohio. Their witnesses testified about personal experiences in California and Missouri that departed from established guidelines, and some speculated that similar substandard care was happening nationwide. The only evidence about how gender-affirming medical care is provided to 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 detailed treatment that carefully follows the guidelines. *See supra* SOC Section III.

But even if there *were* evidence of some doctors in Ohio providing substandard treatment in the way described by the Government's witnesses—and again, there was no such evidence—there are already mechanisms in place to address inappropriate conduct by doctors, such as

employer-level discipline, state medical licensing board action, or medical malpractice. 7.16 Tr.180:16-183:4 (Antommaria). No other medical treatment is banned because of individual instances of inappropriate care by individual doctors. *Id.* at Tr.181:20-23. Banning all gender-affirming medical care for minors—*including care that is provided in accordance with guidelines*—is simply not narrowly tailored to address a purported concern about isolated departures from guidelines.

Because the Ban is not narrowly tailored to further any compelling government interest, it violates the equal protection clause. Indeed, the disconnect between what the Ban does and the asserted justifications is so extreme that it does not survive any level of scrutiny. The stated justifications for banning gender-affirming medical care for minors "ma[k]e no sense in light of how" Ohio treats medical care provided for purposes other than "gender transition." *Bd. of Trustees of Univ. of Ala. v. Garrett*, 531 U.S. 356, 366 n.4 (2001) (citation omitted). What the law does is "so far removed from [the asserted] justifications that . . . it [is] impossible to credit them." *Romer v. Evans*, 517 U.S. 620, 635 (1996).

The Government cannot explain why the State bans only this

medical care when other medical care that presents comparable risks and is supported by comparable evidence of efficacy is not banned. In every other context where there are risks, the State leaves medical decision-making to patients, their parents, and their doctors. There is no rational basis to conclude that allowing adolescents with gender dysphoria to receive gender-affirming medical care that they, their parents, and their doctors agree is medically necessary "would threaten legitimate interests of [Ohio] in a way that" allowing other types of care "would not." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 448 (1985).

V. Assignment of Error No. 4: Due Course of Law

The Health Care Ban violates Article I, Section 16 of the Ohio Constitution by infringing the Parent Plaintiffs' fundamental right to seek appropriate medical care for their children. As such, it is subject to strict scrutiny—a standard it cannot satisfy.

A. The Parent Plaintiffs' Due Process Claims Are Subject to Strict Scrutiny

Under the Ohio Constitution, parents have a "fundamental liberty interest … in the custody, care and control of their children." *In re S.H.*,

2013-Ohio-4380, ¶ 13. This interest extends to parents' right to make medical decisions for their children, including "within reason, whether and what type of medical care the child will receive." *In re I.S.*, 2022-Ohio-3923, ¶ 102 n.8 (8th Dist.). The U.S. Constitution is in accord. As the U.S. Supreme Court has recognized, fundamental liberty interests include parents' rights to make decisions "concerning the care, custody, and control of their children," based on a "presumption" that "fit parents act in the best interests of their children." *Troxel v. Granville*, 530 U.S. 57, 66, 68 (2000). Indeed, this right is "perhaps the oldest of the fundamental liberty interests recognized by [the] Court." *Id.* at 65. At a minimum, this includes parents' right to "seek and follow medical advice" for their children. *Parham v. J.R.*, 442 U.S. 584, 602 (1979). The law usurps parents' role in medical decision-making for the treatment of their minor children's serious medical condition.

Because any restriction of parents' rights in this area "infringe[s] upon a fundamental right," the restriction must satisfy strict scrutiny. *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶ 64. The government cannot "infringe certain 'fundamental' liberty interests at *all*, no matter

what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302 (1993); *see also Middleton v. City of Fint*, 92 F.3d 396, 404 (6th Cir. 1996) (where a fundamental right is burdened, government must show a "compelling state interest," and "that the plan is narrowly tailored to further" that interest). The Ban fails this standard.

Specifically, H.B. 68 burdens parents' fundamental right to make medical decisions for their children by prohibiting parents from obtaining for their children otherwise available treatments. *See L.W. by and through Williams v. Skrmetti*, 83 F.4th 460, 491 (6th Cir. 2023) (White, J., dissenting) (noting that "the legal analysis on this point is rather simple"). In doing so, the state is substituting itself for the parents in deciding whether they may obtain available medical treatments for their children.

B. The State Cannot Satisfy Strict Scrutiny

For the same reasons as with Appellants' equal protection claim, the Government has failed to carry its burden to show that H.B. 68 withstands strict scrutiny.

CONCLUSION

For the foregoing reasons, this Court should reverse the trial court's judgment. Appellants are entitled to judgment in their favor on all claims.

Respectfully submitted,

/s/ Freda J. Levenson

Freda J. Levenson (45916)
Counsel of Record
Amy Gilbert (100887)
ACLU OF OHIO FOUNDATION
4506 Chester Avenue
Cleveland, Ohio 44103
(614) 586-1972
flevenson@acluohio.org
agilbert@acluohio.org

David J. Carey (88787)
Carlen Zhang-D'Souza (93079)
ACLU OF OHIO FOUNDATION
1108 City Park Ave., Ste. 203
Columbus, Ohio 43206
(614) 586-1972
dcarey@acluohio.org
czhangdsouza@acluohio.org

Chase Strangio*
Harper Seldin*
Leslie Cooper*
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, Floor 18
New York, NY 10004
(212) 549-2500
cstrangio@aclu.org
hseldin@aclu.org
lcooper@aclu.org

Miranda Hooker*
Jordan Bock*
Goodwin Procter LLP
100 Northern Avenue
Boston, MA 02210
(617) 570-1000
mhooker@goodwinlaw.com
jbock@goodwinlaw.com

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

Counsel for Appellants

CERTIFICATE OF SERVICE

I hereby certify that on August 22, 2024, 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:

Thomas.Gaiser@OhioAGO.gov
Erik.Clark@OhioAGO.gov
Amanda.Narog@OhioAGO.gov
Stephen.Carney@OhioAGO.gov

/s/ Freda J. Levenson
Counsel for Appellants