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

MADELINE MOE, et al., *Plaintiff-Appellant*, v. DAVE YOST, et al., *Defendants-Appellees.*	Case No. 24AP-483 REGULAR CALENDAR On appeal from the Court of Common Pleas Franklin County Case No. 24-CV-002481

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APPELLEES' STATEMENT OF APPELLANTS' ASSIGNMENTS OF ERROR

Assignment of Error No. 1: Did the trial court err in entering judgment for the Government on Appellants' claim under Article II, Section 15(D) of the Ohio Constitution (the Single Subject Rule)?

Assignment of Error No. 2: Did the trial court err 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")?

Assignment of Error No. 3: Did the trial court err in entering judgment for the Government on Appellants' claim under Article I, Section 2 of the Ohio Constitution (the Equal Protection Clause)?

Assignment of Error No. 4: Did the trial court err in entering judgment for the Government on Appellants' claim under Article I, Section 16 of the Ohio Constitution (the Due Course of Law Clause)?

STATEMENT OF THE ISSUES

1. Did H.B. 68 satisfy the Ohio Constitution's Single-Subject Clause, which allows for distinct topics as long as they have a common purpose and relationship, when the law extends protections to various groups affected by transgender children and young adults, including the youth themselves, their parents, and their potential athletic competitors?

(Issue 1 addresses Appellants' Assignment of Error No. 1.)

2. Do Ohio's limits on transitioning minors, including bars on surgery, cross-sex hormones, and puberty blockers, fall within the State's traditional power to regulate the practice of medicine?

3. Does Ohio's Health Care Freedom Amendment, which preserves the State's right to define "wrongdoing . . . in the health care industry," preserve the State's traditional power to define the appropriate practice of medicine, as opposed to allowing each doctor or other professional to self-license?

(Issues 2 and 3 address Appellants' Assignment of Error No. 2.)

4. Do Ohio's limits on medicating children or performing surgery for sex- or gender-transition purposes, which apply to males and females alike, constitute discrimination on the basis of sex under Ohio's Equal Protection Clause?

5. Does Ohio have a rational or even compelling interest in restricting surgery and medication of minors aimed at transition, in light of the debate and uncertainty concerning such treatment's efficacy, safety, and lifetime effects?

(Issues 4 and 5 address Appellants' Assignment of Error No. 3.)

6. Where there is no deeply rooted tradition of transitioning minors with medication and surgery, do Ohio's limits on medicating children or performing surgery for sex- or gender-transition purposes satisfy Ohio's Due Course of Law Clause?

(Issue 6 addresses Appellants' Assignment of Error No. 4.)

INTRODUCTION

This is a case about how a self-governing people can address a controversial subject through the democratic process. Ohio's Constitution provides the answer: they may enact a law that protects the vulnerable and otherwise leaves citizens free to order their lives.

The last decade has seen a dramatic increase in children who experience gender dysphoria or identify as transgender. Ohio has been no exception. This social trend affects real people profoundly, and often painfully. It affects the parents of children they love, and can divide families. It affects the friends, classmates, and teammates of children experiencing gender dysphoria or assuming a transgender identity. It affects voters, policymakers, and cultural leaders with strong passions about this controversial subject. Most important, it affects the children experiencing discord between their sex and their gender identity.

People of good will disagree about how to address the subject of transgenderism. Some passionately believe that the right policy approach is to allow medical organizations and doctors to perform medical

interventions on children, require female sports teams to accept males as competitors and teammates, and diminish the rights of parents who do not agree.

Others believe in a different approach. That approach follows the public-policy tradition that leaves adults free to order their own lives so long as they do not affect the rights of others without their consent, but also accords special solicitude to minor children who lack the same capacities as adults.

The People of Ohio, through their elected representatives, addressed this controversial subject by enacting a law within that tradition. This law does not confront every facet of this social challenge. Rather, it establishes basic regulatory guardrails in discrete spheres to protect those most affected: children, parents, doctors, and schools. The law protects children who identify as transgender from the risks of experimental medical treatments, doing so by regulating doctors. It protects girls and women who play scholastic sports from the threats to safety and fairness that arise when students born as biological males seek to compete against

them, doing so by regulating schools and colleges. It protects parents who do not want to lose custody of their children, even if they disagree with how to treat or discuss gender dysphoria. And after months of delay and a five-day trial on the merits, these protections have finally gone into effect.

After hearing testimony from ten witnesses and arguments from sophisticated counsel from around the country, the trial court ruled that Plaintiffs failed in their attempt to have the judiciary set aside the democratic will of the People of Ohio. This Court should affirm.

FACTUAL AND PROCEDURAL BACKGROUND

I. Gender dysphoria among children and youth skyrockets in Ohio.

In recent years, Ohio has experienced a dramatic increase in the rate of youth who identify as transgender and are diagnosed with gender dysphoria. The causes of this dramatic increase are not known with certainty. Tr. 7/17 112:18-114:2 (Dr. Cantor). Some say it could be a result of a more tolerant society in which transgender youth need not hide their identity as often as in the past. Others say it is a product of social contagion.

Another hypothesis notes that the dramatic increase is related in part to the concurrent explosion of social media. *Id.* 109:3-8. Such media bombards children—particularly females, who now suddenly comprise between 70-80% of gender-dysphoric youth, *id.* 111:24-112:1; Tr. 7/18 69:17-22 (Dr. Levine)—with images of the "perfect" female body and with feelings of comparative inadequacy. Tr. 7/17 109:10-25.

What is known about this surge is that this newer population of children is not like the few that have obtained treatment in the past. Earlier, the typical patient was male, and his gender dysphoria started in early childhood or adulthood. *Id.* 110:16-111:23. Now, roughly 70% of the patients are female, and their gender dysphoria often starts in early adolescence, not long before they naturally begin puberty. *Id.* 111:24-112:8. And this sea change in the population of gender-dysphoric youth correlates in time with skyrocketing rates of several mental-health concerns, including depression, anxiety, and suicidality (*i.e.*, contemplation of suicide, which itself is concerning, but which is not a strong predictor of actual suicide attempts). *Id.* 123:13-22; 91:22-93:9.

II. Expert testimony establishes the risks of medical intervention on children, along with the uncertainty of net potential benefits.

Regardless of the cause of this sudden new surge in gender dysphoria, some quarters of the medical profession have responded to it with increased use of medical interventions on children through puberty blockers, hormone treatment, and even surgery. While Plaintiffs' experts testified in favor of such medical intervention, the State provided both expert and lay testimony explaining the countervailing risks and concerns. Dr. James Cantor, who has a Ph.D in Clinical Psychology and has practiced in this discipline for over 30 years, testified as an expert on research methodology and the scientific evidence related to the use of pubertal-suppression drugs and cross-sex hormones for the treatment of minors with gender dysphoria. *See generally* Tr. 7/17 56:16-71:78. Dr. Stephen Levine, M.D., is a psychiatrist with over 50 years of experience specializing in sexuality, sexual relationships, and sexual dysfunctions including gender-identity issues. He opened the first clinic in the country in 1973 dealing with gender-identity issues. *See generally* Tr. 7/18 57:17-65:6. Dr.

Paul Hruz has practiced as a pediatric endocrinologist for almost 30 years and was the Director of Pediatric Endocrinology and Diabetes at Washington University. *See generally* Tr. 7/19 4:5-17:12. Jamie Reed has a master's degree in Clinical Research Management and was a whistleblower with respect to issues she observed related to the provision of medical treatment to transgender youth at Washington University Gender Clinic, where she served as the Pediatric Care Coordinator. *See generally* Tr. 7/18 151:6-169:1. Chloe Cole is a young woman known as a "detransitioner," who underwent medicalization, including surgery, as a child, and explained her regrets and suffering from that process. *See generally* Tr. 7/19 79:21-116:6.

That extensive testimony demonstrated that medical practitioners who offer gender-transition services to minors in Ohio, and throughout the United States, typically rely on guidelines by groups known as the Endocrine Society and the World Professional Association for Transgender Health (WPATH). *See* Tr. 7/15 105:1-106:14, 304:17-22 (Dr. Turban); Tr. 7/16 153:1-9, 189:17-190:1 (Dr. Antommaria); Tr. 7/17 165:5-

16, 167:1-4, 238:13-24 (Dr. Cantor). Both groups' guidelines require a diagnosis of gender dysphoria before any medical intervention can be provided to a minor. *See, e.g.,* Tr. 7/15 121:8-16. Plaintiffs' experts all characterized the use of puberty blockers and cross-sex hormones for the treatment of gender dysphoria as safe and effective. *See* Tr. 7/15 131:7-132:14; Tr. 7/16 37:10-38:18, 167:8-11.

Each of the State's experts—Dr. Cantor, Dr. Levine, and Dr. Hruz—disagreed on all points. They disputed the claim that the WPATH and Endocrine Society guidelines were developed using well-accepted processes for reviewing the evidence and developing recommendations. Tr. 7/17 134:10-135:14, 141:1-145:20, 146:1-150:4; Tr. 7/18 62:1-63:18; Ex.A ¶¶102-18; Ex.B ¶¶83-93; Ex.C ¶¶81-86. They strongly disagreed with Plaintiffs' experts on the advisability of gender transition in minors generally. Tr. 7/18 20:19-21:10, 99:16-100:2; Tr. 7/19 63:17-64:13. For example, Dr. Cantor testified that "in medical ethics, we don't decide if something is safe" because "[t]here's no such thing as a zero-risk medical intervention. All we can ever do is decide whether the potential risks are

worth the potential benefits." Tr. 7/18 20:19-21:10. And that analysis requires balancing "the potential risk; potential benefits; it has to include each of the alternatives; and it has to acknowledge the unknowns." *Id.* The State's experts detailed known risks and acknowledged unknowns in the literature, and likewise questioned the claimed benefits to conclude that medical interventions to treat gender dysphoria is not supported.

The experts demonstrated that all aspects of the medical intervention at issue—puberty blockers, cross-sex hormones, and surgery—stunt a child's typical biological and physical process of puberty. And while surgery does occur in the U.S. on minors, *see* Tr. 07/19 109:2-111:24 (Cole), most trial testimony focused on medication.

Testimony established that puberty, especially puberty that takes place at a typical age, is important for the physical and mental development of a person. *Id.* 19:20-23; 20:14-17 (Dr. Hruz). Puberty is often when a person first experiences sexual function and romantic attraction. Tr. 7/17 128:19-24; Tr. 7/18 102:7-10 (Dr. Cantor). But when children are "on a puberty blocker, they do not develop a sex drive and crushes." *Id.* 128:6-11; 128:17-

22. Indeed, puberty blockers result in "a prepubescent child in a prepubescent body" living well into the years that their peers have teenaged bodies, leaving children on puberty blockers with "the body of [a] 9- or 10-year-old" until "roughly age 14." Tr. 7/17 127:5-7. Puberty blockers for both boys and girls use the same drug. Tr. 7/19 40:2-8 (Dr. Hruz). While literature generally shows "puberty will kick in" if a child stops taking that drug, there is no "evidence that it's reversible" and "no studies" on all of the systems affected by delaying puberty. Tr. 7/17 129:17-18; 130:8-13 (Dr. Cantor).

But studying the effect of puberty blockers alone would be incomplete because "upwards of 98 percent" of adolescents who start puberty blockers will continue to the next step: cross-sex hormones. Tr. 7/18 7:13-19. Plaintiffs' expert agreed that his clinical research yielded similar high percentages. Tr. 7/15 235:22-236-4 (Dr. Turban). Such cross-sex hormones—estrogen to boys, and testosterone to girls—steer the child's body toward physical features that stereotypically align with their then-current concept of gender identity. Tr. 7/19 38:7-20 (Dr. Levine). These

hormones also steer the child's body away from physical features that stereotypically align with their enduring natal sex—features that would develop naturally without medical intervention.

Cross-sex hormones entail significant risks, including a risk of infertility so significant that when children embark on such hormone treatment (typically between the ages of 13 and 15), Plaintiffs' own expert testified that doctors "counsel patients ... *essentially assuming* that [hormone treatment] will cause infertility." Tr. 7/15 249:23-24 (Dr. Turban) (emphasis added). Indeed, to preserve fertility in a patient treated with puberty blockers, Plaintiffs' expert testified that patient would have to allow endogenous puberty—that is, puberty aligned with the patient's natal sex—to progress. *Id.* 331:12-332:2. And "exposure of a prepubescent body, specifically prepubescent ovaries and testicles, to cross-sex hormones, *permanently sterilizes the person*," and there "is no technology currently to change that." Tr. 7/17 126:3-12 (Dr. Cantor) (emphasis added).

Beyond sterilization, medical intervention through puberty blockers and hormone treatment also carries a significant risk of low bone density leading to increased risk of osteoporosis. Tr. 7/17 125:24-126:1; Tr. 7/19 31:18-32:3. These medical interventions present a risk of blood clots, as plaintiffs' expert admitted. Tr. 7/15 248:22-249:1 (Dr. Turban); *see also* Tr. 7/19 105:22-25 (Cole). This risk increases dramatically if patients smoke or engage in other unhealthy but addictive behaviors. Tr. 7/15 248:22-249:1. Thus, doctors who administer this medical intervention must try to counsel their adolescent patients not to smoke or engage in these behaviors. *Id.*

While puberty blockers and hormone treatment have been used to treat other physical conditions, such as early or late onset of puberty and polycystic ovary syndrome (PCOS), the physical risks of those uses are fairly well known compared to uses for gender dysphoria. Tr. 7/19 31:3-10; 34:13-36:10 (Dr. Levine); *see also* 20:20-25:21.

To assess the risks against the benefits of medical interventions, experts throughout Europe have conducted systematic reviews of the

existing scientific studies on puberty blockers, hormone treatment, and medical intervention for gender-dysphoric youth. Tr. 7/17 79:21-23 (Dr. Cantor). These studies endeavor to eliminate selection bias and compile and synthesize all available scientific evidence of sufficient quality, as judged by neutral standards. *Id.* 78:18-79:19; 81:25-83:7; Tr. 7/18 16:20-17:13. "[E]ach of these systematic reviews looked at the safety and the effectiveness of medicalized transition for minors." Tr. 7/17 80:1-4.

The results are startling. The systematic reviews have all concluded that the known and unknown risks of treating youth with gender dysphoria through medical intervention, including but not limited to puberty blockers and hormone treatment, outweigh any potential benefits. *Id.* 80:5-11. Dr. Cantor explained the breadth of the consensus, recently augmented by the Cass Review, a comprehensive review commissioned by the United Kingdom's National Health Service. "Every systematic review that has been conducted, they've been unanimous. They've all come to the same conclusion: We don't have evidence of benefit outweighing the much more solid and objective evidence of risk." Tr. 7/17 83:25-87:1; s*ee also id.*

86:4-9 (Dr. Cantor) (testifying, as an undisputed expert on research methodology, that "in this situation, when one applies, again, the standard risk-to-benefit ratio of all of the alternatives, acknowledging the many unknowns, we do not have nearly substantial enough evidence of benefit to outweigh the attendant risks").

Meanwhile, gender dysphoria—that is, the diagnosable mental illness associated with significant distress caused by incongruence between gender identity and natal sex, *id.* 96:22-97:1—can and often does resolve without medical intervention. *Id.* 98:13-99:5. Indeed, gender identity—that is, a person's own concept of their gender, as distinguished from their natal sex—is not innate or immutable. Tr. 7/18 88:16-89:16. In fact, a person's gender identity often changes throughout a person's life. *Id.*

This does not mean that a transgender identity is not genuinely felt. Nonetheless, a child or adolescent with a transgender identity before puberty can and often does desist from this transgender identity after puberty is allowed to take its natural course. In fact, in multiple studies of prepubescent children with gender dysphoria, roughly 80 percent of those

who did not begin the process of transitioning "cease to feel gender dysphoric over the course of puberty." Tr. 7/17 98:14-18.

III. Chloe Cole's story reveals the dangers of medical intervention for transgender minors.

While expert testimony established significant safety concerns, lay testimony established the personal consequences for those who experience these risks. In the weeks after her double-mastectomy surgery, 15-year-old Chloe Cole "felt like Frankenstein's monster." Tr. 07/19 110:8-9; *see also* 109:2-110:24. She was physically sickened by the appearance of her own body. *Id.* 110:22-24. Her surgery was upon advice of her doctors, who had stressed to Cole's parents that *social* transition alone (dressing as a boy, changing her name to "Leo") was insufficient to keep her safe. *Id.* 100:2-25. Without *medical* transition—puberty blockers at 13, testosterone injections after that, and surgical removal of her breasts at 15—the doctors warned Cole's parents that she was at high risk of suicide. *Id.* 98:21-99:19; 100:2-25; 101:2-104:16; 109:24-110:7.

To drive home this same point, doctors in Missouri have told reticent parents that they have a simple choice to make: "Would you rather have a dead daughter or a living son?" Sometimes, they have said this in front of the children. Tr. 7/18 214:13-215:4 (Reed).

Back in California, puberty blockers, the first stage of the intervention, numbed Cole's emotions. At 13, she experienced hot flashes normally associated with menopause. Tr. 7/19 102:01-103:23.

Testosterone injections, the second stage, had the opposite effect on her emotions. She felt as if she were on stimulants. She wanted to fight boys. She discovered a new and overactive sex drive. *Id.* 103:24-104:16. Launched out of her numbness, the testosterone made her feel confident that this ongoing medical intervention was the right path for her.

Surgery, the third stage, sent her into a deep depression she now recognizes as grief. At 15, her breasts were permanently removed. While her body was recuperating, the sight of it made her physically ill. *Id.* at 109:23-113:2. Only later, in her junior year of high school, was it time for Cole to take biology class. She learned in more depth what the female body

can accomplish. Organ systems interconnect in inimitable complexity to conceive children, carry them to term, and give them birth. The food she feeds herself becomes the nutrients for her child, both in the womb and through breastfeeding. *Id.* 113:10-116:8.

> I didn't know just how important breastfeeding was. I, partly due to sexual trauma that I had from early in my adolescence, had seen my breasts as nothing more than a burden and a sexual object, and I thought that I wanted nothing of them.
>
> But I was wrong.
>
> I had a maternal instinct. I wanted to fulfill the role of a wife in a marriage. I wanted to naturally conceive, and I longed – I still struggle with this. I wish I could have that ability to – to nourish my children the way that God intended.

Id. 113:25-114:5. She realized she "would never even have a chance at that, that parts of [] myself as an adult, as an aspiring mother, were being ripped away from me at a time where I had no idea just how much that would mean to me as a grown woman." *Id.* 114:14-18.

In high school biology class, Chloe Cole discovered her nascent maternal instinct. But she also already knew she would never give birth or breastfeed. Upon doctors' advice, her parents already made that choice

for her. *Id.* 113:3-116:8. To be sure, she "assented"—the official term for when a minor, incapable of actual "consent," writes her own name on a form below her parents' signatures, sometimes while marveling at the elegance of their parents' names drawn in cursive pen. But now, at age 20, Cole wonders how any child can really understand.

> I don't think any child really understands what "permanence" really means. I don't think, at the age that I was, and in the psychological state that I was, that I would have been able to really fully understand the repercussions of what this would do to me, and I didn't. And by time that I did, it was already too late.

Id. 109:2-10.

IV. Ohio enacts a law to advance its interest in protecting all affected Ohioans, whether or not they identify as transgender, through regulations of medicine, sports, and courts.

In January 2024, cognizant of testimony similar to that presented in the trial record below, Ohio's General Assembly adopted a law establishing basic regulatory guardrails for several aspects of this pressing social issue. Overcoming the Governor's veto, the Ohio General Assembly enacted H.B. 68 to codify several statutory provisions related to the three primary

places this issue intersects with the State's interest in protecting children and families.

First, several provisions aim at "Saving Ohio Adolescents from Experimentation" by regulating different aspects of the medical and mental-health professions. Specifically, these provisions prohibit the medical profession from performing various forms of medical "gender transition services" upon minors. R.C. 3129.01(F) (defining such services); *see* R.C. 3129.02(A) (barring action). The prohibited services include "gender reassignment surgery," R.C. 3129.02(A)(1), "prescrib[ing] a cross-sex hormone," R.C. 3129.02(A)(2), or prescribing "puberty-blocking drug[s]," *id.* Other provisions govern mental-health professionals in counseling regarding gender dysphoria or transition, R.C. 3129.03, and bar Ohio's Medicaid program from paying for minors to transition, R.C. 3129.06. Notably, those currently taking medication are "grandfathered in," and may indefinitely continue any course of medication that began by the law's effective date. R.C. 3129.02(B).

Second, several more provisions are designed to "Save Women's Sports" by regulating the institutions that hold student sporting events—schools and colleges. Those provisions require schools and colleges to preserve girls' and women's sports teams for those born female. Among other things, those provisions require schools and colleges that participate in interscholastic sports, and any interscholastic associations that organize sports, to designate separate male and female teams (allowing for co-ed teams, too). R.C. 3313.5320(A). With those designations in place, biological males may not play in female sports: "No school, interscholastic conference, or organization that regulates interscholastic athletics 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." R.C. 3313.5320(B).

Third, another provision addresses the rights of parents in the judicial system. R.C. 3109.054. That custody-adjudication provision ensures that courts adjudicating disputes over parental rights and responsibilities for children who identify as transgender do not penalize a parent who refers

to a child consistent with the child's biological sex, declines to consent to their child undergoing a medical transition to the opposite gender, or declines to consent to certain mental-health services intended to affirm the child's perception of gender that is inconsistent with the child's biological sex. *Id.*

The law's effective date was April 24, 2024, but was initially restrained by the trial court. It went into effect on August 6, 2024.

V. Plaintiffs sue to challenge the law and obtain immediate relief, but lose after a comprehensive five-day trial.

A. Plaintiffs raise several legal claims, aimed mostly at the medical provisions.

Plaintiffs sued to challenge the law on March 26, 2024. *See* Compl. Plaintiffs are two families, using the pseudonyms "Goe" and "Moe." The Goes use the pseudonyms "Gina" and "Garrett" as the "Parent Plaintiffs," and "Grace" for their 12-year-old child. The Moes use the names "Michael" and "Michelle" as the "Parent Plaintiffs," and "Madeline" for their 12-year-old child. The Parent Plaintiffs identify both Minor Plaintiffs as "transgender," with each a "girl with a female gender

identity" who was "designated as male" at birth. Compl. ¶¶96, 108. Plaintiffs presented four counts, all under the Ohio Constitution. *See* art. II, §15(D); art, I, §21; art. I, §2; art. I, §16.

The named defendants (together, "State Defendants" or the "State") are the "State of Ohio" and State officials with roles regarding the law: Ohio Attorney General Dave Yost and the State Medical Board.

B. Both Plaintiff families say that the medical provisions could harm them, if and when their doctors recommend new or different medication, and the Goes testified about an upcoming medical checkup in November.

Both Plaintiff families alleged that the medical provisions could harm the Minor Plaintiffs by interfering with future medical treatment. The Goes alleged that their child is not yet on any medication, but they might wish to begin "puberty blockers," if and when providers recommend it when their child shows signs of puberty. Compl. ¶110. At trial, Gina Goe, mother of Grace, testified that their next checkup for that purpose is in Ohio in November. Tr. 7/15 66:6-11. The Moes alleged, and father Michael Moe testified, that their child is currently taking "puberty

blockers," and that doctors are monitoring for a potential change in medication to a cross-sex hormone, estrogen, at some unidentified point. Compl. ¶103; Tr. 7/16 265:14-19, 267:16–268:10. Mr. Moe testified that the puberty blocker is an implant, and that it was inserted in February 2023 and lasts for two years—that is, until February 2025. *Id.* He also testified that the "plan for when it no longer works is to get a new one inserted into her." *Id.* 268:9-10. Mr. Moe did not testify about any upcoming appointments or plans to consider cross-sex hormones but spoke of that only as a possibility at some unspecified point. *Id.* 270:7–271:2. Neither family alleged in the Complaint, or testified at trial, that either child is involved in school or college sports or will be affected in any way by the custody provision.

C. The trial court ruled against Plaintiffs on all claims.

The five-day trial ran from July 15-19, 2024, and was followed by post-trial briefing. On August 6, the trial court issued its decision, rejecting all four of Plaintiffs' constitutional claims. Com.Pl.Op. 12.

ARGUMENT

The trial court rightly rejected all of Plaintiffs' attacks on Ohio's law. Plaintiffs had their day in court—five days, in fact—and did not prove their claims. To the contrary, the evidence showed that there is a vigorous and unresolved debate about the wisdom of *medically* "transitioning" children, whether by surgery, cross-sex hormones, or puberty blockers. The debate over such procedures' effectiveness and their possibly profound lifetime effects continues. Given such uncertainty, the Ohio Constitution leaves our democratic process free to hit pause for minors.

First, Ohio's law satisfies the Single Subject Clause. The entire law serves a unified purpose: protecting all affected Ohioans amid a growing trend of children who identify as transgender or have been diagnosed with gender dysphoria. Ohio thus addressed one subject—the debate over transgenderism—where it most intersects with state public policy: medicine, athletics, and parental rights. Even if medicine, school sports, and parental-conscience rights are different *subtopics* within the challenges presented by the broader social issue, bills may have "more than one topic

... as long as a common purpose or relationship exists between the topics." *State ex rel. Ohio Civ. Serv. Emps. Ass'n v. State*, 2016-Ohio-478, ¶17. The subtopics here are related, and the title reflects those related subtopics.

Second, Ohio's law satisfies the "Health Care Freedom Amendment," because the Amendment allows freedom to purchase only *what the law defines as legitimate health care*, and it does not abolish the State's power to define allowable medical care. The HCFA's text preserves that State power, and the voters who adopted it had no intent of legalizing everything. Otherwise, every controverted topic from abortion to medical marijuana would have been resolved overnight in 2011, and no debates or laws since would have been needed.

Third, Ohio's law satisfies Ohio's Equal Protection Clause, because Ohio limits medical "transition" for all children equally, with no discrimination by sex. Boys and girls alike are protected from "puberty blockers," cross-sex hormones, and surgery. Further, any potential classification here serves a purpose that is both rational and compelling: delaying life-altering decisions until adulthood.

Fourth, the due-course-of-law claim fails because the Ohio Constitution has no textual or historical support for a deeply rooted right to change sex or gender or to assist in procuring experimental medical interventions to that end. And again, the law has a rational and compelling purpose in protecting children from medical interventions that risk permanent effects.

I. Ohio's Law satisfies the Single Subject Clause.

Ohio's "Single Subject Clause," art. II, §15(D), provides that "[n]o bill shall contain more than one subject, which shall be clearly expressed in its title." Plaintiffs claim that Ohio's law concerning minors and gender transitions violates this rule, because, they say, the provisions addressing medical treatment and sports are not within the same "Subject." Plaintiffs ignore the parental-custody provision. Their claim fails.

A. A bill may have multiple topics if they are "related."

Begin with precedent, which provides both a legal standard and guidance on how to apply it. Courts adjudicating single-subject challenges must review the law liberally in favor of the democratic process. They

must not construe "the one-subject provision so as to unnecessarily restrict the scope and operation of laws ... to prevent legislation from embracing in one act all matters properly connected with one general subject." *In re Avon Skilled Nursing & Rehab.*, 2019-Ohio-3790, ¶48 (quoting *State ex rel. Ohio Civ. Serv. Emps. Ass'n v. State Emp. Relations Bd.*, 2004-Ohio-6363, ¶27). To that end, only "a manifestly gross and fraudulent violation" is illegal. *State ex rel. Dix v. Celeste*, 11 Ohio St. 3d 141, 145 (1984). Thus, when a lower court has been too quick to find a violation, the Ohio Supreme Court has reversed and instead reaffirmed the General Assembly's power to combine topics with some commonality. *State ex rel. Ohio Civ. Serv. Emps. Ass'n*, 2016-Ohio-478 at ¶64.

Most important, the Ohio Supreme Court has held that the Clause does not bar a "plurality" of topics, only a "disunity in subject matter." *Id.* at ¶28. Thus "embrac[ing] more than one topic is not fatal, as long as a common purpose or relationship exists between the topics." *Id.* Assessing a bill's subject is a legal, not factual, question, based on a bill's "particular language and subject matter." *Dix*, 11 Ohio St. 3d at 145.

Applying that deferential standard, the Ohio Supreme Court and appeals courts—including this one—have repeatedly upheld laws against single-subject challenges based on relationships between topics that were somewhat "distinct." For example, the Ohio Supreme Court rejected a single-subject attack on a bill that "addresse[d] two distinct topics—postrelease control and the sealing of juvenile delinquency records," because, the Court explained, "those topics share a common relationship because they concern the rehabilitation and reintegration of offenders into society." *State v. Bloomer*, 2009-Ohio-2462, ¶53. And it found that provisions governing the process of selling prisons, and provisions for management and operations of privatized prisons, were related to the state budget. *State ex rel. Ohio Civ. Serv. Emps. Ass'n*, 2016-Ohio-478, ¶28.

This court has likewise found relationships among distinct items. *See Riverside v. State*, 2010-Ohio-5868, ¶45 (10th Dist.) (restrictions on *cities'* taxing power was related to the State budget, because the State also funds cities); *Avon*, 2019-Ohio-3790, ¶50 (provision governing administrative review of nursing-home certificate was related to provisions regarding

institutional care, including funding and regulation of personnel, hospitals, and dispensaries); *Cuyahoga Cty. Veterans Serv. Comm. v. State*, 2004-Ohio-6124, ¶14 (10th Dist.) (giving county commissioners power over veterans services and budget bill were single subject); *see also Newburgh Heights v. State*, 2021-Ohio-61, ¶67 (8th Dist.), *rev'd on other grounds,* 2022-Ohio-1642 (provision granting exclusive jurisdiction over photo-based traffic violations was connected to transportation budget).

By contrast, courts have found single-subject violations only when the disunity of topics was egregious. For example, the Ohio Supreme Court found a violation when a provision about mortgage recording "appear[ed in a bill] cryptically between provisions covering aviation and construction certificates for major utility facilities on one side and regulations for the Department of Transportation on the other, which are themselves surrounded by a host of provisions that involve topics ranging in diversity from liquor control to food-stamp trafficking and compensation for county auditors, none of which bears any relation to a mortgage-recording law." *In re Nowak*, 2004-Ohio-6777, ¶59. Another court found a violation when

a bill included criminal penalties for bestiality and regulation of small wireless communications towers. *City of Toledo v. State*, 2018-Ohio-4534, ¶20 (6th Dist.). Another case involved a provision governing price transparency in health care for all patients, but it was tacked onto the workers' compensation budget. *Cmty. Hosps. & Wellness Ctrs. v. State*, 2020-Ohio-401, ¶¶62–63 (6th Dist.).

Importantly, the sole issue in such cases is whether the resulting bill has a common relationship among the topics it addresses. It does not matter whether legislative history shows that provisions were added later or started out in another introduced bill. The Ohio Supreme Court, in rejecting a claim under the analogous "separate-vote" clause that applies to constitutional amendments, found varying topics "not so incongruous" as to be combined, "although seemingly the product of a tactical decision" to combine them. *State ex rel. Willke v. Taft*, 2005-Ohio-5303, ¶38. This separates forbidden and anti-democratic "logrolling and stealth and fraud"—where a legislative minority is able to slip unrelated provisions past the majority through—from the orderly pro-

democratic process of legislative compromise to combine "provisions on a large number of topics." *Dix*, 11 Ohio St. 3d at 145.

In addition, the Supreme Court has explained that, in a single-subject challenge, a party "must prove standing as to each provision" challenged. *Preterm-Cleveland, Inc. v. Kasich*, 2018-Ohio-441, ¶30. That makes sense, because standing always requires a party to show injury in fact, causation (*i.e.*, that the challenged law caused the injury), and "redressability"—that is, that the requested relief will fix that injury. *Moore v. Middletown*, 2012-Ohio-3897, ¶22. Further, the standard remedy for a single-subject violation is to sever offending "rider" provisions (when those provisions affect a plaintiff), and to leave the core of a law intact. *State ex rel. Hinkle v. Franklin Cty. Bd. of Elecs.*, 62 Ohio St. 3d 145, 149 (1991).

B. Ohio's law meets the "related" standard, as all parts protect Ohioans most affected by the rise of transgenderism in youth.

Applying this precedent, the trial court correctly held that the law contained only one subject. Com.Pl.Op.7. Even if the medical, sports, and custody provisions are considered different "topics," they easily have a

"common purpose or relationship"—protecting youth and their families from the challenges of an increasingly pressing social trend.

The medical, sports, and custody provisions are related in multiple ways. Each protects individuals in the State within the broader classical liberal tradition of public policy. That tradition leaves adults largely free to make their own decisions while also according special protection to minors—and protecting the rights of others that might be affected by such decisions. The medical provisions protect still-developing children from the irreversible physical effects of medication, especially when substantial scientific uncertainty clouds the efficacy and long-term consequences of such severe chemical interventions. *See below* at 11–13. The sports provisions protect the rights of both minor and adult females to safe and fair competition from the physical risks and unfairness of males competing against them. And the custody provisions—which Plaintiffs curiously ignore entirely—protect adult parents with deeply held convictions in court proceedings, ensuring parents do not lose rights to their children over their approach to this sensitive subject.

All provisions of the law thus involve situations in which families and other institutions interact with young Ohioans who wish to express a transgender identity. The General Assembly understandably connected these topics because they, like most ordinary people discussing the topic, recognize the common thread running through these contexts.

Indeed, in public discussions of transgender issues, especially as to minors, people often talk in the same breath of sports issues, medical issues, and more. For example, the Pew Research Center has tracked together in the same survey American's views on medical transition, sports, parental rights, and more. *See* Pew Research Center, *Americans' Complete Views on Gender Identity and Transgender Issues* (June 28, 2022), https://perma.cc/Y3YD-SE8N.

To put a fine point on it, the national ACLU has a page for talking points about transgender youth issues, and back-to-back items cover sports and medication. *Guide to Talking About Attacks on Trans Youth*, ACLU (Feb. 17, 2022), https://perma.cc/TL86-F2NW. A politician supporting what she views as trans rights posted on social media that

"[t]rans kids deserve . . . the freedom to just be kids, play sports, and get the health care they need." *See* Tammy Baldwin (@SenatorBaldwin), X (Oct. 4, 2023, 9:26 PM), https://perma.cc/4SLD-UG8G.

Similarly, other States that have legislated in this area—including in differing policy directions that Plaintiffs would presumably support—have combined topics with even greater variance in issues. For example, the State of Michigan added "gender identity" to its list of protected classes under its omnibus civil rights law, thus governing, in one swoop, contexts as distinct as education, employment, housing, and public accommodations. MI Const. art. IV, §24; *People v. Kevorkian*, 447 Mich. 436, 454–59 (1994). Ohio's own ACLU supports a similar omnibus protection approach to Ohio discrimination law, listing as a legislative priority"the Ohio Fairness Act to extend basic statewide protections to LGBTQ Ohioans by adding sexual orientation and gender identity into Ohio's non-discrimination laws," thus reaching employment, housing, and more in one action. *Legislative Priorities*, ACLU Ohio,

https://perma.cc/W7UM-STWE. If plaintiffs' view of the Single Subject Clause were right, then such a bill would be invalid.

While the Ohio Supreme Court has not yet applied our Single Subject Clause to this or similar laws, a recent Nebraska Supreme Court decision is helpful. That decision rejected a single-subject challenge to a law that, like Ohio's, limited medication and surgery for minors—but reached topics Ohio's law does not, namely, limits on abortion procedures. *Planned Parenthood v. Hilgers*, 317 Neb. 217 (2024).

The relationship between the parts of Ohio's laws is surely just as strong as the relationship in the Ohio cases cited above, such as the link between the "two distinct topics" of "postrelease control and the sealing of juvenile delinquency records." *Bloomer*, 2009-Ohio-2462, ¶53. Even if the contexts of sports, medication, and custody seem like "distinct topics," they are not entirely *unrelated* here, or lacking in any common purpose, so no "blatant disunity" exists.

Finally, a coda about remedy. Not only does Ohio's law satisfy the Single-Subject Clause, but also, Plaintiffs lack standing to challenge the

surgical, sports, and custody provisions. They do not allege any involvement in sports or custody disputes and disclaim any challenge to gender-transition surgeries. Those provisions do not injure them, and enjoining enforcement of those provisions would redress nothing for them. *Middletown*, 2012-Ohio-3897 at ¶22. Yet they ask this court to enjoin enforcement of those laws, too. Thus, their repeated disclaimers that they do not challenge the surgical limits in Ohio's law are actually false—their request to enjoin enforcement of the *entire bill* based on the single-subject claim would of course encompass the surgical restrictions.

In sum, the court should reject the single-subject claim fully, on the merits and for lack of standing as to most provisions.

C. Plaintiffs' contrary arguments do not establish a single-subject claim.

None of Plaintiffs' single-subject arguments overcome the reality that all parts of Ohio's law have a "common purpose or relationship ... between the topics." *State ex rel. Ohio Civ. Serv. Emps. Ass'n*, 2016-Ohio-478 at ¶17.

1. Plaintiffs do not refute the "common relationship" among the law's provisions.

Alone fatal to Plaintiffs' claim, they nowhere even *cite* or acknowledge the governing "common relationship" test, let alone assert a true lack of any relationship. They cite only the language of "blatant disunity" and talk about the anti-logrolling *purpose* of the clause, but ignore the most important test that the Supreme Court uses to validate bills. They do not even acknowledge, let alone try to distinguish, the many cases rejecting single-subject claims by finding a common relationship, even among distinct topics within a subject. Instead, they cite mostly older Supreme Court cases that found violations—not the many recent ones rejecting challenges. *See* Apt.Br. at 35–44; *see also State ex rel. Ohio Civ. Serv. Emps. Ass'n*, 2016-Ohio-478 at ¶64; *Bloomer*, 2009-Ohio-2462 at ¶53.

Given that mistaken framing, it is not surprising that Plaintiffs conclude that Ohio's law covers different topics, but that does not show a lack of *any* relationship at all. And to the extent that Plaintiffs' claims of disunity are implicitly a charge of "no relationship," they are wrong.

The law protects minors by telling doctors that they may not provide medication or surgery designed to alter a person's appearance of sex or gender. The law protects girls and women by telling schools and other sports leagues that those who were born as biological males may not play on female sports teams. And the law protects parents by telling courts that they may not deprive a parent of custody over a child based on the parent's viewpoint regarding transitioning.

The connections between these contexts—all address transgender youth—are not undercut in the least merely because Plaintiffs believe that Ohio's means to address them are negative rather than positive. That is, when Plaintiffs compare the common thread of addressing transgender youth to invidious religious discrimination, Apt. Br. 41-42, that comparison simply reflects their strong policy perspective.

Nowhere in Ohio's single-subject precedent has any court assessed whether the policy changes at issue were "good" or "bad" as part of assessing whether they are "related." And for good reason: it makes no

sense. Plaintiffs' approach simply smuggles their other objections into this flawed single-subject claim.

2. The bill's legislative history is irrelevant.

Plaintiffs' attempted reliance on legislative history or the law's structure adds nothing to their claim. True, the General Assembly originally considered the medical provisions—and the custody provisions, too—in one bill, and the sports provisions in another. But bills that touch related matters are often combined in the legislative process "for the purposes of bringing greater order and cohesion to the law," *Dix*, 11 Ohio St. 3d at 145. That reality does not violate the Single Subject Clause. Indeed, not *one* case by the Supreme Court or this court looks to the specific process. And that makes sense in both directions: That is, if a law violates the relationship test, it does not get a free pass simply because it was first introduced in one package. Conversely, if a law *meets* the relationship test, it should not be found unconstitutional merely because it started in pieces that were combined.

Indeed, such a standard is totally unworkable: it would require one relatedness test for bills enacted as introduced, and a second, tighter relatedness test for amended bills. And what if one house of the General Assembly advances two bills and then combines them, while the other house starts with one bill—does it matter which chamber's bill becomes law? Are courts to assess what parts "would have" passed alone? Any process-based approach collapses, which is perhaps why the Ohio Supreme Court has always looked only at the resulting enactment.

3. Ohio law does not include a separate title requirement.

Plaintiffs' attack on the bill's title, which reflects its related parts, is unavailing. For starters, the Single Subject Clause establishes only *one* requirement—a single subject—and notes, "which shall be clearly expressed in the title." That description does not establish a second, independent "title" requirement. But even if it did, the title here does accurately reflect the different contexts that are addressed by the legislation.

Indeed, the State could not find a single case in which a court examined a bill's title in a single-subject challenge, regardless of whether the claim was sustained or rejected. And the titles of the bills involved in those cases, including those with failed claims, involved far more complex and diverse topics than the one here. For example, the title of the bill reviewed in *Bloomer* was titled thus:

> To amend sections 2151.313, 2152.72, 2929.14, 2929.19, 2930.13, 2967.28, 3301.0714, 3313.64, 3313.662, 3314.03, 3323.01, and 4301.69; to amend, for the purpose of adopting a new section number as indicated in parentheses, section 2151.357 (2151.362); to enact new sections 2151.357 and 2151.358 and sections 2151.355, 2151.356, and 2929.191; and to repeal section 2151.358 of the Revised Code to revise the procedure by which a juvenile court may seal records of alleged and adjudicated delinquent and unruly children and adjudicated juvenile traffic offenders, to make changes to the post-release control law, to amend the version of section 2929.14 of the Revised Code that is scheduled to take effect on August 3, 2006, to continue the provisions of this act on and after that effective date, and to declare an emergency.

See H.B. 137 (126th General Assembly), archives.legislature.state.oh.us/bills.cfm?ID=126_HB_137. If anything, the relevance of the bill's title is whether the legislators voting on the bill

knew what was in the bill. *See Dix*, 11 Ohio St. 3d at 143. Here, the title leaves no doubt.

4. None of Plaintiffs' other arguments show a single-subject violation.

Nothing else about the provisions' different structure, code sections, or enforcement mechanisms makes the *topics unrelated within a common subject,* which is all that matters. Nothing bars a law from having some parts enforced by private suits while other parts are enforced by other state action. And here, it makes sense that the medical provisions require the Attorney General or the Medical Board to step up, because the regulated activity is by private parties. By contrast, the custody provisions are directed at state actors—namely, judges—so no extra layer is needed. The sports provisions have a bit of both. On one hand, they are mostly directed at government actors—namely, public schools and universities. On the other hand, private enforcement both backs that up and also covers private schools and colleges where students also compete.

All told, nothing about the process, title, or content shows "logrolling," or smuggling in provisions that legislators do not notice or do not support. This was a high-profile bill, and all knew what was in it—and a super-majority enacted it *again* to override a gubernatorial veto.

Finally, some points about Plaintiffs' requested relief and standing. Plaintiffs use this claim to try to enjoin *all* of the law, including the sports and custody provisions that do not affect them, *and* including the surgical restrictions, which they sometimes insist—wrongly—that they are not challenging. Through this single-subject claim, Plaintiffs *are* asking the court to allow surgery on minors. What they seek is a form of "injunctive logrolling," or obtaining an injunction about sports and custody that cannot obtain on any merits theory, and an injunction about surgery that they wish to disclaim, so they try to sneak those in here. That is wrong.

Because they are not affected by those provisions, they lack standing to challenge them. *Preterm-Cleveland, Inc. v. Kasich*, 2018-Ohio-441, ¶30. Calling this a "whole-bill" challenge does not change that, as even if the Court finds the bill cannot be salvaged in any part in its merits inquiry—

though that is wrong, as all parts of the bill are severable, R.C. 1.50,—it should still not grant *injunctive* relief beyond what the *parties* need to obtain relief from the harms they allege. That remains a fundamental part of the law of injunctions: to give relief no broader than needed. *See State ex rel. Yost v. Holbrook*, 2024-Ohio-1936, ¶7.

The Single-Subject-Clause claim was rightly rejected below, and this court should affirm.

II. Ohio's law does not violate the Health Care Freedom Amendment.

Ohio's Health Care Freedom Amendment provides, "[n]o federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance." art. I, §21(B). Plaintiffs argue that this entitles them to purchase gender-transition services as a form of "health care." They are mistaken. The Amendment concerns only the purchase or sale of services that the State chooses to recognize as valid health care. It does not limit the State's underlying, fundamental power to define the contours of the legitimate practice of medicine. Voters did not give every

Ohio doctor or other provider a blank check to sell any "service" he or she wants to, with no democratic check. This claim fails, too.

A. The Health Care Freedom Amendment preserves State power to define the legitimate practice of medicine.

To determine the Amendment's meaning, a court of course "consider[s] first the terms of the constitutional provision." *State v. Carswell*, 2007-Ohio-3723, ¶11. Here, the State's power to define allowed or disallowed medical practices is expressly preserved in Part (D) of the Amendment, which says that the Amendment does not "affect any laws calculated to deter fraud or punish wrongdoing in the health care industry." That preserves the General Assembly's pre-existing power to define wrongdoing in the healthcare industry, since the General Assembly cannot bar wrongdoing without first defining what constitutes wrongdoing. This provision thus reserves to the General Assembly the power to identify and prohibit medical procedures that it considers wrongdoing or bad medical practice, even if some citizens or doctors disagree.

Further, the limited nature of the right to purchase health care in Part (B) is shown by the text of Parts (A) and (C), and confirmed by the historical context in which it was adopted. When the Amendment was adopted in 2011, citizens were concerned that the then-new federal Affordable Care Act might force citizens into certain healthcare plans, might forbid fee-for-service care, and more. The Amendment sought to protect Ohioans from such coercion, as shown by the repeated references to federal law. Part (A) thus says no "person, employer, or health care provider" shall be compelled to participate in a health care system, and Part (C) bars any "penalty or fine for the sale or purchase of health care." Those confirm that the provisions are meant to preserve freedom in the market for buying (or refusing to buy) licensed health care or insurance, not to repeal the General Assembly's power to define what is allowed or licensed as "health care."

And to the extent that it covers "health care" itself, apart from insurance, the meaning most consistent with contemporary debate is this: It prevents the State from outlawing fee-for-service provision of

something acknowledged as health care. That is, it prevents the State from requiring everyone wanting a certain service to purchase it only through certain State-run or State-directed channels. Indeed, Ohio politicians had proposed to introduce an Ohio version of the Massachusetts model for the federal ACA. *See* Blackwell-Raga, Policy Statements, https://web.archive.org/web/20061101151911/http:/www.kenblackwell.com/PolicyStatements.aspx?ID=3 ("Blackwell proposes the 'Buckeye Health Plan' to provide health insurance coverage to currently uninsured Ohioans. The program would require all Ohioans to have some form of health insurance: individually, directly or indirectly through their employer or through a new marketplace sponsored by the State of Ohio for the uninsured. ... The program will ask all Ohioans to participate in their own health care as a matter of personal responsibility.").

While the text alone answers the question, the history of its adoption further confirms that Ohioans did not grant providers license to decide for themselves what health care is, and did not eliminate the State's power to regulate medicine. A court reviewing an amendment must "consider[]

how the words and phrases would be understood by the voters in their normal and ordinary usage." *City of Centerville v. Knab*, 2020-Ohio-5219, ¶22. Further, "the 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." *Id.* (internal citations omitted). Thus, the Ohio Supreme Court has looked not only at ballot language, and at the official arguments for and against, but broadly at the terms of public debate. *Beaver Excavating Co. v. Testa*, 2012-Ohio-5776, ¶¶19–21 (detailed discussion of official ballot arguments); *Centerville*, 2020-Ohio-5219 at ¶30 (broader public debate).

Here, voters approving this amendment were repeatedly told that it would provide a barrier against the federal ACA and especially any mandate to buy health insurance. Opponents said it would not be effective because of the federal law. Indeed, the official ballot arguments for and against, as well as an analysis by the League of Women Voters, focused solely on insurance, and said nothing about limiting the State's power to

regulate medicine. *See Issue 3: Impartial Analysis from League of Women Voters of Ohio*, Smart Voter, https://perma.cc/D4Z7-UMNA.

Notably, if the Amendment *would have* legalized anything claimed as health care, that would have meant that Ohio had already granted—in 2011—constitutional rights to abortion, medical marijuana, and more. That would mean that Ohio's recent abortion amendment, and the medical marijuana statute enacted in 2016, were redundant, because we had already made such initiatives law back in 2011. R.C. 3796.02 *et seq.* Had voters understood abortion legalization to be implicated by the Amendment, it would have been a major point of debate. Significantly, Ohio Right to Life *endorsed* the amendment, which it would not have done if it legalized abortion. *See Vote Yes on Issue 3*, Ohio Right to Life (Sept. 6, 2011), https://perma.cc/G5JT-Y7Z3.

To be sure, the idea that the Amendment had such broader implications was briefly floated after enactment—but contemporary evidence shows voters did not commonly understand the Amendment to do anything of the sort. For example, in a post-election article, a well-

known abortion-rights activist said that they would look into the idea that the Amendment created a broad abortion right—yet no such case was filed for over a decade. *See* Aaron Marshall, *State Issue 3 won't have a big impact on health care in the short term, experts say*, Cleveland Plain Dealer (Nov. 10, 2011), https://perma.cc/7XH4-6YXM. In that same article, the Amendment's author, whom plaintiffs repeatedly quote as an expert, observed that the General Assembly would likely enact "legislation saying abortion doesn't fit the definition of health care to head off such a suit." *Id.* Surely the view of proponents—including, again, Ohio's primary organization opposing abortion—carries more weight than light speculation by an opponent. Taken together, that confirms an understanding that the Amendment did *not* impliedly strip the General Assembly's power to regulate the practice of medicine or even outlaw what many medical professionals consider health care. In fact, that article's headline says, "State Issue 3 won't have a big impact on health care in the short term, experts say."

That consensus, accepted implicitly for over a decade, is not undercut simply because a trial court in 2022 cited the Amendment in granting a TRO and preliminary injunction. *See Preterm-Cleveland v. Yost*, Hamilton C.P. No. A2203203 (Sept. 12, 2022), TRO Op. at 14, cited in Apt. Br. 49. For starters, that was merely a preliminary order, with the merits of the appeal eventually cut off by Ohio's adoption of the abortion-specific amendment. And even in that order, the court did not find a freestanding HCFA claim was likely to succeed, but instead cited it as additional support for a count labeled "due course of law."

On top of the Amendment's text and the circumstances of its adoption, the shocking results of the alternative confirm that the State retained its power to define the boundaries on lawful health care. It would lead to the absurd result that *no legislative limits* on care could be allowed, such that any service labeled "health care" by a willing buyer and a willing seller would be constitutionally protected, such as amputation of a healthy body part or experimental surgery outside the accepted standard of care. It would mean not only the long-ago legalization of medical marijuana, but

also that the State could no longer forbid the purchase of *any* controlled substances that a willing buyer and seller deem health care.

Ohio continues to rightly regulate the practice of medicine. Among other things, Ohio still bars the unlicensed practice of medicine; the Amendment gives citizens no right to purchase medical care from someone with no license to practice. *See, e.g.*, R.C. 4731.41. Similarly, Ohio still forbids physicians from using steroids to enhance athletic performance, or from using cocaine hydrochloride except in narrowly defined circumstances. O.A.C. 4731-11-03. It also bans female genital mutilation for minors and assisted suicide. *See, e.g.*, O.A.C. 5122-3-03(D)(2); R.C. 2903.32; R.C. 3795.02.

Nor are these limits preserved solely because of the Amendment's grandfather clause, which says that laws in place by the time of passage of the federal ACA are unaffected. That specific date shows that it was focused on insurance, not the regulation of the practice of medicine. It does not mean that Ohioans froze in time the practice-of-medicine limits of 2010, leaving no room for the legislature to update standards of care

and other regulations to account for new scientific discoveries—or new forms of wrongdoing in the health care industry. In fact, Ohio has codified specific standards of medical care since the Amendment's enactment. For example, R.C. 4731.055 sets conditions for prescribing opioid analgesics or benzodiazepine drugs—and it was first effective in 2013, and amended in 2015. Likewise, R.C. 4731.056—first effective in 2015, and amended in 2017—directs the Medical Board to adopt rules (which it has done) regarding use of controlled substances in federal schedules III, IV, or V for medication-assisted treatment. *See also* O.A.C. 4731-11.

B. The State acts within its legitimate power to regulate the practice of medicine when it protects minors from debatable treatments with lifetime effects.

The governing legal point shown above—that Ohio retains the power to regulate the practice of medicine—leaves no real work to be done in applying that legal standard to this case. If Ohio retains any power at all, that power includes the power to restrict to adults such life-altering surgery and medication, and to pause such treatment for minors.

The debate between the two sides' views on the Amendment leaves no middle ground. If the State is right—and it is—then the State can easily regulate as it has here, just as it traditionally has regulated the practice of medicine, and as the above examples show. Conversely, if the State is wrong, that means the State cannot newly legislate against *anything* that one doctor or other healthcare provider is willing to sell and label as "healthcare."

Thus, for example, despite Plaintiffs' alleged disavowal of attacking Ohio's limit on surgery, a win for them on the Amendment claim would logically include license to surgically alter minors' bodies to conform to opposite sex stereotypes. Moreover, if the State's power does not allow it to draw a line at age 18, then no legal basis exists to draw a line instead at 16 or anywhere else. Transition surgery would be a constitutional right, along with all manner of other experimental surgery, subject to no *legal* restrictions at all. Such surgeries would be subject only to whatever self-regulation providers voluntarily adopt.

But the Health Care Freedom Amendment does no such thing. Ohio remains free to regulate the practice of medicine, including by limiting certain surgical and chemical interventions to adults.

C. Plaintiffs' contrary arguments are mistaken.

Against all that, Plaintiffs nevertheless claim that voters intended such radical change, regardless of their consequences. Each point is flawed.

First, Plaintiffs cite articles that they say show that voters understood that they were radically limiting the State's power to regulate medicine, but the cited sources say no such thing. To the contrary, they undercut Plaintiffs claims. Indeed, many Plaintiffs' cited articles focus on the insurance market and the federal government.

To be sure, one article did include some back-and-forth between the Amendment's opponents, who charged broader effects, and proponents, who disputed those claims. *See* Marshall, *above* at 49, https://perma.cc/7XH4-6YXM. The article cites opponents saying that the "broadly written language" "could prevent future changes to workers' compensation, child support orders, a new bill cracking down on

prescription drug abuse as well as school immunization efforts." *Id.* But, says the article, the issue's "supporters . . . said the examples the professors gave were off base." *Id.* The professors' examples were further detailed in a report they wrote. *See Bad Medicine: Unintended Consequences of Ohio's Issue 3*, Innovation Ohio (Sept. 1, 2011), https://innovationohio.org/featured/bad-medicine-unintended-consequences-of-issue-3/.

That report names several statutes—in fifteen bullet points—that allegedly would be nullified or, at a minimum, could no longer be amended—but each of those predictions were wrong. *See id.* at 3–5. As noted above, new limits on "prescription drug abuse" *were* enacted. Likewise, a new 2015 law *added* a new requirement that all school students be immunized against meningococcal disease, contrary to the opponents' warning. *See* R.C. 3313.671 (amended in 2015). The State could find no reported case of any of the many items even being challenged, let alone successfully.

Notably, the report singled out one abortion restriction—R.C. 2919.171's limit on "'late term' abortions" and associated reporting requirements. *Bad Medicine* at 4. Yet, not only was no challenge against that restriction filed, and not only was an abortion-specific amendment adopted—but even under the newer abortion amendment, no challenge to late-term provisions has been filed. During the great debates about State power to combat the Covid-19 pandemic, some parties even brought challenges citing the Amendment—but none succeeded. *See 11/24/2021 Case Announcements*, *State ex rel. Maras v. DeWine,* 2021-Ohio-4086, at 4 (dismissing claim under Health Care Freedom Amendment). This suggests that opponents' reading of the Amendment was mistaken, and that its supporters intended no radical remake.

Second, Plaintiffs say that the State's suggested consequences do not flow from Plaintiffs' reading, but none of their stated or implied limiting principles hold up. For example, they suggest that certain extreme outcomes would still be limited by rules about "negligence, malpractice, and/or the unlicensed practice of medicine." Apt. Br. 59. Put aside

whether a constitutional freedom can be limited by civil liability—for example, the First Amendment limits what the State can police through making defamation actions available, *see New York Times Co. v. Sullivan*, 376 U.S. 254, 292 (1964)—Plaintiffs are unclear on what the *State* can do through its Medical Board or other regulatory approaches as to *licensed* professionals who act against the State's policy preferences.

Plaintiffs' view seems to be that the Medical Board can no longer address new problems and new debatable practices at all—and in that case, their view *does* allow for extreme actions to go unremedied by the State. On the other hand, if, somehow, Plaintiffs concede that the Medical Board's pre-existing power does allow them to address new problems through rules or licensure, that raises the question of whether the Medical Board could, without the Assembly's specific direction, enforce limits against the gender-transition procedures at issue. It seems absurd that the Medical Board, as a State agency created by the Assembly, with its powers bequeathed by the Assembly, *can* evolve new standards, but the Assembly *cannot* even step in and directly tell the Board what standards to adopt.

But if the Medical Board cannot act, then the State's warnings are true: the State can do nothing for new issues, new challenges, or new scientific developments.

Perhaps Plaintiffs' implicit limiting principle is that the medical profession collectively acts as a self-regulating check—that somehow the Amendment means that the Medical Board or the General Assembly can act only against "rogue" doctors, but cannot limit something that "most" of the profession supports. But nothing in the Amendment's text suggests an unbounded delegation of State power to the AMA or any other organization. If State power is limited, it would mean that no one can stop whatever Ohio's most unorthodox doctor wants to do.

Finally, Plaintiffs say that the State's view entirely "nullifies" the Amendment. Not so. The Amendment provides a robust limit on how the State may regulate health *insurance*: the State cannot ban it or require its purchase. And the Amendment also guarantees that any legally allowed service be available in an open fee-for-service market, so no one is indirectly forced into an insurance policy or other third-party

arrangement. The Amendment thus has a powerful effect on the economics of the marketplace for health care while ensuring the People's representatives retain their longstanding control over the outer boundaries of lawful medical practice.

In short: The State's reading still gives the Amendment much to do. The Plaintiffs' reading cripples State regulatory power and opens up a Wild West of medical experimentation (and litigation to drag the courts in, too). The Court should reject the latter.

III. Ohio's law does not violate equal protection.

The trial court rightly rejected Plaintiffs' equal-protection claim. Ohio's Equal Protection Clause says that government is instituted for the people's "equal protection and benefit," art. 1, §2. The Ohio Supreme Court has held that the equal-protection provisions in the Ohio and federal constitutions are co-extensive. *Am. Ass'n of Univ. Professors, Cent. State Univ. Chapter v. Cent. State Univ.*, 87 Ohio St. 3d 55, 60 (1999).

Notably, Plaintiffs do not argue (and thus forfeit) that Ohio's Medical Provisions unconstitutionally discriminate based on "transgender"

status. Instead, they argue that the law constitutes *sex* discrimination, Apt. Br. 60–61, thus triggering strict scrutiny. And they concede that protecting children can be a compelling interest (at 67), but attack the law as not narrowly tailored. They are mistaken on both counts: Ohio's law is not sex discrimination, and in any case, the State has both a rational and compelling interest in protecting children from debatable medical treatment.

A. Ohio's Medical Provisions do not discriminate based on sex.

As just noted, Plaintiffs express their claim in terms of discrimination on the basis of *sex* itself, not directly on the basis of transgender identity. But two preliminary points are important before assessing their sex-discrimination claim. *First*, transgender identity, or gender dysphoria, is not a suspect classification or a protected class, so a claim expressly on that basis warrants only rational-basis review. *L. W. by & through Williams v. Skrmetti*, 83 F.4th 460, 486–89 (6th Cir. 2023), *cert. granted, United States v. Skrmetti*, No. 23-477, 2024 WL 3089532 (U.S. June 24, 2024). (And recall that Ohio follows federal equal-protection law.) Rational basis applies because the category does not meet the well-established tests for

such a classification, such as immutability, political powerlessness, and more. *Id. Second*, any of Plaintiffs' theories of sex discrimination would transmute *any* transgender-affecting laws into sex discrimination—thus effecting a workaround that triggers strict scrutiny *without* meeting the established test for showing a suspect classification. That implication makes the methodology suspect, not the classification.

In any event, Plaintiffs' attempt to recast the Medical Provisions as sex discrimination fails on its own terms. For starters, the Medical Provisions apply equally to boys and girls: sex-change surgery, cross-sex hormones, and puberty blockers are restricted for both boys or girls equally. Neither can use the puberty-blocker drug prescribed to both boys and girls. Nor does it matter that the restriction on cross-sex hormones limits estrogen for those born boys and testosterone for those born girls, because the law operates to categorically limit the use of medication for the purpose of achieving gender *transition. L. W.*, 83 F.4th 460 at 481.

None of Plaintiffs' three theories—*Bostock* and mere reference to sex in a statute, "incongruence" with birth sex, or alleged enforcement of "gender conformity"—show *sex* discrimination.

Start with *Bostock*. That case held that Title VII's statutory text, by forbidding discrimination "because of ... sex," also barred discrimination based on sexual orientation and gender identity, since those exist in relation to sex. *Bostock v. Clayton Cty., Georgia*, 590 U.S. 644 (2020). That was based on the specific text of that specific statute. Important here, *Bostock* itself included a caveat that the Court was not "prejudg[ing]" other contexts. 590 U.S. at 680. Some courts have already held that *Bostock*'s approach does not even extend to other statutes, such as Title IX. *Tennessee v. U.S. Dep't of Educ.*, 615 F. Supp. 3d 807 (E.D. Tenn. 2022), *aff'd sub nom. State of Tennessee v. Dep't of Educ.*, 104 F.4th 577 (6th Cir. 2024); *Louisiana v. U.S. Dept of Educ.*, No. 3:24-CV-00563, 2024 WL 2978786, at *12 (W.D. La. June 13, 2024).

Moreover, a mere reference to sex in a statute does not amount to *sex discrimination* when the statute either treats both sexes equally, but merely

mentions both specifically, or when a statute by its nature can apply to only one sex. Were it otherwise, a slew of innocuous statutes would be subject to strict scrutiny and likely invalidation, such as programs addressing breast and cervical cancer, R.C. 3701.44; programs promoting prostate cancer awareness, R.C. 4503.942; pregnancy *anti-discrimination* laws, R.C. 4112.01(B), 4112.02(A); and even sex-discrimination laws, R.C. 4112.02. *See L.W.*, 83 F.4th at 482. Such a result would be absurd. Thus, Plaintiffs' argument—that any statute that has any reference to sex triggers strict scrutiny, Apt. Br. 62—is mistaken.

Further, the Sixth Circuit explained at length in *L.W.* why *Bostock* does not extend to the constitutional Equal Protection Clause. 83 F.4th at 484–86. Among other reasons that the Sixth Circuit explained, that would require importing Title VII's defenses, too. *Id.* at 485. Most important, "there is a marked difference in application of the anti-discrimination principle." *Id.* In the employment context, the concern was *stereotyping* men and women. Here, a "concern about potentially irreversible medical procedures for a child is not a form of stereotyping." *Id.*

That same reasoning also answers Plaintiffs' claims about incongruence and stereotyping: Ohio's Medical Care Provisions cover only medical and surgical action, but do not mandate any "congruence" or "stereotyping." Minors may dress how they want, and use whatever names and pronouns they want—indeed, they may even change their names legally, with parental support. *See Gender Marker & Name Change Guide for Ohio Residents (Minors),* Equitas Health, https://perma.cc/PSH5-DHDB. They may also express any other characteristics that some might perceive as masculine or feminine. That does not enforce any "stereotype." To the extent that it means, for example, that someone born a boy will maintain, until age 18, the claimed "stereotype" of being a person with male genitals, that is not the State or society creating or imposing a *social stereotype* the way the business in Harris Funeral Homes (the defendant in *Bostock*'s consolidated case) required congruity between sex and dress. Rather, preventing the surgical transition of a child simply reflects a biological reality—a reality that can have its appearance altered by surgery or another medical intervention, to

be sure. But the existence of such medical or surgical procedures cannot mean that the original, natural condition is a "stereotype." In short, a law delaying a medical intervention to conform to certain social characteristics imposes no social characteristics. Consequently, Ohio's medical provisions do not constitute sex discrimination, and rational-basis review applies.

B. Ohio has a rational basis, or even compelling interest, in pausing surgery or medication for minors until they are adults, and the law is sufficiently tailored to serve that interest.

Ohio need only have a rational basis to justify the medical provisions, but even if the Court applies strict scrutiny, Ohio's interest rises to the level of compelling. Indeed, "Appellees agree as a general matter that protecting children can constitute a compelling interest," Apt. Br. 67, and they do not dispute that *in this particular case,* the State's limits serve that "general" compelling interest. Instead, they challenge whether Ohio's law is sufficiently tailored. But the trial evidence showed how strong that

State interest is in protecting children, and why Ohio's approach would satisfy the narrow-tailoring test even if it applied.

The State has a great interest in preventing the many potential risks to children's health if they are medicated. These profound risks were shown extensively at trial. Notably, contrary to Plaintiffs' suggestions, the State's experts did not accept the characterization of these treatments as safe and effective, and instead testified to unjustified risks that possible benefits could not overcome. Children lose bone density and become susceptible to other lifelong conditions. *See above* at 11. Children lose fertility during a period when they do not fully appreciate what it means to sacrifice it. Nor do they understand what it is to likely sacrifice adult sexual responsiveness for life. Thus, while some physical risks are known and others are unknown, the psychological risks of such consequences are understudied and unknown. This includes the risk of profound regret for childhood decisions that result in permanent losses.

The State also reasonably may assess, against all those downsides, that the upsides of medical transition are less certain and outweighed by the

negatives. Trial evidence showed that many children with some degree of gender dysphoria may see it resolve by adolescence or adulthood without medication or surgery. *See above* at 13–14. To be sure, Plaintiffs' experts did say that those who *begin* dysphoria pre-puberty, *and* still are dysphoric after puberty, are unlikely to desist. Tr. 7/15 at 169:25-174:3. But that subset misses those whose dysphoria resolves before, or at the onset of, puberty. That description of a subset also misses those who do not first express dysphoria until adolescence—who account for much of the explosion in new transgender identification in recent years.

The State is likewise legitimately concerned that 98% of those starting on the path with puberty blockers will eventually move to cross-sex hormones, and perhaps surgery from there—as both the State's and Plaintiffs' experts confirmed. *Above* at 9. So the story of blockers as just a "pause"—allowing for puberty to resume if the child and parents decide to leave the transition path—is almost entirely a myth. Not only is there no evidence that puberty blockers' physical effects are truly reversible, but that path dependence, or statistical lock-in, may also explain why desisters

and detransitioners seem rare as a percentage—yet, their numbers grow daily. And as Chloe Cole's testimony showed, *above* at 16, their stories are tragic.

Tying all that together, Plaintiffs cannot identify *which* children might turn out to be Ohio's future Chloe Coles, robbed of childhood and robbed of parenting, and left to rebuild shattered lives. Thus, the State has a rational and compelling interest in pausing such medication and surgery for all children.

Ohio is not alone in that sensible judgment, as 23 States have done likewise by enacting similar laws. *See* Policy Focus: Current State of Laws Governing Gender Transitions, *Independent Women's Forum* (Mar. 2024), https://perma.cc/3LDC-PXHL at 3 (listing 23 States). Similarly, much of Europe—which pioneered such medicalization—is now backing away. In the professional arena, just weeks ago, after this trial was over, the American Society of Plastic Surgeons registered its concerns about gender transition. *ASPS statement to press regarding gender surgery for adolescents*, ASPS (Aug. 14, 2024), https://perma.cc/QFL6-UMF4.

All this shows the strength of Ohio's interest. Again, Plaintiffs do not even dispute that Ohio's interest is compelling. Instead, they put all their eggs in the basket of "narrow tailoring," contending that Ohio should meet its interest by doing something other than barring such treatment for all minors. But they are wrong on that score, too.

First, Plaintiffs insist that procedural hurdles would do enough. That is, they argue that Ohio could demand better education and consent guarantees, to separate "good" or warranted transitions from hasty ones that might be regretted. But, as just noted, Plaintiffs offer no way to identify those with regrets in their future. And the State can reasonably conclude that *no child,* regardless of the amount of education or screening, can truly understand the scope of what they are deciding. Thus, a limit on all minors is the only way to meet Ohio's interest.

And to the extent that Plaintiffs value differently their perceived benefits of *some* youth medical transitions, keep in mind that the narrow-tailoring test asks *only* about the fit between the State's legitimate interest and the means—it does not authorize courts to "balance" competing

costs and benefits. Thus, the State's interest is not undercut by the fact that some youth patients self-report satisfaction with, or benefits from, medical transition. Apt. Br. 21. (And consider that Jamie Reed testified only that some patients self-report satisfaction; she did not agree with the validity of their assessment. *See* Tr. 7/18 223:7-11).

Second, Plaintiffs insist that some transitions should be allowed to continue for research purposes. Apt. Br. 69. To be sure, a State expert noted that more study, if a study were properly designed, could be desirable. But that possibility does not mean that *Ohio's* children must be part of that experiment. Ohio is free to recognize the reality of political diversity and allow California and New York to gather information while Ohio pauses. That is what it means to have "laboratories of democracy." In the face of uncertainty—implied by Plaintiffs' own discussion of research—the State is free to choose among competing views. *See Gonzales v. Carhart*, 550 U.S. 124, 163 (2007).

Consequently, Ohio's law is narrowly tailored. And again, no such tailoring is even needed, as the medical provisions do not involve sex discrimination, so rational basis, not strict scrutiny, applies.

A final note about equal protection and surgery: Once again, Plaintiffs insist strenuously that they are *not* challenging the surgical limits, but that is at most superficially true. Any holding about equal protection would logically sweep in surgery, too. Surely the threshold question of "is this sex discrimination" has the same answer. Perhaps some might say that the State has a compelling interest in pausing *surgery* to adulthood, but not cross-sex hormones—but Plaintiffs do not dispute the interest, only the tailoring.

But their tailoring arguments cannot be separated out into surgical and medication contexts, as their arguments are about why they think it is overbroad to limit treatment for all children versus permitting treatment for some. Thus, a holding for Plaintiffs will, make no mistake, create a fundamental right to gender-transition surgery—with no minimum age.

If, on the other hand, they somehow concede that limiting surgery, even for everyone, *is* narrowly tailored and is constitutional, it is hard to see why there is a magic line between medication and surgery. Medication creates physical changes as strong as many surgeries. Few surgical interventions simultaneously present a risk of weakening a child's bone density and depriving that child of fertility. *See above* at 11.

The Court should reject this equal-protection claim.

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

The trial court rightly rejected Plaintiff's final claim that the medical provisions violate Ohio's "Due Course of Law" Clause. That clause provides that everyone "shall have remedy by due course of law," art. I, §16. Plaintiffs allege that text creates a "substantive due process" right—namely, a parental right to direct their children's medical gender transitions as part of a substantive constitutional right to control their children's healthcare. Plaintiffs strikingly devote just over two pages of their 79-page brief to this featherweight argument. It fails to tip the scales.

The Ohio Supreme Court treats the Due Course of Law Clause as "the equivalent of the 'due process of law' protections in the United States Constitution." *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶48. Because the federal due-process-of-law provisions have been interpreted to confer substantive rights, the Due Course of Law Clause has been interpreted to do the same. That is so despite the original understanding that the provision conferred no substantive rights, but simply entitled injured parties to seek redress—an argument the State preserves. *See State v. Aalim*, 2017-Ohio-2956, ¶¶40, 45–48 (DeWine, J., concurring).

Even still, the Clause protects only certain substantive rights, and only infringements of rights classified as "fundamental" trigger strict scrutiny, while "those that do not need only be rationally related to a legitimate government interest." *Stolz v. J & B Steel Erectors, Inc.*, 2018-Ohio-5088, ¶14. Such "fundamental rights" include only those rights that are "objectively, deeply rooted in this Nation's history and tradition ... and implicit in the concept of ordered liberty, such that neither liberty nor

justice would exist if they were sacrificed." *Aalim*, 2017-Ohio-2956, ¶16 (quotation omitted).

Plaintiffs claim a substantive-due-process right to direct their children's healthcare, including medical gender transition. But that triggers "strict scrutiny" only if they can establish a fundamental right to direct a child's gender transition, or, at a minimum, a broader right to direct a child's healthcare even where the State has barred the particular practice the parents seek. Otherwise, rational-basis review applies.

No evidence suggests that either the State of Ohio or the United States has ever viewed gender transition for minors as a right "objectively, deeply rooted in this Nation's history and tradition." *Aalim*, 2017-Ohio-2956, ¶16. Nor is this surprising, given that young children transitioning from one to another gender is a recent phenomenon. Even viewed as a broader parental right over children's healthcare, no such right has ever been viewed as operating to override the State's right to define allowable medical care—that is, parents have had the right to choose options among those on a menu of lawful health care, but the State has always set the

menu. Otherwise, this parental right would override all sorts of regulations, allowing parents to direct any treatments barred by State law, or even to use drugs not approved by the Federal Drug Administration. *See Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 703, 706 (D.C. Cir. 2007) (en banc) (concluding that neither parents nor their children have a constitutional right to use a drug that the FDA deems unsafe or ineffective). It does not, so no such "fundamental right" exists. The trial court rightly found no such right, and that rational-basis review applied. Com.Pl.Op.10–11.

Further, as detailed above regarding equal protection, the trial here showed that the State has a rational reason—indeed, it would be compelling if that were required—to protect children from experimental medical treatment of uncertain efficacy. *See id.* 11–12. That is why the Sixth Circuit also found a rational basis for similar Tennessee and Kentucky laws. *L.W.*, 83 F.4th at 477. Also, while the U.S. Supreme Court has granted review in that case as to the equal-protection issue, it did not

even grant review of the substantive-due-process claim. *See Skrmetti*, 2024 WL 3089532.

At best for Plaintiffs, there is uncertainty about the right medical treatment for gender dysphoria. And in the face of uncertainty, the State legislature is free to choose among competing views. *L.W.*, 83 F.4th at 477. In sum, Ohio's law does not violate the Due Course of Law Clause.

V. Although no relief is warranted, any relief should be limited to these Plaintiffs and the provisions that affect them.

For all of the above reasons, the Court should fully affirm the decision below. But if the Court disagrees and reverses on any ground, it should limit any resulting injunction to the Plaintiffs before the Court, and only as to the medical provisions that might affect the Minor Plaintiffs. And *if* the Court decides to go any further than required to satisfy these Plaintiffs' claims, it should stay any such broader injunction pending further appeal.

Begin with the scope of relief. If the Court reverses on any ground—though again, it should not—the State urges the Court to limit any

injunction to the Plaintiffs themselves. There is ongoing debate over whether courts even have the power to grant relief to parties not before the Court, but all should agree that it is better not to do so. "[I]njunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Sharpe v. Cureton*, 319 F.3d 259, 273 (6th Cir. 2003); *see also Aluminum Workers Int'l Union, AFL-CIO, Loc. Union No. 215 v. Consol. Aluminum Corp.*, 696 F.2d 437, 446 (6th Cir. 1982). Plaintiffs have not filed a class action—which would require them to meet the class-action standards—and are not entitled to class relief while bypassing that process. *See Felix v. Ganley Chevrolet, Inc.*, 2015-Ohio-3430, ¶25 (noting that "class-action suits are the exception to the usual rule that litigation is conducted by and on behalf of only the individually named parties."); *Waitt v. Kent State Univ.*, 2022-Ohio-4781, ¶25 (10th Dist.) (noting that class-action plaintiffs must show that "all class members suffered some injury").

Indeed, four justices of the Ohio Supreme Court, in a writ action arising from this very case, noted concerns about such "universal injunctions."

Holbrook, 2024-Ohio-1936. Justice DeWine's opinion, for himself and two other Justices, extensively noted questions about the "propriety" of such injunctions, and called for further review when appropriate. *Id.* at ¶1. Chief Justice Kennedy, meanwhile, would have granted the requested writ, which was based solely on the overbroad scope of enjoining enforcement of this very law statewide. This Court should not issue overbroad relief, especially when further review is likely.

Next, the Court can and should tailor any potential relief not only to Plaintiffs, but also to only those *particular* medical provisions that could affect them. Plaintiffs even insist that they do not challenge the ban on sex-change surgery for minors. *See* Apt. Br. at 1, 71 & n.19. And of course they are not affected by the sports and custody provisions, so there is no cause for countless Ohioans to be deprived of those laws' protections while the case continues.

If the Court nevertheless extends broader relief, the State asks the Court to stay such relief pending further appeal. The law has now been in effect for several weeks, and will have been so for a month or two by the

time this Court rules. The fall athletic season is already under way, and Ohio's schools and the Ohio High School Athletic Association have already begun to follow the new law. *See* OHSAA modifies student policy as Ohio's trans athlete ban takes effect, NBC4, at www.nbc4i.com/news/local-news/central-ohio-news/ohsaa-modifies-student-policy-as-ohios-trans-athlete-ban-takes-effect. Moreover, the status quo ought to be in favor of the law's application, even if these Plaintiffs are exempt while the case continues. But again, the Court should find no relief warranted, to any degree, on any timeframe.

One final word: the State also urges the Court to reach and resolve all four of Plaintiffs' claims. Full resolution on the merits best serves judicial economy and the public interest. On a case of such importance, further appeal is likely by either side, and it is best for all issues to be resolved. The alternative—having separate issues go up and down for years, while uncertainty continues—serves no one. As this Court's expeditious scheduling order implies, all involved should want resolution of this case on all grounds as quickly as possible.

CONCLUSION

The Court should affirm the trial court's judgment against Plaintiffs' claims on all counts.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 29th day of August, this Appellees' Brief was filed electronically. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's electronic filing system.

I further certify that a copy of the foregoing was served by email upon the following:

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