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IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, *et al.*, Plaintiffs, v. DAVE YOST, *et al.*, Defendants.	:	Case No. 24 CV 002481 Judge Michael J. Holbrook

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THE STATE OF OHIO'S
POST-TRIAL CLOSING BRIEF

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INTRODUCTION

In the weeks after her double-mastectomy surgery, 15-year-old Chloe Cole "felt like Frankenstein's monster." Tr. 07/19 at 109:2-111:24. She was physically sickened by the appearance of her own body. *Id.* 111:22-24.

The 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.* 90:20-21; 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.* at 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 at 214:13-215:4.

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 at 102:02-103:23.

Testosterone injections, the second stage, had the opposite effect on her emotions. She felt as if she were on stimulants. She wanted to fight other 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.* 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.* 114:10-116:8.

> 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.
>
> And it was then that I realized I would never – I would never even have a chance at that, that parts of my 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. And that was when the regret finally came flooding through. *Id.* 115:8-116:2.

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, with the best of intentions, her parents already made that choice for her. *Id.* 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 mean, 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.* 110:10-18.

* * *

"First, do no harm." This bedrock principle of medical ethics includes, among others, two concepts centrally relevant to the policy choices at the heart of this lawsuit.

The first concept: Sometimes the right thing to do is nothing, especially if medical intervention comes with risk, and if physical or medical conditions (such as gender-dysphoria, the significant distress associated with having a gender identity incongruent with one's natal sex) may resolve themselves on their own, given enough time.

The second concept: Sometimes the right thing to do is nothing, especially if medical experts have the humility to admit that they don't yet know what they need to know about the future physical and psychological consequences of a new (or previously rare) medical intervention. In such cases, first, do no harm.

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 cause of this dramatic increase are not known with certainty. But with it comes the increased use of medical intervention on children through puberty blockers, hormone treatment, and, potentially, as in Cole's case, surgery. This medical intervention stunts a child's typical biological process of puberty. Then, it steers the child's body toward physical features that stereotypically align with their then-current concept of gender identity. It steers the child's body away from physical features that stereotypically align with their enduring natal sex—features that would develop naturally without the intervention. It comes with significant risks, including a risk of infertility so significant that when children embark on hormone treatment (typically between the ages of 13-15), doctors "counsel patients . . . ***essentially assuming*** that [hormone treatment] will cause infertility." Tr. 7/15 at 249:23-24.

It was this new social reality that prompted the General Assembly in 2023 to pass House Bill 68, known as the SAFE Act, which stands for "Saving Adolescents From Experimentation." The law that deals exclusively with issues related to transgender youth. First, it prohibits courts from penalizing a parent in a child-custody dispute for the parent's views on transgender issues. Second, it prohibits schools from allowing biological males to play sports on girls' teams. Third, it prohibits medical intervention on transgender children for the purpose of gender transition, including puberty blockers, hormone treatment, and surgery.

Meanwhile, the law has nothing to say about social transition (e.g., selecting one's own gender identity, clothing, hairstyle, common name, and pronouns), nor does it have anything to say about anything else in the far broader context of LGBTQ+ rights. Likewise, the law has nothing to say about whether any gender identity is better, more genuine, or more permanent than another. Further, the law has nothing to say about what medical intervention doctors may perform once patients turn 18 and are capable of consenting to such treatment on their own. The bill does not ***ban*** medical intervention for purposes of gender transition. Instead, it requires doctors to ***wait*** until their patients are legally old enough to validly consent to what will happen to their own bodies. Finally, if a child was already receiving a medical intervention for this purpose before the bill became law, that treatment is allowed to continue.

Across the Atlantic Ocean, in recent years including the present, medical experts and authorities in several European Countries have concluded several systematic reviews of medical research—reviews that survey all relevant medical research of sufficient quality without bias. These reviews have concluded that the risks, known and unknown, of this medical intervention in children for the purpose of gender transition outweigh any potential benefit. Accordingly, several European countries have recently instituted new and sweeping limitations on such medical intervention. In Europe, where use of this medical intervention generally started earlier,

the clear and present trend is to pause such treatment, at least for the time being, other than for research purposes. Ohio's SAFE Act is wholly consistent with this trend.

The Plaintiffs in this case are two families with pre-teen children who identify as transgender. Both families want to pursue or continue medical intervention for their children. Both families provided testimony to the General Assembly in opposition to the SAFE Act. Neither family offered any opposition to any part of the law other than the prohibition against medical intervention on minors.

After the law was passed, the Plaintiffs filed this lawsuit, asserting that the policy choices in the SAFE Act were never the General Assembly's to make. Through this lawsuit, they seek to obtain the policy victory they were not able to achieve in the legislature. Plaintiffs still raise no challenge to any portion of the law outside of the prohibition against medical intervention on minors. Nonetheless, they sought and obtained an emergency and preliminary statewide injunction, before the law ever took effect, prohibiting enforcement of the entire law anywhere in Ohio. The law's chosen effective date already has been nullified, and irrevocably.

Plaintiffs raise four claims, all under the Ohio Constitution. They claim the law violates the Ohio Constitution's single-subject clause, its Health Care Freedom Amendment, and the Ohio Constitution's guarantees of equal protection and due process. The Plaintiffs failed to establish any of their claims.

First, a threshold issue warrants immediate dismissal of all their claims—an issue that gets to the heart of representative democracy and the rule of law. At trial, the Plaintiffs failed to establish that they had standing to bring this lawsuit in the first place. All of Plaintiffs' experts agreed that, regardless of the SAFE Act, no doctor should ever provide medical intervention to a child for purposes of gender transition unless the child first has a valid diagnosis of gender dysphoria. Gender dysphoria is not an automatic diagnosis. Indeed, some people may identify as

transgender without any associated distress. Despite this undisputed limitation, Plaintiffs provided no evidence whatsoever that their children were ever diagnosed with gender dysphoria, let alone validly diagnosed. Plaintiffs have failed to establish they have standing—that this case is about any concrete injury that this Court can redress, instead of nothing more than a theoretical rehashing of the legislative debate.

Second, even if Plaintiffs did establish standing, their claims fail on the merits. Aside from the standing issue, their first two claims are purely legal. As explained below, the SAFE Act survives challenge under Ohio's single-subject clause. The law deals exclusively with a single subject: transgender youth. This subject is more than sufficiently narrow to qualify as one subject under controlling precedent.

The claim also complies with the Ohio Constitution's Health Care Freedom Amendment. In brief, this amendment, passed in the context of the Affordable Care Act, bars laws that "prohibit the purchase or sale of health care or health insurance." Art. I, Sec. 21(B). 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 what is allowed as "health care" to begin with. The SAFE Act excludes this medical intervention on minors from the "health care" protected by the amendment.

Finally, the claim also complies with the Ohio Constitution's equal-protection and due-course-of-law guarantees. Most of the evidence introduced at trial is relevant, if at all, only to these two claims, the analysis of which involves considering the purpose of the law and the relationship between the law's prohibitions and that purpose. Generally, a plaintiff has a difficult task in establishing that a law violates equal protection or substantive due process. The plaintiff must prove, with a heightened standard of proof, that the law lacks any legitimate purpose (real or conceptual) and that the law's prohibitions bear no rational relationship to any conceivable

valid purpose. That burden (and no heightened or burden-shifting stricter scrutiny) applies here. As courts have held, alleged discrimination against transgender people does not trigger heightened scrutiny, and the right to seek medical care for gender transition is not one with a long history of legal precedent, to say the least. Thus, Plaintiffs retain the burden of proving a constitutional violation. And the law easily survives such limited scrutiny. Protecting the health and welfare of children is legitimate to say the least. So is simply moving forward cautiously when a new phenomenon arises in society.

Accordingly, the State respectfully requests that the Court issue final judgment upholding the SAFE Act, denying all Plaintiffs' requested permanent relief, and immediately dissolving the temporary, preliminary injunction previously issued.

SUMMARY OF EVIDENCE

A. The General Assembly Passes The SAFE Act.

The causes of the recent dramatic increase in gender dysphoria among children are not known with certainty. 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. An environment more tolerant than past may allow more children to experiment with a transgender identity, perhaps only temporarily. This is part of how children always have navigated the work of determining who they fundamentally are—the non-linear process that builds a unique sense of self over years of maturation through trial and error, pain and progress, commonality and uniqueness, addition and subtraction. In an earlier time, it may have been more dangerous to identify as transgender and face the potential of bullying and social rejection. Now, despite the undeniable persistence of bullying and rejection in some settings, a child may perceive that the net social effect of identifying as transgender is positive. Joining a group of transgender friends, and counting

oneself among a historically marginalized group, may lead overall to more social acceptance, less isolation, and a sense of living a life of greater purpose. For some, a transgender identity may fit for the rest of their lives. For others, it may not. Nothing is inherently wrong with adopting a transgender identity and keeping it forever. Nothing is inherently wrong with adopting a transgender identity and later leaving it behind.

Another hypothesis notes that the dramatic increase is related in part to the concurrent explosion of social media, which bombards children—particularly females, who now suddenly comprise 70% of gender-dysphoric youth—with images of the "perfect" female body and with feelings of comparative inadequacy.

Whatever the reason, the rise in gender dysphoria comes with a rise in demand for medical intervention on children. In passing the law, the General Assembly made several factual findings, after extensive testimony by both proponents and opponents of the law. *See, e.g.*, H.B. 68 Section 2(C)-(H).

B. Plaintiffs Attempt To Block Or Erase Virtually All Evidence Against Their Claims.

If Plaintiffs had their way, Chloe Cole's entire testimony would have been erased from the record in this case. To Plaintiffs, her testimony was "not relevant." Likewise, Plaintiffs sought to exclude the testimony of Jamie Reed, who told what she witnessed at a Missouri hospital, including doctors' warnings to parents that failure to consent was akin to choosing "a dead daughter" over "a living son." Tr. 7/18 at 214:13-215:4. To Plaintiffs, Reed's testimony was inadmissible because her name is not followed by "M.D." or some other combination of letters satisfying Plaintiffs' self-serving (and legally incorrect) threshold for expertise.

In fact, before or during trial, Plaintiffs moved to exclude the testimony of ***all*** fact and expert witnesses the State planned to call. (For one expert, Plaintiffs moved only for partial

exclusion of his testimony.) Likewise, Plaintiffs moved to exclude ***all but one*** of the exhibits the State planned to use.

Had Plaintiffs been successful in these efforts to sanitize the record to their liking, they could have more convincingly advanced their alternative narrative. According to Plaintiffs' narrative, the "relevant" associations of the "relevant" experts unanimously agree that medical intervention to treat children with gender dysphoria is safe, effective, and necessary to prevent soaring rates of suicide. According to this narrative, any legitimate debate about this matter has been closed and resolved in their favor. According to this narrative, any remaining hypothetical dissent can be boxed up and discarded as antiscientific religious zealotry. If Cole's testimony had been erased from the record, Plaintiffs' experts could continue to claim, without contrary evidence, that gender reassignment surgery on minors never happens. If Cole's testimony had been erased from the record, Plaintiffs' expert Dr. Sarah Corathers, who administers puberty blockers and hormone treatment to gender dysphoric children, could continue to recount, without contrary examples, details of the stories of her patients whose lives had improved, while claiming that she has "not had the experience where someone is specifically not thriving" under hormone treatment. Tr. 7/16 80:3-5.

Dr. Corathers testified on Monday and Tuesday after sitting in the courtroom (as experts may) while previous witnesses testified. When Chloe Cole told her story on Friday, however, Dr. Corathers was no longer there.

C. Expert Testimony Establishes The Known And Unknown Risks Of Medical Intervention On Children, Which Outweigh Any Potential Benefits.

Ultimately, this Court rejected nearly all Plaintiffs' efforts to whitewash the record in this case. The only excluded exhibits were some internal documents of WPATH, one of the bodies making up the purported "unanimous" "scientific" "consensus" in favor of subjecting gender-

dysphoric children to these interventions. Those exhibits were proffered into the record outside of the Court's hearing.

As to the rest of the evidence, the Court rightly heard it all. The Court heard Chloe Cole and Jamie Reed. The Court heard Dr. James Cantor, Dr. Levine, and Dr. Hruz. Among them, these experts confirmed what European experts have concluded, and what Chloe Cole and Jamie Reed have experienced:

- Medical practitioners in Europe and North America have seen an emerging explosive growth in pre-pubescent minors seeking medical intervention as part of a transition from one gender identity to another.

- This newer population of children are 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. Now, 70% of the patients are female, and their gender dysphoria often starts in early adolescence, not long before they naturally begin puberty.

- 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).

- This dramatic increase in mental-health concerns among youth also coincides in time with the prevalence of social media, which now bombards youth, especially females, with algorithmically conjured images of, and pressure to conform to, "perfect" female body types.

- Experts throughout Europe have conducted systematic reviews of what scientific studies do exist on puberty blockers, hormone treatment, and medical intervention for gender-dysphoric youth. These studies endeavor to eliminate selection bias and compile and synthesize all available scientific of sufficient quality, as judged by neutral standards.

- These systematic reviews have concluded that the risks (known and unknown) of treating youth with gender dysphoria through medical intervention, including but not limited to puberty blockers and hormone treatment (regardless of additional risks of surgery), outweigh any potential benefits.

- Plaintiffs' experts' attacks on the margins of the specific methodologies of these systematic reviews are irrelevant to outcome, as shown in part by the systematic studies' independent and consistent conclusions.

- Gender dysphoria (that is, the diagnosable mental illness associated with significant distress caused by incongruence between gender identity and natal sex) can and often does resolve without medical intervention.

- Gender identity (that is, a person's own concept of their gender, as distinguished from their natal sex) is not innate or immutable; in fact, a person's gender identity frequently changes throughout a person's life. This does not mean that transgenderism is not real, nor does it mean that a transgender identity is less genuine or valid than a non-transgender identity.

- 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.

- Puberty, especially puberty that takes place at a normative (i.e., typical) age, is important for the physical and mental development of a person.

- Puberty is often when a person first experiences sexual pleasure.

- Medical intervention through puberty blockers and hormone treatment can delay, and permanently damage or eliminate, a person's ability to experience sexual pleasure.

- Thus, a child may "ascent" to medical intervention before ever experiencing sexual pleasure, and the medical intervention may result in permanent inability to experience it later.

- Medical intervention through puberty blockers and hormone treatment carries a high risk of permanent infertility.

- This medical intervention carries a risk of low bone density leading to increased risk of osteoporosis.

- This medical intervention carries a risk of blood clots, which increases dramatically if patients smoke or engage in other unhealthy but addictive behaviors.

- Thus, doctors who administer this medical intervention must try to counsel their adolescent patients not to smoke or engage in these behaviors.

- 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)), and the physical risks of this treatment are fairly well known, it is not known if the risks are different when these treatments are used to treat the mental condition of gender dysphoria.

- While some physical risks (and mitigation strategies) may (or may not) be the same for patients with gender-dysphoria, it is likely that the psychological risks

> are different, novel, and unknown when this medical intervention is used in the new and emerging context of widespread gender dysphoria that first appears in adolescence.

ARGUMENT

A. Burden And Standard Of Proof.

A statute enacted by the legislature carries a strong presumption of constitutionality. *City of Toledo v. State* (2018), 154 Ohio St. 3d 41, ¶ 18; *See Also* R.C. 1.47. A plaintiff may rebut that presumption on an as-applied or facial basis. An as-applied challenge alleges a constitutional violation as the statute is applied to a particular set of facts. A facial challenge alleges there is no set of facts where the statute is constitutional. *State ex rel. Ohio Congress of Parents & Teachers v. State Bd. of Edn. (*2006), 111 Ohio St.3d 568, ¶ 20.

In either challenge the plaintiff has the initial evidentiary burden. *Belden v. Union Cent. Life Ins. Co. (1944)*, 143 Ohio St. 329, paragraph six of the syllabus. A facial challenge requires a constitutional violation to be established beyond a reasonable doubt. *State ex rel. Ohio Congress* at ¶ 20. An as-applied challenge requires a showing of clear and convincing evidence. Id. at ¶ 21.

To apply the appropriate level of review, a court must first evaluate the interest at stake. If a court finds an alleged violation impinges on a fundamental right or implicates a suspect class, the court's review must be done with strict scrutiny. *Harrold v. Collier* (2005), 107 Ohio St. 3d 44, ¶ 39. Strict scrutiny requires a burden shifting analysis. If a plaintiff establishes the requisite quantum of proof, a rebuttable presumption of unconstitutionality is created. This presumption is overcome when the State establishes a compelling state interest exists, and the statute in question is narrowly tailored to that interest. *Sorrell v. Thevenir* (1994), 69 Ohio St. 3d 415, 423. However, if neither a fundamental right nor a suspect class is at issue, the court applies rational basis review. Here the burden remains with the plaintiff throughout. To overcome a

statute's strong presumption of constitutionality, the plaintiff must establish that a statute is not reasonably related to any legitimate government purpose, and it is unreasonable or arbitrary. *See, e.g., Mominee v. Scherbarth*, 28 Ohio St. 3d 270, 274 (1986); *Arbino v. Johnson & Johnson* (2007), 116 Ohio St. 3d 468, ¶ 49.

B. Plaintiffs Failed To Prove Standing For Any Claim.

Plaintiffs brought this action challenging the constitutionality of H.B. 68 on the premise that it prohibits treatment "for ***gender dysphoria*** in adolescents." Complaint ¶ 2 (emphasis added). "[B]eing transgender," they confirmed, "is not itself a condition to be treated." *Id.* at ¶ 25. Rather, "gender dysphoria" is the "serious medical condition." *Id.* Accordingly, Plaintiffs acknowledged in their complaint that "[p]uberty-delaying medications and gender-affirming hormones are ***prescribed only after*** . . . a qualified health professional, "assesses the ***diagnosis of gender dysphoria*** and any other co-occurring diagnoses" and "ensures that, if co-occurring mental health conditions are present, they do not interfere with the accuracy of the diagnosis of gender dysphoria, among other things." *Id.* at ¶ 61 (emphasis added).

At trial, Plaintiffs' experts all testified, unequivocally, that without a diagnosis of gender dysphoria, no such treatment would be medically indicated, much less medically necessary. Dr. Corathers testified that treatment of youth with gender dysphoria is highly individualized, without any one-size-fits-all approach, but one unifying characteristic of treatment is that a valid diagnosis of gender dysphoria is always necessary before puberty blockers or hormones can be administered.

Inexplicably, however, Plaintiffs failed to introduce any evidence establishing that the minor Plaintiffs were diagnosed with gender dysphoria at all, let alone properly diagnosed. In a case claiming that they have a right to certain medical treatment, they chose not to call any treating medical professional. They chose not to introduce a single medical record. And they

failed, entirely, to introduce any evidence that they have the diagnosis without which, they admit, they would not be entitled to that same medical treatment. That means that they failed to introduce any evidence, let alone prove, that the relief they seek in this case—invalidation of HB 68 in its entirety—would have any effect on them whatsoever. This is a failure to prove an essential element of each of their claims. Even more fundamentally, it is a failure to establish that they have standing to pursue their claims.

"It is well established that prior to an Ohio court's considering the merits of a legal claim, 'the person or entity seeking relief must establish standing to sue.'" *Ohioans for Concealed Carry, Inc v. City of Columbus*, 164 Ohio St. 3d 291, 294-295, 2020-Ohio-6724, P12-P13, 172 N.E.3d 935, 939-940, 2020 Ohio LEXIS 2809, *7-8, 2020 WL 7409665, quoting *Ohio Pyro, Inc. v. Ohio Dep't of Commerce,* 115 Ohio St.3d 375, 2007-Ohio-5024, 875 N.E.2d 550, ¶ 27. "At a minimum, common-law standing requires the litigant to demonstrate that he or she has suffered (1) an injury (2) that is fairly traceable to the defendant's allegedly unlawful conduct and (3) is likely to be redressed by the requested relief." *Id.,* citing *Moore v. City of Middletown*, 133 Ohio St.3d 55, 2012-Ohio-3897, 975 N.E.2d 977, ¶ 22, citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-561, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992). These three factors—injury, causation, and redressability—constitute "the irreducible constitutional minimum of standing." *Lujan* at 560;

Further, the Plaintiffs cannot testify to their own purported diagnosis in the absence of any evidence supporting such self-serving claims. "Although victims have personal knowledge of their medical diagnoses, they may not testify to those facts. The diagnoses of doctors may only be established through admission of the relevant doctors' records or the sworn testimony of these doctors." *State v. Fleming*, 12th Dist. Butler No. CA2002-11-279, 2003-Ohio-7005, ¶ 33 citing *Holt v. Olmsted Tp. Bd. of Trustees* (N.D.Ohio, 1998), 43 F. Supp. 2d 812, 819.

At trial, Plaintiffs failed to establish that the minor Plaintiffs have the underlying medical condition that their own experts say is a predicate to allow any medical professional under the to prescribe or render the prohibited treatments. This is fatal to their case.

C. Plaintiffs Failed To Prove A Violation Of The Single-Subject Clause.

Ohio's "Single-Subject Clause," Art. II, sec. 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." They are wrong.

First, Plaintiffs do not even have standing to challenge provisions related to sports or custody decisions. The Ohio 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. "[I]deological opposition to a program or legislative enactment is not enough." *ProgressOhio.org, Inc. v. JobsOhio*, 2014-Ohio-2382, ¶1. Even if Plaintiffs could manage to have provisions related to girls' sports or custody decisions permanently enjoined (which they cannot), that would redress nothing for *them* and *their injuries*, which are based solely on provisions related to medicine. 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).

Second, the claim fails on the merits, because all parts of the law are tied to one common purpose: addressing gender transition in youth—and more specifically, protecting children—even if it advances that purpose in different aspects, such as medicine, sports, and judicial proceedings. Ohio courts 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, the Ohio Supreme Court has held that the Clause does not bar a "plurality" of topics, only a "disunity in subject matter," and "embrac[ing] more than one topic is not fatal, 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, ¶28. Only "a manifestly gross and fraudulent violation" is illegal. *State ex rel. Dix v. Celeste*, 11 Ohio St. 3d 141, 145 (1984). Here, even if the medical, sports, custody provisions are considered different "topics," they easily have a "common purpose or relationship"—protecting children and families from the challenges of an increasingly pressing social trend.

Notably, the sole issue 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 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.

D. PLAINTIFFS FAILED TO PROVE A VIOLATION OF THE HEALTH CARE FREEDOM AMENDMENT.

Ohio's Healthcare Freedom Amendment provides that "[n]o federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance." Art. I, Sec. 21(B). Plaintiffs argue that this entitles them to purchase gender-transition services as a form of "health care." They are mistaken, as 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 what is allowed as "health care" to begin with, and expressly disclaims such a sweeping result.

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 health-care 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 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 define what is allowed as "health care."

E. Plaintiffs Are Unlikely To Succeed On Their Equal Protection Claim.

Plaintiffs are also mistaken in claiming that they will likely succeed in showing that the Health Care Provisions violate Ohio's Equal Protection Clause, which says that government is instituted for the people's "equal protection and benefit." Art. 1, Sec. 2. This claim fails.

First, as an overarching matter, the Ohio Supreme Court has held that the equal-protection provisions in the state 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). While some justices' opinions have addressed the potential room for different Ohio protections, no Ohio Supreme Court majority opinion has ever found a state equal-protection violation where no federal one existed. That makes it notable that the U.S Court of Appeals for the Sixth Circuit has concluded that equal protection claims similar to Plaintiffs' are unlikely to succeed, reversing preliminary injunctions against Kentucky's and Tennessee's similar laws barring minors' gender transitions. *L. W. by & through Williams v. Skrmetti*, 83 F.4th 460 (6th Cir.).

Second, all of Plaintiffs' theories fail, for reasons in the Sixth Circuit's opinion and more. Plaintiffs allege that the provisions restricting the medical profession's treatment of minors discriminate on the basis of sex. The argument goes like this: the law's ban on cross-sex hormones applies differently for those born male but who identify as female, who are barred from taking estrogen, from those born female but who identify as male, who are barred from taking testosterone. *See* Compl. ¶¶89–90. But that biological granularity does not change the fact that categorically, each is barred from taking the hormone opposite to their birth sex. *L. W.*, 83 F.4th at 483. Thus, the intent and effect of the law is equal by applying to the type of treatment. Further, even if Plaintiffs' view were correct as to cross-sex hormones, it does not apply at all to puberty blockers, because the identical medicine is given to males and females alike. *Id.*

Plaintiffs likewise fail in their attempt to charge unlawful discrimination based on transgender status. First, they are wrong that transgender status is a "suspect classification," triggering strict scrutiny. *Id.* at 486–88. As the Sixth Circuit noted, among other things, transgender persons are not insular and politically powerless. Although some might feel that they lost this particular political fight in Ohio, transgender persons have the support of the federal

executive branch and many other State and local governments, as well as the support of much of corporate America, the public schools, and more. "These are not the hallmarks of a skewed or unfair political process." 83 F.4th at 487. Second, the challenged provisions satisfy the rational-basis test and provide even a compelling interest. Given the evidence at trial, the State has a compelling and rational interest in protecting children from experimental medication regimens that have lifetime effects. When there is such uncertainty, the State is free to choose among competing views. *See Gonzales v. Carhart*, 550 U.S. 124, 163 (2007).

F. PLAINTIFFS FAILED TO PROVE A VIOLATION OF THE DUE COURSE OF LAW CLAUSE.

Plaintiffs finally claim that the medical provisions violate Ohio's "Due Course of Law" clause, which provides that everyone "shall have remedy by due course of law." Art. I, Sec. 16. Plaintiffs allege that clause, the equivalent of the federal Due Process Clause, covers a "substantive due process" right. Plaintiffs claim that the parents here have a right to direct their children's medical gender transitions as part of a substantive constitutional right to control their children's healthcare. Here, too, they are mistaken.

Today, the Due Course of Law Clause is treated as "the equivalent of the 'due process of law' protections in the United States Constitution." *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, ¶48. Under the substantive-due-process doctrine, "[g]overnment actions that infringe upon a fundamental right are subject to 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. But "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).

The Plaintiffs argue that the substantive-due-process doctrine creates a right to direct their children's healthcare, including medical gender transition. But they can obtain "strict scrutiny" review only if they can show that there is 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 practice the parents seek.

There is no evidence that either the State of Ohio or the United States has 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, 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.

As noted above regarding equal protection, 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. 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, adopting even a minority one if it wishes. *J.W.*, 83 F.4th at 477.

CONCLUSION

For the foregoing reasons, the State respectfully requests that the Court issue final judgment upholding the SAFE Act, denying all Plaintiffs' requested permanent relief, and immediately dissolving the temporary, preliminary injunction previously issued.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that the foregoing was filed electronically and served by e-mail on July 22, 2024 upon all counsel of record.

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