IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____ PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION PRECEDED BY TEMPORARY RESTRAINING ORDER IF NECESSARY AND MEMORANDUM IN SUPPORT

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION PRECEDED BY TEMPORARY RESTRAINING ORDER IF NECESSARY

Pursuant to Civ. R. 65, Plaintiffs Madeline, Michael, and Michelle Moe, and Grace, Garrett, and Gina Goe (collectively "Plaintiffs"), move this Court for a preliminary injunction to enjoin enforcement of Ohio's recently enacted ban against gender-affirming health care for minors (the "Health Care Ban,") consisting of Sections 3109.054, 3129.01-3129.06, 3313.5319, and 3335.562 of the Ohio Revised Code, contained in H.B. 68, before the Health Care Ban takes effect on April 24, 2024. If the Court is not able to issue a preliminary injunction in time to take effect by April 24, Plaintiffs also move for a TRO to issue on April 24, enjoining the Health Care Ban until a Preliminary Injunction is issued.

The Health Care Ban prohibits physicians from providing gender-affirming medication to patients under the age of eighteen. If the Ban is permitted to take effect on April 24, 2024, it will have devasting consequences on the health and well-being of Ohio transgender youth, who will

be deprived of access to the medical profession's standard of care treatment for gender dysphoria, a serious medical condition, for which there is no effective alternative treatment.

As supported by the accompanying Memorandum, its attached affidavits, and the Complaint, emergency injunctive relief is necessary to prevent the irreparable harm that will occur if H.B. 68 goes into effect on April 24.

Respectfully submitted,

/s/ Freda J. Levenson

Freda J. Levenson (45916)
Trial Attorney
Amy Gilbert (100887)
ACLU OF OHIO FOUNDATION, INC.
4506 Chester Avenue
Cleveland, Ohio 44103
Levenson: (216) 541-1376
Office: (614) 586-1972
flevenson@acluohio.org
agilbert@acluohio.org

David J. Carey (88787)
ACLU OF OHIO FOUNDATION, INC.
1108 City Park Ave., Ste. 203
Columbus, Ohio 43206
(614) 586-1972
dcarey@acluohio.org

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

**PHV motion forthcoming*

Miranda Hooker*
Kathleen McGuinness*
Jordan Bock*
GOODWIN PROCTER LLP
100 Northern Avenue
Boston, MA 02210
(617) 570-1000
mhooker@goodwinlaw.com
kmcguinness@goodwinlaw.com
jbock@goodwinlaw.com

Allison DeLaurentis*
GOODWIN PROCTER LLP
One Commerce Square
2005 Market Street, 32nd Floor
Philadelphia, PA 19103
(445) 207-7800
adelaurentis@goodwinlaw.com

Lora Krsulich*
GOODWIN PROCTER LLP
601 S Figueroa St., 41st Floor
Los Angeles, CA 90017
(213) 426-2500
lkrsulich@goodwinlaw.com

Counsel for Plaintiffs Madeline Moe, by and through her parents and next friends, Michael Moe and Michelle Moe; Michael Moe; Michelle Moe; Grace Goe, by and through her parents and next friends, Garrett Goe and Gina Goe; Garrett Goe; and Gina Goe

IN THE COURT OF COMMON PLEAS
FOR FRANKLIN COUNTY, OHIO

MADELINE MOE, et al. Plaintiffs, v. DAVID YOST, et al. Defendants.	Case No. _____ Judge _____ MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION PRECEDED BY TEMPORARY RESTRAINING ORDER IF NECESSARY

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION PRECEDED BY TEMPORARY RESTRAINING ORDER IF NECESSARY

Table of Contents

INTRODUCTION

This lawsuit challenges the constitutionality of House Bill 68 ("H.B. 68"), which bans medical interventions when, and only when, they are provided to transgender adolescents to treat gender dysphoria. Gender dysphoria is a serious condition that, when left untreated, causes severe harm to patients. The prohibited interventions are evidence-based and medically necessary care essential to the health and well-being of transgender adolescents. For Parent Plaintiffs Michael and Michelle Moe, this care has allowed their twelve-year-old transgender daughter, Madeline, to thrive and be her true self. Before treatment, Madeline wanted to die so she could come back as a girl. Now, with the benefit of treatment, she is successful and happy in school and in her community. Parent Plaintiffs Gina and Garrett Goe want the same for their twelve-year-old transgender daughter, Grace. She has been living happily as a girl for most of her life, and the prospect of being unable to access the medical care that she will soon need threatens to push the entire Goe family out of their loving and supportive community.

H.B. 68 overrides the informed decision-making of the Parent Plaintiffs. Rather than allowing loving and caring parents, along with the adolescents' treating physicians, to make considered decisions about when and whether to pursue medical care for their adolescent children's gender dysphoria, the law makes one decision for every parent and family in Ohio: starting April 24, 2024, no adolescent may begin receiving this care. This government intrusion into private family decision-making violates four separate provisions of the Ohio Constitution. First, it violates the Health Care Freedom Amendment ("HCFA") in Article I, Section 21, because it "prohibits the purchase of health care." Second, it violates the Equal Protection Clause in Article I, Section 2, because it discriminates on the basis of sex. Third, it violates the Due Course of Law provision in Article I, Section 16, because it infringes on parents' rights to direct their children's

medical care. Fourth, it violates the one-subject rule in Article II, Section 15(D) because H.B. 68 is not one, but two, entirely separate acts: the Health Care Ban, and an unrelated act regulating sports.

These are more than bare constitutional injuries. The Health Care Ban endangers the health and wellbeing of transgender adolescents, including Plaintiffs Grace Goe and Madeline Moe, and it forces Parent Plaintiffs to make an unbearable decision: leave their homes and communities in Ohio, or watch their children suffer needlessly. This court should preliminarily enjoin the Ohio Attorney General and State Medical Board from enforcing the Health Care Ban before it goes into effect on April 24, 2024, to prevent these irreparable injuries.

FACTUAL BACKGROUND

I. The Healthcare Ban Was Passed Only After Being Logrolled With A Restriction On Interscholastic Sports Participation

As its title states, H.B. 68 comprises two distinct Acts regulating two distinct subject matters (respectively, the "Health Care Ban" or the "Ban," and the "Sports Prohibition"). H.B. 68 expressly provides:

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

2024 Sub.H.B. No. 68. [1]

In relevant part, the Health Care Ban prohibits physicians from providing gender-affirming health care—which it dubs "gender transition services"—to patients under the age of eighteen. That prohibition specifically forbids physicians from prescribing "a cross-sex hormone or puberty-

[1] This action challenges the enactment of H.B. 68 as a whole because it is a logrolled combination of the "Health Care Ban" and the "Sports Prohibition", and also specifically challenges the substance of the Health Care Ban.

blocking drug for a minor individual for the purpose of assisting the minor individual with gender transition." *Id.* (enacting R.C. 3129.02(A)(2)). It further forbids physicians from knowingly engaging in "conduct that aids or abets in" such treatment. *Id.* (enacting R.C. 3129.02(A)(3)).

The Ban contains a limited exemption for preexisting care, applicable only to some patients. Under the exemption, a physician may "continue to prescribe cross-sex hormones or puberty-blocking drugs" to a minor patient if (a) the patient has been a continuous Ohio resident since the effective date of the law; and (b) the physician has both (1) "[i]nitiated a course of treatment for the minor individual prior to the effective date of this section that includes the prescription of a[n otherwise prohibited] cross-sex hormone or puberty-blocking drug[,]" and (2) "[d]etermined and documented in the minor individual's medical record that terminating the minor individual's prescription for the cross-sex hormone or puberty-blocking drug would cause harm to the minor individual." *Id.* (enacting R.C. 3129.02(B)). Many, if not all, physicians in Ohio with patients who are already undergoing puberty-delaying treatment have advised those patients that they interpret the exemption to prevent them from prescribing hormone therapy to patients who are currently on puberty blockers.[2]

The Health Care Ban includes penalties and enforcement mechanisms. Defendant Yost is authorized to "bring an action to enforce compliance" with the Health Care Ban, and the Defendant State Medical Board is instructed that any violation of the Health Care Ban "shall be considered

[2] As set forth in the expert affidavit of Dr. Corathers, a pediatric endocrinologist who has treated hundreds of youth and young adults with gender dysphoria in Ohio, the medical guidelines governing treatment for gender dysphoria dictate that clinicians and families consider how to initiate puberty after a period of time on puberty-delaying medication and after the adolescent matures. If puberty delaying medication is discontinued, endogenous puberty will begin. Most adolescents with gender dysphoria continue to experience severe distress and, after assessment, go on to receive hormone therapy, which allows them to go through a puberty consistent with their gender identity alongside their peers. See Corathers Aff. ¶¶ 26, 34, 55.

unprofessional conduct and subject to discipline[.]" *Id.* (enacting R.C. 3129.02(A)(2)–(3), 3129.05(A)).

When it was first introduced, H.B. 68 consisted solely of the Health Care Ban, with no mention of interscholastic sports. *See generally* H.B. No. 68, As Introduced version, 135th General Assembly (February 27, 2023). A separate bill introduced earlier that month, House Bill 6, contained what would become the "Sports Prohibition"—a series of restrictions on interscholastic girls' and women's sports at the grade school and collegiate levels. *See* H.B. No. 6, As Introduced version, 135th General Assembly (February 15, 2023). Four months later, on June 14, 2023, the contents of H.B. 6 were rolled into H.B. 68 as a second "Act" within that bill. *See Saving Ohio Adolescents from Experimentation Act: hearing on H.B. 68 before the H. Comm. on Public Health Policy*, 2023 Leg., 135th Sess. The combined H.B. 68 thus contains both the Health Care Ban *and* the Sports Prohibition.

The Sports Prohibition specifically requires that schools designate sex-segregated sports teams, and mandates that no school or interscholastic conference "shall knowingly permit individuals of the male sex to participate on athletic teams or in athletic competitions designated only for participants of the female sex." 2024 Sub.H.B. No. 68 (enacting R.C. 3313.5319). This portion of the bill is not subject to enforcement by the Attorney General or the State Medical Board. Instead, H.B. 68 creates private rights of action for damages and injunctive relief for "[a]ny participant who is deprived of an athletic opportunity," "[a]ny participant who is subject to retaliation or other adverse action," or "[a]ny school or school district that suffers any direct or indirect harm" as a result of a violation. *Id.* (enacting R.C. 3313.5139(E)(1)-(3)).

II. Gender-Affirming Care Is A Widely Accepted Form Of Health Care To Treat Minors With Gender Dysphoria.

A. Gender dysphoria is a serious medical condition

Gender dysphoria is the distress that results from an incongruence between a person's gender identity and their sex assigned at birth. Being transgender is not in itself a medical condition to be treated, but gender dysphoria is a serious medical condition, recognized in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., Text Revision. Corathers Aff. ¶¶ 26–27. A gender dysphoria diagnosis requires that the incongruence between a person's gender identity and designated sex has persisted for at least six months and is accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Id.* at ¶ 26. Untreated, gender dysphoria can result in not just decreased quality of life, but also debilitating anxiety, severe depression, self-harm, suicidal ideation, and suicide attempts. *Id.* at ¶ 27. Gender-affirming medical care improves mental health for the adolescents who require such care. *Id.* at ¶ 46.

B. Gender-affirming health care is the standard of care to treat gender dysphoria

The widely accepted standard of care for gender dysphoria includes the use, where appropriate, of puberty-delaying medication and/or hormone therapy. This treatment regimen is referred to as gender-affirming health care, or simply gender-affirming care. *See id.* at ¶¶ 37–47. (The text of the Health Care Ban instead uses the term "gender transition services.")

Every major medical organization in the United States recognizes the efficacy of gender-affirming medical care to treat adolescents with gender dysphoria and has issued an explicit statement opposing bans on this care. These organizations include The American Medical Association, The American Academy of Pediatrics, The American Psychiatric Association, The American College of Physicians, The American Academy of Family Physicians, The American

Academy of Child & Adolescent Psychiatry, The Endocrine Society, The Pediatric Endocrine Society, The World Professional Association for Transgender Health, and the United States Professional Association for Transgender Health, among many others. *Id.* at ¶ 74.

Gender-affirming care, including medical intervention for adolescents, is not a novel or experimental type of health care. Puberty-delaying medication has been prescribed for over twenty years, and hormone therapy has been available for decades. Antommaria Aff. ¶ ¶ 27, 28; Corathers Aff. ¶ ¶ 31, 71. The current version of the WPATH standards is Standards of Care Version 8 ("SOC-8"), published in 2022. SOC-8 provides guidelines for multidisciplinary care of transgender individuals, including children and adolescents, and describes criteria for medical treatment of gender dysphoria in adolescents and adults. Such treatment includes puberty-delaying medication and hormone treatment where medically indicated. Antommaria Aff. ¶ 29.

The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has also published a clinical practice guideline for the treatment of individuals with gender dysphoria ("Endocrine Society Guideline"), including pubertal suppression and sex hormone treatment. The Endocrine Society Guideline provides protocols for the medically necessary treatment of gender dysphoria similar to those outlined in the WPATH Standards of Care. *See id.* at ¶¶ 37, 42.

The SOC-8 and the Endocrine Society Guideline are both widely accepted. Antommaria Aff. ¶ 29. Clinicians throughout Ohio and throughout the country follow the SOC-8 and the Endocrine Society Guideline to diagnose and treat people with gender dysphoria. *See id.* at ¶ 36–42.

C. Gender-affirming health care is not "experimentation"

Contrary to the title of the Health Care Ban, ("Saving Ohio Adolescents from Experimentation") gender-affirming care is not experimental in either the colloquial sense

(because it is not new, novel, or unproven), or the technical sense. Experimental treatments are interventions that have shown some promise as a cure and are administered to advance knowledge for the potential benefit of *future* patients. In contrast, gender-affirming care is provided to benefit *individual* patients and the treatment is modified based on their individual responses. Antommaria Aff. ¶¶ 27-28. The quality of evidence supporting SOC-8 and the Endocrine Society Guideline is comparable to the support for guidelines that medical providers use to treat many other widely accepted conditions, including in the field of pediatrics. There are decades of studies—going back over 25 years—supporting the benefits of gender-affirming care where medically indicated, which is why it is the standard of care for gender dysphoria. Antommaria Aff. ¶¶ 27-29; Turban Aff. ¶¶ 12-21.

D. The Health Care Ban prohibits medication for gender dysphoria while permitting the same medication for other purposes

The Health Care Ban prohibits the use of well-established medications for gender dysphoria in transgender adolescents—including puberty-delaying treatment and hormone therapy—when these medications are provided "for the purpose of" assisting the minor individual with gender transition." Ohio Revised Code. § 3129.02(A)(2). But the Health Care Ban does not prohibit the use of these same medications for any other purpose. As one example, puberty-delaying medication is commonly used to treat conditions like precocious puberty. Corathers Aff. ¶¶ 30-31. The Health Care Ban prohibits puberty-delaying medication to treat a youth with gender dysphoria, but would permit the same medication for a youth with precocious puberty, simply because it would not be "for the purpose of assisting the minor individual with gender transition[.]" Ohio Revised Code. § 3129.02(A)(2).

Likewise, the Health Care Ban prohibits hormone therapy when prescribed "for the purpose of" treating a transgender adolescent's gender dysphoria but would allow that same

hormone therapy when prescribed to other patients. For example, non-transgender boys with delayed puberty or hypogonadism may be prescribed testosterone. *See* Corathers Aff. ¶ 33. Similarly, non-transgender boys who experience gynecomastia or overdevelopment of breast tissue may be treated to reduce breast tissue, and non-transgender girls with polycystic ovarian syndrome may be treated with hormone therapy to minimize undesired facial and body hair. *Id.* at ¶ 72. But transgender patients are denied these treatments for gender dysphoria.

E. The risks of gender-affirming health care treatments are comparable to those of other health care treatments

Puberty-delaying medications and gender-affirming hormones are prescribed only after a comprehensive psychosocial assessment by a qualified health professional who: (i) assesses for the diagnosis of gender dysphoria and any other co-occurring diagnoses, (ii) ensures the child can assent and the parents/guardians can consent to the relevant intervention after a thorough review of the risks, benefits, and alternatives of the intervention, and (iii) ensures that, if co-occurring mental health conditions are present, they do not interfere with the accuracy of the diagnosis of gender dysphoria or impair the ability of the adolescent to assent to care. *See id.* at ¶¶ 54-60.

Unwanted side effects from gender-affirming hormone therapy are rare when treatment is provided, as they are, under clinical supervision. *See id.* at ¶¶ 62-65. But to the extent there is a risk, the side effects of puberty delaying treatment and hormone therapy are comparable when used to treat gender dysphoria and versus other conditions. *See id.* at ¶ 65. In each circumstance, doctors advise patients and their parents about the risks and benefits of treatment and tailor recommendations to the individual patient's needs. *See id.* at ¶¶ 64-65. For adolescents, parents consent to treatment and the patient gives their assent. *See id.* at ¶ 58.

III. The Ban Will Deprive Plaintiffs Of Necessary Health Care, Without Which They Will Suffer Great Harm.

A. Gender-affirming care is safe and effective at treating gender dysphoria

For youth with gender dysphoria who have not yet started puberty, there are no pharmaceutical interventions. *See* Corathers Aff. ¶ 53. Care for these children may include "social transition" which means supporting the child living consistently with their persistently expressed gender identity (for example, adopting a new name and pronouns or changes in clothing or hairstyle), along with supportive therapy. Under SOC 8 and the Endocrine Society Guideline, medical interventions may become medically necessary and appropriate when youth with gender dysphoria begins puberty. *See* Corathers Aff. ¶¶ 37-47.

1. Puberty-delaying medication

When a child with gender dysphoria enters endogenous puberty—becomes an adolescent—their body typically begins to develop in accordance with their sex designated at birth. *See* Corathers Aff. ¶ 25. Transgender girls, if not treated, develop facial hair, a pronounced Adam's apple, and a deepening voice. Transgender boys develop breasts and begin to menstruate. *Id.* For many transgender adolescents, this can cause extreme distress. *Id.*

For these individuals, puberty-delaying medication—known as gonadotropin-releasing hormone agonists ("GnRH agonists") and referred to in the Health Care Ban's text as "puberty-blocking drugs"—can minimize and potentially prevent the heightened gender dysphoria and the often permanent and unwanted physical changes that puberty would cause. For adolescents with gender dysphoria who are experiencing severe distress upon the onset of puberty, this provides a pause in these physiological changes that alleviates the worsening distress of progressing puberty. *Id.* at ¶ 32.

Treatment with puberty-delaying medication is part of the standard of care for treating gender dysphoria in adolescents. *Id.* at ¶ 31. In all cases, the precise treatment recommended for gender dysphoria will depend upon each patient's individualized considerations. *Id.* at ¶ 64. Under the Endocrine Society Guideline, adolescents may be eligible for puberty-delaying treatment if:

"1. A qualified MHP [mental health professional] has confirmed that:

- the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
- gender dysphoria worsened with the onset of puberty,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment, and
- the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment.

2. And the adolescent:

- has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:

- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),[3]
- has confirmed that there are no medical contraindications to GnRH agonist treatment." *Id.* at ¶ 47.

Puberty-delaying medication has been shown to be safe and effective at treating gender dysphoria in adolescents and is associated with improved mental health outcomes that include significantly lower levels of anxiety, depression, disruptive behaviors, and suicidality and suicidal ideation, as well as improved global functioning (i.e., how well a person functions in their daily life). *Id.* at ¶¶ 37, 66 The use of puberty-delaying treatment after the onset of puberty can also eliminate or reduce the need for surgery later in life. *See id.* at ¶ 41

Puberty-delaying treatment does not permanently affect fertility and is reversible. *See id.* at ¶¶ 30, 54; Antommaria Aff. ¶ 44, 45. If it is stopped, there are no lasting effects of treatment, and puberty resumes on a timeline typical of their peers. Corathers Aff. ¶ 67.

2. Gender-affirming hormone therapy

For some adolescents, later in puberty, it may be medically necessary and appropriate to treat their gender dysphoria with gender-affirming hormone therapy (testosterone for transgender boys, and testosterone suppression and estrogen for transgender girls). Corathers Aff. ¶¶ 44-46. If puberty-delaying medications are withdrawn without any further medical interventions, then endogenous puberty resumes. *Id.* at ¶ 55. If gender-affirming hormone therapy follows the cessation of puberty-delaying medication, then that individual will develop secondary sex characteristics consistent with the individual's gender identity. *See id.* at ¶ 43. For adolescents who

are not prescribed puberty-delaying medication, the first medical intervention they receive may be hormone therapy. *Id.* at ¶ 44.

The psychological benefits of gender-affirming hormone treatment for adolescents with gender dysphoria include reduction of anxiety, depression, and suicidality, and improvements in life satisfaction. *Id.* at ¶ 46.

Under the Endocrine Society Guidelines, transgender adolescents may be eligible for gender-affirming hormone therapy if:

> "1. A qualified MHP [Mental Health Professional] has confirmed:
>
> - the persistence of gender dysphoria,
> - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
> - the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
>
> 2. And the adolescent:
>
> - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
> - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to

the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:

- agrees with the indication for sex hormone treatment,
- has confirmed that there are no medical contraindications to sex hormone treatment." *Id.* at ¶ 47.

Through decades of clinical experience and research, gender-affirming hormone therapy has been shown to be safe and effective at treating gender dysphoria in adolescents. *See id.* at ¶ 66. Treatment with gender affirming hormone therapy is demonstrated to result in improvement in symptoms of gender dysphoria, depression, and anxiety in transgender youth, as well as improved psychological functioning among transgender young adults who receive treatment for gender dysphoria. *Id.* at ¶ 46.

B. Absent gender-affirming care, Plaintiffs will suffer significant harm

In the absence of intervention, the physical changes of puberty will progress. For a person with gender dysphoria, these changes can cause clinically significant distress. *See* Corathers Aff. ¶ 25. To not intervene, when gender-affirming medical care is indicated, thus causes significant harm to the patient in the form of increasing gender dysphoria associated with the development of secondary sex characteristics that do not match that person's gender identity. *Id.*

There is no evidence-based intervention other than gender-affirming medical care to effectively treat adolescent gender dysphoria. *See id.* at ¶ 37-48; Antommaria Aff. ¶ 50. Psychotherapy alone does not effectively treat gender dysphoria. Antommaria Aff. ¶ 50. Not only does withholding the medically indicated gender-affirming treatment from adolescents with gender dysphoria put them at risk of severe and irreversible harm to their health in the near

term, but also providing medical treatment in adolescence can reduce life-long gender dysphoria, possibly eliminating the need for surgical intervention in adulthood, and further can significantly improve mental health outcomes. Antommaria Aff. ¶ 42; Corathers Aff. ¶ 41.

Without treatment, transgender adolescents and young adults report several fold higher rates of depression, anxiety, suicidal ideation and suicide attempts, compared to their cisgender counterparts. Corathers Aff. ¶ 73. Over twenty years of clinical experience and research has shown that when transgender adolescents are able to access puberty-delaying medication and hormone therapy, their distress recedes, and their mental health improves. For many young people, this treatment is transformative, and they go from experiencing pain and suffering to thriving. *Id.* at ¶ 61.

If the Health Care Ban goes into effect, medical and mental health providers across Ohio will be left with no evidence-based treatments for their adolescent patients with gender dysphoria. Turban Aff. ¶ 18. Given the well-documented benefits of gender-affirming medical care, and the known harms of untreated adolescent gender dysphoria, banning this care will lead to substantial deterioration of mental health for adolescents diagnosed with gender dysphoria. For many of these patients, this is likely to include worsening suicidality. Corathers Aff. ¶ 73.

IV. The Plaintiffs

Madeline Moe is a twelve-year-old transgender girl. Michael Moe Aff. ¶ 4, 7. Madeline has been living as a girl in all aspects of her life since she was seven years old. Moe Aff. ¶ 17. She has been on pubertal suppression medication for a year to treat her diagnosed gender dysphoria, and she is thriving. Moe Aff. ¶ 14. Puberty-delaying medication has given her significant relief from her gender dysphoria: she no longer has to worry about going through a puberty that does not match her gender identity. Moe Aff. ¶ 15-16. Michelle and Michael Moe do not want their daughter to return to the self-harm and mental anguish she felt at six years old, when she said, "I want to

die and come back as a girl. Can't God just make me come back as a girl?" Moe Aff. ¶ 9. The Moe family wants to remain in their supportive and loving community in Ohio and to be able to access their daughter's need for hormone therapy so that she can grow into a healthy young woman. Moe Aff. ¶ 17-18.

Grace Goe is also a twelve-year-old transgender girl. Gina Goe Aff. ¶ 4, 7. Grace first told her parents, Gina and Garrett, that she was a girl at five years old, and was diagnosed with gender dysphoria at six years old. Goe Aff. ¶ 10-11. Since her parents allowed her to live as a girl—as her true self—in all aspects of her life, she has been the happiest and healthiest version of herself. Goe Aff. ¶ 12. That has been her life for the past six years. Goe Aff. ¶ 13. Now that she is twelve, her parents and doctor are monitoring her for the first signs of puberty to identify the right time to begin medication that will pause puberty temporarily. Goe Aff. ¶ 13. When puberty begins, Gina and Garrett want to be able to discuss these options with Grace and her doctor in Ohio and, if medically indicated, begin treatment so that she does not develop physical characteristics that do not match her gender identity. Goe Aff. ¶ 14. Grace's parents worry about her mental health and safety in the community if she is unable to start pubertal suppression and is thus outed as being transgender against her will. Goe Aff. ¶ 14-15. Although the Goe family has deep roots in Ohio and does not want to leave, they are considering moving, or even temporarily separating their family, to ensure that Grace can receive medical care when she needs it. Goe Aff. ¶16-17.

ARGUMENT

A party seeking a preliminary injunction "must ordinarily show that (1) there is a substantial likelihood that the plaintiff will prevail on the merits, (2) the plaintiff will suffer irreparable injury if the injunction is not granted, (3) no third parties will be unjustifiably harmed if the injunction is granted, and (4) the public interest will be served by the injunction." *Vineyard*

Fellowship v. Anderson, 2015-Ohio-5083, 53 N.E.3d 910, ¶ 11 (internal citation and quotation marks omitted). The factors to be considered for a temporary restraining order are the same, and the plaintiff must show that irreparable injury would be immediate in the absence of relief. *Coleman v. Wilkinson*, 147 Ohio App. 3d 357, 2002-Ohio-2021, 770 N.E.2d 637, ¶ 2; *see* Civ. R. 65(A). "In determining whether to grant injunctive relief, no one of the four preliminary injunction factors is dispositive; rather, the four factors must be balanced with 'flexibility which traditionally has characterized the law of equity.'" *AIDS Taskforce of Greater Cleveland v. Ohio Dep't of Health*, 2018-Ohio-2727, 116 N.E. 3d 874, ¶ 23. Where a plaintiff has shown "a high likelihood of irreparable harm," then "likelihood of success on the merits" is less critical. *Id.*

Regardless, Plaintiffs here satisfy all four prongs of the inquiry.

I. Plaintiffs Are Likely to Succeed on the Merits.

A. Plaintiffs are likely to succeed on their single-subject rule claim

H.B. 68 violates the Ohio Constitution's single-subject (or one-subject) rule, which imposes "a constitutional limitation on the legislative power of the General Assembly." *Rumpke Sanitary Landfill, Inc. v. State*, 128 Ohio St.3d 41, 2010-Ohio-6037, 941 N.E.2d 1161, ¶ 20. Article II, Section 15(D) of the Ohio Constitution provides: "No bill shall contain more than one subject, which shall be clearly expressed in its title." This rule "attacks logrolling by disallowing unnatural combinations of provisions in acts, *i.e.*, those dealing with more than one subject[.]" *In re Nowak*, 104 Ohio St.3d 466, 2004-Ohio-6777, 820 N.E.2d 335, ¶ 71 (quoting *State ex rel. Dix v. Celeste*, 11 Ohio St.3d 141, 143, 464 N.E. 2d 153 (1984)).[3] The result "is a more orderly and fair legislative process. By limiting each bill to one subject, the issues presented can be better grasped and more

[3] "Logrolling" is "the practice of combining and thereby obtaining passage for several distinct legislative proposals that would probably have failed to gain majority support if presented and voted on separately." *Nowak* at ¶ 31.

intelligently discussed." *State ex rel. Dix v. Celeste*, 11 Ohio St.3d 141, 143, 464 N.E.2d 153 (1984). Constitutional challenges to statutes under this rule are challenges "to the authority of the General Assembly to enact the bill," not to the underlying provisions of the bill. *Rumpke* ¶ 20. Nonetheless, even if a bill's two or more constituent parts are independently valid (e.g., are not otherwise unconstitutional), the impermissible combination of multiple acts in violation of the one-subject rule renders the entire bill unconstitutional.

H.B. 68's title announces its violation of the single-subject rule by "clearly express[ing]" two separate subjects: the "Saving Ohio Adolescents from Experimentation (SAFE) Act regarding gender transition services for minors, *and* … the Save Women's Sports Act to require schools, state institutions of higher education, and private colleges to designate separate single-sex teams and sports for each sex." 2024 Sub.H.B. No. 68 (emphasis added). This dual title is no accident: H.B. 68 jams two separate bills together as one, creating two Acts not even united by their title.

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

The individual provisions of H.B. 68 underscore the distance between the Acts. To start, the Health Care Ban and the Sports Prohibition each have their own separate statutory definitions; indeed, neither Act uses any terms defined in the other Act. *See* 2024 Sub.H.B. No. 68 (enacting

R.C. 3129.01, containing definitions for the health care ban, and R.C. 3345.532, containing definitions for the sports restrictions). In other words, each Act can accomplish its objective with no mention of the subject matter of the other Act. Each Act also has its own enforcement mechanism, with no overlap between the degree or type of penalty. The Health Care Ban authorizes the Attorney General to bring an "action to enforce compliance," and provides that violations of some of its sections "shall be considered unprofessional conduct and subject to discipline by the applicable professional licensing board." *See id.* (enacting R.C. 3129.05). The Sports Prohibition, meanwhile, is to be enforced solely by private actions for damages or injunctive relief. *See id.* (enacting R.C. 3345.562). Again, this disconnect reveals that the Acts target entirely different conduct that will be barred through entirely different means. Finally, the General Assembly's findings in Section 2 pertain only to gender-affirming health care with no mention of interscholastic sports. *See id.* at Section 2. That is, again, unsurprising since the Sports Prohibition was logrolled on to the pre-existing bill that contained the Health Care Ban.

Though "[t]he one-subject provision does not require evidence of fraud or logrolling beyond the unnatural combinations themselves," the history of H.B. 68 reveals flagrant logrolling. *Nowak* ¶ 71. Each of H.B. 68's component bills—the Health Care Ban and the Sports Prohibition—failed to pass as a standalone bill. Senate Bill 132 from the 2021-2022 General Assembly session attempted to regulate interscholastic sports in the same fashion as the Sports Prohibition. *See* S.B. No. 132, As Introduced version, 134th General Assembly (March 16, 2021). And, like the Health Care Ban, House Bill 454 from that same legislative session would have banned gender-affirming care for adolescents. *See* H.B. No. 454, As Introduced version, 134th General Assembly (October 19, 2021). Both S.B. 132 and H.B. 454 failed to pass in the 2021-2022 session. But the combined bill encountered no such roadblocks; it cleared the Ohio House within

a week after they were joined together, and subsequently passed the Senate as well. *See* Ohio Legislative Service Commission, Final Analysis of Sub.H.B. No. 68, as passed by the General Assembly (2024), at 9. This maneuver is precisely what the single-subject rule is intended to prevent and the Court should enjoin enforcement of H.B. 68 because it plainly runs afoul of the Ohio Constitution

B. Plaintiffs are likely to succeed on their claim that H.B. 68 unconstitutionally restricts the sale and purchase of health care under Article I, Section 21 of the Ohio Constitution

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

> (B) No federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance.
>
> (C) No federal, state, or local law or rule shall impose a penalty or fine for the sale or purchase of health care or health insurance.

The HCFA contains only a handful of limited exemptions: laws that were already "in effect as of March 19, 2010," laws affecting which services a health care provider is "*required to* perform or provide," the terms and conditions of government employment, or "any laws calculated to deter fraud or punish wrongdoing in the health care industry." Sec. 21(D) (emphasis added). By banning a single group of Ohioans from purchasing a specific category of medical treatment, H.B. 68 violates both Section 21(B) and 21(C), and none of the exemptions in Section 21(D) apply.

1. Article I, Section 21 protects Ohioans' right to make their own individual health care decisions

"In construing constitutional text that was ratified by direct vote, we consider how the language would have been understood by the voters who adopted the amendment." *City of Centerville v. Knab*, 162 Ohio St.3d 623, 2020-Ohio-5219, 166 N.E.3d 1167, ¶ 22. As with a statutory provision, courts are to begin "with the plain language of the text," and consider "how

the words and phrases would be understood by the voters in their normal and ordinary usage." *Id.* (citing *District of Columbia v. Heller*, 554 U.S. 570, 576-577 (2008)); *see also, e.g.*, *State ex rel. Sylvania Home Tel. Co. v. Richards*, 94 Ohio St. 287, 294, 114 N.E. 263 (1916) (in constitutional interpretation, "[i]t is the duty of the court to ascertain and give effect to the intent of the people, and the language used should be given its ordinary and reasonable meaning").

The text of the HCFA is simple, direct, and unambiguous. It forbids the General Assembly from prohibiting or penalizing "the purchase or sale of health care[.]" Art. I Sec. 21(B)-(C), where "health care" refers to medical treatment, procedures, diagnoses, and related services and items. This definition accords with contemporary definitions of "health care" (or "healthcare") from the 2011 passage of the HCFA[4] and is likewise consistent with the General Assembly's use of the term "health care" elsewhere in the Revised Code. In two separate provisions—one enacted before the HCFA and one enacted after—"health care" is similarly defined as "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health." R.C. 2135.01(G) (enacted in 2003); R.C. 1337.11(G) (enacted in 2013).

"Health care" is distinct from health insurance or insurance coverage, as evidenced by the HCFA's repeated use of the disjunctive phrase "health care or health insurance." *See Cowher v. Million*, 380 F.3d 909, 913 (6th Cir. 2004) ("[I]t is a basic principle of statutory construction that terms joined by the disjunctive 'or' must have different meanings because otherwise the statute or provision would be redundant."); *see also State ex rel. Liberty Council v. Brunner*, 125 Ohio St.3d

---

[4] *See, e.g.*, Merriam-Webster Online Dictionary (Feb. 19, 2010) Internet Archive https://web.archive.org/web/20100409025253/http://www.merriam-webster.com/dictionary/healthcare ("efforts made to maintain or restore health especially by trained and licensed professionals"); Dictionary.com (Mar. 4, 2011) Internet Archive https://web.archive.org/web/20110324080003/http://dictionary.reference.com:80/browse/healthcare ("the field concerned with the maintenance or restoration of the health of the body or mind" and "any of the procedures or methods employed in this field").

315, 2010-Ohio-1845, 928 N.E.2d 410, ¶ 57 (noting the then-prospective amendment's "general object or purpose of preserving freedom of choice in health care *and* health-care coverage") (emphasis added). The only Ohio court to interpret the substance of the HCFA took this view, explaining that "the use of the disjunctive 'or' renders the term [health care] separate and distinct from the purported target of the amendment – health insurance." *See* Decision and Entry Granting Temporary Restraining Order, *Preterm-Cleveland v. Yost*, Hamilton C.P. No. A2203203 ("*Preterm-Cleveland* TRO Decision," attached as Exhibit 1).

The plain text of the HCFA thus resolves its meaning. It exists not only to protect an individual's ability to select health insurance coverage, but also to ensure constitutional protection for an individual's right to select—and a provider's right to provide—particular health care services, procedures, and treatments. As the court explained in *Preterm-Cleveland*, "[t]he plain language of subsections B and C of the HCFA is simple and clear[.] …[A]s a result of the HCFA, the Ohio Constitution contains a direct recognition of the fundamental nature of the right to freedom in health care decisions." *Preterm-Cleveland* TRO Order at 12–13.

The background and circumstances of the HCFA's adoption only bolster this conclusion. *See City of Centerville* ¶ 22 (a court may "review the history of the amendment and the circumstances surrounding its adoption, the reason and necessity of the amendment, the goal the amendment seeks to achieve, and the remedy it seeks to provide to assist the court in its analysis"). The HCFA was enacted against the backdrop of a nationwide debate over the federal Affordable Care Act ("ACA"). The HCFA was itself an effort to reject or undercut portions of the ACA based on perceived governmental interference in the relationship between physician and patient.[5]

[5] *See generally, e.g.*, *Opponents of health care law continue petition drive*, WFMJ21, (June 25, 2010) https://www.wfmj.com/story/12709736/opponents-of-health-care-law-continue-petition-

Proponents of the HCFA made clear that they were "attempting to draw a line in the sand and say that the federal government shouldn't get any further in between doctors and patients."[6] A board member of the HCFA's proponent committee wrote in a national publication that the HCFA was about freedom to choose health care, not merely to choose how to pay for it: "It's about freedom – the freedom of Ohioans and others to make some of the most important personal decisions they can make about their choice of health care *and* how to pay for it" (emphasis added).[7] Likewise, the committee's campaign manager declared that "[h]ealth care decisions should be made between patients and doctors. Not politicians and bureaucrats."[8] He stated further that the amendment would "allow voters to have a choice this fall if health care decisions should be made by patients and doctors or politicians in Washington D.C."[9]

In fact, the HCFA was designed to protect not only the right to choose standard-of-care health care—such as the well-established care at issue here—but also the right to choose alternative and innovative medicine and treatment. HCFA proponents specifically intended the amendment to protect against efforts to penalize or punish disfavored forms of health care. As the Hamilton County court found in *Preterm-Cleveland*:

Proponents of the HCFA argued that its passage would not 'further overcrowd our

---

drive; *Obama health care foes score big court win*, CBS News (Aug. 12, 2011), available at https://www.cbsnews.com/news/obama-health-care-foes-score-big-court-win/

[6] Aaron Marshall, *Opponents of Issue 3 say amendment would interfere with many Ohio laws*, The Plain Dealer (Sept. 1, 2011), available at https://www.cleveland.com/open/2011/09/opponents_of_issue_3_say_amend.html.

[7] Ed Meese & Jack Painter, *Ohio's battle for health care freedom*, Politico (Nov. 7, 2011), available at https://www.politico.com/story/2011/11/ohios-battle-for-health-care-freedom-067727.

[8] Robert Wang, *Issue 3 low-key, but has long reach*, The Repository (Oct. 30, 2011), available at https://www.cantonrep.com/story/news/politics/elections/issues/2011/10/30/issue-3-low-key-but/42071877007/.

[9] Jo Ingles, *Ohio court says anti-Obamacare amendment can be on November ballot*, Reuters (Aug. 12, 2011), available at https://www.reuters.com/article/us-ohio-obamacare/ohio-court-says-anti-obamacare-amendment-can-be-on-november-ballot-idUSTRE77B50V20110812/

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

Preterm-Cleveland TRO Order at 14 n.11 (emphasis added) (citing Maurice Thompson, 1851 Center, *Passage of Issue 3 will protect liberty, restrain health care costs, and preserve health care choice and privacy*, available at https://www.healthpolicyohio.org/wp-content/uploads/2014/01/1851_issue3essay.pdf (Sept. 29, 2011)).

2. The Health Care Ban is unconstitutional under Article I, Section 21

The Health Care Ban violates the HCFA. Gender-affirming health care is "health care" within any reasonable understanding of that term—and so soundly within that understanding that it is both covered by the prevailing clinical practice guidelines and standards of care, and supported by every major American medical association. Turban Aff. ¶ 13. Because puberty-delaying medication and hormone therapy to treat gender dysphoria are "health care," these treatments are necessarily protected by the HCFA. By prohibiting the use of those medicines for the purpose of providing gender-affirming health care, the Ban restricts the sale and purchase of widely accepted treatments for gender dysphoria, a serious medical condition. *See* Ohio Const. Art. I Sec. 21(B). And by threatening physicians who provide gender-affirming health care with government enforcement actions and professional discipline from the State Medical Board, the Ban also "impose[s] a penalty" for the sale or purchase of health care. Ohio Const. Art. I Sec. 21(C). In short, the Health Care Ban is the Ohio General Assembly's effort to substitute its own judgment for that of Ohio adolescents, their parents, and physicians —thus infringing on individual "freedom of choice in health care." *State ex rel. Liberty Council v. Brunner*, 125 Ohio St.3d 315, 2010-Ohio-1845, 928 N.E.2d 410, ¶ 57. That is precisely what the HCFA was enacted to prevent.

Nor can the government evade the HCFA by summarily declaring gender-affirming health care to be "experimental," as the title of the Health Care Ban suggests. To start, gender-affirming

health care is not experimental because it is not novel or unproven. Antommaria Aff. ¶ 28. Experimental treatments are interventions that have shown some promise as a cure and are administered to advance knowledge for the potential benefit of *future* patients. In contrast, gender-affirming care is provided to benefit *individual* patients and the treatment is modified based on their individual responses. But there are already ample studies supporting the benefits of gender-affirming care where medically indicated, which is why it is not an "experiment." To the contrary, it has long been the standard of care to treat gender dysphoria. *Id.*

Moreover, as its proponents repeatedly stated, the HCFA was intended to protect a broad swath of medical care, including "cutting-edge services [and] procedures" and even "alternative medicine." *Preterm-Cleveland* TRO Order at 14 n.11 (internal citation omitted). The HCFA's protection thus extends well beyond widely accepted treatments like puberty-delaying medicine and hormone therapy. At bottom, the HCFA removes politicians' authority to draw arbitrary lines defining what is or is not an accepted medical treatment. All "health care" is protected by the HCFA's plain terms, with only limited, statutorily defined exceptions: most notably, restrictions that were already in place as of March 19, 2010, and "laws calculated to deter fraud or punish wrongdoing in the health care industry." Ohio Const. Art. I Sec. 21(D).

Neither exception applies here. First, H.B. 68 was passed long after March 19, 2010, so it was not a restriction in place at the time.

Second, the phrase "deter fraud or … wrongdoing in the health care industry" has no bearing on the provision of gender-affirming health care. While the terms "fraud" and "wrongdoing" are not defined in the HCFA, if the General Assembly could dictate via statute that a particular form of health care is tantamount to "fraud" or "wrongdoing," then the HCFA would provide no protection at all for "health care." Tellingly, H.B. 68 does not categorically define any

particular medical intervention as "fraud" or "wrongdoing," on its own, and the legislative findings are silent on those points. There is no specific intervention—pharmaceutical or surgical—that the Health Care Ban categorically proscribes in the State of Ohio. Rather, it prohibits a specific subset of patients—transgender adolescents with gender dysphoria —from purchasing health care to treat their medical diagnosis, while allowing all other Ohioans, of any age, to purchase those same interventions. And the Ban's prospective prohibition still allows physicians to continue providing gender-affirming health care to adolescent Ohio residents who are already receiving it, as well as to all adults. *See* 2024 Sub.H.B. No. 68 (enacting R.C. 3129.02(B)).

Moreover, the study and provision of gender-affirming health care to treat adolescents with gender dysphoria pre-dates the HCFA. *See* Antommaria Aff. ¶ 28 ("The first reference to the use of GnRH analogs for the treatment of gender dysphoria in the medical literature was in 1998, over 25 years ago."). That the HCFA didn't exclude it from protection shows that it was covered. "The [HCFA] drafters could have excluded existing and future regulation of the health care profession … but they did not." *Preterm-Cleveland* TRO Order at 13–14.

In sum, the Health Care Ban both prohibits and penalizes the purchase and sale of health care and is therefore unconstitutional under the plain text, ordinary meaning, and avowed purpose of the HCFA.

C. Plaintiffs are likely to succeed on their equal protection claim

Plaintiffs are likely to succeed on their equal protection claim because the Health Care Ban is a sex-based classification that fails to satisfy strict scrutiny, meaning it is not narrowly tailored to serve a compelling state interest. Ohio's Equal Protection Clause broadly proclaims that "[a]ll political power is inherent in the people." Ohio Const., Art. I, Section 2. As such, the "Government is instituted for [the people's] equal protection and benefit," meaning "[the people] have the right to alter, reform, or abolish the same, whenever they may deem it necessary; and no special

privileges or immunities shall ever be granted, that may not be altered, revoked, or repealed by the general assembly." *Id.* The Ohio Equal Protection Clause has both "unique language" and an independent "historical background." *Stolz v. J & B Steel Erectors, Inc.*, 155 Ohio St.3d 567, 2018-Ohio-5088, 122 N.E.3d 1228, ¶28-29 (Fischer, J., concurring) (noting that Ohio's Equal Protection Clause predates its federal counterparty by 17 years). While the U.S. Constitution focuses on "proscriptions against taking or denying benefits," i.e. a check against government action, the Ohio Constitution is fundamentally oriented toward greater protections and elevates equal protection to one of the "foundational reasons for the existence of state government." *League of Women Voters of Ohio v. Ohio Redistricting Comm.*, 167 Ohio St.3d 255, 2022-Ohio-65, 192 N.E.3d 379, ¶ 151 (Brunner, J., concurring). In light of this difference, the Ohio Supreme Court has noted that it "can and will interpret [the Ohio] Constitution to afford greater rights to [Ohio] citizens" since it is "not confined by the federal courts' interpretation of similar provisions in the federal Constitution." *State v. Mole*, 149 Ohio St.3d 215, 2016-Ohio-5124, 74 N.E.3d 368, ¶ 21; *see also id.* ¶ 23 (holding that "the guarantees of equal protection in the Ohio Constitution independently forbid" certain conduct, regardless of federal constitutional protections).

The Health Care Ban violates the Ohio Constitution's sweeping commands. By prohibiting treatment if and only if that treatment is deemed to facilitate a "gender transition"—defined as allowing the "social, legal, or physical changes" involved in allowing someone to identify as a gender "different from" the patient's "biological sex—H.B. 68 classifies on the basis of sex in multiple ways. Because sex is a suspect classification, the Ban is subject to strict scrutiny, which requires the government to show that it is narrowly tailored to advance a compelling governmental interest. H.B. 68 fails that test.

1. The Health Care Ban classifies based on sex

The Healthcare Ban facially classifies based on sex in three ways. First, it classifies based

on an adolescent's sex designated at birth. Second, it classifies based on the incongruence between a person's gender identity and their sex designated at birth. Third, it conditions treatment based on the government's preferences about a person's sex—namely, that they live and identify with their sex designated at birth.

First, the Health Care Ban is a sex-based classification because it facially classifies based on sex designated at birth: whether an individual adolescent can access a particular medical intervention depends on their designated sex. In other words, a person's sex designated at birth is the but-for cause of the Health Care Ban's prohibition. Treatment is prohibited only when it relates to "gender transition," which is the "process in which an individual goes from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex." R.C. 3129.01(E). In each instance a physician must know and prohibit treatment based on whether an adolescent was designated male at birth or female at birth. Sex "plays an unmistakable" role when the government "penalizes a person identified as male at birth for traits or actions that it tolerates in [a person] identified as female at birth." *Bostock v. Clayton Cnty.*, 590 U.S. 644, 140 S. Ct. 1731, 207 L.Ed.2d 218, 659-663. That is precisely how the Ban operates. A person designated female at birth can obtain any medical intervention to affirm a female gender identity, regardless of whether it is to treat a medical diagnosis or for cosmetic purposes, but a person designated male at birth cannot, even with a diagnosis of gender dysphoria. *See* Corathers Aff. ¶ 72. That is precisely what the *Bostock* Court identified as a sex classification.

Second, the Ban classifies based on the incongruence between a person's sex designated at birth and their gender identity. Whether any medication or intervention is prohibited depends on whether the treatment is deemed consistent with the minor's designated sex at birth. "Gender

transition services" are defined by virtue of whether they "alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex, or to instill or create physiological or anatomical characteristics that resemble a sex different from the individual's birth sex…[or] promote the development of feminizing or masculinizing features in the opposite sex." Sec. 3109.054(F). By drawing a line based on the incongruence between a person's sex designated at birth and gender identity, the Ban "unavoidably discriminates against persons with one sex identified at birth and another today." *Bostock*, 590 U.S. at 669.

Finally, by hinging the prohibition on whether a particular intervention is typical of what is expected of a person designated a particular sex at birth, the law imposes a government preference for gender conformity. This is a "form of sex stereotyping where an individual is required effectively to maintain [their] natal sex characteristics." *Boyden v. Conlin*, 341 F. Supp. 3d 979, 97 (W.D. Wis. 2018); *cf. Kadel v. Folwell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020) (rule discriminates based on sex if it "tethers [people] to sex stereotypes which, as a matter of medical necessity, they seek to reject"). Indeed, the Health Care Ban specifically allows treatment for intersex conditions, also described as disorders of sex or sexual development, thus allowing parents to consent to any treatment—pharmaceutical or surgical—that would tether their child to their "biological sex." R.C. 3129.04.

Because the Health Care Ban classifies based on sex in multiple ways, it must survive strict scrutiny. Under this standard, the state has the burden of demonstrating that the law passed is narrowly tailored to a compelling government interest. They cannot do so here.

2. Sex-based classifications are subject to strict scrutiny

Under the Ohio Constitution, sex is a suspect class. *See, e.g.*, *Adamsky v. Buckeye Loc. Sch. Dist.*, 73 Ohio St.3d 360, 362, 1995-Ohio-298, 653 N.E.2d 212 ("[A] suspect class … has been defined as one involving race, national origin, religion, or sex."); *In re A.W.*, 5th Dist. Knox No.

15CA3, 2015-Ohio-3463, ¶ 23 ("Suspect classes include race, sex, religion, and national origin[.]"), *aff'd in part, appeal dismissed in part on other grounds*, 147 Ohio St.3d 110, 2016-Ohio-5455, 60 N.E.3d 1264 (Mem), *reconsideration denied*, 147 Ohio St.3d 1414, 2016-Ohio-7455, 62 N.E.3d 186 (Table). Sex-based classifications are therefore subject to strict scrutiny under the Ohio Constitution. *See Arbino v. Johnson & Johnson*, 116 Ohio St.3d 468, 2007-Ohio-6948, 880 N.E.2d 420, at ¶ 64.[10]

3. The Health Care Ban cannot survive strict scrutiny because it is not narrowly tailored to advance a compelling state interest

None of the reasons set forth in H.B. 68's legislative findings justify singling out gender-affirming medical care for prohibition. And, in fact, the Health Care Ban undermines, rather than advances, the government's interest in protecting the health and safety of children. To survive strict scrutiny, the Health Care Ban must be narrowly tailored to serve a compelling state interest. *See Groch v. Gen. Motors Corp.*, 117 Ohio St.3d 192, 2008-Ohio-546, 883 N.E.2d 377, ¶ 155; *see also Rowitz v. McClain*, 2019-Ohio-5438, 138 N.E.3d 1241, ¶ 19 (10th Dist.). Strict scrutiny places a "heavy" burden of proof on the state—a burden the State cannot satisfy here. *Crowe v. Owens Corning Fiberglass*, 8th Dist. Cuyahoga No. 73206, 1998 WL 767622, *4 (Oct. 29, 1998), aff'd, 87 Ohio St.3d 204, 1999-Ohio16, 718 N.E.2d 923 (Mem).

a) The legislative findings reveal that the Ban is not supported by a compelling state interest

[10] That is a higher level of judicial scrutiny than similar classifications under the U.S. Constitution. Under the Fourteenth Amendment to the U.S. Constitution, "heightened scrutiny" applies to gender-based classifications, including those that purport to classify based on physical differences between the sexes. *See United States v. Virginia*, 518 U.S. 515, 555, 116 S.Ct, 2264, 135 L.Ed.2d 735 (1996) ("*VMI*"); *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 n.9, 102 S.Ct. 3331, 73 L.Ed. 1090 (1982). The Ohio Constitution must, at a minimum, provide the same protection, but it in fact goes beyond the level of protection provided under the U.S. Constitution. *See State v. Broom*, 146 Ohio St.3d 60, 2016-Ohio-1028, 51 N.E.3d 620, ¶ 55 ("The United States Constitution provides a floor for individual rights and civil liberties, but state constitutions are free to accord greater protections.").

To start, the Ban does not serve a compelling state interest. The legislative findings in Section 2 assert that the "state has a compelling government interest in protecting the health and safety of its citizens, especially vulnerable children." H.B. 68 (Sec. 2(A)). That is a compelling interest, but the Ban itself does not protect the health or safety of any minors, and in fact inflicts great harm transgender adolescents by depriving them of the only evidence-based medical care for gender dysphoria. Moreover, the legislative findings contained in the Health Care Ban are wholly unsupported by evidence, riddled with factual errors, and rest on misleading claims.

Evidence Base: There is ample evidence that gender-affirming medical care is both safe and effective at alleviating gender dysphoria in adolescents and young adults. Antommaria Aff. ¶¶ 27-29. Longitudinal and cross-sectional studies support the efficacy and effectiveness of puberty blockers and gender-affirming hormones for the treatment of adolescents with gender dysphoria, and experts in the field are confident regarding the positive mental health impacts of these treatments. Turban Aff. ¶ 35. Contrary to legislative finding (F), *see* H.B. 68 (Sec. 2(F)), longitudinal studies examining mental health before and after gender-affirming medical interventions have found that mental health is improved after treatment. Turban Aff. ¶ 35. Controlled cross-sectional studies compared those who accessed gender-affirming medical care to those who desired but did not access this treatment and found that people who accessed treatment had better mental health outcomes than those who did not. *Id.* These studies are well-accepted in medical research and often relied upon in medicine, especially when it is neither feasible nor ethical to conduct randomized controlled trials. *Id.* at ¶ 36. With respect to legislative finding (G) regarding the absence of randomized controlled trials for the provision of hormone therapy to adolescents with gender dysphoria, *see* H.B. 68 Sec. 2(G), randomized controlled trials are not feasible or ethical: the evidence supporting gender-affirming care is already so strong that it would

be difficult to recruit people to accept a placebo instead, and for pediatric populations, it is not considered ethical to randomize patients to placebo treatments when there is substantial evidence that active treatment confers important benefits. Turban Aff. ¶ 36. Moreover, the existing studies supporting the efficacy of care are supplemented by decades of clinical experience from experts around the world, and in Ohio, who have seen the substantial clinical benefits that their adolescent patients with gender dysphoria have experienced from gender-affirming medical treatment. Turban Aff. ¶ 36; Corathers Aff. ¶ 66, 69.

Efficacy: Gender-affirming medical care relieves gender dysphoria in adolescents and improves mental health outcomes. Turban Aff. ¶ 14. It is the only evidence-based intervention to treat gender dysphoria. *Id.* at ¶ 18. The legislative finding (E) that certain negative health outcomes are more common after gender-affirming surgery, *see* H.B. 68 (Sec. 2(E)), is misleading and irrelevant to the provision of puberty-delaying medications and hormone therapy to adolescents. First, surgery is a red herring. Plaintiffs are not seeking access to surgery, and the major multidisciplinary gender clinics in Ohio do not provide gender-affirming surgery to minors in Ohio. Corathers Aff. ¶ 69 n.9; *id.* at ¶ 75 n.12. Second, mental health improves following gender-affirming medical care for adolescents with gender dysphoria. Turban Aff. ¶ 34; Corathers Aff. ¶ 46. Third, transgender people face a range of stressors that affect their mental health, most prominently societal rejection based on being transgender, which can lead to elevated rates of mental health problems compared to cisgender people, even after receiving gender-affirming care. Turban Aff. ¶ 34. Banning gender-affirming medical care because it does not resolve all potentially co-occurring mental health diagnoses is no more logical than prohibiting psychiatric medications for treating depression or anxiety simply because all symptoms do not completely abate in every patient. *Id.* at ¶ 34. Similarly, legislative findings (N) and (O), *see* H.B. 68 (Secs. 2(N)-(O)) are

incorrect to the extent they claim there is a lack of sufficient studies or that risks outweigh benefits. *Id. at* ¶ 37. To the contrary: gender-affirming medical care is the standard of care for gender dysphoria precisely because, where medically-indicated, the benefits of providing treatment outweigh the risks, which include deteriorating mental health from allowing gender dysphoria to go untreated. *Id.* at ¶ 23.

Risks of Side Effects: There is nothing uniquely risky about the care provided to transgender minors to treat gender dysphoria when compared to any other type of health care. Notably, the endocrine treatments prohibited by the Ban are used to treat other conditions and carry comparable risks and side effects regardless of the indication for which they are prescribed. Corathers Aff. ¶¶ 70-72. Many of the potential risks and side effects of hormone therapy are the same or similar for cisgender and transgender patients. Corathers Aff. ¶ 65. Contrary to legislative finding (H) regarding the risks of gender-affirming hormone therapy, *see* H.B. 68 (Sec. 2(H)), the majority of potential side effects are tied to genetic and behavioral risk factors, not the medications themselves. *Id.* at ¶ 64. The risks and side effects of gender-affirming medical care are rare, manageable through clinical monitoring, and disclosed via informed consent. *Id.* at ¶ 58. Many people with gender dysphoria are on hormone therapy for decades and there is no evidence that negative health outcomes outweigh the substantial benefits. Corathers Aff. ¶ 71.

The Standards of Care: Prior to initiating gender-affirming care, the standards of care require a biopsychosocial mental health assessment, which can be extended for youth with complex mental health histories, autism, or other co-occurring diagnoses. Turban Aff. ¶ 33. Contrary to legislative finding (D), *see* H.B. 68 (Sec. 2(D)), which misrepresents the model of gender-affirming care, adolescents with gender dysphoria also receive evaluation and treatment for other co-occurring mental health conditions, which are considered alongside potential gender

dysphoria diagnoses. Turban Aff. ¶ 33. These assessments distinguish other mental health conditions from gender dysphoria and help determine whether gender-affirming medical interventions are appropriate. *Id.* Further, while psychotherapy can be very helpful for adolescents with gender dysphoria to help explore their gender identity and address other mental health conditions, there are no evidence-based psychotherapy protocols that effectively treat gender dysphoria itself. Turban Aff. ¶¶ 18, 33.

Pre-adolescents: Only at the onset of puberty do adolescent patients with gender dysphoria become candidates for gender-affirming medical care. Corathers Aff. ¶ 42. Once transgender youth begin puberty—the earliest point in time where a medical intervention might be considered—it is extremely rare for them to later identify as cisgender. Turban Aff. ¶ 23. Legislative finding (C), *see* H.B. 68 (Sec. 2(C)), is extraordinarily misleading in suggesting otherwise by referencing children who have not yet reached puberty. Turban Aff. ¶ 32. Because prepubertal children are not candidates for gender-affirming medical interventions under current guidelines, studies regarding prepubertal children and their likelihood of ultimately identifying as transgender should not be used to assess medical interventions that are provided only to adolescent patients. *Id.* at ¶ 22-25, 32.

Ultimately, the Health Care Ban does not serve a compelling government interest in protecting the health and well-being of minors because it does the opposite: it endangers minors by prohibiting the only evidence-based treatment for a serious medical condition. Turban Aff. ¶ 38; Corathers Aff. ¶¶ 73-76; Antommaria Aff. ¶¶ 50, 63.

The personal experiences of the Moe family illustrate how this treatment positively transforms the lives of the adolescents who need it: Madeline is a thriving twelve-year-old girl because she was able to access puberty-delaying medication when she needed it, and when her

parents and her doctors decided with her that such treatment was appropriate. Only puberty-delaying medication is capable of preventing Madeline from going through male puberty, which would immensely exacerbate her gender dysphoria. Only hormone therapy in the form of estrogen will allow her, at the appropriate time, to begin female puberty and continue to grow into a young woman. Depriving Madeline of this care will prevent her from continuing to live her life with her loving family in her supportive community. The Goe family wants that same opportunity for their daughter: they want Grace to avoid the debilitating symptoms of gender dysphoria and continue living her life as a girl. Grace is poised to start puberty at any time; when it happens, only puberty-delaying medication and later estrogen can bring her body into alignment with her gender. Rather than harming these adolescents, gender-affirming care has enabled them to thrive or provided them with hope for their futures. The Health Care Ban fails strict scrutiny because it endangers, rather than protects, transgender minors like Grace Goe and Madeline Moe.

b) The Health Care Ban is not narrowly tailored

Moreover, the Health Care Ban is not narrowly tailored to address the legislature's purported concerns about safety, efficacy, reversibility, or fertility with respect to surgical interventions, as set forth in legislative findings (E), (I), (J), (K), (L), and (N). *See* H.B. 68 (Sec. 2(E), (I)-(L), (N)). None of these findings have any bearing on the provision of puberty-delaying medication or hormone therapy, which are the most common interventions provided to minors. Surgical interventions are very rare. *See* Corathers Aff. ¶ 69 n.9. The Health Care Ban nonetheless prohibits the vast majority of care provided to transgender adolescents in the form of puberty-delaying medication or hormone therapy, neither of which implicate the concerns in those legislative findings about surgical frequency, outcomes, reversibility, or infertility. There is a profound disconnect between these legislative findings about surgery and the ban on puberty-delaying medication and hormone therapy. Medication and hormonal treatment do not invoke any

of those concerns, which are specific to surgical intervention.

Further, the exceptions in the Health Care Ban itself reveal the lack of narrow tailoring: none of the surgical interventions listed in the law are prohibited based on evidence of safety, efficacy, reversibility, or fertility: they are banned when provided "for the purpose of assisting an individual with gender transition" or to "alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex." R.C. 3109.054(C). Under the Health Care Ban, surgeons in Ohio remain free to provide irreversible and sterilizing surgeries, regardless of the evidence for efficacy, to treat any "disorder of sex development." Antommaria Aff ¶ 56. The Health Care Ban explicitly protects a parent's right to make any decision that aligns with biological sex, but not treatment that departs from it: physicians are not prohibited from treating intersex conditions, also known as "disorder[s] of sex[ual] development," R.C. 3129.04(A) , or when an individual "does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a biological male or female." *id.*, R.C. 3129.04(B). The legislative findings are at odds with the contours of the Ban.

Contrary to the Ban's legislative findings, the provision of gender-affirming medical care is consistent with professional medical standards, developed based on rigorous review of existing evidence and comparable to the types of guidelines used to treat other conditions. Corathers Aff. ¶¶ 66-72; Turban Aff. ¶¶ 12-21; Antommaria Aff. ¶¶ 16-36. Peer-reviewed longitudinal and cross-sectional studies have shown that the treatments prohibited by the Ban are safe and effective, and the legislative findings greatly exaggerate the risks associated with the care. Antommaria Aff. ¶¶ 31-35. The overwhelming consensus of the medical community, based on research and clinical experience, is that gender-affirming medical care greatly improves the health and well-being of adolescent patients with gender dysphoria. Corathers Aff. ¶¶ 66-72; Turban Aff. ¶¶ 12-21;

Antommaria Aff. ¶¶ 16-36. This care reduces symptoms of anxiety, depression, and suicidality, and improves health outcomes for adolescent patients. Corathers Aff. ¶ 73; Turban Aff. ¶¶ 14-19; Antommaria Aff. ¶ 43.

D. Plaintiffs are likely to succeed on their due course of law claim

The Health Care Ban violates Article I, Section 16 of the Ohio Constitution by infringing the Parent Plaintiffs' fundamental right to seek appropriate medical care for their children. As such, it is subject to strict scrutiny—a standard it cannot satisfy. *See supra*, pp. 31-35.

1. The Parent Plaintiffs' due process claims are subject to strict scrutiny

Under the Ohio Constitution, parents have a "fundamental liberty interest … in the custody, care and control of their children." *In re S.H.*, 9th Dist. Medina No. 13CA0066-M, 2013-Ohio-4380, 2013 WL 5519847, ¶ 13 (Oct. 1, 2013). This interest extends to parents' right to make medical decisions for their children, including, "within reason, whether and what type of medical care the child will receive." *In re I.S.*, 2022-Ohio-3923, 199 N.E.3d 1130, ¶ 102 n.8, (8th Dist.). The U.S. Constitution is in accord. *See* supra, p. 31 n.10 (recognizing that state constitutional protections must, at a minimum, track analogous federal protections). As the U.S. Supreme Court has recognized, fundamental liberty interests include parents' rights to make decisions "concerning the care, custody, and control of their children," based on a "presumption" that "fit parents act in the best interests of their children." *Troxel v. Granville*, 530 U.S. 57, 66, 68, 120 S.Ct. 2054, 147 L.Ed.2d 49 (2000). Indeed, this right is "perhaps the oldest of the fundamental liberty interests recognized by [the] Court." *Id.* at 65; *see also Parnham v. J.R.*, 442 U.S. 584, 602, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1979) (collecting cases).

Because any restriction of parents' rights in this area "infringe[s] upon a fundamental right," the restriction must satisfy strict scrutiny. *Stolz*, 155 Ohio St.3d 567, 2018-Ohio-5088, 122 N.E.3d 1228, ¶ 14; *see also Pre-Term Cleveland* TRO Order at 12 ("governmental action that

limits the exercise of a fundamental constitutional right is subject to the highest level of judicial scrutiny"). The government cannot "infringe certain 'fundamental' liberty interests at *all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302, 113 S.Ct. 1439, 123 L.Ed.2d 1 (1993); *see also Middleton v. City of Flint*, 92 F.3d 396, 404 (6th Cir. 1996) (where a fundamental right is burdened, government must show "a compelling state interest," and "that the plan is narrowly tailored to further" that interest). The Ban fails this standard.

2. The Health Care Ban cannot survive strict scrutiny

As discussed above and below, the Ban cannot survive any level of review, and thus necessarily fails the strict scrutiny that governs state intrusions into fundamental rights. In addition to the reasons discussed above, the Ban fails strict scrutiny because Ohio's chosen means are nowhere near the "least restrictive." *See Bernal v. Fainter*, 467 U.S. 216, 219, 104 S.Ct. 2312, 81 L.Ed.2d 175 (1984). Nothing about the Ban is narrowly tailored to *any* interest, compelling or not. Rather than address the Legislature's purported concerns, the Ban simply rules out *any* new courses of medical treatment for gender dysphoria in adolescents.

Moreover, where Ohio courts have deprived parents of this fundamental right, it has been in rare cases where "parents cannot or will not consent to" affirmatively *provide* treatment for a minor's significant (typically life-threatening) medical condition. *In re I.S.*, 2022-Ohio-3923, 199 N.E.3d 1130, ¶ 102 (8th Dist.); *see also In re S.H.*, 9th Dist. Medina No. 13CA0066-M, 2013-Ohio-4380, 2013 WL 5519847, ¶ 25 (noting that "the state that can intervene and *order* medical procedures for a child against their parents' wishes under certain circumstances") (emphasis added); *In re Willmann*, 24 Ohio App. 3d 191, 198-99, 493 N.E.2d 1380 (1st Dist. 1986) (appointing temporary custodian where parents disagreed with consensus of physicians and surgeons that son needed treatment for cancer). But there is no authority supporting the State's

authority to take this decision away from parents when the parents, the adolescent child, and medical professional are all aligned in the view that treatment will be beneficial.

3. The Health Care Ban fails any level of review

Although the Ban is properly subject to strict scrutiny, it ultimately fails any level of review. At minimum, the law's "classification [must] be rationally related to a legitimate government purpose." *Thorp v. Strigari*, 155 Ohio App.3d 245, 2003-Ohio-5954, 800 N.E.2d 392, ¶ 15. What this law does, however, is "so far removed from [the asserted] justifications that it [is] impossible to credit them." *Romer v. Evans*, 517 U.S. 620, 635, 116 S.Ct. 1620, 134 L.Ed.2d 855 (1996). Rather than protect children, the Ban harms them.

There is no rational basis to conclude that allowing adolescents with gender dysphoria to receive gender-affirming medical care that they, their parents, and their doctors agree is medically necessary "would threaten legitimate interests of [Ohio] in a way that" allowing other types of care "would not." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 448 105 S.Ct. 3249, 87 L.Ed.2d 313 (1985); *see also Eisenstadt v. Baird*, 405 U.S. 438, 452, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972) (health risks of birth control pills not a rational basis for banning access for unmarried people while allowing for married people). Even under rational basis review, the justifications for the Ban "ma[k]e no sense in light of how the [statute] treat[s] other [procedures] similarly situated in relevant respects." *Bd. of Trust. Of Univ. of Ala. V. Garrett*, 531 U.S. 356, 366 n.4, 121 S.Ct. 955, 148 L.Ed.2d 866 (2001). Notably, an improper motive for legislation "rises not from malice or hostile animus alone," but "may result as well from insensitivity caused by simple want of careful, rational reflection or from some instinctive mechanism to guard against people who appear to be different in some respects from ourselves." *Id.* at 374 (Kennedy, J., concurring). That is precisely the case here. Indeed, the entirety of H.B. 68—both the Health Care Ban and Sports Prohibition—is concerned with limiting rights for transgender people. Regardless of the intent

behind those two Acts, the targeting of transgender people for unique restrictions it is not a proper legislative purpose.

II. Plaintiffs Will Suffer Irreparable Harm Absent Injunctive Relief.

If permitted to go into effect, the Ban will inflict on Plaintiffs severe and irreparable harm for which no adequate remedy at law exists. To start, "[a] finding that a constitutional right has been threatened or impaired mandates a finding of irreparable injury as well." *Magda v. Ohio Elec. Comm.*, 58 N.E. 3d 1188, 2016-Ohio-5043, ¶ 38 (10th Dist.) (citing *Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir. 2001)). As shown above, Plaintiffs are substantially likely to succeed in demonstrating that H.B. 68 violates four distinct provisions of the Ohio Constitution: the single-subject rule, the Health Care Freedom Amendment, the Equal Protection Clause, and the Due Course of Law provision. Those constitutional injuries constitute irreparable harm as a matter of law.

But the irreparable harm here is much more dire: allowing the Health Care Ban to go into effect will immediately deny patients life-saving medical care and force families to watch their children suffer or uproot their lives in Ohio. Grace Goe is twelve years old; she has been living as a girl since she was five. Goe Aff. ¶¶ 4,9. Her life as a girl is all she and her community know. As puberty approaches and her distress at the potential for permanent changes to her body increase, it is likely that the only way to preserve her health will be the puberty-delaying medication consistent with the medical standard of care, if recommended by her doctors. But the Health Care Ban prevents her from receiving that treatment, contrary to her wishes, her parents' considered judgment, and her doctors' recommendations. To undergo puberty inconsistent with her gender identity would be extraordinarily distressing: developing facial and body hair, a deepening voice, and an Adam's apple, would be profoundly disturbing. For transgender adolescents like Grace, the development of these unwanted sex characteristics exacerbates gender dysphoria and risks their

mental health, including increased anxiety and depression, and, potentially, suicidality. Corathers Aff. ¶ 73; Turban Aff. ¶¶ 14-19; Antommaria Aff. ¶ 43. If Grace is forced to develop these characteristics, they may be difficult, if not impossible to eliminate when she is an adult. Corrathers Aff. ¶ 41. But in the absence of an injunction, Grace will be forced to do exactly that, causing irreparable harm to her well-being.

Madeline Moe, meanwhile, has already been on puberty-delaying medication for approximately one year, and she and her parents anticipate that, at the appropriate time, they will want to consult with Madeline's doctors about whether hormone therapy is medically indicated for her gender dysphoria. Moe Aff. ¶ 17. Remaining on puberty-delaying medication indefinitely is not an option. Corathers Aff. ¶ 75. Her treating physician, however, has already informed Madeline and her parents that as a result of the Health Care Ban, while he can continue prescribing specific medications or treatments that have already commenced, he cannot prescribe hormone therapy in the form of estrogen, which would be the appropriate medication to treat her if her distress continues. Corathers Aff. ¶¶ 43-46. Absent injunctive relief, Madeline will be unable to continue the course of care recommended by her physician to treat her gender dysphoria, leading to risks of suicidality and self-harm. Moe Aff. ¶ 16. Being unable to start estrogen before she turns eighteen means that she will not develop as a young woman alongside her peers, and it is medically untenable for her to remain on puberty-delaying medication for such a prolonged period of time. But if she stops puberty-delaying medication without being able to begin hormone therapy, she will start male puberty. For the girl who had "want[ed] to die and come back as a girl," pleading with God to make her a girl, this would be profoundly disturbing. "Even the thought of growing facial and body hair, developing an Adam's apple, or her voice deepening distresses her." Moe Aff. ¶ 15. For Madeline, without injunctive relief, her distressing fear would become her reality.

Untreated, her gender dysphoria will lead to substantial deterioration of her mental health. For many patients, this is likely to include worsening suicidality. Corathers Aff. ¶ 73; Turban Aff. ¶¶ 14-19; Antommaria Aff. ¶ 43. Absent injunctive relief, Madeline will be deprived of the opportunity to benefit from the one effective treatment to reduce the anxiety, depression, and suicidality that stems from gender dysphoria, and to increase her potential for life satisfaction. *See id.*

III. No Third Parties Will Be Unjustifiably Harmed By The Requested Relief.

Injunctive relief will not result in any harm—let alone unjustifiable harm—to third parties. In stark contrast to the deeply personal and irreparable harms Plaintiffs face, an injunction would merely preserve the status quo while Plaintiffs pursue their claims. Prior to H.B. 68 and the Health Care Ban, physicians in Ohio were permitted to provide gender-affirming medical care to adolescents when parents provided informed consent, adolescents provided assent, and in the physicians' clinical judgment, such interventions were medically indicated to alleviate gender dysphoria. Such medical care was provided in accordance with rigorous guidelines, informed by decades of research and clinical experiences. Corathers Aff. ¶¶ 66-72; Turban Aff. ¶¶ 12-21; Antommaria Aff. ¶¶ 16-36. And, importantly, the decision about whether to provide such treatments ultimately rested with parents, not the State of Ohio. Ensuring that parents remain the decision-makers for their adolescent children's health care, and that health care remains available for adolescents cannot, in itself, cause unjustifiable harm to anyone. Moreover, even without H.B. 68 and the Health Care Ban, physicians and patients in Ohio can rely on the full range of professional and legal safeguards, such as professional practice standards and other protections against negligence and malpractice.

Nor would the government be unjustifiably harmed. H.B. 68's Health Care Ban is unconstitutional, for the reasons discussed above. The government can suffer no "unjustifiable"

harm or injury merely because an unconstitutional statute is enjoined. Nor is the government harmed by families—that is, parents, their adolescent children, and their physicians—making individualized decisions about the appropriate course of medical care for gender dysphoria.

IV. The Public Interest Weighs In Favor of Injunctive Relief.

"[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *G & V Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994). The public also has a strong interest in preventing discrimination against a vulnerable class of individuals, such as transgender adolescents. *See, e.g.*, *Dodds v. U.S. Dep't of Educ.*, 845 F.3d 217, 222 (6th Cir. 2016) (public interest weighed "strongly" against staying an injunction, when a stay would have allowed continued discrimination against a student based on gender identity). Injunctive relief from this Court would serve both of these interests.

Moreover, halting the Health Care Ban will serve the pressing interests of any number of transgender adolescents who, like Plaintiffs, fear the loss or deprivation of critical health care. As Governor DeWine explained when vetoing H.B. 68, "[m]any parents have told me that their child would be dead today if they had not received the treatment they received from an Ohio children's hospital. I have also been told, by those that are now grown adults, that but for this care, they would have taken their lives when they were teenagers." Gov. Mike DeWine, *Statement of the Reasons for the Veto of Substitute House Bill 68*, available at https://content.govdelivery.com/attachments/OHIOGOVERNOR/2023/12/29/file_attachments/2731770/Signed%20Veto%20Message%20HB%2068.pdf (Dec. 29, 2023).

Finally, as Governor DeWine also acknowledged, it is in the public interest for parents to be able to make health care decisions on behalf of their children: "Were I to sign [H.B. 68] or were [it] to become law, Ohio would be saying that the State, that the government, knows what is best medically for a child rather than the two people who love that child the most, their parents." *Id.*

H.B. 68 denies parents that autonomy and privacy, and the public thus has a strong interest in enjoining the statute.

V. The Injunction Should Issue Without Bond

This Court has broad discretion under Civ. R. 65(C) to waive the bond requirement. *See Vanguard Transp. Sys. Inc. v. Edwards Transfer & Storage Co., Gen. Commodities Div.*, 109 Ohio App.3d 786, 793, 673 N.E.2d 182 (10th Dist. 1996) (recognizing courts have discretion to issue preliminary injunctions without requiring bond). The Court should exercise that discretion here, where the relief sought will result in no monetary loss to Defendants. *See Molton Co. v. Eagle-Picher Indus.*, 55 F.3d 1171, 1176 (6th Cir. 1995) (affirming decision to waive bond because of "the strength of [the plaintiff's] case and the strong public interest involved"); *Preterm-Cleveland v. Yost*, 394 F.Supp.3d 796, 804 (S.D. Ohio 2019) (waiving bond).

CONCLUSION

For the foregoing reasons, Plaintiffs ask that this Court enter a temporary restraining order and/or preliminary injunction as follows:

1. Enjoining implementation and enforcement of H.B. 68 in its entirety, on the basis that it violates Article II, Section 15(D) of the Ohio Constitution; or
2. In the alternative, enjoining implementation and enforcement of H.B. 68's Health Care Ban, including its prohibition on the prescription of "cross-sex hormone[s] or puberty-blocking drug[s] for a minor individual for the purpose of assisting the minor individual with gender transition," its prohibition on "[e]ngag[ing] in conduct that aids or abets" in the same, its authorization of Defendant Yost to "bring an action to enforce compliance" with these restrictions, and its provision that any violation of these sections "shall be considered unprofessional conduct and subject to discipline by" the Defendant State Medical Board. *See* 2024 Sub.H.B. No. 68 (enacting R.C.

3129.02(A)(2)–(3); R.C. 3129.05(C); R.C. 3129.05(A)).

Respectfully submitted,

/s/ Freda J. Levenson

Freda J. Levenson (45916)
Trial Attorney
Amy Gilbert (100887)
ACLU OF OHIO FOUNDATION, INC.
4506 Chester Avenue
Cleveland, Ohio 44103
Levenson: (216) 541-1376
Office: (614) 586-1972
flevenson@acluohio.org
agilbert@acluohio.org

David J. Carey (88787)
ACLU OF OHIO FOUNDATION, INC.
1108 City Park Ave., Ste. 203
Columbus, Ohio 43206
(614) 586-1972
dcarey@acluohio.org

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

Miranda Hooker*
Kathleen McGuinness*
Jordan Bock*
GOODWIN PROCTER LLP
100 Northern Avenue
Boston, MA 02210
(617) 570-1000
mhooker@goodwinlaw.com
kmcguinness@goodwinlaw.com
jbock@goodwinlaw.com

Allison DeLaurentis*
GOODWIN PROCTER LLP
One Commerce Square
2005 Market Street, 32nd Floor
Philadelphia, PA 19103
(445) 207-7800
adelaurentis@goodwinlaw.com

Lora Krsulich*
GOODWIN PROCTER LLP
601 S Figueroa St., 41st Floor
Los Angeles, CA 90017
(213) 426-2500
lkrsulich@goodwinlaw.com

**PHV motion forthcoming*

Counsel for Plaintiffs Madeline Moe, by and through her parents and next friends, Michael Moe and Michelle Moe; Michael Moe; Michelle Moe; Grace Goe, by and through her parents and next friends, Garrett Goe and Gina Goe; Garrett Goe; and Gina Goe

CERTIFICATE OF SERVICE

I hereby certify that on March 26, 2024, the foregoing was electronically filed via the Court's e-filing system. I further certify that a copy of the foregoing was served by email upon the following parties:

DAVID YOST, Attorney General of Ohio
THE STATE OF OHIO
Julie.Pfeiffer@OhioAGO.gov

STATE MEDICAL BOARD OF OHIO,
Kim.Rothermel@Med.Ohio.gov

I further certify that a copy of the foregoing was served by the clerk via certified mail and upon the following parties:

DAVID YOST,
Attorney General of Ohio
30 E. Broad Street, 14th Fl.
Columbus, OH 43215,

STATE MEDICAL BOARD OF OHIO,
30 E. Broad Street, 3rd Fl.
Columbus, OH 43215,

and

THE STATE OF OHIO
c/o Attorney General Dave Yost
30 E. Broad Street, 14th Fl.
Columbus, OH 43215.

/s/ Freda J. Levenson
Trial Attorney for Plaintiffs