

Academy of Medicine of Cleveland/Northern Ohio Medical Association

Legislative Update

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House Bills

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House Bill 27 – Testing Pregnant Women for HIV

Representative Mary Cirelli (D – Canton)

House Health Committee – Hearing 3/26/03

Position: Support with Technical Assistance, but only if third party payers pay for this (or the State pays for uninsured)

House Bill 27 would require physicians to offer pregnant women the opportunity to have HIV testing and counseling at the time of the first examination or within 10 days thereof. The physician would be required to offer to take a venous blood sample for HIV testing and be required to counsel the patient about the availability of treatment if the woman tests HIV positive.

If the patient refuses the HIV testing, the physician would be required to take reasonable steps to obtain a written statement of her objection, which would be signed by the patient. A provision is included in the bill making the physician who attends a pregnant patient who refuses HIV testing from being immune from liability arising out of or related to the contracting of HIV infection or AIDS by the child of the patient.

House Bill 33 – Mental Health Parity

Representative Lynn Olman (R – Maumee)

House Insurance Committee – Sponsor hearing on 4/29/03; at the hearing on 5/6/03, Dr. S. R. Thorward testified as a proponent; at the hearing on 5/20/03, Kirby Neilsen of the Ohio Association of Health Underwriters and Jenny Baader of Baader Brown Manufacturing Company opposed the bill. At the hearing on 6/10/03, the following individuals testified as proponents of the legislation: Dr. Dennis Eary, an attorney with the Ohio State University Medical Center’s Talbot Hall Substance Abuse Center; Denise Nichols, an individual suffering from a bi-polar disorder; and Dr. Virginia Haller, the Medical Director with Ohio Department of Health.

At the hearing on 6/17/03, Terry Russell, the Executive Director of NAMI, and Robert Meyer with the Ohio State University, testified as proponents. John Ruhlin, representing the National Federation of Independent Businesses and Kelly McGivern, the Executive Director of the Ohio Association of Health Plans, testified as opponents.

Position: Neutral – Support concept, but not fiscally responsible to mandate this at this time

House Bill 33 would prohibit discrimination in health care insurance policies, contracts and agreements in the coverage provided for the diagnosis, care, and treatment of mental illness and substance abuse or addiction. This bill would make mental health services and services for alcohol and drug abuse or addiction basic health services, instead of supplemental health services.

House Bill 57 – Mental Health Discrimination

Representative Jamie Callender (R – Willowick)

House Insurance Committee – Sponsor hearing 5/13/03

Position: Neutral

House Bill 57 prohibits discrimination in health care policies, contracts and agreements in the coverage provided for the diagnosis, care and treatment of mental illness. This bill also permits the State Board of Psychology to license psychological associates to practice associate psychology. The “Practice of Associate Psychology” means rendering or offering to render to individuals, groups, organizations, or the public, psychological procedures that are within the nature and extent of psychological associates’ training and experience as identified by the State Board of Psychology in rules adopted.

A psychological associate would need to have received a master’s degree in clinical psychology, counseling psychology, or a field the Board of Psychology considers equivalent to clinical or counseling psychology and at least two years of post master’s degree supervised professional experience in psychological work of a type satisfactory to the Board.

House Bill 68 – Termination of Life

Representative Keith Faber (R – Celina)

House Health and Family Services Committee – Hearings held 3/24/2004, 5/5/2004, and 5/12/2004.

Position: Neutral

House Bill 68 prohibits a person from having to perform or participate in medical procedures or the distribution of any medication which will or may result in abortion or termination of life, and refusal to perform or participate in the medical procedures or distribution of medication is not grounds for civil liability nor a basis for disciplinary or other recriminatory action. Violation of this provision incurs liability in civil damages.

House Bill 71 - Ownership of Specialty Hospitals

Representative Jon Peterson (R – Delaware)

Senate Health, Human Services and Aging Committee – Hearing held 12/3/2003

House Health and Family Services Committee – Hearing 3/12/03; at the hearing on 4/30/03, testifying in opposing to the bill were Dr. Carl Berasi, a physician investor in the New Albany Surgical Hospital; Tim Maglione, Ohio State Medical Association; Ken Howell, CEO of the Dayton Heart Hospital; and Dr. Ajay Mangal with the Butler County Surgical Center. Testifying in support of the legislation at the 4/30/03 hearing were Nick Baird, Director of the Ohio Department of Health; Larry Anstine, OSU Hospital East; Dr. David Yashon, a neurosurgeon from Columbus, and Mike Geyer, an Attorney with Bricker and Eckler law firm representing the Ohio Hospital Association.

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At the hearing on 6/25/03, Mary Gallagher of the Ohio Hospital Association, Joe Calvaruso, the CEO of Mount Carmel Health System, Mary Jo Welker, M.D., with the Ohio State University Department of Medicine, and Cathy Levine, the Executive Director of Universal Health Care Action Network of Ohio, spoke in favor of the legislation. Testifying in opposition to the legislation were Harvey Yampolsky, a health lawyer with a Washington, D.C. firm, and Dennis Kelly, the Executive Vice President of MedCath Corporation.

At the hearing on 8/12/03, Dr. Timothy Duffey, an orthopedic surgeon, and Robert Comer, a patient at the Dayton Heart Hospital, testified in opposition to the bill. Testifying in favor of the bill were Terry Brook, a lawyer representing the Ohio Hospital Association, and Ken Hanover, CEO of the Greater Cincinnati Health Alliance.

The bill was substituted, amended and reported at the hearing on 9/17/03. The bill passed the Ohio House of Representatives by a vote of 72 –23 on 9/18/03.

Position: Active Opposition

House Bill 71 will prohibit a physician or podiatrist from making certain referrals for inpatient hospital services and to make other revisions to the law prohibiting certain referrals for designated health services. As substituted in the Ohio House, the bill provides the following:

- Two year halt for new projects related to for-profit specialty hospitals, unless a certificate of intent has been filed;
- Creates a Special Hospitals Study Committee;
- Requires written disclosure of physician financial interests in for-profit special hospitals.
- The moratorium does not affect any project for which a certificate of intent was filed on or before September 15, 2003.
- New construction must have obtained permits to build within one year of the effective start date of the moratorium and these facilities must have obtained 100 percent financing within 120 days prior to the start of the moratorium.
- The study commission to examine the feasibility of requiring specialty hospitals to provide a certain percentage of indigent care.
- The Dayton Heart Hospital is exempt from being defined as a specialty hospital due to its unique structure whereby it offers an emergency room and a maternity ward.
- Prohibits discrimination using economic credentialing against physicians with ownership interests in specialty hospitals that are to be grand-fathered under the bill.
- A temporary, two-year law banning physician self-referral on non-grandfathered hospitals.

House Bill 76 – Shaken Baby Syndrome

Representative John Widowfield (R – Cuyahoga Falls)

House Health and Family Services – Sponsor hearing 3/12/03; at the hearing on 3/26/03, Renee Dillon of Prevent Child Abuse Ohio, Kimberly Friedman of the National Council of Jewish Women, Angela Canepa an assistant prosecutor for Franklin County, and Dr. Daryl Steiner of Children's hospital Medical Center of Akron testified in support of the bill. More hearings were held on 4/2/03 and 5/21/03. At the hearing on 5/28/03, Jon Fishpaw, a parent advocate, testified in support of the legislation. The Ohio Hospital Association is concerned with the bill because hospitals need liability protection from parents who might sue if they are improperly educated, and need funds for educational materials and reporting requirements.

Position: Neutral (no funding mechanism in bill)

House Bill 76 requires the Director of the Ohio Department of Health to establish the Shaken Baby Awareness and Prevention program by doing the following:

- Providing to each hospital and freestanding birthing center an educational video recording that presents readily comprehensible information describing the medical effects on infants and children of shaken baby syndrome and ways to prevent its occurrence;
- Making available on the Department's website a form developed in cooperation with the Ohio Hospital Association that parents of a newborn child may sign to record their participation in the program.

The bill requires each hospital and freestanding birthing center to do the following:

- Inform parents of all newborn children of the program;
- Make available to the parents for viewing the video recording provided by the Department;
- Make available to the parents for signing, after viewing the video, the program participation forms developed;
- Keep on file all signed participation forms;
- By no later than March 1 of each year, report to the Department the following information regarding the previous calendar year:

The total number of births that occurred at the hospital or center;

The total number of viewing of the video recording

The total number of program participation forms signed.

Parents of newborn children may choose whether to participate in the program. Parents who participate may, after viewing the video, choose to sign a participation form to record their participation in the program.

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The Director may request that the controlling Board approve, if funds are available from any appropriation to the Department, a transfer of funds for the purchase of video recordings for the program.

House Bill 122 - Genetic Screening

Representative Tim Schaffer (R – Lancaster)

House Insurance Committee – Sponsor hearing 5/13/03. The substance of this bill has been included in House Bill 95, the biennial budget bill.

Position: Support

House Bill 122 extends the current prohibition on genetic screening and testing in connection with health care policies, contracts, plans, and agreements, currently scheduled for repeal on 2/9/04, for ten years.

House Bill 146 – Coverage of Diabetes

Representative Michelle Schneider (R – Cincinnati)

House Health and Family Services Committee – Sponsor Hearing 4/2/03; On 6/18/03, Debbie Martin, the mother of a six year old with Type I diabetes, and Francine Haddad of the American Diabetes Association testified in support of the bill. On 9/17/03, Stuart Perry, the Chair of the National Diabetes Advocacy Group, Nicole Johnson, representing the American Diabetes Association and a former Miss American, and Jane Turner an American Diabetes Association Volunteer, testified in support of the bill.

On 10/15/03, Dr. William Zipp, a practicing doctor of pediatric medicine testified in support of the bill. Testifying in opposition were Kelly McGivern, President of the Ohio Association of Health Plans, and Kirby Nielsen, representing the Ohio Association of Health Underwriters.

On 12/10/2004, Rep. Schneider explained that a number of drafting mistakes and interpretation problems still need to be fixed before she feels comfortable passing the bill out of committee.

Position: Neutral with Technical Assistance

House Bill 146 requires certain health care policies, contracts, agreements, and plans to provide benefits for equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes and for diabetes self-management education, including medical nutrition therapy, for the treatment and management of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes.

All of the following apply to the provision of benefits for the expenses of diabetes self-management education:

- Requires the benefits to cover the expenses only if the education is prescribed by a physician or other individual whose professional practice includes the authority to prescribe the education;

- During the first 12 month period immediately after a patient begins to receive diabetes self-management education, the benefits are to cover the expenses of 10 hours of education, which may include one hour used for assessment of the patient's training needs, but only if the education includes the completion of an individual diabetes education plan;
- In each year following the provision of coverage the benefits are to cover the expenses for two hours of education as an annual education maintenance program for the patient, but only if the patient undergoes an examination by a physician to make a medical determination of the patient's diabetes condition.
- The benefits are to cover the expenses of any education provided during home visits when the individual prescribing the education considers home visits to be important in meeting management or treatment goals.
- The benefits are to cover the expenses of education only if the education is provided by an individual with expertise in diabetes care, including an expert who is a dietitian, physician, pharmacist, registered or licensed practical nurse, or other individual whose professional practice includes the authority to provide the education, except that the benefits are to cover the expenses of medical nutrition therapy only if it is provided by a dietitian.
- The benefits are to cover the expenses of any education provided in a group setting, but coverage is not to be limited to education provided in a group setting.

This legislation does not prevent the benefits provided from being subject to copayments; does not prevent an individual, employer, or other entity from negotiating for or obtaining a policy, contract, or agreement that provides benefits that exceed the benefits required; does not prevent an individual diabetes education plan from being disclosed to an insurer if the insurer makes a request for disclosure in writing or by electronic transmission; and does not prevent an insurer from discussing an individual diabetes education plan with the patient or with the physician or other individual who formulated the plan.

This legislation does not prevent a patient from choosing not to seek or accept diabetes self-management education and notifying the insurer of that decision; and does not prevent a patient or the physician or other individual who prescribed the education for the patient from petitioning an insurer for additional coverage of education that is medically necessary.

This legislation does not interfere with the authority of an insurer to administer the policy, contract, or agreement through a network and to negotiate reimbursement amounts with providers; and does not interfere with the authority of an insurer to include in its provider network for the purpose of administering the benefits individuals with expertise in diabetes care.

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House Bill 166 – Prescription Drug Program

Representative Dale Miller (D – Cleveland)

House Health and Family Services Committee

Position: Neutral

House Bill 166 creates the prescription drug program in the Ohio Department of Job and Family Services and allows the Director to coordinate the program with other programs administered by the Director, or pursuant to an interagency agreement, with other directors of state departments. The Prescription Drug Program Fund is to consist of rebates by manufacturers of dangerous drugs and wholesale distributors and the money is to be used to reimburse a terminal distributor of dangerous drugs of the discount provided a prescription drug program participant on prescription drugs. The Director is to determine the simplified eligibility determination procedures and the claim form to be used.

House Bill 171 - Minority HIV/AIDS Task Force

Representative Shirley Smith (D – Cleveland)

House Health and Family Services Committee

Position: Support

House Bill 171 requires the Director of the Ohio Department of Health to appoint four HIV and AIDS regional minority coordinators and one statewide HIV and AIDS minority coordinator to facilitate statewide efforts to develop and administer the HIV and AIDS prevention campaign directed at minority group members.

The campaign is to use a variety of means of communication, including television, radio, outdoor activities, public service announcements, and peer-to-peer outreach; provide information on the risk of HIV and AIDS infection and strategies to follow for prevention, early detection, and treatment; use culturally sensitive literature and educational materials; and promote the development of individual skills for behavior modification.

The bill creates the Minority HIV and AIDS Task Force of 15 members to represent persons who are infected with HIV or have AIDS, minority community based support organizations; minority treatment providers; the religious community within groups of persons who are infected with HIV or have AIDS, and the Commission on Minority Health. The Task Force is to study ways to strengthen HIV and AIDS prevention programs and early intervention and treatment efforts in the State's Black, Hispanic, and other minority communities and ways to address the many needs of the State's minorities who have AIDS and their families; provide specific recommendations to the Governor, the Ohio General Assembly, the Ohio Department of Health, and the Commission on Minority health; and prepare and submit findings and recommendation in a report.

The bill makes an appropriation to the Ohio Department of Health for each fiscal year of the biennium of \$525,000.

House Bill 177 – Smallpox Vaccination

Representative Michael Skindell (D – Cleveland)

House Health and Family Services Committee -

Position: Support

House Bill 177 amends the section of the Worker's Compensation law which lists occupational diseases for which an employee may become disabled, to apply to a person suffering an adverse medical condition from an adverse reaction to a smallpox vaccination after receiving a smallpox vaccination pursuant to the Homeland Security Act of 2002 suffering an adverse medical condition.

The bill defines "adverse medical condition" to mean a physical malady that has resulted directly from receipt of a smallpox vaccine and includes, but is not limited to, the following conditions: eczema vaccinatum; erythema multiformis; generalized vaccinia; post-vaccinia encephalitis or meningoencephalitis; progressive vaccinia or vaccinia necrosum; and vaccinia keratitis. The bill will also grant specified employees certain benefits if they suffer an adverse medical condition as a result of receiving a smallpox vaccination as part of homeland security measures. This legislation provides that a state employee who is absent from work because the state employee suffers an adverse medical condition as a direct result of receiving a smallpox vaccine pursuant to the federal Homeland Security Act of 2002, or because the state employee suffers an adverse medical condition as a direct result of living in the same household with a member of the state employee's family who received the vaccine, is to be paid the state employee's total rate of pay for the work schedule the state employee normally would work during the period the state employee is unable to work due to the adverse medical condition.

The bill also provides that a state employee who is eligible to receive Worker's Compensation benefits due to suffering an adverse medical condition as a direct result of receiving a smallpox vaccine pursuant to the federal Homeland Security Act of 2002 is to receive benefits in lieu of receiving the state employee's total rate of pay.

The bill would also allow the state employee to continue to accrue sick leave and personal leave credit and the time the state employee is absent is not to be charged to the state employee's accumulation of sick leave, personal leave, vacation leave, or other form of paid leave credit.

The Director of the Ohio Department of Administrative Services is to adopt rules specifying the criteria the Director is to use to determine whether a state employee is suffering an adverse medical condition; criteria the Director is to use to determine whether a state employee's adverse medical condition directly resulted from receiving a smallpox vaccination; conditions under which a state employee must present a physician's verification that the state employee's adverse medical condition has directly resulted from receiving a smallpox vaccination; and criteria the Director is to use to determine the period of time that a state employee is qualified to receive pay in accordance with the conditions described.

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House Bill 182 – Immunity for Health Care Providers

Representative Larry Flowers (R – Canal Winchester)

House Civil and Commercial Law Committee – Sponsor hearing 6/11/03; on 9/17/02, Dr. Phil Cass, a member of the Board of Directors of Access Health Columbus, and Dr. Patrick Ecklar, President of the Columbus Medical Association, testified in support of the bill.

Position: Support

House Bill 182 extends immunity from liability for services provided by volunteer health care professionals and workers to more health care facilities and to nonprofit referring organizations; and increases the maximum allowable income of individuals who may be served by volunteers having immunity from liability.

House Bill 225 – Mental Illness Treatment/Coverage

Representative Lynn Olman (R – Maumee)

Senate Insurance Commerce and Labor Committee – 5/11/2004, sponsor testimony.

House Health and Family Services Committee – At the Sponsor hearing on 10/8/03 an attempt was made to re-refer this bill to the House Rules Committee for referral to the House Insurance Committee; however, the attempt failed. On 10/15/03, Dr. Sul Ross Thorward of the Ohio Psychiatric Association, Crystal Ward Allen, the Executive Director of Public Children Services Association of Ohio, and Denise Nichols, who suffers from a bipolar disorder, testified as proponents of the legislation. Hearing 11/12/03. The bill was amended and reported out of the House Health and Family Services Committee on 12/10/03.

The bill was amended and passed the Ohio House of Representatives on 2/4/04 by a vote of 52 – 40.

As amended on the House floor the bill prohibits discrimination in the coverage provided for the diagnosis, care, and treatment of biologically based mental illnesses in sickness and accident insurance policies and in private and public employer self-insurance plans; includes biologically based mental illnesses as part of the definition of "basic health care services" for purposes of the health insuring corporation law, thereby requiring all health insuring corporations that offer coverage for basic health care services to offer like coverage for these services; and permits mental health services that must be provided by a licensed physician or psychologist in order to be included in certain health insurance coverage requirements to be provided by a clinical nurse specialist whose nursing specialty is mental health or by a professional clinical counselor, professional counselor, or independent social worker.

Position – Neutral with Technical Assistance

House Bill 225 prohibits discrimination in group health care policies, contracts, and agreements in the coverage provided for the diagnosis, care and treatment of mental illness. The bill includes the diagnostic and treatment services for biologically based mental illnesses under the definition of a "basic healthcare service" for insurance coverage purposes.

The bill allows an insurance company to offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services and allows an insurance company to offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services.

However, an insurance company that offers coverage for any other basic health care service is required to offer coverage for diagnostic and treatment services for biologically based mental illnesses with the offer of coverage for all other listed basic health care services.

The bill defines "biologically based mental illnesses" to mean a mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder.

As amended in the House Committee, the first amendment exempts policies and certificates of sickness and accident insurance underwritten on an individual basis; the amendment clarifies that the bill applies to group plans only. The second amendment excludes prescription drug services in the definition of biologically based mental illnesses. The final amendment clarified the licensed health care professionals who may diagnose mental illness as the following: physicians, psychologists, professional clinical counselor, professional counselor, or independent social worker, or a clinical nurse specialist whose nursing specialty is mental health.

House Bill 228 – Cancer Death Rates of African Americans

Representative Lance Mason (D – Shaker Heights)

House Health and Family Services Committee -

Position – Neutral Until Have More Data

House Bill 228 creates a Task Force under the Department of Health to study the cancer death rates among African Americans in Ohio. Members of the Task Force are to include the President of Central State University or the President's appointee, and the Executive Director of the James Cancer Hospital or the Director's appointee. The Director of Health is to appoint the remaining members of the Task Force. Not more than two years after the effective date of this bill, the Task Force is to submit a report to the General Assembly discussing reasons why the cancer death rate among African Americans in Ohio is thirty-two percent higher than the cancer death rate among Caucasians in Ohio. After submitting the report the Task Force is to cease to exist.

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House Bill 234 – Anesthesia Administered by Dental Hygienist

Representative John Willamowski (R – Lima)

House Health and Family Services Committee -

Position – Oppose

House Bill 234 allows a dental hygienist under the supervision of a dentist to administer local anesthesia or nitrous oxide to a patient. The bill establishes that under the supervision of a dentist, a dental hygienist may administer intraoral, block, and infiltration anesthesia if he/she has obtained current certification to perform basic cardiac life-support procedures and has done both of the following: Successfully completed a course in the administration of local anesthesia offered by an accredited dental or dental hygiene program that has been approved by the State Dental Board; and within eighteen months of completion of the anesthesia course, successfully passed the State or regional written examination on local anesthesia administered by the Board. The local anesthesia administration course must meet certain criterion to be approved by the Board. A dental hygienist may administer and monitor nitrous oxide-oxygen analgesia if he/she has obtained a current certification to perform basic cardiac life-support procedures and has successfully completed training in the administration and monitoring of nitrous oxide-oxygen analgesia offered by an accredited dental or dental hygiene program that has been approved by the State Dental Board.

House Bill 238 – Patient’s Compensation Fund

Representative Larry Flowers (R – Canal Winchester)

House Civil and Commercial Law Committee – Sponsor testimony 5/5/2004. At the hearing on 5/12/2004, Ann Womer Benjamin, Superintendent of the Ohio Department of Insurance testified as a proponent.

Position – Neutral

House Bill 238 establishes a Patient’s Compensation Fund to pay catastrophic medical malpractice judgments and settlements. The fund is to be used solely to pay amounts in settlements and judgments of medical claims involving qualified providers that are in excess of \$250,000. A qualified provider must maintain a minimum amount of medical malpractice insurance and must have coverage of at least \$250,000 per occurrence and \$750,000 in annual aggregate. The Superintendent of Insurance is to collect a surcharge on qualified providers’ malpractice insurance to pay for the fund. “Qualified providers” have to file proof of insurance and must pay the surcharge through their malpractice carrier. The surcharge must be adequate to support the fund, must be a minimum of \$100, and will be assessed uniformly on all providers practicing in the same specialty.

House Bill 239 – Costs of Hospital Facilities

Representative Tony Core (R – Rushsylvania)

House Health Committee – Sponsor hearing 12/3/03. Hearing 3/24/04, 5/5/04, amended 5/12/04 and reported out. Amended and passed the House on 5/25/04 by a vote of 96 – 3.

Position: No Position at this time

House Bill 239 amends the definition of “public hospital agency” to include the state; and amends the definition of “governing body” in the case of the state, to include the Director of Development or the Ohio Higher Educational Facilities Commission. The bill amends the definition of “costs of hospital facilities” to include the costs of refinancing obligations issued by, or reimbursement of money advanced by, nonprofit hospital agencies or others the proceeds of which were used for the payment of costs of hospital facilities, if the governing body of the public hospital agency determines that the refinancing or reimbursement advances the purposes of the hospital agency law, whether or not the refinancing or reimbursement is in conjunction with the acquisition or construction of additional hospital facilities.

The bill also specifies that a trustee, officer, or director of a hospital agency does not have an interest in the profits or benefits of an agreement between hospital agencies solely by virtue of being a trustee, officer, or director of one of the participating hospital agencies.

The bill also amends the definition of “bond proceedings” to provide that terms may include variable interest rates; and amends the definition of “costs of hospital facilities” in the law governing hospital agencies by providing that the term includes the costs of interests in hospital facilities, including membership interests in nonprofit hospital agencies.

The bill provides that if the costs of the hospital facilities are to be paid with funds derived from revenue obligations issued pursuant to section 140.06 of the Revised Code and with other funds derived from the nonprofit hospital agency, a public hospital agency, pursuant to negotiation and in the manner determined in its sole discretion by the governing body of the public hospital agency, may enter into a contract for the acquisition, construction, improvement, equipment, or furnishing of a hospital facility that is to be leased by a public hospital agency to a nonprofit hospital agency. Any requirement of competitive bidding, other restriction, or other procedures that are imposed on a public hospital agency with respect to contracts is not applicable to any contract entered into pursuant to this section.

The bill allows the board of county commissioners to transfer operational control of the county home to the board of county hospital trustees of a county hospital located in the county

House Bill 248 – Not-for-Profit Hospital Charity Care

Representative Mike Gilb (R – Findlay)

House Health and Family Services Committee -

Position – Oppose

House Bill 248 requires a not-for-profit hospital to provide a certain amount of charity care each year. Each not-for-profit hospital is to provide charity care during each calendar year in an amount equal to at least four percent of the hospital’s total gross receipts for compensated care for the preceding calendar year.

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The amount the Medicaid program would pay for the charity care if the charity care was provided to a Medicaid recipient is to be used to determine the value of the charity care. Between February 1st and May 31st of each year, each not-for-profit hospital is to submit a report to the State Auditor that provides the following: the hospital's total gross receipts for compensated care for the preceding calendar year; the total amount of charity care provided during that calendar year; and any other information specified in rules that the Auditor determines necessary to determine a hospital's compliance. The Auditor may extend the time for filing a report for good cause and may adopt rules as necessary to implement the reporting requirements.

House Bill 257 – Death Certificates

Representative Patricia Clancy (R – Cincinnati)

House Health and Family Services Committee – Sponsor hearing on 10/15/03; hearings on 5/5/04, amended and reported out of Committee on 5/12/04; amended and passed the Ohio House on 5/25/04 by a vote of 99 – 0.

Position: Neutral

House Bill 257 adds a requirement that all death certificates are required to include, in the medical certification portion of the certificate, a space to indicate, if the deceased individual is female and the manner of death is determined to be a suspicious or violent death, whether any of the following conditions apply to the individual:

- (1) Not pregnant within the past year;
- (2) Pregnant at the time of death;
- (3) Not pregnant, but had been pregnant within forty-two days prior to the time of death;
- (4) Not pregnant, but had been pregnant within forty-three days to one year prior to the time of death;
- (5) Unknown whether pregnant within the past year.

Current law requires the Director of the Department of Health to prescribe through rules the form of death certificates. Death certificates must include the items and information prescribed by the Director, including the items recommended by the National Center for Health Statistics of the United States Department of Health and Human Services as approved and modified by the Director.

According to Representative Clancy historically deaths defined as “pregnancy-related” were deaths caused by a medical complication of pregnancy, or deaths that occurred when pregnancy aggravated an existing health problem. Medical research now believe that homicide, and not medical complications, is the leading cause of pregnancy-related death. Representative Clancy believes that collection of this information will help clarify the cause of death and will help identify maternal deaths.

House Bill 264 – Naturopathic Medicine

Representative Mary Cirelli (D – Canton)

House Health and Family Services Committee -

Position: Oppose

House Bill 264 would create the State Board of Naturopathic Medicine and would regulate the practice of naturopathic medicine. Persons desiring to practice naturopathic medicine would be required to submit an application to the Board and the Board would issue a certificate of authority to practice naturopathic medicine. The naturopathic physician would be permitted to use for preventive and therapeutic purposes naturopathic medicine and any therapeutic or clinical modalities taught at any board accepted naturopathic medical college and, for diagnostic purposes, physical and orificial examinations, x-rays, electrocardiograms, ultrasound, phlebotomy, clinical laboratory tests and examinations, physiological function tests, and any diagnostic procedures commonly used by physicians in general practice.

A naturopathic physician could prescribe, administer, or dispense nonprescription medications, natural medicines, or therapeutic devices. A naturopathic physician could use the title doctor, physician, naturopathic physician, naturopathic doctor, naturopath, doctor of naturopathic medicine, or doctor of naturopathy. A naturopathic physician would be considered a physician who performs medical services under Medicaid and Workman's Compensation and would be eligible for reimbursement under those programs.

The bill creates a five member State Board of Naturopathic Medicine with four naturopathic members and one public member. The Board is to adopt rules for the training requirements and practice parameters of naturopathic physician assistants; the areas of naturopathic medicine in which a naturopathic physician may specialize; the number of hours of continuing education; guidelines for programs providing postdoctoral training in naturopathic specialties for naturopathic physicians; and information to be included in the application for a certificate of registration.

The bill defines the following terms:

“Naturopathic medicine” to mean a system of primary health care that uses education, counseling, biofeedback, acupuncture, natural medicine, topical medicine, naturopathic physical medicine, therapeutic devices, chelation, minor surgery, immunizations, nutritional assessment and counseling, hypnotherapy, and dietary therapy to support and stimulate the patient's intrinsic healing processes and includes prevention, diagnosis, treatment, and management of human health conditions, injuries, and diseases.

“Naturopathic musculoskeletal therapy” is defined to mean the manually administered, mechanical treatment of body structures or tissues in accordance with naturopathic principles for the purpose of restoring normal physiological and movement functions of the body.

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“Naturopathic physical medicine” is defined to mean the therapeutic use of the physical, chemical, or other properties of air, water, heat, cold, sound, light, and electromagnetic non-ionizing radiation and of the physical modalities of electrotherapy, diathermy, ultraviolet light, infrared light, ultrasound, hydrotherapy, massage, naturopathic musculoskeletal therapy, reflexology, and therapeutic exercise.

“Certificate of Authority” means a certificate issued by the State Board of Naturopathic Medicine authorizing an individual to practice naturopathic medicine.

“Minor surgery” means the use of operative, electrical, or other methods for the surgical repair and care of superficial lacerations, abrasions, and lesions; the removal of foreign bodies located in the superficial tissues; and the use of antiseptics and local anesthetics in connection with these methods.

House Bill 305 – Nonprofit Corporations

Representative Tim Schaffer (R – Lancaster)

House Civil and Commercial Law Committee – hearings 1/21/04, 1/28/04 and 2/04/04

Position: No Position

House Bill 305 pertains to the use of electronic or telephonic transmissions in certain meetings and votings of nonprofit corporations and the authority to take action on behalf of a nonprofit corporation without a meeting of incorporators, directors, or members. This bill clarifies that all meetings of a nonprofit corporations are to be held at the principal office of the corporation unless the articles or the regulations of the nonprofit corporation the use of holding meetings by means of electronic or telephonic transmission.

The bill also clarifies that the articles or the regulations may provide that voting at elections and votes on other matters may be conducted by mail, electronic mail, telephone call, or any other means of electronic or telephonic transmission permitted by the regulations, provided that any such mail, electronic mail, telephone call, or other means of electronic or telephonic transmission sets forth or is submitted with information from which it can be determined that the mail, electronic mail, telephone call, or other means of electronic or telephonic transmission was authorized and accurately reflects the intentions of the member.

House Bill 314 – Public Employee Benefit Plans

Representative Jon Peterson (R – Delaware)

House Health and Family Services Committee –

Position: No Position

House Bill 314 requires certain health care policies, certificates, contracts, and agreements and public employees benefit plans to provide qualified benefits for polypeptide-based and amino acid based formulas.

House Bill 331 – Mammographies

Representative Jean Schmidt (R – Loveland)

Awaiting Referral to a Senate Committee

House Health and Family Services Committee – Sponsor hearing 5/12/04; bill substituted on 5/19/04. Amended and reported out on 5/26/04. Passed the Ohio House on 5/26/04 by a vote of 96 – 2.

Position: Neutral

House Bill 331, as substituted, raises the cap on the amount of benefits health care plans may provide for the expense of screening mammography¹ from \$85 to 130% of the Medicare reimbursement rate² per year.

House Bill 331 provides the total benefit for a screening mammography is not to exceed 130% of the Medicare reimbursement rate in Ohio for screening mammography. If there is more than one Medicare reimbursement rate in Ohio for screening mammography or a component of a screening mammography, the reimbursement limit is to be 130% of the lowest Medicare reimbursement rate in Ohio. If a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit and submits a separate claim for that component, a separate payment is to be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. A provider, hospital, or other health care facility is prohibited from seeking or receiving remuneration in excess of the payment made in accordance with this legislation, except for approved deductibles and copayments

House Bill 348 – Commission on Responsible Legal Reform

Representative John Willamowski (R – Lima)

House Civil and Commercial Law Committee – Hearing 1/28/04, 2/4/04, and 2/11/04. The bill is supported by the Ohio Academy of Trial Attorneys and the Ohio Chapter of the American Board of Trial Advocates.

¹ "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film. "Screening mammography" does not include diagnostic mammography.

² "Medicare reimbursement rate" means the reimbursement rate paid in Ohio under the Medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

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Position: Active Opposition

House Bill 348 requires that before January 15 of each year, every clerk of court of common pleas is to send to the Ohio Department of Insurance and the Ohio Supreme Court an annual report containing all of the following information relating to each tort action that was filed or is pending in that court of common pleas: the style and number of the case; the date of the filing; whether or not there has been a trial and the dates of the trial if there was a trial; the current status of the case; whether or not the parties have agreed on a settlement; whether or not a judgment has been rendered, the nature of the judgment, including the amounts of compensatory damages that represent economic loss and noneconomic loss, and the date of entry of the judgment; and if a judgment has been rendered, whether or not a notice of appeal of the judgment has been filed or whether the time for filing an appeal has expired. This provision currently applies to the filing of an annual report with only the Ohio Department of Insurance in each civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim and specific reference to such tort actions are now lumped under the tort actions to be filed.

The bill also creates the Commission on Responsible Legal Reform, consisting of thirteen members. The President of the Senate is to appoint four of the members, and the Speaker of the House is to appoint four of the members. The Minority Leader of the Senate is to appoint two members, and the Minority Leader of the House of Representatives is to appoint two members. The Superintendent of Insurance or the Superintendent's designee is to be the thirteenth member of the Commission.

The following representatives are to be appointed by the President of the Senate: Ohio Chamber of Commerce, Ohio Manufacturer's Association, National Federation of Independent Businesses-Ohio, and the Senate Majority Caucus. The following representatives are to be appointed by the Speaker of the House of Representatives: Ohio Academy of Trial Lawyers, Ohio State Bar Association, American Association of Retired Persons-Ohio, and the House Majority Caucus. The following representatives are to be appointed by the minority leader of the Senate: the Ohio Common Pleas Judges Association and the Senate Minority Caucus. The following representatives are to be appointed by the minority leader of the House of Representatives: the Ohio AFL-CIO and the House Minority Caucus.

The Commission is to do all of the following:

- (1) Determine the number of cases annually in Ohio that involve awards for compensatory damages for noneconomic loss that are greater than two hundred fifty thousand dollars and the number of cases annually in Ohio that involve awards for compensatory damages for noneconomic loss that are greater than one million dollars;

Analyze the impact of awards for compensatory damages for noneconomic loss that are greater than two hundred fifty thousand dollars and awards for compensatory damages for noneconomic loss that are greater than one million dollars on taxpayers, injury and wrongful death victims and their families, the competitiveness of businesses, and the court system.

- (2) Determine the number of cases annually in Ohio that involve awards for punitive or exemplary damages that are greater than one hundred thousand dollars and the number of cases annually in Ohio that involve awards for punitive or exemplary damages that are greater than one million dollars.

Analyze the impact of awards for punitive or exemplary damages that are greater than one hundred thousand dollars and awards for punitive or exemplary damages that are greater than one million dollars on taxpayers, victims and their families, businesses, and the court system.

Evaluate the effect of assigning a percentage of an award for punitive or exemplary damages to a charity, including the legal implications of making that charity a party to the action.

- (3) Determine the number of health care insurance entities that currently include subrogation clauses in order to evaluate the potential savings that may result from abolishing the collateral source rule.

Consider the impact on the court system of litigating the issue regarding subrogation clauses in front of a jury.

- (4) Determine the number of actions filed in the last ten years in Ohio in which the person filing the action discovered the injury that is the basis of the action after the statute of limitations had run and, for each of those actions, compare the time when that person is alleging the injury occurred with the time when that person filed the action.

Determine whether or not it is in the best interest of the people of the state to enact a statute of repose in product liability actions.

Consider the concept of "useful safe life."

- (5) Evaluate the effect changes in the prejudgment interest law would have on settlements in tort actions.

The Commission is to submit a report of its findings to the Speaker of the House of Representatives, the President of the Senate, the Minority Leader of the House of Representatives, the Minority Leader of the Senate, and the Governor by December 31, 2004.

House Bill 350 – Immunity for Food Sellers/Tort Reform

Representative Bob Gibbs (R – Lakeville)

House Concurrence – the House continues to “informally pass” House Bill 350 at each session so it will retain its place on the calendar.

Senate Agriculture Committee – Hearings 4/21/04 and 4/28/04. Bill then re-referred to Senate Judiciary Committee were the bill was amended to include Senate Bill 80 in House Bill 350, as by the Ohio Senate. House Bill 350, with Senate Bill 80, passed the Ohio Senate on 5/5/04 by a vote of 20 – 12.

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House Civil and Commercial Law Committee – Sponsor hearing held on 1/21/04; hearing 1/28/04, 2/4/0, and 2/11/04. At the 2/11/04 hearing, the bill was amended to clarify exceptions to immunity and injury resulting from or related to cumulative consumption and the bill was reported out of the Committee. The bill was then brought back to the Committee at the request of Representative Grendell to make an amendment dealing with immunity for owners of private property located near recreational trails. The bill was amended and reported out of Committee for the second time on 3/10/04 and passed the Ohio House on 3/10/04 by a vote of 89 – 7.

Position –

House Bill 350 precludes any manufacturer or seller of a qualified product (generally, food or drink) and any trade association from being liable for injury, death, or loss to person or property for damages, from not being subject to an action for declaratory judgment, injunctive, or declaratory relief, and from being responsible for restitution or other relief arising out of, resulting from, or related to an injury from cumulative consumption of a qualified product, weight gain or obesity or any health condition that is related to weight gain, obesity, or cumulative consumption. The bill permits a party that prevails on a motion to dismiss an action described above to recover reasonable attorney's fees and costs that the party incurred in connection with the motion to dismiss.

An amendment to the bill includes provisions of Senate Bill 80, the tort reform legislation. The following is a summary of the amendments to the bill: U-pick operation immunity from liability for damages caused by natural conditions on the property; recreational trail immunity from liability for conditions on the premises; If a civil judgment is entered in favor of a decedent, prior to his or her death, the estate of the decedent cannot file another civil action; If a judgment is reversed, or if the plaintiff dies during the pendency of the case, the personal representative is limited to one year to file the claim; If the action occurred in another state and the statute of limitations is shorter in that State, than in Ohio the claim must be filed within the shorter time period; The jury is to be instructed that an award is not subject to taxation; Expands the definition of "frivolous conduct" and awards attorney fees in the event the conduct is frivolous and the court may award fees and costs on its own initiative; No ticket for seatbelt violation is to be issued if the purpose of the stop was a safety check of the vehicle; and Failure to use a seatbelt is to be considered as contributory negligence in a tort action if the failure to wear the belt contributed to the harm.

House Bill 365 – Physician Patient Privileges

Representative Steve Buehrer (R – Delta)

Awaiting Referral to a Committee in the Ohio Senate

House Judiciary Committee – Hearings 2/4/04, 2/11/04, 2/18/04, and 3/4/04. Amended and reported out on 4/29/04. Passed the Ohio House on 5/25/04 by a vote of 82 – 16.

Position: Neutral – Need more information

House Bill 365 would waive the physician-patient testimonial privilege in probate cases concerning a communication between a deceased client and the deceased client's attorney if the communication is relevant to a dispute between parties who claim through that deceased client, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction.

If neither the spouse of a patient nor the executor or administrator of that patient's estate gives consent, testimony or the disclosure of the patient's medical records by a physician, dentist, or other health care provider is a permitted use or disclosure of protected health information, and an authorization or opportunity to be heard is not to be required. This provision does not require a mental health professional to disclose psychotherapy notes.

An interested person who objects to testimony or disclosure may seek a protective order pursuant to Civil Rule 26. A person to whom protected health information is disclosed is not to use or to disclose the protected health information for any purpose other than the litigation or proceeding for which the information was requested and is to return the protected health information to the covered entity or destroy the protected health information, including all copies made, at the conclusion of the litigation or proceeding.

House Bill 377 – Dangerous Drugs Database

Representative Tom Raga (R – Mason)

Senate Health, Retirement and Aging Committee – Sponsor hearing 5/26/04.

House Health and Family Services Committee – Sponsor hearing 3/27/04; the Sponsor said the Ohio Board of Pharmacy had been able "to get a commitment from the U.S. Department of Justice for \$180,000 towards the start-up of a prescription drug monitoring program." Those funds must be spent by July 2005 or they will be forfeited. Raga said this program would be modeled on Kentucky's KASPER prescription monitoring program. Hearing 4/21/04; substituted on 4/28/04; amended and reported out on 5/5/04. Passed the Ohio House on 5/11/04 by a vote of 73 – 25.

Position: Oppose with Technical Assistance

House Bill 377, as substituted and amended, would require the State Board of Pharmacy to establish and maintain a drugs database by electronically collecting and disseminating information to monitor the misuse and diversion of controlled substances and other dangerous drugs³ the board includes in the database.

³ Section 4729.01 (F) of the Ohio Revised Code defines "dangerous drug" to mean any of the following:

- (1) Any drug to which either of the following applies:
- (a) Under the "Federal Food, Drug, and Cosmetic Act," 52 Stat. 1040 (1938), 21 U.S.C.A. 301, as amended, the drug is required to bear a label containing the legend "Caution: Federal law prohibits dispensing without prescription" or "Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian" or any similar restrictive statement, or the drug may be dispensed only upon a prescription; (b)

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Each pharmacy licensed terminal distributor of dangerous drugs⁴ that dispenses drugs to patients in Ohio is required to submit the following prescription information to the Board:

1. Terminal distributor identification;
2. Patient identification;
3. Prescriber identification;
4. Date prescription was issued by prescriber;
5. Date prescription was dispensed;
6. Indication of whether prescription dispensed is new or a refill;
7. Name, strength, and national drug code of the drug dispensed;
8. Quantity of drug dispensed;
9. Number of days' supply of drug dispensed;
10. Serial or prescription number assigned by the terminal distributor;
11. Source of payment for the prescription.

The information is to be submitted electronically in the format specified by the Board unless a waiver has been granted by the Board to the terminal distributor. Information is to be transmitted as designated by rule of the Board, unless the Board grants an extension. An extension may be granted if either of the following occurs: the distributor suffers a mechanical or electronic failure, or cannot meet the deadline established for other reasons beyond the distributor's control; or the Board is unable to receive electronic submissions. The bill does not apply to a prescriber personally furnishing or administering dangerous drugs to the prescriber's patient.

Under Chapter 3715 or 3719 of the Revised Code, the drug may be dispensed only upon a prescription.

(2) Any drug that contains a schedule V controlled substance and that is exempt from Chapter 3719 of the Revised Code or to which that chapter does not apply;

(3) Any drug intended for administration by injection into the human body other than through a natural orifice of the human body.

⁴Section 4729.01 (Q) of the Ohio Revised Code defines "terminal distributor of dangerous drugs" to mean a person who is engaged in the sale of dangerous drugs at retail, or any person, other than a wholesale distributor or a pharmacist, who has possession, custody, or control of dangerous drugs for any purpose other than for that person's own use and consumption, and includes pharmacies, hospitals, nursing homes, and laboratories and all other persons who procure dangerous drugs for sale or other distribution by or under the supervision of a pharmacist or licensed health professional authorized to prescribe drugs.

House Bill 377 requires each wholesale distributor of dangerous drugs⁵ that delivers drugs to prescribers in Ohio to submit the following purchase information to the Board:

1. Purchaser identification;
2. Identification of the drug sold;
3. Quantity of the drug sold;
4. Date of sale;
5. The wholesale distributor's license number issued by the Board.

The bill requires the information to be submitted electronically in the format specified by the Board unless a waiver has been granted by the Board to the distributor. Information is to be transmitted as designated by rule of the Board unless the board grants an extension. An extension may be granted if either of the following occurs: the distributor suffers a mechanical or electronic failure, or cannot meet the deadline established for other reasons beyond the distributor's control; or the Board is unable to receive electronic submissions.

House Bill 377 allows the Board to provide information from the drug database to all of the following:

1. A person who is a designated representative of a government entity responsible for the licensure, regulation, or discipline of licensed health care professionals authorized to prescribe drugs and is involved in an investigation of a person licensed, regulated, or subject to discipline by the entity;
2. A federal, state, county, township, or municipal officer of this or any other state, or the United States, whose duty is to enforce the laws relating to drugs and who is actively engaged in a specific investigation of a specific person or drug specified by the officer;
3. A properly convened grand jury pursuant to a subpoena properly issued;
4. A pharmacist or prescriber who requests the information and certifies in a form specified by the Board that it is for the purpose of providing medical or pharmaceutical treatment to a current patient of the pharmacist or prescriber;

⁵ Section 4729.01(O) of the Ohio Revised Code defines "wholesale distributor of dangerous drugs" to mean a person engaged in the sale of dangerous drugs at wholesale and includes any agent or employee of such a person authorized by the person to engage in the sale of dangerous drugs at wholesale.

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5. An individual who requests the individual's own database information in accordance with the procedure established in rules adopted by the Board.

The Board is to maintain a record of each individual or entity that requests information from the database and the Board may use the records to document and report statistics and law enforcement outcomes.

The Board may provide records of an individual's requests for database information to the following individuals:

1. A designated representative of a government entity that is responsible for the licensure, regulation, or discipline of licensed health care professionals authorized to prescribe drugs who is involved in a specific investigation of the individual who submitted the dangerous drugs database information request;
2. A federal, state, county, township, or municipal officer of this or any other state, or the United States, whose duty is to enforce the laws relating to drugs and who is actively engaged in a specific investigation of the individual who submitted the dangerous drugs database information request.

The information contained in the database and any information obtained from it is not a public record. Information contained in the records of requests for information from the database is not a public record.

The information collected for the database is to be retained in the database for two years. It is then to be destroyed unless a law enforcement agency or a government entity responsible for the licensure, regulation, or discipline of licensed health care professionals authorized to prescribe drugs has submitted a written request to the Board for retention of specific information in accordance with rules adopted.

The bill establishes that nothing in the bill requires a pharmacist or prescriber to obtain information about a patient from the database. A pharmacist or prescriber is not to be held liable in damages to any person in any civil action for injury, death, or loss to person or property on the basis that the pharmacist or prescriber did or did not seek or obtain information from the database.

House Bill 377 provides the Board is not to impose any charge on a terminal distributor of dangerous drugs, pharmacist or prescriber for the establishment or maintenance of the database. The board is not to charge any fees for the transmission of data to the database or for the receipt of information from the database, except that the Board may charge a fee in accordance with rules adopted to an individual who requests the individual's own database information.

The bill requires the board to review the information in the database. If the board determines that a violation of law may have occurred, it may notify the appropriate law enforcement agency or a government entity responsible for the licensure, regulation, or discipline of licensed health care professionals authorized to

prescribe drugs and supply information required for an investigation.

The bill requires the Board to adopt rules specifying all of the following:

- A means of identifying each patient, terminal distributor, and each purchase at wholesale of dangerous drugs about which information is entered into the drug database.
- An electronic format for the submission of information from terminal distributors and wholesale distributors of dangerous drugs.
- A procedure whereby a terminal distributor or a wholesale distributor of dangerous drugs unable to submit information electronically may obtain a waiver to submit information in another format.
- A procedure whereby the Board may grant a request from a law enforcement agency or a government entity responsible for the licensure, regulation, or discipline of licensed health care professionals authorized to prescribe drugs that information that has been stored for two years be retained when the information pertains to an open investigation being conducted by the agency or entity.
- A procedure whereby a terminal or wholesale distributor may apply for an extension to the time by which information must be transmitted to the board;
- A procedure whereby a person or government entity to which the board is authorized to provide information may submit a request to the board for the information and the board may verify the identity of the requestor;
- A procedure whereby the Board can use the database request records to document and report statistics and law enforcement outcomes;
- A procedure whereby an individual may request the individual's own database information and the Board may verify the identity of the requestor;
- A reasonable fee that the Board is to assess for providing an individual with the individual's own database information.
- The specific dangerous drugs other than controlled substances that must be included in the database.

The Board is to designate which types of terminal distributors of dangerous drugs will be required to submit prescription information to the Board.

Two years after the effective date of the legislation and every two years thereafter, the Board is to present to the standing committees of the Ohio House of Representatives and the Ohio Senate that are primarily responsible for considering health and human services issues a report of the following:

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1. The cost to the state of implementing and maintaining the database;
2. Information from terminal distributors, prescribers, and the Board regarding the Board's effectiveness in providing information from the database;
3. The Board's timeliness in transmitting information from the database.

House Bill 394 – Insurance Commissioner

Representative Chris Redfern (D – Port Clinton)

House State Government Committee – Hearing scheduled for 3/9/04; however, the bill was not heard.

Position: Oppose

House Bill 394 makes the position of head of the Ohio Department of Insurance an elective office and names the officeholder the Insurance Commissioner.

House Bill 451 – Naturopathic Medicine

Representative Merle Kearns (R – Springfield)

House Commerce and Labor Committee – Hearing 5/4/04 and 5/11/04

Position –

House Bill 451 creates the State Board of Naturopathic Medicine, provides for the regulation of naturopathic physicians, authorizes pharmacists to fill prescriptions ordered by naturopathic physicians pursuant to a formulary, and exempts naturopathic physicians from certain drug and controlled substance criminal laws when their conduct is in accordance with naturopathic law.

The bill creates a seven member State Board of Naturopathic Medicine with five naturopathic members and two public members. The Board is to adopt rules to specify the following: Fees; training and continuing education requirements; the formulary specifying the drugs, dangerous drugs, homeopathic preparations, natural antibiotics, natural medicines, topical medicines, and therapeutic devices that a naturopathic physician may prescribe or furnish; the training requirements to prescribe and furnish drugs, dangerous drugs, homeopathic preparations, natural antibiotics, natural medicines, topical medicines, and therapeutic devices specified on the formulary; the training requirements to be, and the practice parameters of, naturopathic physician assistants; the extent to which a naturopathic physician may render naturopathic medicine to another naturopathic physician.

The State Board of Naturopathic Medicine is to issue a certificate of authority to practice naturopathic medicine to an individual who meets certain requirements. A naturopathic physician may use the title "doctor," "physician," "naturopathic physician," "naturopathic doctor," "naturopath," "doctor of naturopathic medicine," or "doctor of naturopathy," or use the terms "N.D." or "N.M.D." to show that the naturopathic physician is a practitioner of naturopathic medicine.

The naturopathic physician's certificate shall be prominently displayed in the naturopathic physician's office or the place where the major portion of the naturopathic physician's practice is conducted.

A naturopathic physician may use for preventive and therapeutic purposes naturopathic medicine and any therapeutic or clinical modalities taught at any naturopathic medical college operating legally in the state and for diagnostic purposes physical and orificial examinations, x-rays, electrocardiograms, EAV testing, ultrasound, phlebotomy, clinical laboratory tests and examinations, physiological function tests, and any diagnostic procedures commonly used by physicians in general practice.

A naturopathic physician may, upon completion of the training adopted by rule, prescribe or furnish a drug, dangerous drug, homeopathic preparation, natural antibiotic, natural medicine, topical medicine, or therapeutic device that is included in the types of drugs, dangerous drugs, homeopathic preparations, natural antibiotics, natural medicines, topical medicines, or therapeutic devices listed on the formulary established in rules.

A naturopathic physician may use an assistant to assist in the naturopathic physician's practice of naturopathic medicine if the assistant meets the training requirements for, and complies with the practice parameters of, naturopathic physician assistants specified in rules

No naturopathic physician is to do any of the following: Engage in the practice of parturition; perform any procedure, or practice any limited modality of naturopathy for which the naturopathic physician has not been trained; exceed the limitation on the extent, scope, or type of practice imposed on the naturopathic physician; refer a patient to a person for a designated health service if the naturopathic physician, or a member of the naturopathic physician's immediate family, has either of certain financial relationships with the person.

The bill defines the following terms:

"Acupuncture" means the traditional Chinese therapeutic technique of treating specific areas of the human body, known as acupuncture points or meridians, by puncturing the body with fine needles or applying electricity, heat, or both to the body.

"Certificate of authority" means a certificate of authority that the State Board of Naturopathic Medicine issues or renews authorizing an individual to practice naturopathic medicine.

"Homeopathic preparations" means medicines prepared according to the United States and internationally accepted homeopathic pharmacopoeias.

"Minor surgery" means the use of operative, electrical, or other methods for the surgical repair and care of superficial lacerations, abrasions, and lesions; the removal of foreign bodies located in the superficial tissues; and the use of antiseptics and local anesthetics in connection with these methods.

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"Natural antibiotics" means antimicrobial, antifungal, antiviral, and antiprotozoal agents that are naturally occurring substances, or manufactured substances that are chemically identical to those naturally occurring substances.

"Natural medicine" means food, food extracts, vitamins, minerals, essential oils, enzymes, digestive aids, nutraceuticals, glandular substances, plant substances, herbal preparations, homeopathic preparations, oligotherapeutic preparations, gemmotherapeutic preparations, and natural antibiotics.

"Naturopathic joint mobilization and neuromuscular re-education" means the manually administered, mechanical treatment of body structures or tissues, in accordance with naturopathic principles, for the purpose of restoring normal physiological functions of the body by normalizing and balancing the musculoskeletal system of the body.

"Naturopathic medicine" means a system of primary health care practiced by naturopathic physicians, including prevention, diagnosis, treatment, and management of human health conditions, injuries, and diseases that uses education, counseling, biofeedback, acupuncture, natural medicine, topical medicine, naturopathic physical medicine, therapeutic devices, chelation, barrier devices for contraception, minor surgery, immunizations, nutritional assessment and counseling, hypnotherapy, joint mobilization and neuromuscular re-education, naprapathy, and dietary therapy to support and stimulate the patient's intrinsic healing processes.

"Naturopathic physical medicine" means the therapeutic use of the physical, chemical, or other properties of air, water, heat, cold, sound, light, and electromagnetic nonionizing radiation and of the physical modalities of electrotherapy, diathermy, ultraviolet light, infrared light, ultrasound, hydrotherapy, massage, joint mobilization and neuromuscular re-education, reflex therapy, and therapeutic exercise.

"Naturopathic physician" means an individual who holds a valid certificate of authority.

"Parturition" means childbirth.

"Topical medicine" means topical analgesics, anesthetics, scabicides, antifungals, compounded preparations, antibacterials, antiseptics, and antivirals.

House Bill 463 – Chicken Pox Immunization

Representative Courtney Combs (R – Hamilton)

Yet to be Referred to a Committee in the Ohio Senate

House Health and Family Services Committee – At the 4/28/2004 hearing a substitute bill was accepted; hearings held 5/5/2004, 5/12/2004 and 5/19/2004. The bill was substituted and amended and reported out of Committee on 5/26/04 and passed the Ohio House by a vote of 69 – 27 on 5/26/04.

Position –

Substitute House Bill 463 requires students to be immunized against chicken pox effective during or after the school year beginning in 2006. Exempt from such requirement are the following: students who have had natural chicken pox and presents a signed letter from a parent, guardian, or physician to that effect; students whose parent or guardian decline immunizations for their child for such reasons as religious purposes; and students whose physician certifies, in writing, that such immunization against any disease is medically contraindicated is not required to be immunized against that disease.

The bill also provides that to the extent appropriations are made by the Ohio General Assembly, the Director of the Ohio Department of Health is to provide the means of immunization against chicken pox to boards of health, legislative authorities of municipal corporations, and boards of township trustees.

House Bill 476 – Alternative Dispute Resolution

State Representative Ron Young (R – Painesville)

House Insurance Committee – Sponsor hearing 5/11/04. At the hearing on 5/24/04, the following individuals testified in favor of the legislation: Babu Achanti, M.D., a practicing neonatologist at Fairview Hospital; Arthur Dick, M.D., a neurologist from Lakewood Hospital; Satish Mahna, M.D.; and Daniel McLaughlin, M.D., a vascular surgeon.

Position:

House Bill 476 would establish an alternative form of dispute resolution for medical malpractice claims against physicians. The bill allows a plaintiff to elect to use the alternative form of dispute resolution that allows an expert witness to give an opinion as to whether malpractice was committed or not and if committed whether the malpractice resulted in damage to the plaintiff, or that the expert could not give a firm opinion and recommends a review of the records by reviewing physicians. Then the parties can accept the report, request a review of the report, or, in the case of the plaintiff, prosecute a civil action at law. The reviewing physicians would be required to be selected at random from those physicians on a list who specialize in the same branch of medicine as the defendant. If the defendant is found to have not committed malpractice, the plaintiff's attorney is personally liable for the total amount of damages alleged. The bill requires the Superintendent of Insurance to develop a schedule of compensation to be used for the determination of economic and noneconomic compensatory damages in proceedings and in actions involving claims that are heard by a judge without a jury.

The bill creates the Disadvantaged Patients Fund consisting of money received from a plaintiff's attorney, interest on awards placed in escrow accounts, proceeds from the sale of books by the State Medical Board to physicians of selected medical malpractice cases for the continued education of physicians in medical malpractice law, and any other money appropriated or donated to the fund to be used only to pay the legal costs of disadvantaged patients. The bill requires a physician to maintain medical malpractice insurance in amounts not less than \$500,000 per occurrence and not less than \$1,500,000 in the aggregate.

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The bill requires each party, attorney, insurance company, or other person responsible for paying damages, attorney fees, costs, expenses, or other items pursuant to a decision, order, or judgment of a court to submit to the Superintendent an itemized statement of the amounts due and the amounts paid.

House Bill 499 – Seat Belts

Representative Kathleen Chandler (D – Kent)

House Criminal Justice Committee –

Position –

House Bill 499 makes a seat belt violation a primary offense that is enforceable in the same manner as any other traffic offense.

House Joint Resolution 15 – Med Mal Constitutional Amendment

Representative Ron Young (R – Leroy)

House Civil and Commercial Law Committee – Sponsor testimony held 5/11/2004.

Position – Support

House Joint Resolution 15 calls for a constitutional amendment to allow the Ohio General Assembly to determine the limits of liability for all non-economic damages and losses in a civil action upon a medical, dental, optometric or chiropractic claim. The limits would be placed upon damages such as pain and suffering, mental anguish, and loss of enjoyment in a claim against a health care provider for medical negligence. Economic damages, such as lost earnings, medical care and rehabilitation costs will not be limited.

The resolution is modeled after a resolution in Texas which called for an amendment to their state constitution and was recently narrowly passed and enacted. The initiative needs a three-fifths vote in both houses of the Ohio General Assembly and then the issue would be brought to the ballot for a vote.

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Senate Bill 6 – Bioterrorism

Senator Steve Stivers (R – Columbus)

House Homeland Security, engineering, and Architectural Design Committee –

Senate Finance and Financial Institutions – Heard 2/25/03, 3/4/03, and amended and reported out on 3/11/03. Passed Ohio Senate on 3/12/03 by a vote of 33 - 0.

Position: Support with technical assistance

Senate Bill 6 will enhance the authority of the Director of the Ohio Department of Health, as well as the Ohio Department of Health's authority to step up surveillance of diseases in Ohio and will do the following:

1. Provides that any person who has custody or control over a document or other record the Director or authorized person considers to be necessary for entering, examining, or surveying any grounds, vehicles, dwellings, or places are to make the document or record available to the Director or person.
2. Requires the Public Health Council to adopt rules under which a trauma center is required to report to the Director of the Ohio Department of Health information describing the trauma center's preparedness and capacity to respond to disasters, mass casualties, and bioterrorism; the Council's rules may require the reporting of any information the Council considers necessary for the Director to obtain a proper description of a trauma center's preparedness and capacity to respond to disasters, mass casualties, and bioterrorism.
3. Gives the Department the supreme authority in matters of isolation; the Department currently has supreme authority in matters of quarantine.
4. Requires pharmacists to report medication-related events that might be caused by bioterrorism, epidemic or pandemic disease, or established or novel infectious agents or biological toxins posing a risk of human fatality or disability.
5. Provide the Director may conduct investigations or inquiries at any time the Director considers a matter to be a threat to the public's health.
6. Requires laboratories outside the State of Ohio to report specified diseases in Ohioans to the Ohio Department of Health.
7. Protects "personal health information" reported to the Ohio Department of Health and avoids premature disclosure of pending public health investigations, with limited exceptions.
8. Gives the Ohio Department of Health the ability to sell its services not only to other state agencies, but to local boards of health, other states and the federal government.

9. Authorizes the Ohio Department of Health to collect information from trauma centers describing their preparedness to respond to bioterrorism and other catastrophic events.
10. Allows the Ohio Department of Health to purchase and store vaccines, serums, antibiotics, etc.
11. Prohibits any person from failing to comply with any reporting requirement established in rules by the Ohio Department of Health;
12. Establishes that the Director of Health may impose fines for violations of items to be reported with the fines being deposited to the credit of the general operations fund of the Department. Such violations are considered either a minor misdemeanor or a misdemeanor of the first degree.

Senate Bill 14 – Prescription Drug Program

Senator Bob Hagan (D – Youngstown)

Senate Health, Human Services and Aging – Sponsor testimony on 6/24/03; Hearing held on 6/25/03

Position: Neutral with Technical Assistance

Senate Bill 14 creates in the Ohio Department of Job and Family Services the Rx Program. The program would be open to residents of Ohio who are not eligible for a program under which federal, state, or county funds are used to pay part or all of the cost of the individual's prescription drugs. The participant could not have prescription drug coverage through a third party payer. Applicants for the program would apply to the county department of job and family services.

The program is to be funded by rebates made by manufacturers and wholesale distributors of dangerous drugs pursuant to rebate agreements entered into and money appropriated by the Ohio General Assembly. The money in the fund is to reimburse a terminal distributor of dangerous drugs for the amount of the discount the terminal distributor provides an Rx program participant and to pay the terminal distributor a professional fee. The money would also go for the administration of the program.

Each terminal distributor is to discount the amount it charges a an Rx participant for a prescription drug covered by the program. The amount of the discount would be the amount of the rebate a manufacturer or wholesale distributor pays the Director of the Department for the prescription drug pursuant to the rebate agreement.

Senate Bill 41 – Surgical Treatment of Morbid Obesity

Senator Robert Hagan (D – Youngstown)

Senate Insurance, Commerce and Labor Committee – Sponsor hearing 3/18/03

Position: Support

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Senate Bill 41 requires health insuring corporations and sickness and accident insurers to offer coverage for the surgical treatment of morbid obesity on the same terms as for any other medically necessary surgical procedure, and requires that such coverage be included in the medical assistance program and public employee benefit plans.

Senate Bill 60 – Meningitis Vaccination

Senator Jeffry Armbruster (R – North Ridgeville)

Senate Health, Human Services and Aging Committee – Sponsor hearing 6/4/03

Position – Neutral

Senate Bill 60 establishes a requirement that institutions of higher education require students living in on-campus housing be vaccinated for meningitis or obtain a waiver of the vaccination requirement. The Department of Health is to approve vaccinations against meningitis and may adopt rules it considers necessary to implement this program.

Senate Bill 61 – Coverage of Diabetes

Senator Jeffry Armbruster (R – North Ridgeville)

Yet to be Referred to a Committee in the Senate

Position – Neutral with Technical Assistance

Senate Bill 61 requires certain health care policies, contracts, agreements, and plans to provide benefits for equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes and for diabetes self-management education, including medical nutrition therapy, for the treatment and management of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes.

All of the following apply to the provision of benefits for the expenses of diabetes self-management education:

- Requires the benefits to cover the expenses only if the education is prescribed by a physician or other individual whose professional practice includes the authority to prescribe the education;
- During the first 12 month period immediately after a patient begins to receive diabetes self-management education, the benefits are to cover the expenses of 10 hours of education, which may include one hour used for assessment of the patient's training needs, but only if the education includes the completion of an individual diabetes education plan;
- In each year following the provision of coverage the benefits are to cover the expenses for two hours of education as an annual education maintenance program for the patient, but only if the patient undergoes an examination by a physician to make a medical determination of the patient's diabetes condition.

- The benefits are to cover the expenses of any education provided during home visits when the individual prescribing the education considers home visits to be important in meeting management or treatment goals.
- The benefits are to cover the expenses of education only if the education is provided by an individual with expertise in diabetes care, including an expert who is a dietitian, physician, pharmacist, registered or licensed practical nurse, or other individual whose professional practice includes the authority to provide the education, except that the benefits are to cover the expenses of medical nutrition therapy only if it is provided by a dietitian.
- The benefits are to cover the expenses of any education provided in a group setting, but coverage is not to be limited to education provided in a group setting.

This legislation does not prevent the benefits provided from being subject to copayments; does not prevent an individual, employer, or other entity from negotiating for or obtaining a policy, contract, or agreement that provides benefits that exceed the benefits required; does not prevent an individual diabetes education plan from being disclosed to an insurer if the insurer makes a request for disclosure in writing or by electronic transmission; does not prevent an insurer from discussing an individual diabetes education plan with the patient or with the physician or other individual who formulated the plan; does not prevent a patient from choosing not to seek or accept diabetes self-management education and notifying the insurer of that decision; and does not prevent a patient or the physician or other individual who prescribed the education for the patient from petitioning an insurer for additional coverage of education that is medically necessary.

This legislation does not interfere with the authority of an insurer to administer the policy, contract, or agreement through a network and to negotiate reimbursement amounts with providers; and does not interfere with the authority of an insurer to include in its provider network for the purpose of administering the benefits individuals with expertise in diabetes care.

Senate Bill 80 – Tort Reform

Senator Steve Stivers (R – Columbus)

House Judiciary Committee – Bill substituted on 10/1/03 to remove the provisions pertaining to asbestos and include such asbestos provisions in House Bill 292, which has been referred to the House Civil and Commercial Law Committee. Hearing 12/4/03 and 3/11/04. Hearings to continue in March, April and May on punitive damages and pain and suffering. Hearings on statute of repose and product liability are to be announced. Hearings are to continue throughout the summer.

Senate Judiciary on Civil Justice Committee – Sponsor hearing on 5/7/03; At the hearing on 5/14/03, Eric Burkland, representing the Ohio Manufacturers' Association, and Jack Pottmeyer, an Architect for MKC Association, testified in support of the bill; testifying in opposition to the bill was Frank Tadero of the Ohio Academy of Trial Lawyers and Shannon Montgomery, a citizen.

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At the hearing on 5/21/03, Marty White, attorney, Deborah Smith, the mother of a brain damaged daughter, and Jody Burress, whose daughter was the victim of medical malpractice, testified against the bill. At the 5/27/03 hearing, Frank Ciatolla, Chair of the National Federation of Independent Businesses, testified as a proponent; William Wisenberg, a lobbyist for the Ohio State Bar Association, testified in opposition to the bill; and Beth Dorsey, a citizen, and Dennis Mulvihill with the Ohio Academy of Trial Lawyers, testified in opposition to the bill. On 6/4/03, Bruce Johnson, Director of the Ohio Department of Development, testified in support of the legislation and Robert Bunda, a partner with Bunda Stutz and DeWitt, testified in support of the legislation on behalf of Owens – Illinois, Inc.. The bill is to be amended and possibly reported out of Committee on 6/10/03.

Amended in Committee on 6/11/03 to provide an owner, lessee, or occupant of a recreational trail premises does not assume, has no responsibility for, does not incur liability for, and is not liable for any injury to person or property caused by any act of a user of a recreational trail; to include a legislative intent provision; to include a severability clause; to request the Ohio Supreme Court to adopt a “Legal Consumer’s Bill of Rights”; and to provide an exception to the punitive damage cap for victims of rape and sexual battery. Senate Bill 80 was reported out of Committee on 6/11/03 and passed the Ohio Senate by a vote of 19-13 on 6/11/03.

Position: Support

Senate Bill 80 is the general tort reform legislation and does the following:

Specific Causes of Action

- Provides that in a tort action an owner, lessee, renter, or operator of premises that are open to the public for direct access to growing agricultural produce is not imputed to extend any assurance to a person that the premises are safe from naturally occurring hazards by giving permission to the person to enter the premises or by receiving consideration for the produce picked, or to assume responsibility or liability for injury, death, or loss to person or property allegedly resulting from the natural condition of the terrain of the premises.
- Prohibits the commencement of a wrongful death action if the decedent was compensated for the decedent's injuries prior to the decedent's death, the decedent executed a valid release of the decedent's claim, and the decedent's personal injuries could be the basis of a civil action for wrongful death.
- Prohibits the commencement of a wrongful death action if a judgment for damages was entered in a civil action prior to the decedent's death, the judgment was fully satisfied, and the decedent's personal injuries that were the subject of that civil action were sustained under the same circumstances that otherwise could have been the basis of a civil action for wrongful death.

- Provides that no civil action that is based upon a cause of action that accrued in any other state, territory, district, or foreign jurisdiction may be commenced and maintained if the period of limitation that applies to that action under the laws of that other state, territory, district, or foreign jurisdiction has expired or the period of limitation that applies to that action under the laws of this state has expired.
- Requires that an action based on a product liability claim and an action for bodily injury or injury to personal property be brought within two years after the cause of action accrues and provides that generally such a cause of action accrues when the injury or loss to person or property occurs.
- Provides that a cause of action for bodily injury that is not caused by exposure to asbestos, not incurred by a veteran through exposure to chemical defoliants or herbicides or other causative agents, and not caused by exposure to DES or other nonsteroidal synthetic estrogens, and is caused by exposure to hazardous or toxic chemicals, ethical drugs, or ethical medical devices, accrues upon the earlier of the date competent medical authority informs the plaintiff of the injury that is related to the exposure or the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff has an injury that is related to the exposure.
- Provides that a cause of action for bodily injury incurred by a veteran through the exposure to chemical defoliants or herbicides or other causative agents, including agent orange, accrues upon the earlier of the date on which competent medical authority informs the plaintiff of the injury that is related to the exposure or the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff had an injury that is related to the exposure.
- Provides that a cause of action for bodily injury caused by exposure to DES or other nonsteroidal synthetic estrogens accrues upon the earlier of the date on which competent medical authority informs the plaintiff that the plaintiff has an injury that is related to the exposure or on the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff had an injury that is related to the exposure.

Statutes of Repose

- Prohibits the accrual of a wrongful death action involving, or another cause of action based on, a product liability claim against the manufacturer or supplier of a product later than ten years from the date the product was delivered to the first purchaser or first lessee who was not engaged in a business involving the product, but excepts a wrongful death action or another cause of action from this statute of repose if the manufacturer or supplier engaged in fraud in regard to information about the product and the fraud contributed to the harm alleged.

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- Specifies that the ten-year statute of repose described in the prior dot point does not bar a civil action for wrongful death or another tort action against a manufacturer or supplier of a product who made an express, written warranty as to the safety of the product that was for a period longer than ten years and that has not expired and permits a wrongful death action or another tort action involving such a product liability claim to be commenced within two years after the cause of action accrues, if the cause of action accrues less than two years prior to the expiration date of the ten-year statute of repose.
- Provides that if death or bodily injury occurs during the above-described ten-year statute of repose and the claimant cannot commence a civil action during that period due to a disability, a civil action for wrongful death or a tort action based on such a product liability claim may be commenced within two years after the disability is removed.
- Prohibits a cause of action to recover damages for injury or wrongful death that arises out of a defective and unsafe condition of an improvement to real property and a cause of action for contribution or indemnity for such damages that arises out of a defective and unsafe condition of an improvement to real property from accruing later than ten years from the date of the performance of the services or the furnishing of the design, planning, supervision of construction, or construction.
- Allows a cause of action to recover damages for injury or wrongful death to be brought within two years from the date of discovery of a defective and unsafe condition of an improvement to real property if that discovery is made during the ten-year statute of repose but less than two years prior to the expiration of that period.
- Specifies that the ten-year statute of repose described in the prior two dot points does not apply to a civil action for injury or wrongful death against the owner of, tenant of, or other person in possession and control of an improvement to real property and who is in actual possession and control of the improvement at the time the defective and unsafe condition of the improvement constitutes proximate cause of the injury or wrongful death.
- Prohibits the above-described ten-year statute of repose from being asserted as an affirmative defense by any person who engages in fraud with regards to an improvement to real property.
- Modifies the categories of persons who may be awarded compensatory damages in a civil action for wrongful death to include the decedent's "dependent children" instead of minor children.
- Limits the compensatory damages for noneconomic loss that may be awarded in a tort action as follows:
 - (1) Generally, the greater of \$250,000 or an amount equal to three times the plaintiff's economic loss, to a maximum of \$350,000 for each plaintiff or a maximum of \$500,000 for each occurrence;
 - (2) If the noneconomic losses are for permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or for permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life-sustaining activities,
 - (3) \$500,000 for each plaintiff or \$1 million for each occurrence.
- Provides that a court of common pleas has no jurisdiction to enter judgment on an award of compensatory damages for noneconomic loss in excess of the limits in the prior dot point.
- Requires, upon the motion of any party, the bifurcation of a tort action involving compensatory damages and punitive or exemplary damages and provides procedures for a bifurcated trial for a tort action that is tried by a jury and for a tort action that is tried by a judge.
- Limits the recovery of punitive or exemplary damages to the amount of compensatory damages awarded or \$100,000, whichever is greater or, if the defendant is a small employer, to the lesser of the amount of compensatory damages awarded or \$100,000.
- Prohibits the award of punitive or exemplary damages if punitive damages have already been awarded or collected based on the same act or course of conduct that is alleged and the aggregate of those damages exceed the limits described in the prior dot point.
- Permits awarding punitive or exemplary damages in subsequent tort actions involving the same act or courses of conduct for which punitive or exemplary damages have already been awarded if it is determined that the plaintiff will offer new and substantial evidence of previously undiscovered, additional behavior of the defendant other than the injury or loss for which compensatory damages are sought.
- Permits awarding punitive or exemplary damages in subsequent tort actions involving the same act or course of conduct for which punitive or exemplary damages have already been awarded if the total amount of prior punitive or exemplary damages awards was insufficient to punish the defendant's behavior and to deter the defendant and others from similar behavior in the future.
- Prohibits an award of prejudgment interest on punitive or exemplary damages.

Trial, Liability, Damages, and Judgment

- Requires that the court in all tort actions instruct the jury regarding the extent to which an award of compensatory damages or punitive or exemplary damages is not subject to federal or state income tax.
- Requires the trier of fact to consider the failure to wear a seat belt as contributory fault or other tortious conduct or for any other relevant purpose with regards to an injury if the failure to wear the seat belt contributed to the harm alleged and permits the trier of fact, because of that failure, to reduce compensatory damages.

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- Expands the definition of "conduct" with regards to frivolous conduct actions to include the filing of a pleading, motion, or other paper in a civil action.
- Expands the definition of "frivolous conduct" to include conduct that is for another improper purpose, conduct that cannot be supported by a good faith argument for establishment of new law, conduct that consists of allegations or other factual contentions that have no evidentiary support, or conduct that consists of denials or factual contentions that are not warranted by the evidence.
- Removes the definition of and references to "negligence claim" from the law dealing with civil actions and trial procedure and replaces the references with "tort claim."
- Limits attorney contingency fees in connection with a tort action to not exceed 35% of the first \$100,000 recovered, 25% of the next \$500,000 recovered, and 15% on any amounts recovered over \$600,000.
- Requires each licensed attorney to append to every written retainer agreement or contract for legal services a legal consumer's bill of rights and provides the form for that document.

Senate Bill 88 – Mental Health Parity

Senator Kirk Schuring (R – Canton)

Senate Insurance Committee – Sponsor hearing on 6/10/03 was not held.

Position: Neutral

Senate Bill 88 requires policies of sickness and accident insurance to provide benefits for the diagnosis and treatment of severe mental illnesses on the same terms and conditions as, and no less extensive than, those provided for the diagnosis and treatment of all other diseases and disorders. "Severe mental illness" is defined to include all of the following disorders, as these disorders are commonly understood by physicians: schizophrenia; bipolar disorder (manic depressive illness); major depression; panic disorder; obsessive compulsive disorder; and schizoaffective disorder. This provision applies to but is not limited to inpatient and outpatient services, medication, copayments, deductibles, and maximum lifetime benefits. This provision only applies to severe mental illnesses that have been clinically diagnosed by a physician.

Nothing prohibits a sickness and accident insurance company from taking any of the following actions: negotiating separately with mental health care providers with regard to reimbursement rates and delivery of health care services; offering policies of sickness and accident insurance that provide benefits solely for the diagnosis and treatment of mental illness; managing the provisions of benefits for the treatment of severe mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment deemed to be medically necessary.

The bill requires the diagnosing or treating physician to provide the insurer with information that substantiates that the treatment was, and continues to be, medically necessary and with information, upon request, pertaining to the beneficiary's response to treatment.

Requires every group health care policy that also provides coverage for the diagnosis and treatment of mental or emotional disorders other than those severe mental illnesses listed above, to provide benefits for outpatient services for the diagnosis and treatment of these mental or emotional disorders that are at least equal to \$550 in any calendar year or 12-month period.

Product liability actions

- Modifies the provision regarding defects in design or formulation of a product by specifying that a product is defective only if, at the time it left the control of the manufacturer, the foreseeable risks exceeded the benefits associated with the design or formulation.
- Removes the provision that provided that a product is defective in design or formulation if it is more dangerous than expected when used in an intended or reasonably foreseeable manner.
- Prohibits the award of punitive or exemplary damages against the manufacturer of an over-the-counter drug marketed pursuant to federal regulations and generally recognized as safe and effective and not misbranded; provides for the forfeiture of that immunity from punitive or exemplary damages if the manufacturer fraudulently and in violation of FDA regulations withheld from the FDA information known to be material and relevant to the harm allegedly suffered or misrepresented to the FDA that type of information.
- Specifies that a manufacturer or supplier is not liable for punitive or exemplary damages if the harm is caused by a product other than a drug or device and if the manufacturer or supplier fully complied with all applicable standards with regard to the product's manufacture, construction, design, formulation, warnings, instructions, and representations when it left the manufacturer's or supplier's control.
- Specifies that the bifurcated trial provisions or ceiling on recoverable punitive and exemplary damages apply to awards of punitive or exemplary damages awarded under the Product Liability Law.
- Incorporates the product liability contributory fault provisions into the general contributory fault provisions.

Miscellaneous

- Permits defendants in tort actions to introduce evidence of the plaintiff's receipt of collateral benefits, except if the source of the benefits has a mandatory self-effectuating federal right of subrogation or a contractual or statutory right of subrogation.

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Senate Bill 96 – Department of Health Care Administration

Senator Ray Miller (D – Columbus)

Senate Finance and Financial Institutions Committee – Hearing 1/27/04.

Position: Neutral with Technical Assistance

Senate Bill 96 creates the Department of Health Care Administration and transfers administration of the Medicaid Programs, the Hospital Care Assurance Program and Children's Health Insurance Program Parts I and II from the Department of Job Family Services to the Department of Health Care Administration.

Senate Bill 98 – Prejudgment Interest

Senator Steve Austria (R – Beavercreek)

Senate Insurance, Commerce and Labor Committee – Sponsor hearing 6/10/03; Hearing held 6/17/03 and 10/14/03. The House bill was enacted.

Position: Support

Senate Bill 98 prohibits an award of prejudgment interest on future damages and provides that the rate of interest a creditor is entitled to is the federal short-term rate.

Senate Bill 111 – Joint Underwriting Association

Senator Eric Fingerhut (D – Shaker Heights)

Senate Insurance, Commerce and Labor Committee – Hearing held 10/14/03

Position: Neutral

Senate Bill 111 recreates and provides for the operation of the Joint Underwriting Association relative to the issuance of medical malpractice insurance and establishes a stabilization reserve fund for the Joint Underwriting Association.

Senate Bill 112 – Medical Malpractice Insurance

Senator Eric Fingerhut (D – Shaker Heights)

Senate Insurance, Commerce and Labor Committee – Hearing held 12/2/03

Position: Neutral

Senate Bill 112 establishes a term of five years, for medical malpractice insurance policies and limits premium increases during that period.

Senate Bill 113 – Medical Malpractice Insurance

Senator Eric Fingerhut (D – Shaker Heights)

Senate Insurance, Commerce and Labor Committee – Hearing held 12/2/03.

Position: Neutral

Senate Bill 113 creates the Medical Malpractice Insurance Review Commission and provides for the assessment of insurance companies and health insuring corporations to cover the Commission's operating expenses.

Senate Bill 114 – Medical Malpractice Insurance

Senator Eric Fingerhut (D – Shaker Heights)

Senate Insurance, Commerce and Labor Committee – Hearing held 10/14/03

Position: Neutral

Senate Bill 114 provides for the formation of a nonprofit corporation, controlled by, and a membership consisting exclusively of physicians, designed to assist its members in obtaining medical malpractice insurance coverage.

Senate Bill 124 – Civil Immunity for Health Care Workers

Senator Ron Amstutz (R – Wooster)

House Civil and Commercial Law Committee – Hearings 4/28/04, 5/5/04, and amended and reported out on 5/12/04. The House Committee amended the bill to include the successor liability language that the Ohio Senate stripped out of the asbestos bill, House Bill 292. Passed the Ohio House on 5/12/04 by a vote of 78 – 18. The Ohio Senate did not consider concurrence with the bill because of the successor liability language that was included by the House Committee.

Senate Judiciary – Civil Justice Committee – Hearing 11/12/03 and 1/7/04. According to the sponsor, the bill was drafted in consultation with the Free Clinic Association in order to alleviate pressing insurance liability requirements that limit the viability of free clinics. Hearings 1/21/04, 1/28/04, 2/4/04, 2/18/04 and 3/17/04. Amended and reported out 3/31/04 and passed Ohio Senate on 4/20/04 by a vote of 32 – 1.

Position: Oppose

Senate Bill 124 modifies the current civil immunity for health care professionals and health care workers who are volunteers in the provision of care at a nonprofit shelter or health care facility to indigent and uninsured persons for medical, dental, or other health-related diagnosis, care, or treatment.

The immunities provided by this law would not be available to an individual or nonprofit shelter or health care facility if, at the time of an alleged injury, death, or loss to person or property, the individuals involved are:

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- providing an operation to which all of the following apply: the operation requires the administration of a general anesthetic; the operation requires the support of a surgical facility; the operation is a procedure that is not typically performed in an office; and the individual involved is a physician, and the operation is beyond the scope of practice of the physician;
- Delivery of a baby or any other purposeful termination of a human pregnancy.

The bill also changes the monetary threshold for being considered indigent and uninsured from 150% of the current poverty threshold to 200% of the current poverty threshold.

According to the sponsor, the bill will "strengthen and expands Ohio's Good Samaritan Act" since it expands the covered population by increasing the income threshold from 150 percent to 200 percent of the federal poverty level; and expands the scope of covered activities by clarifying the definition of "operations" to which immunity does not apply.

Under current law, an "operation" is any "form of incision;" and the bill changes this to "any procedure or procedures which require the use of a general anesthetic, commonly requiring a surgical facility, or not typically done in an office."

According to the sponsor, the bill will permit free clinics to perform routine medical procedures commonly performed in a doctor's office, such as the treatment of ingrown toenails, wart and mole removal, or minor skin biopsies of cysts, lesions and small tumors of potential skin cancers.

As amended in the House Committee, this bill also does the following:

- Requires the Dental Board to issue a volunteer's certificate to retired dental practitioners upon submission of the application and all required attachments.
- Specifies the types of nurses in specialty practice who may refer to themselves as advanced practice nurses and who may use the initials A.P.N. and provides that in this capacity those nurses are subject to existing law, unchanged by the bill, that specify their scopes of practice.
- Generally limits the successor asbestos-related liabilities of certain corporations to the fair market value of the acquired stock or assets of the transferor if the corporation is a successor in a stock or asset purchase, or to the fair market value of the transferor's total gross assets if the corporation is a successor in a merger or consolidation.
- Provides methods by which a corporation may establish the fair market value of assets, stock, or total gross assets under the provisions covered by the preceding dot point and the formula for the annual increase of that fair market value.

- Provides that the bill's limitations on successor asbestos-related liabilities apply to all asbestos claims and all litigation involving asbestos claims, including claims and litigation pending on the bill's effective date, and that those limitations do not apply to workers' compensation benefits, claims against a successor that do not constitute claims for a successor asbestos-related liability, any obligation arising under the federal "National Labor Relations Act" or under any collective bargaining agreement, or any contractual rights to indemnification.
- Requires courts in Ohio to apply, to the fullest extent permissible under the United States Constitution, Ohio's substantive law, including the bill's provisions, to the issue of successor asbestos-related liabilities.
- Provides that for any cause of action that arises before the act's effective date, the provisions described in the preceding four dot points apply unless a court finds that a party's substantive right has been altered and the alteration is otherwise in violation of the Ohio Constitution's Retroactivity Clause.

Senate Bill 125 – Seat Belts

Senator Jeffrey Armbruster (R – North Ridgeville)

Senate Highways and Transportation Committee – Hearing 10/14/03, 10/21/03, and 2/3/04

Position: Support

Senate Bill 125 makes a seat belt violation a primary offense that is enforceable as any other traffic offense; limits the search authority of a law enforcement officer who stops a vehicle for a seat belt violation by prohibiting the law enforcement officer from searching or inspecting any automobile, or the operator, any passenger, or the contents of the automobile, solely because of a seat belt violation; and prohibits an insurer from increasing the cost of certain automobile insurance policies based on the insured's being charged with a seat belt violation.

Senate Bill 136 – Health Insurance Risk Pool

Senator Lynn Wachtmann (R – Napoleon)

Senate Insurance, Commerce and Labor Committee – Sponsor hearing 12/2/03 – bill introduced at the request of the Ohio Association of Health Underwriters. Hearing 2/4/04.

Position: *No Position at this Time*

Senate Bill 136 will establish the Ohio Health Insurance Risk Pool and repeal existing open enrollment provisions in the Health Insuring Corporation law.

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The bill creates the Ohio Health Insurance Risk Pool with a nine member Board of Directors consisting of the following members appointed by the Superintendent of the Ohio Department of Insurance: two individuals affiliated with an insurer; one member of the Ohio Association of Health Underwriters licensed to sell insurance; one representative of the general public who is not employed by or affiliated with an insurer, hospital, or health care provider; one individual representing health care providers; and two representatives of the business community (one small and one large employer). Other appointments to the Board include: an appointment by the House Insurance Chair of one committee member and an appointment by the Senate Insurance Chair of one committee member.

The Board is required to submit a plan of operation for the risk pool to the Superintendent of the Ohio Department of Insurance within 180 days after the initial appointments of the Board members. The Board is to design the plan of operation and it is to be designed to assure the fair, reasonable, and equitable administration of the pool. The plan of operation is to include provisions governing all of the following: operation of the pool; selection of a third party administrator using the competitive bidding process; creation of a fund, managed by the Board, for the payment of administrative expenses; management and auditing of the pool's assets and money; development and implementation of a program to publicize the existence of the pool, the eligibility requirements for coverage under the pool, and enrollment procedures; creation of a grievance committee to review complaints presented by applicants to the pool and insureds; and matters as are necessary and proper to the operation of the Board and the Board's execution of its powers, duties, and obligations.

The Board is to establish a list of medical conditions for which an individual is eligible for coverage under a benefit plan without needing to first apply for other health insurance. The Board will select an insurer or a third party administrator to administer the pool.

The Board may adjust rates and rate schedules for appropriate risk factors. The Board is to consider any appropriate risk factors in accordance with established actuarial and underwriting practices. The Board is to determine the standard risk rate by considering premium rates charged by insurers offering individual health insurance and is to set the standard risk rate using reasonable actuarial techniques. The standard risk rate is to reflect anticipated experience and expenses for such coverage.

The Board is to assess insurers monthly for such amounts as the Board finds necessary to obtain funds for the operation of the pool. The assessment is a fee and is exempt from all premium taxes levied or assessed by Ohio or any political subdivision. The pool may not assess an insurer in an amount exceeding \$2.00 per month for each individual with a health insurance policy, contract, or agreement, certificate of group health insurance, or stop loss or reinsurance contract, in force with the insurer. The pool may not impose any additional assessment on the insurer, either directly or indirectly. An insurer may pass the cost of the assessment through to the insurer's policy, contract and certificate holders.

Senate Bill 147 – Physician Assistants

Senator Lynn Wachtmann (R – Napoleon)

Senate Health, Human Services and Aging Committee - Sponsor hearing 1/28/04; at the proponent hearing 2/4/04 Jeffrey Bachtel, a Tallmadge family physician, testified in support of the bill. Hearings held 3/17/2004, 3/31/2004, and 4/21/2004. Substituted on 5/19/04. Hearing scheduled for 5/26/04, but the bill was not heard.

Position: Neutral

Senate Bill 147 revises the laws regarding the practice of physician assistants, including the establishment of physician-delegated prescriptive authority. As substituted, the bill makes the following changes:

- Formulary - lists the drugs physician assistants (PAs) can prescribe and applies the formulary of the advanced practice nurses (APNs) to PAs until a separate one is established.
- Prohibits the PA formulary from being more restrictive than the one for APNs.
- Requires qualifying degrees be obtained from specified accredited programs and extends the time from one to two years for existing PAs with 10 years' experience to obtain prescriptive authority without obtaining a master's degree.
- Prohibits a PA from performing an abortion and from prescribing any drug or device to perform an abortion and designates violations fourth degree felonies.
- Other areas the sub bill addresses include carrying out PA medical orders; health care facility policies for PA practice; staggered terms for the PA Policy Committee; and the timeframe for rules to be developed.

Senate Bill 138 – RX Program

Senator Bob Spada (R – North Royalton)

Awaiting Floor Vote in Ohio Senate – the House version of the bill passed both houses and was enacted.

Senate Finance and Financial Institutions Committee – Hearings 10/29/03, 11/06/03, 11/12/03, 11/18/03, and on 12/02/03 the bill was substituted, amended and reported out of Committee.

Position: House Version of Bill Enacted

Senate Bill 138 established the Ohio's Best Rx Program under which eligible individuals who enroll in the Program may purchase drugs at discounted prices that are derived from rebates provided by drug manufacturers or the average prices otherwise established by the health benefit plans offered by the five state retirement systems and the state health benefit plan offered to state employees through the Ohio Med Preferred Provider Organization or a successor selected by the state.

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Senate Bill 194 – Coverage of Contraceptive Drugs and Devices

Senator Teresa Fedor (D – Toledo)

Yet to be Referred to a Committee in the Ohio Senate

Position: Neutral

Senate Bill 194 prohibits sickness and accident insurance policies, public employee benefit plans, and health insuring corporations policies, contracts, and agreements from limiting or excluding coverage of prescription contraceptive drugs and devices and outpatient services related to the provision of such drugs and devices.

Senate Bill 204 – Moratorium Med Mal Increases

Senator Kirk Schuring (R – North Canton)

Senate Insurance, Commerce and Labor Committee – Sponsor testimony offered 4/20/2004.

Position: Oppose

Senate Bill 204 establishes that for a period of one year, starting on the effective date of the legislation, an insurer is prohibited from delivering, issuing for delivery, or renewing a policy of medical malpractice insurance with a higher premium rate than the premium rate in use by the insurer for the same or similar coverage as of the effective date of the legislation, unless the insurer first obtains the approval of the Superintendent of Insurance.

The bill provides that the insurer may make written application to the Superintendent to use a premium rate in excess of that permitted under the bill and the Superintendent may approve the use of that premium rate if the insurer demonstrates to the satisfaction of the Superintendent that the rate is on an actuarially sound basis and is not unreasonable or excessive.

An emergency provision has been included in the bill that provides “This Act is hereby declared to be an emergency measure necessary for the immediate preservation of the public peace, health, and safety. The reason for this necessity is that Ohio's physicians and hospitals are losing ready access to affordable medical liability insurance in this state and that Ohio's physicians and hospitals need ready access to affordable medical liability insurance in order to continue their practices and operations in this state, providing Ohio's residents with needed medical care. In addition, the Ohio Medical Malpractice Commission is not scheduled to report its findings as to the problems and issues surrounding medical malpractice and the effects of Senate Bill 281 of the 124th General Assembly until 2005. Therefore, this act shall go into immediate effect.”

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House Bill 6 - Bioterrorism

Representative Jimmy Stewart (R – Athens)

Effective February 12, 2004

Senate Finance and Financial Institutions Committee – Heard September 17, 2003; amended and reported out on October 14, 2003. The amendment allows the Director of the Ohio Department of Health to release information if he believes it will aid the investigation of a public health threat.

House Homeland Security, Engineering and Architectural Design Committee – At the sponsor hearing 4/29/03 the bill was substituted. Hearing 5/06/03. At the 5/13/03 hearing, Jodi Govern, Legislative Counsel for the Ohio Department of Health testified in Director Nick Baird's absence as a proponent of the legislation. State Representatives Skindell, Kilbane, Fessler, and Bocchieri were very skeptical of the broad authority delegated to the Director of the Ohio Department of Health, the lack of privacy protections, and the penalty provisions. Heard again on 5/20/03, 6/3/03, 6/10/03 and 6/24/03. The bill was amended and reported out of committee on 6/25/03. The bill passed the Ohio House of Representatives on 6/25/03 by a vote of 98-1.

Position: Support with technical assistance

As substituted, House Bill 6 modifies the authority of the Ohio Department of Health and the Director of Health pertaining to bioterrorism. The bill defines “bioterrorism” to mean the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of a microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, animal, plant, or other living organism as a means of influencing the conduct of government or intimidating or coercing a population.

The bill requires the Ohio Department of Health to adopt rules the Director of the Department considers necessary to provide for the effective fulfillment of the duties and authority of the Ohio Revised Code establishes for the Director and the Department. Allows the Director to take any action pursuant to those rules that the Director considers necessary to fulfill the duties and exercise the authority the Ohio Revised Code establishes for the Director and the Department.

The bill allows the Director of Health to enter into agreements to sell services offered by the Department of Health to boards of health of city and general health districts and to the departments, agencies, and institutions of Ohio, other states, or the United States. The bill allows the Director to enter into written agreements with any person or government entity to share, exchange, or obtain information the Director concludes is necessary, based on an evaluation of relevant information, to carry out the powers and duties the Ohio Revised Code and rules establish for the Director and the Department. Information shared, exchanged, or obtained may include information that is the subject of an ongoing investigation or inquiry and that is confidential and information that is protected health information and confidential.

The Ohio Public Health Council is required to adopt rules that require a trauma center to report information to the Director of the Ohio Department of Health describing the trauma center’s preparedness and capacity to respond to disasters, mass casualties, and bioterrorism. The Council’s rules may require the reporting of any information the Council considers necessary for an accurate description of a trauma center’s preparedness and capacity to respond to disasters, mass casualties, and bioterrorism. Information reported is not a public record. The Director is to review all information received and after reviewing the information, the Director may conduct an evaluation of a trauma center’s preparedness and capacity to respond to disasters, mass casualties, and bioterrorism. An evaluation conducted is not a public record.

The law of the Ohio Department of Health allows the Department to have ultimate authority in matters of quarantine and this bill also gives the Department ultimate authority in isolation. The Department may also take such actions as are necessary to encourage vaccination against those diseases. In addition, the Director is to investigate or make inquiry as to the cause of disease, illness, or any other health condition, especially when contagious, infectious, epidemic, pandemic, or endemic, and to take prompt action to control and suppress it. Information obtained during an investigation or inquiry is confidential during the course of the investigation and is not to be released except under one of the following conditions: the confidential information is released pursuant to a search warrant or subpoena issued by or at the request of a grand jury or prosecutor; or the Director has entered into a written agreement to share or exchange the information with a person or government entity, and that agreement requires the person or entity to comply with the confidentiality requirements established; or the Director determines the release of the information is necessary, based on evaluation of relevant information, to avert or mitigate a clear threat to an individual, or to the public health and the information released is to be limited to those persons necessary to control, prevent or mitigate the disease.

The bill allows the Director to purchase, store, and distribute antitoxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents or medical supplies that the Director deems advisable in the interest of preparing for or responding to a public health emergency.

The bill defines “protected health information” to mean information, in any form, including oral, written, electronic, visual, pictorial, or physical that describes an individual’s past, present, or future physical or mental health status or condition, receipt of treatment or care, or purchase of health products, if either of the following applies: the information reveals the identity of the individual who is the subject of the information; or the information could be used to reveal the identity of the individual who is the subject of the information, either by using the information alone or with other information that is available to predictable recipients of the information. Protected health information is confidential and is not to be released without the written consent of the individual who is the subject of the information, unless specified circumstances exist. Information that does not identify an individual is not protected health information and may be released in summary, statistical, or aggregate form.

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The Public Health Council is to adopt rules under which a poison prevention and treatment center or other health-related entity is required to report events that may be caused by bioterrorism, epidemic or pandemic disease, or established or novel infectious agents or biological or chemical toxins posing a risk of human fatality or disability. Certain specified situations will require a report to the Department.

The bill establishes reporting requirements for certain contagious or infectious diseases, illnesses, health conditions, or unusual infectious agents or biological toxins posing a risk of human fatality or disability.

The bill requires the Public Health Council to adopt rules under which a pharmacy or pharmacist is required to report significant changes in medication usage that may be caused by bioterrorism, epidemic or pandemic disease, or established or novel infectious agents or biological toxins posing a risk of human fatality or disability. The bill sets forth when such report may be required.

Penalties are established for violations of the Department's rules and the provisions in the bill ranging from a minor misdemeanor on a first offense and a misdemeanor of the fourth degree on each subsequent offense.

As amended in the Ohio House Committee, references to anthrax were removed and certain references to "persons" were changed to "individuals" to include corporations. An amendment clarified that information is not public during an investigation, only at the conclusion.

As amended in the Ohio Senate Committee, the Director of the Ohio Department of Health is to release information obtained during an investigation or inquiry that the Director currently is conducting and that is not yet complete, if the Director determines the release of the information is necessary, based on an evaluation of relevant information, to avert or mitigate a clear threat to an individual or to the public health. Information released is to be limited to the release of the information to those persons necessary to control, prevent, or mitigate disease or illness.

House Bill 87 – Transportation Budget Bill

Representative Steve Buehrer (R – Delta)

Effective July 1, 2003

House Bill 87, as passed by the Ohio House increases the gasoline excise tax by six cents a gallon over a three-year period. The bill requires the lowering of the State's blood alcohol concentration levels to .08.

House Bill 95 – Budget Bill

Representative Charles Calvert (R – Medina)

*Effective: July 1, 2003, some provisions have later effective dates
Conference Committee – Hearing 6/11/03 and the week of 6/16/03.*

Conference Committee members include: State Representative Charles Calvert, Chair; Senator Bill Harris, Vice Chair; State Representatives Jim Hoops and Ed Jerse; and State Senators Ron Amstutz and Eric

Fingerhut. State Representative Lynn Olman is trying to get mental health parity included in the Conference Report. Conference Report reported out of Committee on 6/19/03 and both houses concurred with the report on 6/19/03.

Senate Finance and Financial Institutions Committee – Substituted in Committee on 5/29/03; amended and reported on 6/3/03. Passed the Ohio Senate on 6/5/03 by a vote of 24 – 9.

House Finance and Appropriations Committee – Reported out of Committee on April 8, 2003 and passed the Ohio House on April 9, 2003 by a vote of 53 – 46.

House Bill 95 will provide for a temporary one-cent **sales tax increase** and will provide for the following:

Medicaid Fees – Medicaid fees to providers were frozen in the budget bill; however, some providers, as chiropractors and psychologists, were eliminated as Medicaid providers effective January 1, 2004.

Massage Services - As the bill was introduced and finally adopted, massage services were made subject to the 6% state sales tax effective August 1, 2003. The language provides that "on and after August 1, 2003, state sales tax applies to when personal care service is or is to be provided to an individual. As used in this division, "personal care service" includes skin care, the application of cosmetics, manicuring, pedicuring, hair removal, tattooing, body piercing, tanning, massage, and other similar services. "Personal care service" does not include a service provided by or on the order of a licensed physician or licensed chiropractor, or the cutting, coloring, or styling of an individual's hair.

HMO Copayments and Deductibles - In addition, during the ten hour Conference Committee, the Conferees included language that had never appeared in any version of the budget bill that will allow health insuring corporations (HIC) to raise co-payments and charge deductibles to their enrollees.

Under current HIC law, a HIC may not impose copayment charges on basic health care services that exceed 30 % of the total cost of providing any single covered health care service, except for physician office visits, emergency health services, and urgent care services. An open panel plan may not impose copayments on out of network benefits that exceed 50% of the total cost of providing any single covered healthcare service. To ensure that copayments are not a barrier to the utilization of basic health care services, a HIC may not impose, in any contract year, on any subscriber or enrollee, copayments that exceed 200% of the total annual premium rate to the subscriber or enrollees.

This language has been changed to allow the HIC TO charge higher copayments. The language now reads that a HIC, in order to ensure that copayments are reasonable and not a barrier to the necessary utilization of basic health care services by enrollees, may do one of the following:

1. Impose copayment charges on any single covered basic health care service that does not exceed 40% of the average cost to the HIC of providing the service.

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2. Impose copayment charges that annually do not exceed 20% of the total annual cost to the HIC of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, when aggregated as to all persons covered under the filed product in question. In addition, annual copayment charges as to each enrollee are not to exceed 20% of the total annual cost to the HIC of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, as to such enrollee. The total annual cost of providing a health care service is the cost to the HIC of providing the health care service to its enrollees as reduced by any applicable provider discount (The prohibition on imposing copayments on out of network benefits exceeding 50% has been removed).

The amendment also provides that to ensure that copayments are reasonable and not a barrier to the utilization of basic health care services, a HIC may not impose, in any contract year, on any subscriber or enrollee, payments that exceed 200% of the average annual premium rate to the subscriber or enrollees, instead of the current 200% of total annual premium rate.

The amendment also allows a HIC may require that an enrollee pay an annual deductible that does not exceed \$1,000 per enrollee or \$2,000 per family. Under current law, a HIC may not require an annual deductible. The amendment also allows the Superintendent of the Ohio Department of Insurance to adopt rules defining different annual deductible amounts for plans with an employer-sponsored medical savings account, health reimbursement arrangement, or flexible spending account.

House Bill 126 – RU-486

Representative Tom Brinkman (R – Cincinnati)

Awaiting Governor's signature.

Senate Health, Human Services and Aging Committee – Hearing 11/12/03; amended on 12/3/03 and reported out. Passed by the Ohio Senate on 5/19/2004 by a vote of 22-10. House concurred with Senate changes

House Health and Family Services Committee – Sponsor hearing 6/11/03; passed out of Committee on 6/18/03. Passed by the Ohio House of Representatives on 6/25/03 by a vote of 79-20.

Position: Neutral

House Bill 126 prohibits the use of RU-486 (mifepristone) to cause an abortion unless it is administered, provided, or prescribed by a physician in compliance with U.S. Food and Drug Administration (FDA) restrictions. The bill exempts from the prohibition a pregnant woman who obtains or possesses RU-486 for the purpose of terminating her own pregnancy, the legal transport of RU-486, and the distribution, provision, or sale of RU-486 by a legal manufacturer or distributor of the drug.

The bill requires physicians who provide RU-486 to cause an abortion to comply with FDA requirements regarding follow-up care and examinations for persons treated with RU-486; requires physicians who provide RU-486 to cause an abortion to make a report to the State Medical Board regarding any serious events or complications related to the use of the drug; and requires the State Medical Board to compile and retain all physician reports of complications related to use of RU-486.

House Bill 126 makes violation of any of the prohibitions a fourth degree felony on the first offense and a third degree felony if the offender previously has been convicted of or pleaded guilty to violation of the offenses or certain other abortion offenses. The bill subjects a professionally licensed person who violates the prohibitions to further sanction by the regulatory or licensing board that has the authority to suspend or revoke the offender's professional license. The bill requires the suspension of the license of a physician, practitioner of a limited branch of medicine, or podiatrist for at least one year for a second or subsequent violation of the prohibitions.

House Bill 126 requires a prosecutor to notify the State Medical Board if a physician, practitioner of a limited branch of medicine, or podiatrist violates any of the prohibitions or a trial court dismisses the charge for the violation on technical or procedural grounds. The bill requires prescriptions for RU-486 to be in writing.

House Bill 137 – Health Care Alliance

Representative Geoff Smith (R - Upper Arlington)

Effective October 29, 2003

Senate Insurance, Commerce and Labor – Hearing 6/10/03, 6/17/03, and was amended to include the provisions of House Bill 138 and reported out of Committee on 6/24/03; the bill passed the Ohio Senate by a vote of 33-0 on 6/24/03. House concurs in Senate amendments by a vote of 90-7 on 6/25/03

House Insurance Committee – A sponsor hearing was held on 4/29/03 and the bill was substituted. Proponent hearing on 5/6/03 and Tom Hardy of the Independent Insurance Agents of Ohio testified. On 5/13/03, Rick Cornett with the Ohio Optometric Association testified as a proponent. At the hearing on 5/27/03 Eric Feldman of the Cleveland Growth Association, testified in support of the bill. At the 6/3/03 hearing, the bill was amended to allow for disclosure for entities involved as negotiating parties and the bill was reported out of the Committee. Passed the Ohio House by a vote of 96 – 0.

Position: Support with Technical Assistance

House Bill 137 makes changes to the appointments of agents by foreign insurance companies doing business in Ohio. In addition, the provisions of House Bill 138 were included as an amendment into House Bill 137; therefore, House Bill 138 is now apart of House Bill 137. The bill permits an organization comprised exclusively of member who are either health care provider or insurance agents to sponsor a small employer health care alliance program for the members= benefit.

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The bill defines Alliance® or “small employer health care alliance” to mean an existing or newly created organization that has been granted a certificate of authority by the Superintendent of the Ohio Department of Insurance and that is either of the following:

- A chamber of commerce, trade association, professional organization, or any other organization that has all of the following characteristics: is a nonprofit corporation or association; has members that include or are exclusively small employers; sponsor or is part of a program to assist such small employer members to obtain coverage for their employees under one or more health benefit plans; or except as provided, is not directly or indirectly controlled, through voting membership representation on its governing board, or otherwise, by any insurance company, person, firm, or corporation that sells insurance, any provider, or by persons who are officers, trustees, or directors of such enterprises, or by an combination of such enterprises or persons.⁶
- A nonprofit corporation controlled by one or more organizations described above.

“Alliance program or alliance health care program” means a program sponsored by a small employer health care alliance that assists small employer members of such small employer health care alliance or any other small employer health care alliance to obtain coverage for their employees under one or more health benefit plans, and that includes at least one agreement between a small employer health care alliance and an insurer that contains the insurer’s agreement to offer and sell one or more health benefit plans to such small employers and contains all of the other features required under section 1731.04 of the Ohio Revised Code.

“Eligible employees, retirees, their dependents, and members of their families”, as used together or separately, means the active employees of a small employer, or retired former employees of a small employer or predecessor firm or organization, their dependents or members of their families, who are eligible for coverage under the terms of the applicable alliance program.

“Enrolled small employer” or “enrolled employer” means a small employer that has obtained coverage for its eligible employees from an insurer under an alliance program.

“Health benefit plan” means any hospital or medical expense policy of insurance or a health care plan provided by an insurer, including a health insuring corporation plan, provided by or through an insurer, or any combination. “Health benefit plan” does not include any of the following:

- A policy covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, or vision care, except where any of the foregoing is offered as an addition, endorsement, or rider to a health benefit plan;

- Coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- Coverage issued by a health-insuring corporation authorized to offer supplemental health care services only.

“Insurer” means an insurance company authorized to do the business of sickness and accident insurance in Ohio or, for the purposes of this Chapter, a health-insuring corporation authorized to issue health care plans in Ohio.

“Participants” or “beneficiaries” means those eligible employees, retirees, their dependents, and members of their families who are covered by health benefit plans provided by an insurer to enrolled small employers under an alliance program.

“Provider” means a hospital, urgent care facility, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, certified registered nurse anesthetist, dietitian, or other health care provider licensed by Ohio, or group of such health care providers.

“Qualified alliance program” means an alliance program under which health care benefits are provided to \$2,500 or more participants.

“Small employer”, regardless of its definition in any other Chapter of the Ohio Revised Code, in this Chapter means an employer that employs no more than 150 full-time employees, at least a majority of whom are employed at locations within Ohio.

- For this purpose: (a) each entity that is controlled by, controls, or is under common control with, one or more other entities is to, together with such other entities, be considered to be a single employer; (b) “Full-time employee” means a person who normally works at least 25 hours per week and at least 40 weeks per year for the employer; (c) an employer will be treated as having 150 or fewer employees on any day if, during the prior calendar year or any 12 consecutive months during the 24 full months immediately preceding that day, the mean number of full-time employees employed by the employer does not exceed 150.
- An employer that qualifies as a small employer for purposes of becoming an enrolled small employer continues to be treated as a small employer for purposes of this Chapter until such time as it fails to meet the conditions described above for any period of 36 consecutive months after first becoming an enrolled small employer, unless earlier disqualified under the terms of the alliance program.

⁶ This last provision does not apply to an organization comprised exclusively of, and that offer coverage exclusively to, member who are either insurance agents or providers and that is controlled by the organization’s member or by the organization itself.

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House Bill 142 – Meningitis Vaccination

Representative John Hagan (R – Alliance)

Effective July 14, 2004

Senate Health, Human Services and Aging Committee – Sponsor hearing 6/11/03. Hearing on 1/21/04. The bill was amended on 2/04/04. The bill was amended again and reported out on 3/10/04. Passed the Ohio Senate on 3/17/04 by a vote of 32 – 0.

House Health and Family Services Committee – Sponsor hearing held on 4/2/03; At the 5/21/03 hearing, Dr. Forrest Smith, a state epidemiologist for the Ohio Department of Health, testified in support of the legislation and the bill was amended and reported out of Committee. Passed the Ohio House on 6/3/03 by a vote of 97 – 0.

Position: Neutral

House Bill 142 prohibits on or after July 1, 2004, a institution of higher education from permitting a student to reside in on-campus student housing unless the student or parents disclose to the institution whether the student has been vaccinated against meningitis by submitting to the institution the meningitis vaccination status statement. The statement may be submitted in written or electronic form establishes a requirement that institutions of higher education require students living in on-campus housing be vaccinated for meningitis or obtain a waiver of the vaccination requirement. The Department of Health is to approve vaccinations against meningitis and may adopt rules it considers necessary to implement this program.

The bill requires the Ohio Department of Health to make available on its web site information about the risks associated with meningitis, the availability of a vaccine, and the effectiveness of a vaccine. The Department is also to make available on its web site, a meningitis vaccination status statement form for a student or parent to complete to disclose whether the student has been vaccinated against meningitis.

As amended in the Ohio Senate Committee, the implementation date was changed from 2004 to 2005 and the meningitis status statement form was changed.

House Bill 189 – Podiatrists

Representative Charles Blasdel (R – East Liverpool)

Effective August 6, 2004

Senate Health, Human Services and Aging Committee – Hearing 1/21/04, 2/04/04, and amended to make a technical change and reported out on 3/10/04. Passed the Ohio Senate 31 – 0 on 3/18/04.

House Health and Family Services Committee – Sponsor hearing 6/11/03; on 8/12/03, James Holdinger, Ohio Podiatric Medicine Association, testified in support of the bill. On 9/18/03, the bill was unanimously reported out of the Committee. The bill passed the Ohio House of Representatives on 10/7/03 by a vote of 93 – 0.

Position: Support

House Bill 189 would allow podiatrists to make independent hospital admissions.

House Bill 212 – Prejudgment Interest

Representative Bill Seitz (R – Cincinnati)

Effective June 2, 2004

Senate Insurance, Commerce and Labor Committee – Sponsor hearing 12/2/03. Hearings 1/6/04, 1/13/04, and 1/20/04. Reported out of the Senate Committee on 1/29/04. Passed the Ohio Senate on 2/4/02 by a vote of 26 – 7.

House Civil and Commercial Law Committee – Sponsor Hearing held on 6/18/03; Hearing held on 6/25/03, 9/17/03, and on 10/8/03 the bill was amended and reported out of Committee. The bill passed the Ohio House on 10/13/03 by a vote 95 – 0. As amended the bill establishes that the county auditor must notify the clerks of court of rate changes; clarifies that once a rate is determined it would remain effective until the judgment is satisfied; and reduces the filing time to revive dormant judgments from 21 years to 10 years.

Position: Support

House Bill 212 changes the rate of interest on money due under certain contracts and on judgments; changes the computation of the period for which prejudgment interest is due in certain civil actions; precludes prejudgment interest on future damages; and requires that the finder of fact in certain tort actions in which future damages are claimed specify the amount of past and future damages awarded.

Under current law, in cases when money becomes due and payable upon any bond, bill, note, or other instrument of writing, upon any book account, upon any settlement between parties, upon all verbal contracts entered into, and upon all judgments, decrees, and orders of any judicial tribunal for the payment of money arising out of tortious conduct or a contract or other transaction, the creditor is entitled to interest at the rate of 10% per annum and no more unless a written contract provides a different rate of interest in relation to the money that becomes due and payable, in which case the creditor is entitled to interest at the rate provided in that contract.

This section also provides that interest on a judgement, decree, or order for the payment of money rendered in a civil action based on tortious conduct, including, but not limited to a civil action based on tortious conduct that has been settled by agreement of the parties, is to be computed from the date the judgment, decree, or order is rendered to the date on which the money is paid.

This section of the law will be changed to provide that the creditor will be entitled to interest at the rate determined pursuant to section 5703.47 of the Ohio Revised Code, which establishes the definition for the Federal short-term rate and how to compute the statutory interest rate for the following year.⁷

⁷ Section 5703.47 of the Ohio Revised Code establishes the definition for the Federal short-term rate and how to compute the statutory interest rate for following year. This section provides that as used in this

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House Bill 212 provides that if, upon motion of any party to a civil action that is based on tortious conduct, that has not been settled by agreement between the parties, and in which the court has rendered a judgment, decree, or order for the payment of money, the court determines at a hearing held subsequent to the verdict or decision in the action that the party required to pay the money failed to make a good faith effort to settle the case and that the party to whom the money is to be paid did not fail to make a good faith effort to settle the case, interest on the judgment, decree, or order is to be computed as follows:⁸

In an action in which the party required to pay the money has admitted liability in a pleading, from the date the cause of action accrued to the date on which the order, judgment, or decree was rendered.

In an action in which the party required to pay the money engaged in the conduct resulting in liability with the deliberate purpose of causing harm to the party to whom the money is to be paid, from the date the cause of action accrued to the date on which the order, judgment, or decree was rendered.

In all other actions, for the longer of the following periods:

1. From the date on which the party to whom the money is to be paid gave the first notice to the date on which the judgment, order, or decree was rendered. The period is to apply only if the party to whom the money is to be paid made a reasonable attempt to determine if the party required to pay had insurance coverage for liability for the tortious conduct and gave to the party required to pay and to any identified insurer, as nearly simultaneously as practicable, written notice in person or by certified mail that the cause of action had accrued.
2. From the date on which the party to whom the money is to be paid filed the pleading on which the judgment, decree, or order was based to the date on which the judgment, decree, or order was rendered.

The bill includes new language that prohibits a court from awarding interest on future damages that are found by the trier of fact.

section, "federal short-term rate" means the rate of the average market yield on outstanding marketable obligations of the United States with remaining periods to maturity of three years or less, as determined under section 1274 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1274, for July of the current year. On the fifteenth day of October of each year, the Ohio Tax Commissioner is to determine the federal short-term rate. For purposes of any section of the Ohio Revised Code requiring interest to be computed at the rate per annum required by this section, the rate determined by the Commissioner under this section, rounded to the nearest whole number per cent, plus three per cent is to be the interest rate per annum used in making the computation for interest that accrues during the following calendar year.

⁸ The provision that provides that interest on a judgment, decree, or order for the payment of money rendered in a civil action based on tortious conduct and not settled by agreement of the parties, is to be computed from the date the cause of action accrued to the date on which the money is paid, has been deleted from the bills.

In addition, the bill retains the provision that the bill will not apply to a judgment, decree, or order rendered in a civil action based on tortious conduct if a different period for computing interest on it is specified by law, or if it is rendered in an action against the state in the court of claims, or in an action under the Workers Compensation law.

House Bill 212 also provides that in any tort action to which section 2323.55 or 2323.56 of the Ohio Revised Code⁹ does not apply, if a plaintiff makes a good faith claim against a defendant for future damages, the trier of fact is to return a general verdict and, if that verdict is in favor of the plaintiff, answers to interrogatories or findings of fact that specify both of the following: the past damages recoverable by the plaintiff; and the future damages recoverable by that plaintiff.

House Bill 212 also provides in the temporary language in the bill that the interest rate provided applies to actions pending on the effective date of the bill. In the calculation of interest due, in actions pending on the effective date of the bill, the interest rate provided for prior to the amendment of this section is to apply up to the effective date of the bill, and the interest rate provided for in the bill is to apply on and after that effective date.

House Bill 215 – Medical Claims

Representative Jean Schmidt (R – Loveland)

Awaiting Governor's Signing

Senate Insurance, Commerce and Labor Committee – Heard 5/11/04, 5/18/04, 5/19/04, amended and reported out on 5/25/04. Passed Ohio Senate on 5/26/04 by a vote of 31 – 0 and the House concurred with Senate changes.

House Insurance Committee – Sponsor hearing 6/17/03; hearing 9/16/03 and 10/07/03. A letter supporting the bill from John Bastulli, M.D. on behalf of AMC/NOMA was distributed to the Committee members at the 9/16/03 hearing. Hearing 12/9/03. At the hearing on 3/9/04, representatives of the medical association, the Ohio Academy of Trial Attorneys, and the State Bar Association discussed the concepts they have been discussing in their group meetings. Substituted on 4/20/04 to no longer apply to medical screening panels; Heard 4/27/04; Substituted and amended on 5/4/04 and reported out of the House Insurance Committee. The version of the bill reported out of the House Insurance Committee weakened the "I am sorry law", removed language from the "expert witness section", revised the medical claims data to be collected, included an affidavit of noninvolvement, removed the request that the Ohio Supreme Court create a medical court, and included a certificate of expert review. Passed the House by a vote of 94 – 2 on 5/5/04.

Position: Support

⁹ Section 2323.55 of the Ohio Revised Code pertains to future damages recoverable in a medical malpractice actions and periodic payment plans; and section 2323.56 of the Ohio Revised Code applies to periodic payments of certain future damages in tort actions.

Enacted Legislation

125th Ohio General Assembly

As substituted and amended, House Bill 215 provides the following:

Colorado “I am sorry law” - Prohibits the use of a defendant’s statement of sympathy as evidence in a medical liability action. The bill provides that in a civil action brought by an alleged victim of an unanticipated outcome of medical care or in any arbitration proceeding related to a civil action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that are made by a health care provider or an employee of a health care provider to the alleged victim, a relative, or representative of the alleged victim, and that relate to the discomfort, pain, suffering, injury, or death of the alleged victim as a result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or as evidence of an admission against interest. Expressing sympathy has been used as an admission of liability and this provision would allow a physician to express sorrow without having it used against him/her.

Expert Witnesses - The bill sets forth that a physician from another state that testifies as an expert witness in Ohio in any action against a physician for injury or death, whether in contract or tort, arising out of the provision of or failure to provide health care services, is to be deemed to have a temporary license to practice medicine in Ohio solely for the purpose of providing such testimony and is subject to the authority of the State Medical Board of Ohio and the provisions of Chapter 4731 (the State Medical Board laws). The conclusion of an action against a physician is not to be construed to have any effect on the Board’s authority to take action against a physician who testifies as an expert witness under this section.

Current law provides that in order for a person to be deemed competent to give expert testimony, the person is currently required to be licensed by Ohio or another state, and to devote $\frac{3}{4}$ of the person’s professional time to the active clinical practice of medicine or surgery, or to its instruction in an accredited university. This section of current law has been amended to also require that the person practices in the same or a substantially similar specialty as the defendant.

The bill specifically prohibits a court from allowing an expert in one medical specialty to testify against a health care provider in another medical specialty unless the expert shows both that the standards of care and practice in the two specialties are similar and that the expert has substantial familiarity between the specialties. If the person is certified in a specialty, the person must be certified by a board recognized by the American Board of Medical Specialties or the American Board of Osteopathic Specialties in a specialty having acknowledged expertise and training directly related to the particular health care matter at issue.

Current law provides that nothing is to be construed to limit the power of the trial court to adjudge the testimony of any expert witness incompetent on any other ground. The provision providing that nothing is to be construed to limit the power of the trial court to allow the testimony of any other expert witness, has been amended to provide that nothing is to be construed to limit the power of the trial court to allow the testimony of any other witness, on a matter unrelated to the liability issues in the medical claim, when that testimony is relevant to the medical claim involved.

Medical Claims Data Collection – The bill regulates the collection and disclosure of medical claims data by the Ohio Department of Insurance. The Superintendent of the Ohio Department of Insurance, by rule adopted pursuant to Chapter 119, is to require each authorized insurer, surplus lines insurer, risk retention group, self-insurer, captive insurer, the Medical Liability Underwriting Association if created, and any other entity that provides medical malpractice insurance to risks located in Ohio to report information to the Ohio Department of Insurance at least annually regarding any medical, dental, optometric, or chiropractic claim asserted against a risk located in Ohio, if the claim resulted in any of the following: a final judgment in any amount; a settlement in any amount; a final disposition of the claim resulting in no indemnity payment on behalf of the insured.

The report is to contain such information as the Superintendent prescribes by rule adopted in accordance with Chapter 119, including, but not limited to the following information:

- The name, address, and specialty coverage of the insured.
- The insured’s policy number.
- The date of the occurrence that created the claim.
- The name and address of the injured person.
- The date and amount of the judgment, if any, including a description of the portion of the judgment that represents economic loss, noneconomic loss and, if applicable, punitive damages.
- In the case of a settlement, the date and amount of the settlement.
- Any allocated loss adjustment expense.
- Any other information required by the Superintendent pursuant to rules adopted.

The Superintendent may prescribe the format and the manner in which the information is to be reported. The Superintendent may, by rule adopted, prescribe the frequency that the information is reported. The Superintendent may designate one or more licensed rating organizations or other agencies to assist the Superintendent in gathering the information, and making compilations thereof. There is to be no liability on the part of, and no cause of action of any nature arising against, any person or entity reporting or its agents or employees, or the Ohio Department of Insurance or its employees, for any action taken that is authorized.

The Superintendent may impose a fine not to exceed \$500 against any person that fails to timely submit the report required. Fines imposed are to be paid to the credit of the Ohio Department of Insurance Operating Fund.

Except as specifically provided, the information is to be confidential and privileged and is not a public record. The information provided is not subject to discovery or subpoena and is to be made public by the Superintendent or any other person. The Ohio Department of Insurance is to prepare an annual report that summarizes the closed claims reported. The annual report is to summarize the closed claim reports on a statewide basis, and also by specialty and geographic region. Individual claims data is not to be released in the annual report. Copies of the report are to be provided to the members of the Ohio General Assembly.

Enacted Legislation

125th Ohio General Assembly

Medical claims include those claims asserted against a risk located in Ohio that either: meet the definition of a “medical claim under section 2305.113 of the Ohio Revised Code¹⁰”; or have not been asserted in any civil action, but that otherwise meet the definition of a “medical claim” under section 2305.113 of the Ohio Revised Code.

Affidavit of Noninvolvement – A health care provider named as a defendant in a civil action based upon a medical claim is permitted to file a motion with the court for dismissal of the claim accompanied by an affidavit of noninvolvement. The defendant is to notify all parties in writing of the filing of the motion. Prior to ruling on the motion, the court is to allow the parties not less than 30 days from the date that the parties were served with the notice to respond to the motion.

An affidavit of noninvolvement is to set forth, with particularity, the facts that demonstrate that the defendant was misidentified or otherwise not involved individually or through the action of the defendant’s agents or employees in the care and treatment of the plaintiff, was not obligated individually or through the defendant’s agents or employees to provide for the care and treatment of the plaintiff, and could not have caused the alleged malpractice individually or through the defendant’s agents or employees in any way.

The parties are to have the right to challenge the affidavit of noninvolvement by filing a motion and submitting an affidavit with the court that contradicts the assertions of noninvolvement made in the defendant’s affidavit of noninvolvement.

If the affidavit of noninvolvement is challenged, any party may request an oral hearing on the motion for dismissal. If requested, the court is to hold a hearing to determine if the defendant was involved, directly or indirectly, in the care and treatment of the plaintiff, or was obligated, directly or indirectly, for the care and treatment of the plaintiff.

¹⁰ Section 2305.113 defines “medical claim” to mean any claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. “Medical claim” includes the following:

- (a) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person;
- (b) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies: (i) the claim results from acts or omissions in providing medical care; (ii) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.
- (c) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under [section 3721.17](#) of the Revised Code.

The court is to consider all evidence submitted by the parties and the parties’ arguments and may dismiss the civil action based upon the defendant’s lack of involvement in the elements of the plaintiff’s medical claim. The court is to rule on all challenges to the affidavit of noninvolvement within 75 days after the filing of the affidavit of noninvolvement.

A court’s dismissal of a claim against a defendant is to be deemed otherwise than upon the merits and without prejudice pursuant to Civil Rule 41.

If the court determines that a health care provider named as a defendant has falsely filed or made false or inaccurate statements in an affidavit of noninvolvement, the court, upon a motion or upon its own initiative, is to immediately reinstate the claim against that defendant, if previously dismissed. Reinstatement of a party is not to be barred by any statute of limitation defense that was not valid at the time the original affidavit was filed.

In any action in which the defendant is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court is to impose upon the person who signed the affidavit or represented the defendant, or both, an appropriate sanction, including, but not limited to, an order to pay to other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the filing of the false or inaccurate affidavit, including reasonable attorney’s fees.

In any action in which the court determines that a party falsely objected to a defendant’s affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a defendant’s affidavit, the court is to impose upon the party or the party’s counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the submission of the false objection or inaccurate statement, including reasonable attorney’s fees.

Certificate of Expert Review – In the temporary language in the bill, it establishes that the Ohio General Assembly respectfully requests the Ohio Supreme Court to require a plaintiff filing a medical liability claim to include a certificate of expert review as to each defendant. The Ohio General Assembly respectfully requests that the certificate of expert review require the signature of an expert witness from the same specialty as the defendant; said witness is to be required to meet the statutory evidentiary and case law requirements of a medical expert capable of testifying at trial.

A certificate of expert review should be required to state with particularity the expert’s familiarity with the applicable standard of care, the expert’s qualifications, the expert’s opinion as to how the applicable standard of care was breached, and the expert’s opinion as to how the breach resulted in the injury or death.

Mandatory Discovery Disclosure Rules - In another section of temporary language the Ohio General Assembly respectfully requests the Ohio Supreme Court to amend the Rules of Civil Procedure to establish an expedited discovery process in medical liability claims to provide for the timely resolution of the disputes.

Enacted Legislation

125th Ohio General Assembly

House Bill 281 – Assets of Insurer

Representative Earl Martin (R – Avon Lake)

Effective July 2, 3004

Senate Insurance, Commerce and Labor Committee - Sponsor hearing 1/13/04. Hearings 1/27/04, 2/3/04, and reported out of Committee on 2/10/04. Passed the Ohio Senate on 3/17/04 by a vote of 32 – 0.

House Insurance Committee – At the hearing on 10/7/03 the bill sponsor gave testimony and Richard Frederick from the Ohio Department of Insurance testified as a proponent. At the hearing on 10/14/03, John May, of the Ohio Association of Health Underwriters, and Thomas Hardy, Executive Vice President of the Ohio Association of Insurance Agents, testified as proponents of the bill. The bill was amended 12/2/03 to create an administrative sanction for some actions and to lower the criminal sanction for the same actions to a misdemeanor, replacing the current felony designation; and the bill was reported out of the Committee. The bill passed the Ohio House of Representatives by a vote of 96 – 0 on 12/9/03.

Position: Support

House Bill 281 has been introduced at the request of the Ohio Department of Insurance and would address three areas of concern: fraudulent health plans; admitted assets of Health Insuring Corporations (HICs); and certificates of compliance.

The penalties would be increased for selling fraudulent plans from a misdemeanor to a fourth degree felony with 6 to 18 months jail time and a fine of not more than \$5,000. Agents representing the fraudulent companies could be charged with a fifth degree felony.

The bill will ensure that all health insuring corporations will follow the accounting principles of the National Association of Health Insuring Corporations (NAIC). The accounting will allow for the measurement of stability and liquidity of the entities. The bill defines how health insuring corporations are to identify “admitted assets” for the purpose of meeting the required minimum and repeals the current method of listing the assets that qualify as admitted assets.

The bill prohibits any person from establishing, operating, or maintaining a multiple employer welfare arrangement in Ohio, providing benefits through a group self-insurance program, without a valid certificate of authority from the Superintendent of the Ohio Department of Insurance.

Prohibits a person from establishing, operating, or maintaining an entity in Ohio that delivers, issues, or renews policies of sickness and accident insurance or contracts of health care if Ohio law requires the person to have a certificate of authority under the Insurance law or the Health Insuring Corporation law and the person does not have a valid certificate of authority.

House Bill 282 – Medical Liability Underwriting Association

Representative Larry Flowers (R – Canal Winchester)

April 12, 2004

Senate Insurance, Commerce and Labor Committee – Hearing 1/20/04, 2/3/04, 2/10/04 and 2/17/04. At the hearing on 2/17/04 the bill was substituted, amended and reported out of Committee. The bill passed the Ohio Senate on 2/18/04 by a vote of 33 – 0.

House Insurance Committee – Hearing 10/14/03 and 12/2/03. At the 12/2/03 hearing, Director of the Ohio Department of Insurance Ann Womer Benjamin testified asking two medical malpractice amendments be included in House Bill 282, which pertains to insolvent insurance companies. Hearing 12/9/03; at the hearing on 12/16/03 the bill was amended to include language enabling the Superintendent of the Ohio Department of Insurance to establish a medical liability underwriting association by emergency rule and the bill was reported out of Committee. The bill passed the Ohio House of Representatives on 1/7/04 by a vote of 93 – 0.

Position: Support with Technical Assistance (feel inclusion criteria is too stringent)

House Bill 282 lengthens the time period during which the liquidator of an insolvent insurance company may void certain preferential transfers of company assets to creditors; identifies certain transfers of insurance company property that may not be voided by a liquidator but allows a liquidator to void certain other types of property transfers; terminates the Franklin County Court of Common Pleas’ exclusive jurisdiction over proceedings involving a liquidator of an insolvent insurance company; and terminates the personal liability imposed on persons acting on behalf of an insurance company for the amount of the preference given by the insurance company.

As amended, a Medical Liability Underwriting Association would be created by rule of the Superintendent of the Ohio Department of Insurance upon a finding by the Superintendent that both of the following exist:

1. A substantial number of applicants for such class or classes of medical liability insurance have not been placed with insurers authorized to write medical liability insurance in Ohio, and are insurable risks.
2. The lack of such class or classes of medical liability insurance threatens the availability of health care for any group of individuals in Ohio.

The Medical Liability Underwriting Association (MLUA) could issue policies of insurance to physicians and hospitals, including incidental coverages, subject to terms, conditions, exclusions, and limits, established by the MLUA’s Board of Governors subject to the Superintendent’s approval.

Enacted Legislation

125th Ohio General Assembly

Coverages under such policies may be made available as primary or excess protection, provided limits of primary protection under one policy is not to exceed one million dollars for each claim and three million dollars in any year unless otherwise provided for in the plan of operation. The MLUA could underwrite the insurance and adjust and pay losses with respect thereto, or appoint service companies or associations to perform those functions; assume reinsurance; and cede reinsurance.

The bill also allows for the creation of a Stabilization Reserve Fund (SRF) for the MLUA. The SRF is to be administered by thirteen directors, one of whom is to be the Superintendent of the Ohio Department of Insurance or the Superintendent's Deputy. The remaining twelve directors are to be appointed by the Superintendent. Of these twelve directors, five are to be doctors of medicine and surgery, two are to be doctors of osteopathic medicine and surgery, one is to be a doctor of podiatric medicine, and four are to be representatives of hospitals.

Each policyholder of the MLUA is to pay to the MLUA annually a SRF charge. The charge is to be determined by the Directors with the agreement of the Board of Governors of the MLUA, subject to the approval of the Superintendent. In the event that there is no agreement among the Directors, the Board of Governors, and the Superintendent as to the charge, the Superintendent is to determine the charge. The amount of the charge may differentiate between types of coverage, but shall be sufficient to ensure that the MLUA is actuarially sound, adequately reserved, financially stable, and efficiently managed.

If the Board of Governors determines that the moneys contained in the SRF at the end of a fiscal year, exclusive of dollars allocated for pending claims and after payment of all claims and expenses, are in excess of amounts that are necessary to ensure that the MLUA is actuarially sound, adequately reserved, financially stable, and efficiently managed, and the Superintendent concurs, the Superintendent is to cause the return of the excess fund moneys to applicants that have contributed to the fund and that are not MLUA policyholders at the end of the fiscal year.

A Board of Governors consisting of nine members is to govern the MLUA, seven of whom are to be appointed by the Superintendent of the Ohio Department of Insurance. Of the seven members appointed by the Superintendent, five are to be selected from insurers licensed to write and writing liability insurance in Ohio, at least two of which insurers must write medical liability insurance in Ohio. In addition to representatives from the five insurers, the Superintendent also is to appoint one member who is a licensed physician and one member from a hospital operating in Ohio. The Governor is to appoint two members. Of the two members appointed by the Governor, one is to be an insurance agent licensed and writing medical liability insurance in Ohio. The other member appointed by the Governor is to represent the interests of consumers and is neither a member of, or associated with, a health care provider or profession nor associated with a health insuring corporation or an insurance company.

The Board of Governors of the MLUA is to submit to the Superintendent of the Ohio Department of Insurance, for the Superintendent's review, a proposed plan of operation. The Superintendent may adopt this plan by rule or formulate a plan of operation by rule.

The plan of operation is to provide for the economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of medical liability insurance, and is to contain other provisions, including, but not limited to, provisions relating to all of the following: establishment of necessary facilities; management of the MLUA; reasonable and objective underwriting standards; acceptance and cession of reinsurance; the appointment of servicing carriers or the direct issuance of syndicate policies; and the issuance of a binder providing coverage for which an applicant tenders an amount equal to the annual premium as estimated by the MLUA.

The bill also creates a Medical Liability Fund consisting of the remaining funds of the former Joint Underwriting Association (\$12 million). Such funds are to be for the purposes of funding the MLUA or for funding another medical malpractice initiative with the approval of the Ohio General Assembly.

The bill was amended in the Senate Committee to: tighten eligibility language so a physician or hospital must first be declined by two admitted carriers in order to obtain Medical Liability Underwriting Association (MLUA) coverage; require the Governor to appoint the MLUA Board of Governors with the advice of the Superintendent; allow the Superintendent to close down the MLUA if its continued operation undermines its statutory purpose or threatens its ability to meet its contractual obligations; provide the State will not be liable for the liabilities of the MLUA; add an emergency clause in order to have the ability to immediately establish the MLUA fund and cover physicians if the medical liability insurance market were to drastically worsen before the bill's effective date; and include podiatrists under the provisions of the MLUA.

House Bill 292 – Asbestos Lawsuits

Representative Scott Oelslager (R – Canton)

Awaiting Signing by Governor

Senate Judiciary Civil Justice Committee – hearing 3/10/04, 3/24/04, 3/31/04, 4/21/04, 4/27/04, 5/5/04. On 5/11/04, the bill was substituted, amended and reported out of Committee. Passed the Ohio Senate on 5/11/04 by a vote of 22 – 11. House concurred with Senate changes.

House Civil and Commercial Law Committee – Hearings 10/8/03, 10/15/03, 10/22/03, 11/05/03, 11/12/03, and 11/19/03. Substituted on 11/25/03; hearing 12/03/03 and on 12/10/03 the bill was substituted and reported out of the Committee. The bill passed the Ohio House of Representatives by a vote of 61 – 36 on 12/10/03.

Position: Neutral

House Bill 292, as passed, provides that, for purposes of the existing statute of limitations for asbestos-related civil actions and the bill's provisions, "bodily injury caused by exposure to asbestos" means physical impairment of the exposed person to which the person's exposure to asbestos is a substantial contributing factor. The bill provides minimum requirements that are medical in nature for bringing or maintaining an asbestos claim based on a nonmalignant condition or based on lung cancer of an exposed person who is a smoker, or based on a wrongful death of an exposed person.

Enacted Legislation

125th Ohio General Assembly

Other provisions of the bill include the following:

- In a tort action in which an asbestos claim is alleged, requires the filing of a written report and supporting test results constituting prima-facie evidence of the exposed person's physical impairment that meets the minimum requirements for the particular claim.
- Provides procedures for the defendant in the case in which an asbestos claim is alleged to challenge the adequacy of the plaintiff's prima-facie evidence and for the court to resolve the issue of whether the plaintiff has made a prima-facie showing.
- Requires the court, upon a finding of failure to make a prima-facie showing, to administratively dismiss the plaintiff's claim without prejudice and to maintain its jurisdiction over the case, and permits a plaintiff whose case has been administratively dismissed to reinstate the case.
- Provides that, for any cause of action arising before the bill's effective date, the bill's minimum requirements are to be applied unless the court with jurisdiction over the case finds that a party's substantive right has been altered and that alteration is otherwise in violation of the Ohio Constitution's retroactivity clause.
- Provides that a proceeding for a prima-facie showing of the minimum requirements for an asbestos claim or a finding made under the provision described in the preceding dot point are provisional remedies that are subject to appeal under current law.
- Provides that no prima-facie showing is required in a tort action alleging an asbestos claim based upon mesothelioma.
- Specifies that, except for the provisions establishing the medical criteria for a prima-facie case based upon a wrongful death and related provisions, the asbestos litigation provisions are not intended and are not to be interpreted to affect any wrongful death claims.
- Provides that, notwithstanding any other provision of law, with respect to an asbestos claim based upon a nonmalignant condition that is not barred as of the bill's effective date, the period of limitations does not begin to run until the exposed person has a cause of action for bodily injury pursuant to the existing statute of limitations for asbestos-related civil actions.
- Provides that a premises owner generally is not liable for any injury to any individual resulting from asbestos exposure, subject to certain exceptions and presumptions.
- Specifies that the asbestos litigation and premises liability provisions are not intended and are not to be interpreted to affect the rights of any party under bankruptcy proceedings or the ability to make a claim or demand against a trust established pursuant to a plan of reorganization under a Chapter 11 bankruptcy.
- Specifies that the asbestos litigation and premises liability provisions do not affect the scope or operation of any workers' compensation law or veterans' benefit program or related subrogation provisions.
- In tort actions alleging injury or loss to person resulting from exposure to asbestos as a result of a defendant's tortious act, requires the plaintiff to prove that that particular defendant's conduct, and the exposure to asbestos, was a substantial factor in causing the injury or loss. Describes the General Assembly's intent in enacting the provisions covered by the preceding dot point.
- Enacts elements that have to be proven with respect to the liability of a shareholder in an asbestos claim under the common law doctrine of piercing the corporate veil.

- Specifies that any liability of the shareholder under its piercing the corporate veil provisions is exclusive and preempts any other obligation or liability imposed upon that shareholder for that obligation or liability under common law or otherwise.
- States that its provisions regarding piercing the corporate veil in asbestos claims are intended to codify the elements of the common law cause of action for piercing the corporate veil and to abrogate the common law cause of action and remedies relating to piercing the corporate veil in asbestos claims.
- Provides that its provisions regarding piercing the corporate veil in asbestos claims apply to all asbestos claims commenced on or after the bill's effective date or commenced prior to and pending on that effective date.
- Requests the Supreme Court to collect data regarding awards for frivolous conduct and a lack of reasonable good faith basis for certain civil actions.
- Provides the General Assembly's findings and intent regarding its provisions. Specifically requests the Supreme Court to adopt certain rules related to asbestos claims.
- Includes severability clauses regarding items it contains, and the application of such items.

House Bill 311 – Best RX Program

Representative John Hagan (R – Alliance)

Effective December 18, 2003

Senate Finance and Financial Institutions Committee – Hearing 12/10/03 and reported out of Committee. Passed the Ohio Senate on 12/10/03 by a vote of 96 – 1.

House Finance and Appropriations Committee – Hearings 10/27/03, 10/28/03, 11/05/03, 11/12/03, 11/13/03, 11/18/03, 11/19/03, 11/13/03, 12/02/03, 12/03/03, and on 12/09/03 the bill was substituted and reported out of the Committee. Passed the Ohio House of Representatives by a vote of 93 – 1 on 12/9/03.

Position:

House Bill 311 establishes the Ohio's Best Rx Program under which eligible individuals who enroll in the Program may purchase drugs at discounted prices that are derived from rebates provided by drug manufacturers or the average prices otherwise established by the health benefit plans offered by the five state retirement systems and the state health benefit plan offered to state employees through the Ohio Med Preferred Provider Organization or a successor selected by the state.

The bill requires the Program to be administered by the Ohio Department of Job and Family Services (ODJFS), but permits ODJFS to contract with a person to be the Ohio's Best Rx Program administrator and requires ODJFS to adopt rules governing the Program, including any rules ODJFS determines are necessary for the efficient administration of the Program. The bill requires the administrator to offer a mail order system through which Program participants may obtain drugs.

Enacted Legislation

125th Ohio General Assembly

House Bill 311 establishes the following requirements that must be met for an individual to be eligible for the Ohio's Best Rx Program: (1) The individual must be an Ohio resident; (2) The individual must be age 60 or older or have a family income not exceeding 250% of the federal poverty guidelines; (3) The individual must not have outpatient prescription drug coverage paid for in whole or in part by a third-party payer (private health insurance), Medicaid, Disability Assistance Medical Assistance, or another health plan or pharmacy assistance plan that uses state or federal funds to cover drug costs, other than the discount card program offered through the Golden Buckeye Card Program; (4) The individual must not have had the outpatient prescription drug coverage specified above during any of the four months preceding the month in which application is made for the Ohio's Best Rx Program. This restriction does not apply when a person becomes age 60 or the coverage ended because of any of the following: (a) a third-party payer's bankruptcy, (b) the individual is no longer eligible for coverage provided through a federally protected retirement plan, or (c) the individual is no longer eligible for Medicaid or Disability Assistance Medical Assistance.

The bill requires ODJFS to adopt rules establishing application and reapplication procedures and the forms to be used for applying to participate in the Program; allows applications to be made by an individual on behalf of another; and specifies that providing false information on an application constitutes the offense of falsification, a first degree misdemeanor. The bill requires ODJFS to provide applicants with information about the Medicaid program, including information that explains how Medicaid's drug benefits are better than the Ohio's Best Rx Program.

The bill provides that an individual's eligibility for the Program is limited to one year, after which the individual may reapply and requires enrollment cards to be issued when an individual receives a determination of eligibility for the Program, permits the card to cover all eligible individuals in a family, and requires the card to be presented with each drug purchase.

House Bill 311 requires a drug to be included in the Ohio's Best Rx Program if it is either (1) covered by a state health benefit plan or state retirement system health benefit plan or (2) is covered by a rebate agreement that a drug manufacturer enters into with the Program. The bill allows ODJFS to exclude a drug that is covered by a state health benefit plan or state retirement system health benefit plan, if the plan receives a rebate from the drug manufacturer but the drug is not covered by a rebate agreement under the Ohio's Best Rx Program.

The bill sets forth that any drug manufacturer may enter into a rebate agreement with ODJFS under which the manufacturer agrees to make a rebate payment to ODJFS for any drug specified in the agreement that is dispensed to an Ohio's Best Rx Program participant; and requires that the amount of the rebate payment be equal to the number of units dispensed to the participant multiplied by the greater of the following: (1) the weighted average of the per unit rebates for the drug under the state health benefit plans and state retirement system health benefit plans, or (2) a per unit amount specified by the manufacturer.

The bill requires ODJFS to compile a list of the name of each drug manufacturer that enters into a rebate agreement and the names of the drugs included in the rebate agreement; provides that the list of participating manufacturers is a public record; and requires ODJFS to make the list of participating manufacturers available to physicians, participating terminal distributors, and other health professionals. The bill provides that if a drug manufacturer does not enter into a rebate agreement with respect to a drug it manufactures for which a state health benefit plan or state retirement system health benefit plan receives a rebate for the drug from the manufacturer, ODJFS must ask the Department of Administrative Services (DAS) and each state retirement system to determine whether the drug should be placed, for the following plan year, on a prior authorization list for the plan.

House Bill 342 – Silica Claims

Representative Chris Widener (R – Springfield)

Awaiting Governor's signing.

Senate Committee on Civil Justice – Hearing 5/18/04, on 5/21/04 the bill was amended and reported out of Committee. Passed the Ohio Senate on 5/25/04 by a vote of 22–11. House concurred in changes made in Ohio Senate.

House Civil and Commercial Law Committee – Hearings 1/7/04, 1/21/04, 1/28/04, 2/4/04, and 5/5/04. On 5/12/04, the bill was amended and reported out of Committee. The bill passed the Ohio House on 5/12/04 by a vote of 64–32.

Position: No Position

House Bill 342 provides the minimum requirements that are medical in nature required for a silicosis claim or a mixed dust disease claim based on a nonmalignant condition, based on lung cancer of an exposed person who is a smoker, or based on wrongful death of an exposed person. The bill provides the following:

- In a tort action in which a silicosis claim or a mixed dust disease claim is alleged, requires the filing of a written report and supporting test results constituting prima-facie evidence of an exposed person's physical impairment that meets the minimum requirements for the particular claim.
- Provides procedures for the defendant in the case to challenge the adequacy of the plaintiff's prima-facie evidence and for the court to resolve the issue of whether the plaintiff has made a prima-facie showing and provides that a proceeding for a prima-facie showing is a provisional remedy that is subject to appeal under current law.
- Requires the court, upon a finding of a plaintiff's failure to make a prima-facie showing, to administratively dismiss the plaintiff's claim without prejudice and to maintain its jurisdiction over the case, and permits a plaintiff whose case has been administratively dismissed to reinstate the case.
- Provides that the procedures described in the three preceding dot points apply only to tort actions that allege a silicosis claim or a mixed dust disease claim and are filed on or after the provisions' effective date.

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- Provides that the period of limitations with respect to a silicosis claim or a mixed dust disease claim based on a nonmalignant condition does not begin to run until the exposed person discovers, or through the exercise of reasonable diligence should have discovered, a physical impairment due to a nonmalignant condition.
- Generally provides that a premises owner is not liable for any injury to any individual resulting from silica or mixed dust exposure, subject to certain exceptions and presumptions.
- Specifies that the provisions regarding silica and mixed dust litigation and premises liability are not intended or interpreted to affect the rights of any party under bankruptcy proceedings or the ability to make a claim or demand against a trust established pursuant to a plan of reorganization under a Chapter 11 bankruptcy.
- Specifies that the provisions regarding silica and mixed dust litigation and premises liability do not affect the scope or operation of any workers' compensation law or veterans' benefit program.
- Specifies that the provisions regarding silica and mixed dust litigation do not require or permit the exhumation of bodies in making the prima-facie showing or rebutting the presumption set forth in the bill regarding the ten-year latency period.
- Codifies the elements of the common law cause of action for piercing the corporate veil and specifies the elements that have to be proven with respect to the liability of a shareholder in a silica claim or a mixed dust disease claim under the doctrine of piercing the corporate veil.
- Specifies that any such liability of the shareholder is exclusive and preempts any other obligation or liability imposed upon that shareholder for that obligation or liability under common law or otherwise.
- States that the bill's provisions regarding piercing the corporate veil are intended to codify the elements of the common law cause of action for piercing the corporate veil and to abrogate the common law cause of action and remedies relating to piercing the corporate veil in silica and mixed dust disease claims.
- Provides that the bill's provisions regarding piercing the corporate veil apply to all silica claims or mixed dust disease claims commenced on or after the provisions' effective date or commenced prior to and pending on that effective date.
- In tort actions alleging any injury or loss to person resulting from exposure to silica or mixed dust as a result of the defendant's tortious act, requires the plaintiff to prove that that particular defendant's conduct and the exposure to silica or mixed dust was a substantial factor in causing the injury or loss.
- Specifically requests the Supreme Court to adopt certain rules related to silica claims and mixed dust disease claims.
- Includes a statement of the General Assembly's findings and intent

House Bill 392 – Anatomical Gifts

Representative Jeff Wagner (R – Sycamore)

Awaiting Governor's Signing

Senate Health, Retirement and Aging Committee – Bill substituted and reported and then again substituted and reported out of the Committee on 5/26/04 and passed the Ohio Senate on 5/26/04 by a vote of 31 – 0. The House concurred with the Senate changes.

The first substitute bill would have extended the time frame by which a hospital could have applied for trauma certification; however, the second substitute bill took this provision out of the bill.

House Juvenile and Family Law Committee – Hearing 3/10/04, 3/24/04, and on 4/17/04 the bill was substituted and reported out of Committee. The bill passed the Ohio House on 5/5/04 by a vote of 96 – 0.

Position: Neutral

House Bill 392 permits an individual to make an anatomical gift of all or part of the individual's body by specifying the intent to make an anatomical gift in a space provided in the individual's living will ("declaration" under Ohio law). The bill requires a printed declaration form to include a section, before the form's signature line, specifically designed for an individual to declare the individual's intent to make an anatomical gift.

The bill permits an individual who makes an anatomical gift through a declaration to amend or revoke the gift and permits an individual to refuse to make an anatomical gift by specifying the refusal in the declaration.

The bill increases the membership of the Second Chance Trust Fund Advisory Committee within the Ohio Department of Health to include two members appointed by the Director of the Ohio Department of Health who are affiliated with recovery agencies or members of the public. The bill no longer requires the Ohio tissue bank member and the Ohio eye bank member to “not be” affiliated with an organ procurement organization. The Ohio Hospital Association member must now have a transplant program or a facility that has been verified as a Level I or Level II trauma center by the American College of Surgeons to be a member.

The requirement that no two members are to be from the same organ procurement and distribution service area has been removed from the bill. The bill now provides that members are to be geographically and demographically representative of the state and no more than a total of three members appointed are to be affiliated with the same recovery agency or group of recovery agencies. Recovery agencies that recover only one type of organ, tissue, or part, as well as recovery agencies that recover more than one type of organ, tissue, or part, are to be represented.

Senate Bill 35 – Direct Access Physical Therapists

Senator Scott Nein (R – Middletown)

Effective May 4, 2004

House Health and Family Services Committee – Sponsor hearing on 6/25/03; hearings 8/12/03, 9/17/03, and 10/8/03. At the hearing on 9/17/03, an amendment was included in the bill to allow advanced practice nurses to refer patients to physical therapists. On 10/15/03, the bill was amended in Committee and reported out by a vote of 18 – 2. One amendment limited the orthotic devices that could be applied and the second amendment shortened the time frame for notification to the physician. The bill passed the Ohio House of Representatives on 1/6/04 by a vote of 92 – 4

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Senate Insurance, Commerce and Labor Committee – Sponsor hearing on 2/25/03; Hearings 3/4/03, 3/11/03, 3/18/03, and at the 3/18/03 hearing the bill was amended and reported out of Committee by a unanimous vote. The bill passed the Ohio Senate on 3/26/03 by a vote of 30 – 2.

Position: Opposition

Senate Bill 35, as amended, will allow a patient to go to a licensed physical therapist without a referral or prescription from a physician if the patient is willing to pay cash. In order for the physical therapist to see a patient without a referral, the physical therapist is required to have a Master's or Doctorate degree, or by December 31, 2003, have two years of practical experience. The bill prohibits the physical therapist from performing a "medical" diagnosis and clarifies what initials can be used by physical therapists and physical therapist assistants.

The bill provides that if a physical therapist evaluates and treats a patient without the prescription of, or the referral of the patient by, a physician, chiropractor, dentist, podiatrist, or a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, all of the following apply:

- (1) The physical therapist is required, upon consent of the patient, to inform the patient's physician, chiropractor, dentist, podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner of the evaluation not later than five business days after the evaluation is made ("business day" is defined to mean any calendar day that is not a Saturday, Sunday, or a legal holiday);
- (2) If the physical therapist determines, based on reasonable evidence, that no substantial progress has been made with respect to that patient during the 30 day period immediately following the date of the patient's initial visit with the physical therapist, the physical therapist is required to consult with or refer the patient to a physician, chiropractor, dentist, podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, unless either of the following applies:
 - (a) The evaluation, treatment, or services are being provided for fitness, wellness, or prevention purposes;
 - (b) The patient previously was diagnosed with chronic, neuromuscular, or developmental conditions and the evaluation, treatment, or services are being provided for problems or symptoms associated with one or more of those previously diagnosed conditions.
- (3) If the physical therapist determines that orthotic devices are necessary to treat the patient, the physical therapist is limited to the application of the following orthotic devices:
 - (a) Upper extremity adaptive equipment used to facilitate the activities of daily living;
 - (b) Finger splints;

- (c) Wrist splints;
 - (d) Prefabricated elastic or fabric abdominal supports with or without metal or plastic reinforcing stays and other prefabricated soft goods requiring minimal fitting;
 - (e) Nontherapeutic accommodative inlays;
 - (f) Shoes that are not manufactured or modified for a particular individual;
 - (g) Prefabricated foot care products;
 - (h) Custom foot orthotics;
 - (i) Durable medical equipment.
- (4) If, at any time, the physical therapist has reason to believe that the patient has symptoms or conditions that require treatment or services beyond the scope of practice of a physical therapist, the physical therapist is to refer the patient to a licensed health care practitioner acting within the practitioner's scope of practice.

This bill does not mandate coverage of physical therapy services from an insurance company, worker's compensation, or the Medicaid program.

Senate Bill 43 - Prescription Identification Card

Sponsor – Robert Spada (R – North Royalton)

Awaiting Governor's Signing

House Health and Family Services – Hearings 5/12/04 and 5/19/04. The bill was substituted, amended and reported out of Committee on 5/26/04. The bill passed the Ohio House on 5/26/04 by a vote of 93 – 2. The changes were concurred with by the Ohio Senate.

Senate Health, Human Services and Aging Committee – Sponsor hearing 6/11/03; hearing 3/10/04 and 3/17/04. The bill was substituted and amended and reported out of Committee on 4/6/04. The bill passed the Ohio Senate on 4/21/04 by a vote of 33 – 0.

Position – Neutral with Technical Assistance

Senate Bill 43 requires health insurers that issue or require the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims to issue or require the use of a card or technology containing uniform information. The bill provides for those requirements to take effect one year after the bill's effective date.

A standardized identification card or an electronic technology issued or required to be used is required to contain uniform prescription drug information in accordance with either of the following:

- The standardized identification card or the electronic technology is to be in a format and contain information fields approved by the National Council for Prescription Drug Programs or a successor

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organization, as specified in the Council's or successor organization's Pharmacy Identification Card Implementation Guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

- If the health care insurer or the person under contract with the insurer to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology is to contain any of the following information:
 - (a) The insurer's name;
 - (b) The subscriber's name, group number, and identification number;
 - (c) A telephone number to inquire about pharmacy-related issues;
 - (d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";
 - (e) The processor's control number, labeled as "RxPCN";
 - (f) The subscriber's pharmacy benefits group number if different from the subscriber's medical group number, labeled as "RxGrp."

If the standardized identification card or the electronic technology issued or required to be used is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.

The bill also reduces from ten to two the number of employees life insurance must cover to be considered group life insurance.

Senate Bill 86 - Immunity for Health Care Providers

Senator Steve Stivers (R – Columbus)

Some provisions effective 4/13/04 and other provisions effective 7/12/04

House Civil and Commercial Law Committee – On 10/8/03, Senator Steve Stivers gave his sponsor testimony and Dr. Phil Cass, representing ACCESS Health-Columbus testified as a proponent of the bill. On 10/15/03, the following individuals testified against the bill: Rev. Vincent Frosh, First AME Zion Church; Amiee Bowie, Central Community House; Rev. Margaret Barnett, Greater Faith Temple; Father John Statmiller, Corpus Christi Catholic Church; Cathy Levine, UHCAN; Cantor Jack Chomsky, Congregation Tifereth Israel; Rev. Dr. Lee Anne Reat, St. John's Episcopal Church; and others.

Hearing 10/15/03, and 10/22/03. On 11/05/03 the bill was amended to instruct the Ohio Department of Insurance to study the bill under the auspices of their current study on medical malpractice insurance; to include language pertaining to advanced practice nurses; and to require that before uninsured patients are treated by a physician, they must sign a waiver which explicitly states that they are losing their right to sue. The bill was amended and reported out of the House Committee on 11/5/03. The bill was amended on the House floor and passed the House by a vote of 87 – 9.

Senate Health, Human Services and Aging – At the sponsor testimony on 5/21/03, Senator Stivers said the bill would expand the current good Samaritan law to provide immunity to volunteer health care providers. At the hearing on 5/28/03, the bill was substituted and Keith Kerns of the Ohio Dental Association, Reed Fraley of Access Health Columbus, Dr. Edward Bope, one of the founders of the Physicians Free Clinic, and Sheila Grimes, a patient at the Physician Free Clinic testified in support of the bill.

On 6/4/03 Cathy Levine, The Executive Director of Universal Health Care Action Network, spoke in opposition to the bill and said the bill creates two standards of care -- one for the insured and the other for the uninsured-poor where the standard becomes "anything goes". She explained that under the bill the poor patients would have no protection from malpractice. The bill was amended and reported out of Committee on 6/4/03. Passed Ohio Senate on 6/10/03 by a vote of 32 – 0.

Position: Support

Senate Bill 86 extends immunity from liability for services provided by volunteer health care professionals and workers to more health care professionals, health care facilities and to nonprofit referring organizations; and increases the maximum allowable income of individuals who may be served by volunteers having immunity from liability.

A health care professional who is a volunteer and complies with the provisions in the bill is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the volunteer in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, including the provision of samples of medicine and other medical products, unless the action or omission constitutes willful or wanton misconduct. To qualify for the immunity, a health care professional is to do all of the following prior to providing diagnosis, care, or treatment:

- (a) Determine, in good faith, that the indigent and uninsured person is mentally capable of giving informed consent to the provision of the diagnosis, care, or treatment and is not subject to duress or under undue influence;
- (b) Inform the person of the provisions of this bill, including notifying the person that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot hold the health care professional liable for damages in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, unless the action or omission of the health care professional constitutes willful or wanton misconduct;
- (c) Obtain the informed consent of the person and a written waiver, signed by the person or by another individual on behalf of and in the presence of the person, that states that the person is mentally competent to give informed consent and, without being subject to duress or under undue influence, gives informed consent to the provision of the diagnosis, care, or treatment subject to the provisions of this section. A written waiver is to state clearly and in conspicuous type that the person or other individual who signs the waiver is signing it with full

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knowledge that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot bring a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, against the health care professional unless the action or omission of the health care professional constitutes willful or wanton misconduct.

A physician or podiatrist who is not covered by medical malpractice insurance, but complies with the provisions above, is not required to comply with division (A) of section 4731.143 of the Revised Code, which provide each person holding a valid certificate authorizing the certificate holder to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, who is not covered by medical malpractice insurance is to provide a patient with written notice of the certificate holder's lack of such insurance coverage prior to providing nonemergency professional services to the patient.

Health care workers who are volunteers are not liable in damages to any person or government entity in a tort or other civil action, including an action upon a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care worker in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, unless the action or omission constitutes willful or wanton misconduct.

A nonprofit health care referral organization is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the nonprofit health care referral organization in referring indigent and uninsured persons to, or arranging for the provision of, medical, dental, or other health-related diagnosis, care, or treatment by a health care professional, unless the action or omission constitutes willful or wanton misconduct.

A health care facility or location associated with a health care professional, a health care worker, or a nonprofit health care referral organization is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care professional or worker or nonprofit health care referral organization relative to the medical, dental, or other health-related diagnosis, care, or treatment provided to an indigent and uninsured person on behalf of or at the health care facility or location, unless the action or omission constitutes willful or wanton misconduct.

The immunities provided above are not available to a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location if, at the time of an alleged injury, death, or loss to person or property, the health care professionals or health care workers involved are providing one of the following:

(a) Any medical, dental, or other health-related diagnosis, care, or treatment pursuant to a community service work order entered by a court or imposed by a court as a community control sanction;

(b) Performance of an operation;

(c) Delivery of a baby.

The aforementioned provision does not when a health care professional or health care worker provides medical, dental, or other health-related diagnosis, care, or treatment that is necessary to preserve the life of a person in a medical emergency. This bill does not create a new cause of action or substantive legal right against a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location.

This bill does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law to which a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location may be entitled in connection with the provision of emergency or other medical, dental, or other health-related diagnosis, care, or treatment.

This bill does not grant an immunity from tort or other civil liability to health care professional, health care worker, nonprofit health care referral organization, or health care facility or location for actions that are outside the scope of authority of health care professionals or health care workers. This bill does not affect any legal responsibility of a health care professional, health care worker, or nonprofit health care referral organization to comply with any applicable law of this state or rule of an agency of this state.

This bill does not affect any legal responsibility of a health care facility or location to comply with any applicable law of this state, rule of an agency of this state, or local code, ordinance, or regulation that pertains to or regulates building, housing, air pollution, water pollution, sanitation, health, fire, zoning, or safety.

The bill was amended to provide that the Ohio Medical Malpractice Commission created by Senate Bill 281 (124th) is to have the following duties, in addition to the other duties provided by law for the Commission:

(1) To study the affordability and availability of medical malpractice insurance for health care professionals and health care workers who are volunteers and for nonprofit health care referral organizations;

(2) To study the feasibility of whether the State of Ohio should provide catastrophic claims coverage, or an insurance pool of any kind, for health care professionals and health care workers to utilize as volunteers in providing medical, dental, or other health-related diagnosis, care, or treatment to indigent and uninsured persons;

(3) To study the feasibility of whether the State of Ohio should create a fund to provide compensation to indigent and uninsured persons who receive medical, dental, or other health-related diagnosis, care, or treatment from health care professionals or health care workers who are volunteers, for any injury, death, or loss to person or property as a result of the negligence or other misconduct by those health care professionals or workers;

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- (3) To study whether the Good Samaritan laws of other states offer approaches that are materially different from the Ohio Good Samaritan Law as amended by this Act.

In addition, the Commission is to submit a report of its to the members of the Ohio General Assembly not later than two years after the effective date of this Act.

Senate Bill 187 – Medical Malpractice Insurance Policies

Senator Scott Nein (R – Middletown)

Awaiting Governor's Signing

House Insurance Committee – Hearings 4/21/04, 4/27/04, and amended and reported out on 5/11/04. Passed the Ohio House on 5/25/04 by a vote of 89 – 4. Senate concurred with House changes.

Senate Insurance, Commerce and Labor Committee – Senate Bill 187 pertains to deferred annuities. The bill was substituted, amended and reported out of Committee on 3/3/0/04. The amendment included in the bill was included at the request of the Ohio Department of Insurance and pertains to the cancellation and renewal of medical malpractice insurance policies. The Senate passed the bill on 3/31/04 by a vote of 33 – 0.

Position: Support

On March 30, 2004, Senate Bill 187, a bill pertaining to deferred annuities, sponsored by State Senator Scott Nein (R – Middletown), was heard, substituted and amended. The amendment was included at the request of the Ohio Department of Insurance and pertains to the cancellation and renewal of medical malpractice insurance policies.

The law covering a notice of cancellation of a policy for commercial property insurance, fire insurance and casualty insurance, was amended to also apply to medical malpractice insurance policies. The amendment provides a notice of cancellation of medical malpractice insurance is not to be issued unless it is based on one of the following grounds:

- Nonpayment of premium;
- Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted thereunder;
- Discovery of a moral hazard or willful or reckless acts or omissions on the part of the named insured that increase any hazard insured against;
- The occurrence of a change in the individual risk which substantially increased any hazard insured against after insurance coverage has been issued or renewed, except to the extent the insurer reasonably should have foreseen the change or contemplated the risk in writing the contract;
- Loss of applicable reinsurance or a substantial decrease in applicable reinsurance, if the Superintendent of the Ohio Department of Insurance has determined that reasonable efforts have been made to prevent the loss of, or substantial decrease in, the applicable reinsurance, or to obtain replacement coverage;

- Failure of an insured to correct material violations of safety codes or to comply with reasonable written loss control recommendations;
- A determination by the Superintendent that the continuation of the policy would create a condition that would be hazardous to the policyholders or the public.

The notice of cancellation is to be in writing and mailed to the insured and include: the policy number, the date of the notice, the effective date of the cancellation, and an explanation of the reason for the cancellation. The effective date of cancellation must be no less than 60 days from the date of mailing the notice, unless it is for nonpayment of premium, then the effective date of cancellation must be no less than 10 days from the date of mailing the notice. The insurer may issue a policy for a period greater than one year and provide in such policy that the insurer may issue a notice of cancellation at least 60 days prior to an anniversary of such policy, with the effective date of cancellation being that anniversary.

The amendment provides there is no liability on the part of, and no cause of action of any nature arises against, the Superintendent, any insurer, or any person furnishing information requested by the Superintendent or an insurer, or the agent, employee, attorney, or other authorized representative of any such persons, for any oral or written statement made to supply information relevant to a determination on cancellation of any policy of medical malpractice insurance, or in connection with advising an insured or the insured's attorney of the grounds for a cancellation of such insurance, or in connection with any administrative or judicial proceeding arising out of or related to such cancellation.

An insurer that intends to cancel, terminate, or otherwise not renew a policy of medical malpractice insurance that it has issued to any class, type, or specialty of practitioner, or that intends to cancel, terminate, or otherwise not renew all policies in a specific geographic area, which may include the state as a whole, is to file written notice of its intended action with the Superintendent of the Ohio Department of Insurance. Such actions by an insurer are not effective unless the written notice is filed with the Superintendent within the following time frames:

1. At least 180 days prior to the insurer acting to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance that the insurer has issued in Ohio;
2. At least 120 days prior to the insurer acting to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance for a specific class, type, or specialty of practitioner or in a specific geographic area other than this state as a whole.

Written notice is also to be filed with the Superintendent at least 120 days prior to the insurer making changes in its underwriting guidelines, if the effect of the changes will be to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance for a specific class, type, or specialty of practitioner or in a specific geographic area other than Ohio as a whole.

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The written notice filed with the Superintendent is to contain all of the following information:

1. The date of the notice;
2. The number of insureds with policies that will be cancelled, terminated, or not renewed;
3. The date that the insurer intends to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance that the insurer has issued to any class, type, or specialty of practitioner, or that the insurer intends to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance in a specific geographic area, including Ohio as a whole;
4. The specific geographic area, if any;
5. Any other information required by the Superintendent.

An insurer that intends to condition renewal of a medical malpractice insurance policy upon an increase in premium is to mail a notice of the insurer's intention to the agent of record and to the insured at the insured's last known address at least 60 days prior to the expiration date of the policy.

An insurer may refuse to renew a policy of medical malpractice insurance by mailing a notice of the insurer's intention to the agent of record and to the insured at the insured's last known address at least 60 days prior to the expiration date of the policy. The notice mailed is to contain all of the following information:

1. The policy number;
2. The date of the notice;
3. The expiration date of the policy;
4. An explanation of the grounds for nonrenewal.

If the notice is mailed less than 60 days before the expiration date of the policy, the insured's coverage then in effect remains in effect until 60 days after the date of mailing the notice unless either of the following is true:

1. In the case of a premium increase, the insured accepts the increased premium. The change is then effective immediately following the expiration of the insured's coverage then in effect.
2. In the case of nonrenewal, the insured notifies the insurer in writing that the insured accepts the nonrenewal as stated.

If the insured's coverage is extended beyond the original expiration date of the policy, the premium for the time after the original expiration date must be calculated using the rates originally applicable to the insured's coverage then in effect. The insurer is to notify the insured of the amount of the premium for the time after the expiration of the insured's coverage then in effect.

The insured is to pay the premium unless either of the following is true:

1. In the case of a premium increase, the insured notifies the insurer in writing that the insured does not want the coverage then in effect to be extended past the expiration date.
2. In the case of nonrenewal, the insured notifies the insurer in writing that the insured accepts the nonrenewal as stated.

The bill was amended on 5/11/04 to provide for expedited appeals process so that the constitutionality of Senate Bill 281 can be settled sooner than later. The bill classifies any court order determining the constitutionality of statutory changes brought about by the enactment of Senate Bill 281 of the 124th General Assembly (relating to civil actions for damages arising out of medical malpractice claims) as a final order that may be immediately appealed and affirmed, modified, or reversed. Senate Bill 281 of the 124th General Assembly contained several provisions regulating medical malpractice actions. The second amendment provides that if one section is determined unconstitutional, the other sections stay in effect.