

Senate Bill 281 – As Enacted

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Senate Bill 281, sponsored by State Senator David Goodman (R – Bexley), is the medical liability reform legislation. The bill was amended in the Senate Insurance, Commerce and Labor Committee on November 20, 2002 and passed the Ohio Senate by a vote of 22 – 9 on November 21, 2002. The bill was referred to the Ohio House of Representatives Civil and Commercial Law Committee; was substituted and amended by the House Committee; and was reported out of the Committee on December 2, 2002. The bill was amended and passed the Ohio House of Representatives on December 3, 2002 by a vote of 65 – 32.

The Ohio Senate would not concur with the changes made by the Ohio House of Representatives and a conference committee was appointed. The Conference Committee met on Senate Bill 281 on December 5, 2002, agreed upon amendments, and reported it out of conference committee in the early evening. Senators Nein and Goodman and Representatives Grendell and Willamowski voted in favor of the Conference Report. Senator Fingerhut and State Representative Jerse voted no. The Ohio House of Representatives agreed to the Conference Committee Report on December 6, 2002 and the Ohio Senate agreed to the Report on December 10, 2002. The bill will be sent to the Governor for signing.

Reporting of Malpractice Actions – Requires every clerk of a court of common pleas in Ohio, each year, to send to the Ohio Department of Insurance an annual report containing certain information relating to each civil action upon a medical claim that was filed or is pending in that court.

Commencement of Action – Provides that except as otherwise provided in the legislation, an action upon a medical claim is to be commenced within one year after the cause of action accrued.

Written Notice – Sets forth that if prior to the expiration of the one year period, a claimant who allegedly possesses a medical claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within 180 days after the notice is so given.

Prohibition on Insurance Company – Provides that an insurance company is not to consider the existence or nonexistence of a written notice, as provided above, in setting the liability insurance premium rates that the company may charge the company's insured person who is notified by that written notice.

Statute of Repose – Sets forth that except as to persons within the age of minority or of unsound mind, and except as provided below, both of the following apply:

- (1) No action upon a medical claim is to be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical claim;
- (2) If an action upon a medical claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical claim, then, any action upon that claim is barred.

The following additional exceptions are also included:

- (1) If a person making a medical claim in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four year period, the person may commence an action upon the claim not later than one year after the person discovers the injury resulting from that act or omission;
- (2) If the alleged basis of a medical claim is the occurrence of an act or omission that involves a foreign object that is left in the body of the person making the claim, the person may commence an action upon the claim not later than one year after the person discovered the foreign object or not later than one year after the person, with reasonable care and diligence, should have discovered the foreign object.
- (3) A person who commences an action upon a medical claim under the circumstances described above in (1) has the affirmative burden of providing, by clear and convincing evidence, that the person, with reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within the three year period described above within the one year period described above in (2), whichever is applicable.

Evidence of Collateral Source Payments – Provides that in any civil action upon a medical claim, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim from the following sources: the United States Social Security Act; any state or federal income disability or worker's compensation act; any health, sickness or income-disability insurance, accident insurance that provides health benefits, or income-disability coverage; or any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. If the defendant elects to introduce evidence, the plaintiff may introduce evidence of any amount that the plaintiff has paid or contributed to secure the plaintiff's right to receive the insurance benefits of which the defendant has introduced evidence. A source of collateral benefits of which evidence is introduced is not to recover any amount against the plaintiff nor is it to be subrogated to the rights of the plaintiff against a defendant.

Good Faith Motion - Upon the motion of any defendant in a civil action based upon a medical claim, the court is required to conduct a hearing regarding the existence or nonexistence of a reasonable good faith basis upon which the particular claim is asserted against the moving defendant. If the court determines that there was no reasonable good faith basis upon which the plaintiff asserted the claim in question against the moving defendant or that, at some point during the litigation, the plaintiff lacked a good faith basis for continuing to assert that claim, the court is to award all of the following in favor of the moving defendant: all court costs incurred by the moving defendant; reasonable attorneys' fees incurred by the moving defendant in defense of the claim after the time that the court determines that no reasonable good faith basis existed upon which to assert or continue to assert the claim; and reasonable attorneys' fees incurred in support of the good faith motion.

Limitation on Non-Economic Damages – sets forth that in a civil action upon a medical claim to recover damages for injury, death, or loss to person or property, all of the following apply:

- (1) There is not to be any limitation on compensatory damages that represent the economic loss of the person who is awarded the damages in the civil action.
- (2) For non-catastrophic losses, the amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a civil action to recover damages for injury, death, or loss to person or property is not to exceed the greater of \$250,000 or an amount that is equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of \$350,000 for each plaintiff or a maximum of \$500,000 for each occurrence.

- (3) The amount recoverable for noneconomic loss in a civil action for catastrophic losses may exceed the amount described above but is not to exceed \$500,000 for each plaintiff or \$1 million for each occurrence.

Plaintiff Attorney's Fees - sets forth that if pursuant to a contingency fee agreement between an attorney and a plaintiff in a civil action upon a medical claim, the amount of the attorney's fees exceed the applicable amount of the limits on compensatory damages for noneconomic loss as provided in this legislation, the attorney is to make an application in the probate court of the county in which the civil action was commenced or in which the settlement was entered. The application is to contain a statement of facts, including the amount to be allocated to the settlement of the claim, the amount of the settlement or judgment that represents the compensatory damages for economic loss and noneconomic loss, the relevant provision in the contingency fee agreement, and the dollar amount of the attorney's fees under the contingency fee agreement. The application is to include the proposed distribution of the amount of the judgment or settlement.

The attorney is to give written notice of the hearing and a copy of the application to all interested persons who have not waived notice of the hearing. Notwithstanding the waivers and consents of the interested persons, the probate court is to retain jurisdiction over the settlement, allocation, and distribution of the claim. The legislation requires the application to state the arrangements, if any, that have been made with respect to the attorney's fees. The attorney's fees are to be subject to the approval of the probate court.

Periodic Payments for Future Damages - establishes that after the hearing and prior to the entry of judgment, the court is to determine, in its discretion, whether all or any part of the future damages recoverable by the plaintiff are to be received by the plaintiff in a series of periodic payments rather than in a lump sum. If the court determines that a plaintiff is to receive the future damages recoverable by the plaintiff in a series of periodic payments, it may order the payments only as to the amount of the future damages recoverable by the plaintiff that exceeds \$50,000. If the court determines that the plaintiff is to receive the future damages recoverable by the plaintiff in a lump sum, the future damages are to be paid in a lump sum. The legislation establishes that the court, in its discretion, may modify, approve, or reject any submitted periodic payments plan. In approving any periodic payments plan, the court is to require interest on the judgment in question.

Ohio Medical Malpractice Commission - creates the Ohio Medical Malpractice Commission consisting of nine members. The President of the Senate is to appoint three of the members, and the Speaker of the House of Representatives is to appoint three of the members. The minority leader of the Senate is to appoint one member and the minority leader of the House of Representatives is to appoint one member. The Director of the Ohio Department of Insurance or the Director's designee is to be the ninth member of the Commission. Of the six members appointed by the President of the Senate and the Speaker of the House of Representatives, one is to represent the Ohio State Bar Association, one is to represent the Ohio State Medical Association, and one is to represent the insurance companies in Ohio, and all of them are to have expertise in medical malpractice insurance issues. The Commission to do all of the following: study the effects of this act; investigate the problems posed by, and the issues surrounding, medical malpractice; and submit a report of its findings to the members of the Ohio General Assembly not later than two years after the effective date of this act.

Preemption by Federal Law - sets forth that if any item of law that constitutes the whole or part of a section of law contained in this Act, or if any application of any item of law contained in this Act, is held to be preempted by federal law, the preemption of the item of law or its application does not affect other items of law or applications that can be given affect. The items of law of which the sections of this Act are composed, and their applications, are independent and severable.

Legislative Intent – Includes a provision on the legislative intent of the Ohio General Assembly in enacting Senate Bill 281.

Applicability of the Act – provides the Act applies to civil actions upon a medical claim in which the act or omission that constitutes the alleged basis of the claim occurs on or after the effective date of this act.

Severability of Act - establishes the items of law of which the sections contained in this Act are composed, and their applications, are independent and severable.

Study Feasibility of Patient Compensation Fund – requires the Superintendent of the Ohio Department of Insurance to study the feasibility of a Patient Compensation Fund to cover medical malpractice claims, including, but not limited to the following: the financial responsibility limits for providers that are covered in Am. Sub. Senate Bill 281 of the 124th General Assembly, and the Patient Compensation Fund; the identification of methods of funding, excluding any tax on consumers; the operation and administration of such a fund; and the participation requirements. The Superintendent to submit a copy of a preliminary report by March 3, 2003, with a final report by May 1, 2003, to the Governor, the Speaker of the Ohio House of Representatives, the President of the Ohio Senate, and the chairpersons of the committees of the Ohio General Assembly with jurisdiction over issues relating to medical malpractice liability. The final report is to include the Superintendent's recommendations for implementing the Patient's Compensation Fund. The Superintendent of the Ohio Department of Insurance is to make recommendations for the operation of a Patient's Compensation Fund designed to assist health care practitioners in satisfying medical malpractice awards above designated amounts. The purpose of the study is to be to consider the feasibility of the Fund satisfying that portion of the awards for damages for noneconomic loss resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of \$350,000 to a maximum of \$500,000. The recommendations are also to provide for the satisfaction of the awards for damages for noneconomic loss resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of \$500,000 to a maximum of \$1 million dollars. The Superintendent's recommendations are to include sources of revenues for the Fund and a mechanism for making, and the assessment of, claims against the Fund.

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Section 1751.67 – Maternity Benefits

Section 1751.67 establishes the requirements for health insuring corporations relative to maternity benefits in policies, contracts and agreements. This section has been amended to change an Ohio Revised Code Reference pertaining to definitions for medical claims and derivative claims for relief.

Section 2117.06 – Creditor’s Claims

Section 2117.06 pertains to creditors having claims against an estate. This section has been amended to change an Ohio Revised Code reference.

Section 2303.23 – Reporting of Malpractice Actions

Division (A) requires every clerk of a court of common pleas in Ohio, each year, to send to the Ohio Department of Insurance an annual report containing all of the following information relating to each civil action upon a medical claim (dental claim, optometric claim, or chiropractic claim)¹ that was filed or is pending in that court:

- (1) The style and number of the case;
- (2) The date of the filing of the case;
- (3) Whether or not there has been a trial and the dates of the trial if there was a trial;
- (4) The current status of the case;
- (5) Whether or not the parties have agreed on a settlement of the case;
- (6) Whether or not a judgment has been rendered, the nature of the judgment, including the amounts of the compensatory damages that represent economic loss and noneconomic loss, and the date of its entry of the judgment; and
- (7) 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.

Division (B) provides that if a report that relates to a specific civil action as described above includes the information specified above with respect to that action or if the parties have agreed on a settlement, the succeeding annual report that the clerk of the court sends to the Department is no longer to include the information describe above with respect to that action. For the purpose of paying the costs of implementing this section, the court of common pleas is required to collect \$5 as an additional filing fee in each civil action upon a medical claim (dental claim, optometric claim, or chiropractic claim) that is filed with the court.

Section 2305.11 – Statute of Limitations Other than Medical, Dental, Optometric, or Chiropractic Claims

Section 2305.11 establishes the time frame for filing an action for libel, slander, malicious prosecution, or false imprisonment, an action for malpractice other than an action upon a medical, dental, optometric, or chiropractic claim, or an action upon a statute for a penalty or forfeiture. This section has been amended to remove all references for commencing actions upon a medical, dental, optometric, or chiropractic claim since this language is now included in new section 2305.113 of this legislation. This section also removes the definitions listed since the definitions are established under section 2305.113 of the Ohio Revised Code.

Section 2305.113 – Commence Action, 180 Day Notice, Statute of Repose

Division (A) provides that except as otherwise provided, an action upon a medical (dental, optometric, or chiropractic) claim is to be commenced within one year after the cause of action accrued.

¹ The bill applies to medical claims, dental claims, optometric claims, and chiropractic claims throughout the bill; however, references to dental claims, optometric claims and chiropractic claims have been omitted throughout the bill analysis.

Division (B)(1) provides that if prior to the expiration of the one year period, a claimant who allegedly possesses a medical claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within 180 days after the notice is so given.

Division (B)(2) provides that an insurance company is not to consider the existence or nonexistence of a written notice, as provided in division (B)(1) in setting the liability insurance premium rates that the company may charge the company's insured person who is notified by that written notice.

Division (C) provides that except as to persons within the age of minority or of unsound mind, and except as provided in division (D) of this section, both of the following apply:

- (1) No action upon a medical claim is to be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical claim;
- (2) If an action upon a medical claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical claim, then, any action upon that claim is barred.

Division (D) provides the following additional exceptions:

- (1) If a person making a medical claim in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four year period, the person may commence an action upon the claim not later than one year after the person discovers the injury resulting from that act or omission;
- (2) If the alleged basis of a medical claim is the occurrence of an act or omission that involves a foreign object that is left in the body of the person making the claim, the person may commence an action upon the claim not later than one year after the person discovered the foreign object or not later than one year after the person, with reasonable care and diligence, should have discovered the foreign object.
- (3) A person who commences an action upon a medical claim under the circumstances described in division (D)(1) has the affirmative burden of providing, by clear and convincing evidence, that the person, with reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within the three year period described above within the one year period described in (D)(2), whichever is applicable.

Division (E) establishes the following definitions of terms for use in section 2305.113 and other sections of the Ohio Revised Code included in this legislation:

- (1) "Hospital" includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including, but not limited to, those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination of the state, political subdivisions, persons, and corporations. "Hospital" also includes any person, corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. "Hospital" does not include any hospital operated by the government of the United States or any of its branches.
- (2) "Physician" means a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the State Medical Board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in this state.
- (3) "Medical claim" means any claim that is asserted in any civil action against a physician, podiatrist, or 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 Ohio Revised Code.

(4) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the State Medical Board.

(5) "Dentist" means any person who is licensed to practice dentistry by the State Dental Board.

(6) "Dental claim" means any claim that is asserted in any civil action against a dentist, or against any employee or agent of a dentist, and that arises out of a dental operation or the dental diagnosis, care, or treatment of any person. "Dental claim" includes derivative claims for relief that arise from a dental operation or the dental diagnosis, care, or treatment of a person.

(7) "Derivative claims for relief" include, but are not limited to, claims of a parent, guardian, custodian, or spouse of an individual who was the subject of any medical diagnosis, care, or treatment, dental diagnosis, care, or treatment, dental operation, optometric diagnosis, care, or treatment, or chiropractic diagnosis, care, or treatment, that arise from that diagnosis, care, treatment, or operation, and that seek the recovery of damages for any of the following:

- a. Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or spouse;
- b. Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment.

(8) "Registered nurse" means any person who is licensed to practice nursing as a registered nurse by the State Board of Nursing.

(9) "Chiropractic claim" means any claim that is asserted in any civil action against a chiropractor, or against any employee or agent of a chiropractor, and that arises out of the chiropractic diagnosis, care, or treatment of any person. "Chiropractic claim" includes derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

(10) "Chiropractor" means any person who is licensed to practice chiropractic by the Chiropractic Examining Board.

(11) "Optometric claim" means any claim that is asserted in any civil action against an optometrist, or against any employee or agent of an optometrist, and that arises out of the optometric diagnosis, care, or treatment of any person. "Optometric claim" includes derivative claims for relief that arise from the optometric diagnosis, care, or treatment of a person.

(12) "Optometrist" means any person licensed to practice optometry by the State Board of Optometry.

(13) "Physical therapist" means any person who is licensed to practice physical therapy.

(14) "Home" has the same meaning as in section 3721.10 of the Ohio Revised Code.-

(15) "Residential facility" means a facility licensed under section 5123.19 of the Ohio Revised Code.

- (16) "Advanced practice nurse" means any certified nurse practitioner, clinical nurse specialist, or certified registered nurse anesthetist, or a certified nurse-midwife certified by the board of nursing under section 4723.41 of the Ohio Revised Code.
- (17) "Licensed practical nurse" means any person who is licensed to practice nursing as a licensed practical nurse by the State Board of Nursing pursuant to Chapter 4723 of the Ohio Revised Code.
- (18) "Physician assistant" means any person who holds a valid certificate of registration or temporary certificate of registration issued pursuant to Chapter 4730 of the Ohio Revised Code.
- (19) "Emergency medical technician-basic", "emergency medical technician-intermediate", and "emergency medical technician-paramedic" means any person who is certified under Chapter 4765 of the Ohio Revised Code as an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, whichever is applicable.

Section 2305.15 – Tolling of Time Limitations

Section 2305.15 pertains to when a cause of action accrues against a person. This section has been amended to change an Ohio Revised Code reference.

Section 2305.234 – Immunity for Health Care Professionals Who Volunteer

Section 2305.234 establishes the immunity for health care professionals who volunteer their services. This section has been amended to change references to the Ohio Revised Code and to add reference to advanced practice nurses and emergency medical technicians.

Section 2317.02 – Privileged Communications

Section 2317.02 establishes the testimonial privilege. This section has been amended to change an Ohio Revised Code reference and to make some technical changes.

Section 2317.54 – Informed Consent to Medical or Surgical Procedures

Section 2317.54 prohibits a hospital, home health agency, or provider of a hospice care program from being held liable for a physician's failure to obtain informed consent from the physician's patient prior to a surgical or medical procedure or course of procedures. This section has been amended to change references to the Ohio Revised Code.

Section 2323.41 - Evidence of Collateral Source Payments

Division (A) establishes that in any civil action upon a medical claim, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim from the following sources:

- (1) The United States Social Security Act, 42 U.S.C.A. section 301 et seq.;
- (2) Any state or federal income disability or worker's compensation act;
- (3) Any health, sickness or income-disability insurance, accident insurance that provides health benefits, or income-disability coverage;
- (4) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services.

Division (B) provides that if the defendant elects to introduce evidence, the plaintiff may introduce evidence of any amount that the plaintiff has paid or contributed to secure the plaintiff's right to receive the insurance benefits of which the defendant has introduced evidence. A source of collateral benefits of which evidence is introduced is not to recover any amount against the plaintiff nor is it to be subrogated to the rights of the plaintiff against a defendant.

Section 2323.42 - Good Faith Motion

Division (A) provides that upon the motion of any defendant in a civil action based upon a medical claim, the court is required to conduct a hearing regarding the existence or nonexistence of a reasonable good faith basis upon which the particular claim is asserted against the moving defendant. The defendant is to file the motion not earlier than the close of discovery in the action and not later than thirty days after the court or jury renders any verdict or award in the action. After the motion is filed, the plaintiff is to have not less than fourteen days to respond to the motion. Upon good cause shown by the plaintiff, the court is to grant an extension of the time for the plaintiff to respond as necessary to obtain evidence demonstrating the existence of a reasonable good faith basis for the claim.

Division (B) establishes that at the request of any party to the good faith motion, the court is to order the motion to be heard at an oral hearing and is to consider all evidence and arguments submitted by the parties. In determining whether a plaintiff has a reasonable good faith basis upon which to assert the claim in question against the moving defendant, the court is to take into consideration, in addition to the facts of the underlying claim, whether the plaintiff did any of the following:

- (1) Obtained a reasonably timely review of the merits of the particular claim by a qualified medical expert, as appropriate;
- (2) Reasonably relied upon the results of that review in supporting the assertion of the particular claim;
- (3) Had an opportunity to conduct a pre-suit investigation or was afforded by the defendant full and timely discovery during litigation;
- (4) Reasonably relied upon evidence discovered during the course of litigation in support of the assertion of the claim in question;
- (5) Took appropriate and reasonable steps to timely dismiss any defendant on behalf of whom it was alleged or determined that no reasonable good faith basis existed for continued assertion of the claim in question.

Division (C) sets forth that if the court determines that there was no reasonable good faith basis upon which the plaintiff asserted the claim in question against the moving defendant or that, at some point during the litigation, the plaintiff lacked a good faith basis for continuing to assert that claim, the court is to award all of the following in favor of the moving defendant:

- (1) All court costs incurred by the moving defendant;
- (2) Reasonable attorneys' fees incurred by the moving defendant in defense of the claim after the time that the court determines that no reasonable good faith basis existed upon which to assert or continue to assert the claim;
- (3) Reasonable attorneys' fees incurred in support of the good faith motion.

Division (D) establishes that prior to filing a good faith motion, any defendant that intends to file that type of motion shall serve a "notice of demand for dismissal and intention to file a good faith motion." If, within fourteen days of service of that notice, the plaintiff dismisses the defendant from the action, the defendant after the dismissal is to be precluded from filing a good faith motion as to any attorneys' fees and other costs subsequent to the dismissal.

Section 2323.43 - Limitations on Non-Economic Damages

Section 2323.43 (A) sets forth that in a civil action upon a medical claim to recover damages for injury, death, or loss to person or property, all of the following apply:

- (1) There is not to be any limitation on compensatory damages that represent the economic loss of the person who is awarded the damages in the civil action.

- (2) Except as otherwise provided in division (A)(3), the amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a civil action under this section to recover damages for injury, death, or loss to person or property is not to exceed the greater of \$250,000 or an amount that is equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of \$350,000 for each plaintiff or a maximum of \$500,000 for each occurrence.
- (3) The amount recoverable for noneconomic loss in a civil action under this section may exceed the amount described in division (A)(2) of this section but is not to exceed \$500,000 for each plaintiff or \$1 million for each occurrence if the noneconomic losses of the plaintiff are for either of the following:
 - a. Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system;
 - b. Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life sustaining activities.

Division (B) provides that if a trial is conducted in a civil action upon a medical claim to recover damages for injury, death, or loss to person or property and a plaintiff prevails with respect to any claim for relief, the court in a nonjury trial is to make findings of fact, and the jury in a jury trial is to return a general verdict accompanied by answers to interrogatories, that specify all of the following:

- (1) The total compensatory damages recoverable by the plaintiff;
- (2) The portion of the total compensatory damages that represents damages for economic loss;
- (3) The portion of the total compensatory damages that represents damages for noneconomic loss.

Division (C)(1) establishes that after the trier of fact in a civil action upon a medical claim to recover damages for injury, death, or loss to person or property complies with division (B), the court is to enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to division (B)(2) of this section, and, subject to division (D)(1) of this section, the court is to enter a judgment in favor of the plaintiff for compensatory damages for noneconomic loss. In no event is a judgment for compensatory damages for noneconomic loss to exceed the maximum recoverable amount that represents damages for noneconomic loss as provided in divisions (A)(2) and (3) of this section. Division (A) is to be applied in a jury trial only after the jury has made its factual findings and determination as to the damages.

Division (C)(2) provides that prior to the trial in the civil action, any party may seek summary judgment with respect to the nature of the alleged injury or loss to person or property, seeking a determination of the damages as described in division (A)(2) or (3) of this section.

Division (D)(1) establishes 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 set forth in this section. Division (D)(2) provides that if the trier of fact is a jury, the court is not to instruct the jury with respect to the limit on compensatory damages for noneconomic loss described in divisions (A)(2) and (3) of this section, and neither counsel for any party nor a witness is to inform the jury or potential jurors of that limit.

Division (E) provides that any excess amount of compensatory damages for noneconomic loss that is greater than the applicable amount specified in division (A)(2) or (3) of this section is not to be reallocated to any other tortfeasor beyond the amount of compensatory damages that that tortfeasor would otherwise be responsible for under the laws of Ohio.

Division (F)(1) sets forth that if pursuant to a contingency fee agreement between an attorney and a plaintiff in a civil action upon a medical claim, the amount of the attorney's fees exceed the applicable amount of the limits on compensatory damages for noneconomic loss as provided in division (A)(2) or (3) of this section, the attorney is to make an application in the probate court of the county in which the civil action was commenced or in which the settlement was entered. The application is to contain a statement of facts, including the amount to be allocated to the settlement of the claim, the amount of the settlement or judgment that represents the compensatory damages for economic loss and noneconomic loss, the relevant provision in the contingency fee agreement, and the dollar amount of the attorney's fees under the contingency fee agreement. The application is to include the proposed distribution of the amount of the judgment or settlement.

Division (F)(2) establishes the attorney is to give written notice of the hearing and a copy of the application to all interested persons who have not waived notice of the hearing. Notwithstanding the waivers and consents of the interested persons, the probate court is to retain jurisdiction over the settlement, allocation, and distribution of the claim.

Division (F)(3) requires the application to state the arrangements, if any, that have been made with respect to the attorney's fees. The attorney's fees are to be subject to the approval of the probate court.

Division (G) provides that section 2323.43 does not apply to any of the following:

- (1) Civil actions upon a medical claim that are brought against the state in the court of claims, including, but not limited to, those actions in which a state university or college is a defendant and to which division (B)(3) of section 3345.40 of the Ohio Revised Code² applies;
- (2) Civil actions upon a medical claim that are brought against political subdivisions of this state and that are commenced under or are subject to Chapter 2744 of the Ohio Revised Code³. Division (C) of section 2744.05 of the Revised Code applies to recoverable damages in those actions;
- (3) Wrongful death actions brought pursuant to Chapter 2125 of the Revised Code⁴.

Division (H) defines the following terms for use in this section:

- (1) "Economic loss" means any of the following types of pecuniary harm:
 - (a) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim;
 - (b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim;
 - (c) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim, other than attorney's fees incurred in connection with that action.
- (2) "Medical claim" has the same meanings as in section 2305.113 of this legislation.
- (3) "Noneconomic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss.
- (4) "Trier of fact" means the jury or, in a nonjury action, the court.

Section 2323.55 – Periodic Payments of Future Damages

Section 2323.55 (A) defines the following terms:

- (1) "Economic loss" means any of the following types of pecuniary harm:
 - a. All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim;
 - b. All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim;

² Section 3345.40 of the Ohio Revised Code applies to damages awardable for wrongful death or injury to person or property in connection with State Universities.

³ Chapter 2744 of the Ohio Revised Code applies to the tort liability of political subdivisions.

⁴ Chapter 2125 of the Ohio Revised Code applies to wrongful death statutes.

- c. Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim, other than attorney's fees incurred in connection with that action.
- (2) "Future damages" means any damages that result from an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim and that will accrue after the verdict or determination of liability is rendered in that action by the trier of fact. "Future damages" includes both economic and noneconomic loss.
- (3) "Medical claim" has the same meanings as in section 2305.113 of the Ohio Revised Code.
- (4) "Noneconomic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a civil action upon a medical claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss.
- (5) "Past damages" means any damages that result from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim and that have accrued by the time that the verdict or determination of liability is rendered in that action by the trier of fact. Past damages include both economic loss and noneconomic loss.
- (6) "Trier of fact" means the jury or, in a nonjury action, the court.

Division (B) provides that in any civil action upon a medical claim in which a plaintiff makes a good faith claim against the defendant for future damages that exceed \$50,000, upon motion of that plaintiff or the defendant, the trier of fact is to return a general verdict and, if that verdict is in favor of that plaintiff, answers to interrogatories or findings of fact that specify both of the following:

- (1) The past damages recoverable by that plaintiff;
- (2) The future damages recoverable by that plaintiff.

Division (C) establishes that if answers to interrogatories are returned or findings of fact are made and if the future damages recoverable by that plaintiff exceeds \$50,000, the plaintiff or defendant may file a motion with the court that seeks a determination. The plaintiff or defendant is to file the motion at any time after the verdict or determination in favor of the plaintiff is rendered by the trier of fact but prior to the entry of judgment in accordance with Civil Rule 58.

Division (D)(1) sets forth that upon the filing of a motion and prior to the entry of judgment in accordance with Civil Rule 58, the court is to do all of the following:

- a. Set a date for a hearing to address whether all or any part of the future damages recoverable by the plaintiff is to be received by the plaintiff in a series of periodic payments rather than in a lump sum;
- b. Give notice of the date of the hearing to the parties involved and their counsel of record;
- c. Conduct the hearing, allow the parties involved to present any relevant evidence at the hearing, consider the factors in making its determination, and make its determination.

Division (D)(2) provides that in determining whether all or any part of the future damages recoverable by the plaintiff are to be received by the plaintiff in a series of periodic payments rather than in a lump sum, the court is to consider all of the following factors:

- a. The purposes for which those portions of the future damages were awarded to that plaintiff;
- b. The business or occupational experience of that plaintiff;
- c. The age of that plaintiff;
- d. The physical and mental condition of that plaintiff;
- e. Whether that plaintiff or the parent, guardian, or custodian of that plaintiff is able to competently manage the future damages;

- f. Any other circumstance that relates to whether the injury sustained by that plaintiff would be better compensated by the payment of the future damages in a lump sum or by their receipt in a series of periodic payments.

Division (D) (3) establishes that after the hearing and prior to the entry of judgment in accordance with Civil Rule 58, the court is to determine, in its discretion, whether all or any part of the future damages recoverable by the plaintiff are to be received by the plaintiff in a series of periodic payments rather than in a lump sum. If the court determines that a plaintiff is to receive the future damages recoverable by the plaintiff in a series of periodic payments, it may order the payments only as to the amount of the future damages recoverable by the plaintiff that exceeds \$50,000. If the court determines that the plaintiff is to receive the future damages recoverable by the plaintiff in a lump sum, the future damages are to be paid in a lump sum.

Division (E) provides that if the court determines that a plaintiff is to receive the future damages recoverable by the plaintiff in a series of periodic payments, both of the following apply:

- (1) Within 20 days after the court makes that determination, the plaintiff is to submit a periodic payments plan to the court. The plan may include, but is not limited to, a provision for a trust or an annuity and may be submitted by that plaintiff alone or by that plaintiff and the defendant.
- (2) Within 20 days after the court makes that determination, the defendant may submit to the court, alone or jointly with the plaintiff, a periodic payments plan. If the defendant submits a periodic payments plan, the plan may include, but is not limited to, a provision for a trust or an annuity.

Division (F)(1) sets forth that if the defendant and plaintiff do not jointly submit a periodic payments plan and if the defendant does not separately submit a periodic payments plan, then, within ten days after that plaintiff submits a plan, the defendant may submit to the court written comments relative to the periodic payments plan of the plaintiff.

Division (F)(2) provides that if the defendant and plaintiff do not jointly submit a periodic payments plan and if the defendant separately submits a periodic payments plan, then, within 10 days after the defendant submits the plan, the plaintiff may submit to the court written comments relative to the periodic payments plan of the defendant.

Division (G)(1) establishes that the court, in its discretion, may modify, approve, or reject any submitted periodic payments plan. In approving any periodic payments plan, the court is to require interest on the judgment in question in accordance with section 1343.03 of the Ohio Revised Code⁵. Additionally, in approving any periodic payments plan, the court is not required to ensure that payments under the periodic payments plan are equal in amount or that the total amount paid each year under the periodic payments plan is equal in amount to the total amount paid in other years under the plan; rather, a periodic payments plan may provide for payments to be made in irregular or varied amounts, or to be graduated upward or downward in amount over the duration of the periodic payments plan.

Division (G)(2) sets forth that the court is to include in any approved periodic payments plan adequate security to insure that the plaintiff will receive all of the periodic payments under that plan. If the approved periodic payments plan includes a provision for an annuity as the adequate security or otherwise, the defendant is to purchase the annuity from either of the following types of insurance companies:

- (a) An insurance company that the A.M. Best Company, in its most recently published rating guide of life insurance companies, has rated A or better and has rated XII or higher as to financial size or strength;
- (b) An insurance company that the Superintendent of the Ohio Department of Insurance, under rules adopted, for purposes of implementing this division, determines is licensed to do business in this state and, considering the factors described, is a stable insurance company that issues annuities that are safe and desirable. In making determinations, the Superintendent is to be guided by the principle that annuities should be safe and desirable for plaintiffs who are awarded damages. In making those determinations, the Superintendent is to consider the financial condition, general standing, operating results, profitability, leverage, liquidity, amount and soundness of reinsurance, adequacy of reserves, and the management of any insurance company in question and also may consider ratings, grades, and classifications of any nationally recognized rating services of insurance companies and any other factors relevant to the making of such determinations.

⁵ Section 1343.03 of the Ohio Revised Code establishes the interest to pay when the rate is not stipulated.

- (c) If a periodic payments plan provides for periodic payments over a period of 5 years or more to the plaintiff, the court, in its discretion, may include in the approved periodic payments plan a provision in which it reserves to itself continuing jurisdiction over that plan, including jurisdiction to review and modify that plan.
- (d) The court is to specify in the entry of judgment in the tort action the determination made and, if applicable, the terms of any approved periodic payments plan.

Division (H) sets forth that after a periodic payments plan is approved, the future damages that are to be received in periodic payments are to be paid in accordance with the plan, including, if applicable, payment over to a trust or annuity provided for in the plan.

Division (I) provides that if a court orders a series of periodic payments of future damages and the plaintiff dies prior to the receipt of all of the future damages, the liability for the unpaid portion of those damages that is not yet due at the time of the death of that plaintiff is to continue, but the payments are to be paid to the heirs of that plaintiff as scheduled in and otherwise in accordance with the approved periodic payments plan or, if the plan does not contain a relevant provision, as the court orders.

Division (J)(1) provides that nothing in this section of the legislation precludes a plaintiff and a defendant from mutually agreeing to a settlement of the action. Division (J)(2) sets forth that, except as otherwise provided in this section, nothing in this section increases the time for filing any motion or notice of appeal or taking any other action relative to a civil action upon a medical claim, alters the amount of any verdict or determination of damages by the trier of fact in a civil action upon a medical claim, or alters the liability of any party to pay or satisfy the verdict or determination.

Division (K) sets forth that this section of the legislation does not apply to tort actions that are brought against political subdivisions of this state and that are commenced under or are subject to Chapter 2744. of the Revised Code or to tort actions brought against the state in the court of claims.

Section 2323.56 – Periodic Payment of Certain Future Damages in Tort Actions

Section 2323.56 pertains to periodic payment of certain future damages in tort actions and has been amended to make a reference change to the Ohio Revised Code.

Section 2711.21 – Arbitration of Medical Claims

Section 2711.21 concerns arbitration of medical claims. This section has been amended to make a reference change to the Ohio Revised Code and to make a technical change.

Section 2711.22 – Valid Written Contracts

Section 2711.22 establishes requirements pertaining to valid written contracts. Division (A) has been amended to provide that, except as otherwise provided, a written contract between a patient and a hospital or healthcare provider⁶ to settle by binding arbitration any dispute or controversy arising out of the diagnosis, treatment, or care of the patient rendered by a hospital or healthcare provider, that is entered into prior to the diagnosis, treatment, or care of the patient is valid, irrevocable, and enforceable once the contract is signed by all parties.⁷ New language has been included that the contract remains valid, irrevocable, and enforceable until or unless the patient or the patient's legal representative rescinds the contract by written notice within 30 days of the signing of the contract. A guardian or other legal representative of the patient may give written notice of the rescission of the contract if the patient is incapacitated or a minor.

⁶ All references to "physician" in the current section 2711.22 of the Ohio Revised Code are being changed to "healthcare provider".

⁷ The current language in section 2711.22 of the Ohio Revised Code also pertains to written contracts entered into subsequent to the rendering of diagnosis, treatment, or care; however, this language is being removed by Senate Bill 281. Also being removed is language that provided an exception when such grounds exist in the law or in equity for revocation of any contract.

Division (B) contains definitions for use in this section, and sections 2711.23 and section 2711.24 of the Ohio Revised Code:

(1) "Healthcare provider" means a physician, podiatrist, dentist, licensed practical nurse, registered nurse, advanced practice nurse, chiropractor, optometrist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, emergency medical technician-paramedic, or physical therapist.

(2) "Hospital," "physician," "podiatrist," "dentist," "licensed practical nurse," "registered nurse," "advanced practice nurse," "chiropractor," "optometrist," "physician assistant," "emergency medical technician-basic," "emergency medical technician-intermediate," "emergency medical technician-paramedic," "physical therapist," "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Ohio Revised Code.

Section 2711.23 – Arbitration Agreement Provisions

Section 2711.23, as amended, establishes that to be valid and enforceable any arbitration agreements for controversies involving a medical claim that is entered into prior to a patient receiving any care, diagnosis, or treatment is to include or be subject to the following conditions⁸:

- (A) The agreement is to provide that the care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;
- (B) The agreement is to provide that the patient, or the patient's spouse, or the personal representative of the patient's estate in the event of the patient's death or incapacity, are to have a right to withdraw the patient's consent to arbitrate the patient's claim by notifying the healthcare provider or hospital in writing within 30 days after the patient's signing of the agreement. This provision is not to be construed to mean that the spouse of a competent patient can withdraw over the objection of the patient the consent of the patient to arbitrate⁹;
- (C) The agreement is to provide that the decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence;¹⁰
- (D) The agreement is to, if appropriate, provide that its terms constitute a waiver of any right to a trial in court, or a waiver of any right to a trial by jury;
- (E) The agreement is to provide that the arbitration expenses shall be divided equally between the parties to the agreement;
- (F) Any arbitration panel is to consist of three persons, no more than one is to be a physician or the representative of a hospital;
- (G) The arbitration agreement is to be separate from any other agreement, consent, or document;
- (H) The agreement is not to be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

⁸ Section 2711.23 currently provides that to be valid and enforceable any arbitration agreement for controversies involving hospital or medical care, diagnosis, or treatment which are entered into prior to rendering such care, diagnosis or treatment are to include the conditions specified.

⁹ This provision currently provides that the patient, representative or spouse has a right to withdraw the patient's consent to arbitrate the claim by notifying the physician or hospital in writing within 60 days after the patient's discharge from the hospital for any claim arising out of hospitalization, or within 60 days after the termination of the physician-patient relationship for the physical condition involved for any claim against a physician. This language has been removed.

¹⁰ Language pertaining to "influence by the physician or hospital" has been removed.

- (I) Filing of a medical claim within the 30 days provided for withdrawal of a patient from the arbitration agreement is to be deemed a withdrawal from the agreement;¹¹
- (J) The agreement is to shall contain a separately stated notice that clearly informs the patient of the patient's rights.

Reference to this section of the bill applying to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine has been removed from the bill since this section now applies to a medical, dental, chiropractic, or optometric claim.

Section 2711.24 – Arbitration Agreement Form and Cancellation

Section 2711.24 pertains to the form for the arbitration agreement. This section has been amended to change references of “physician or hospital” to “healthcare provider” and to change references of “medical or hospital care” to “care”. Changes have been made in the actual form similar to section 2711.23 of this legislation; under the provision “Patient’s Right to Cancel Agreement to Arbitrate”, as amended, the language now provides:

The patient, or the patient’s spouse or the personal representative of the patient’s estate in the event of the patient’s death or incapacity, has the right to cancel this agreement to arbitrate by notifying the healthcare provider in writing within 30 days after the patient’s signing of the agreement. The patient, or the patient’s spouse or representative, as appropriate, may cancel this agreement by merely writing “cancelled” on the face of one of the patient’s copies of the agreement, signing the patient’s name under such word, and mailing, by certified mail, return receipt requested, the copy to the healthcare provider within the 30 day period.¹²

Filing of a medical claim in a court within the 30 days provided for cancellation of the arbitration agreement by the patient will cancel the agreement without any further action by the patient.¹³

Reference to this section of the bill applying to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine has been removed from the bill since this section now applies to a medical, dental, chiropractic, or optometric claim.

Section 2743.02 – State Waives Immunity from Liability

Section 2743.02 pertains to the state waiving its immunity from liability and consenting to be sued. This section has been amended to make technical changes and change a reference to a section of the Ohio Revised Code.

Section 2743.43 – Expert Testimony on Liability Issues

Section 2743.43 concerns expert testimony on liability issues and has been amended to change a reference to the Ohio Revised Code. This provision was amended by the Conference Committee Report to provide that nothing in division (A) of this section is to be construed to limit the power of the trial court to allow the testimony of any other expert witness that is relevant to the medical claim involved.

¹¹ This provision currently provides that the filing of a claim within the 60 days provided for withdrawal of a patient from the arbitration agreement is to be deemed a withdrawal from such agreement.

¹² This provision currently provides that the patient, representative or spouse, in the event of the patient’s death or incapacity, has the right to cancel the agreement to arbitrate by notifying the physician or hospital in writing within 60 days after the patient’s discharge from the hospital for any claim against a hospital, or within 60 days after the termination of the physician patient relationship for the physical condition involved for claims against physicians....and the copy is to be mailed to the healthcare provider within 60 days. This language has been removed.

¹³ In this provision “60 days” has been changed to “30 days”.

Section 2919.16 – Definitions

Section 2919.16 establishes the definitions for the section of law pertaining to offenses against the family. This section has been amended to change a reference to the Ohio Revised Code.

Section 3923.63 – Maternity Benefits

Section 3923.63 establishes the provisions concerning maternity benefits under the individual and group sickness and accident insurance laws. This section has been amended to change a reference to the Ohio Revised Code.

Section 3923.64 – Public Employee Maternity Benefits

Section 3923.64 establishes the provisions concerning maternity benefits for public employee under a public employee benefit plan. This section has been amended to change a reference to the Ohio Revised Code.

Section 3929.71 – Definitions for Joint Underwriting Association

Section 3929.71 establishes the definition of terms for the Joint Underwriting Association. This section has been amended to change a reference to the Ohio Revised Code in the definition of “medical malpractice insurance”.

Section 5111.018 – Inpatient and Follow-Up Care for Mothers and Newborns

Section 5111.018 pertains to the inclusion of coverage of inpatient care and follow-up care for a mother and her newborn under Medical Assistance program. This section has been amended to change a reference to the Ohio Revised Code.

Section 3 – Legislative Intent

Section 3 of the temporary language provides that the Ohio General Assembly makes the following statement of findings and intent:

(A) The Ohio General Assembly finds:

- (1) Medical malpractice litigation represents an increasing danger to the availability and quality of health care in Ohio.
- (2) The number of medical malpractice claims resulting in payments to plaintiffs has remained relatively constant. However, the average award to plaintiffs has risen dramatically. Payments to plaintiffs at or exceeding one million dollars have doubled in the past three years.
- (2) This state has a rational and legitimate state interest in stabilizing the cost of health care delivery by limiting the amount of compensatory damages representing noneconomic loss awards in medical malpractice actions. The overall cost of health care to the consumer has been driven up by the fact that malpractice litigation causes health care providers to over prescribe, over treat, and over test their patients. The Ohio General Assembly bases its finding on this state interest upon the following evidence:
 - (a) The Superintendent of the Ohio Department of Insurance has stated that medical malpractice insurers' investments are not to blame for the increase in medical malpractice insurance premiums. The vast majority of these insurers' assets are invested in bonds and other fixed income investments, not in stocks. Investment income declined by less than one per cent from 1996 to 2001.

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- (b) Many medical malpractice insurers left the Ohio market as they faced increasing losses, largely as a consequence of rapidly rising compensatory damages and noneconomic loss awards in medical malpractice actions. The Ohio Department of Insurance reports that only six admitted carriers continue to actively write coverage in Ohio at this time.
- (c) As insurers have left the market, physicians, hospitals, and other health care practitioners have had an increasingly difficult time finding affordable medical malpractice insurance. Some health care practitioners, including a large number of specialists, have been forced out of the practice of medicine altogether as a consequence. The Ohio State Medical Association reports fifteen per cent of Ohio's physicians are considering or have already relocated their practices due to rising medical malpractice insurance costs.
- (d) As stated in testimony provided by Lawrence E. Smarr, President of the Physician Insurers Association of America, medical malpractice costs have increased even while sixty-one per cent of all claims filed against individual practitioners are dropped or dismissed by the court and even while the defendants win eighty per cent of all claims that are continued through trial to verdict.
- (e) The United States Department of Health and Human Services published a report in 2002 stating that health care practitioners in states with effective caps on noneconomic damages are experiencing premium increases in the twelve to fifteen per cent range, as compared to an average forty-four per cent increase in states that do not cap noneconomic damage awards.
- (4) (a) The distinction among claimants with a permanent physical functional loss strikes a reasonable balance between potential plaintiffs and defendants in consideration of the intent of an award for noneconomic losses, while treating similar plaintiffs equally, acknowledging that such distinctions do not limit the award of actual economic damages.
- (b) The limits on compensatory damages representing noneconomic loss as specified in section 2323.43 of the Revised Code, as enacted by this act, are based on testimony asking the members of the Ohio General Assembly to recognize these distinctions and stating that the cap amounts are similar to caps on awards adopted by other states.
- (c) In *Evans v. State* (Sup. Ct. Alaska, August 30, 2002), No. 5618, 2002 Alas. LEXIS 135, one of the issues addressed by the Alaska Supreme Court is whether the caps on noneconomic and punitive damages constitute a violation of the right to a trial by jury granted by the Alaska Constitution and the Seventh Amendment to the United States Constitution. The Court held that the damages caps do not violate the constitutional right to a trial by jury and agreed with the reasoning by the Third Circuit Court of Appeals in *Davis v. Omitowaju* (3d Cir. 1989), 883 F.2d 1155, which interpreted the Seventh Amendment to the United States Constitution to allow damages caps. The Alaska Supreme Court relied on the *Davis* holding that a damages cap did not intrude on the jury's fact-finding function, because the cap was a "policy decision" applied after the jury's determination and did not constitute a re-examination of the factual question of damages. *Evans v. State, supra*, at pp. 11-12.
- It is the intent of the Ohio General Assembly that as a matter of policy, the limits on compensatory damages for noneconomic loss are applied after a jury's determination of the factual question of damages.
- (d) A report from the United States Department of Health and Human Services, *Update on the Medical Litigation Crisis: Not the Result of the Insurance Cycle* (Sept. 25, 2002), states that among states that have adopted a two hundred fifty thousand dollar cap on noneconomic damages are: Indiana, Colorado, California, Nebraska, Utah, and Montana. These states, as well as others that have imposed meaningful caps on noneconomic damages, report significantly lower increases in average premium rates than those states without caps. Limits on damages have been upheld by other state supreme courts, as in *Fein v. Permanente Medical Group* (1985), 38 Cal.3d 137, 695 P.2d 665, *Johnson v. St. Vincent Hospital, Inc.* (1980), 273 Ind. 374, 404 N.E.2d 585, and *Evans v. State, supra*.
- (5) This legislation does not affect the award of economic damages, such as for lost wages and medical care.
- (6) (a) That a statute of repose on medical, dental, optometric, and chiropractic claims strikes a rational balance between the rights of prospective claimants and the rights of hospitals and health care practitioners;
- (b) Over time, the availability of relevant evidence pertaining to an incident and the availability of witnesses knowledgeable with respect to the diagnosis, care, or treatment of a prospective claimant becomes problematic.

- (c) The maintenance of records and other documentation related to the delivery of medical services, for a period of time in excess of the time period presented in the statute of repose, presents an unacceptable burden to hospitals and health care practitioners.
 - (d) Over time, the standards of care pertaining to various health care services may change dramatically due to advances being made in health care, science, and technology, thereby making it difficult for expert witnesses and triers of fact to discern the standard of care relevant to the point in time when the relevant health care services were delivered.
 - (e) This legislation precludes unfair and unconstitutional aspects of state litigation but does not affect timely medical malpractice actions brought to redress legitimate grievances.
 - (f) This legislation addresses the aspects of current division (B) of section 2305.11 of the Revised Code, the application of which was found by the Ohio Supreme Court to be unconstitutional in *Gaines v. Preterm-Cleveland, Inc.* (1987), 33 Ohio St.3d 54. In *Dunn v. St. Francis Hospital, Inc.* (Del. 1982), 401 Atl.2d 77, the Delaware Supreme Court found the Delaware three-year statute of repose constitutional as not violative of the Delaware Constitution's open courts provision.
- (B) In consideration of these findings, the Ohio General Assembly declares its intent to accomplish all of the following by the enactment of this act:
- (1) To stem the exodus of medical malpractice insurers from the Ohio market;
 - (2) To increase the availability of medical malpractice insurance to Ohio's hospitals, physicians, and other health care practitioners, thus ensuring the availability of quality health care for the citizens of this state;
 - (3) To continue to hold negligent health care providers accountable for their actions;
 - (4) To preserve the right of patients to seek legal recourse for medical malpractice.
 - (5)
 - (a) To abrogate the common law collateral source rules as adopted by the Ohio Supreme Court in *Pryor v. Webber* (1970), 23 Ohio St.2d 104, and reaffirmed in *Sorrell v. Thevenir* (1994), 69 Ohio St.3d 415;
 - (b) To address the aspects of former section 2317.45 of the Revised Code that the Supreme Court found in *Sorrell v. Thevenir* (1994), 69 Ohio St.3d 415, *May v. Tandy Corp.* (1994), 69 Ohio St.3d 415, and *DePew v. Ogella* (1994), 69 Ohio St.3d 610, to be unconstitutional as being violative of the equal protection provision of Section 2, the right to a trial by jury provision of Section 5, and the due course of law, right to a remedy, and open court provision of Section 16 of Article I of the Ohio Constitution.
- (C)(1) The Ohio General Assembly respectfully requests the Ohio Supreme Court to uphold this intent in the courts of Ohio, to reconsider its holding on damage caps in *State v. Sheward* (1999), Ohio St.3d 451, to reconsider its holding on the deductibility of collateral source benefits in *Sorrell v. Thevenir* (1994), 69 Ohio St.3d 415, and to reconsider its holding on statutes of repose in *Sedar v. Knowlton Constr. Co.* (1990), 49 Ohio St.3d 193, thereby providing health care practitioners with access to affordable medical malpractice insurance and maintaining the provision of quality health care in Ohio.
- (2) The Ohio General Assembly acknowledges the Court's authority in prescribing rules governing practice and procedure in the courts of this state as provided by Section 5 of Article IV of the Ohio Constitution.

Section 4 – Ohio Medical Malpractice Commission

Section 4 of the temporary language provides in division (A) the creation of the Ohio Medical Malpractice Commission consisting of nine members. The President of the Senate is to appoint three of the members, and the Speaker of the House of Representatives is to appoint three of the members. The minority leader of the Senate is to appoint one member and the minority leader of the House of Representatives is to appoint one member.

The Director of the Ohio Department of Insurance or the Director's designee is to be the ninth member of the Commission. Of the six members appointed by the President of the Senate and the Speaker of the House of Representatives, one is to represent the Ohio State Bar Association, one is to represent the Ohio State Medical Association, and one is to represent the insurance companies in Ohio, and all of them are to have expertise in medical malpractice insurance issues.

Division (B) requires the Commission to do all of the following:

- (1) Study the effects of this act;
- (2) Investigate the problems posed by, and the issues surrounding, medical malpractice;
- (3) Submit a report of its findings to the members of the Ohio General Assembly not later than two years after the effective date of this act.

Division (C) provides that any vacancy in the membership of the Commission is to be filled in the same manner in which the original appointment was made. Division (D) sets forth that the members of the Commission are to by majority vote elect a chairperson from among themselves. Division (E) establishes that the Ohio Department of Insurance is to provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties.

Section 5 – Feasibility Study of Patient Compensation Fund

Section 5 of the temporary language establishes in division (A)(1) that in recognition of the statewide concern over the rising cost of medical malpractice insurance and the difficulty that health care practitioners have in locating affordable medical malpractice insurance, the Superintendent of the Ohio Department of Insurance is to study the feasibility of a Patient Compensation Fund to cover medical malpractice claims, including, but not limited to the following:

- (a) The financial responsibility limits for providers that are covered in Am. Sub. Senate Bill 281 of the 124th General Assembly, and the Patient Compensation Fund;
- (b) The identification of methods of funding, excluding any tax on consumers;
- (c) The operation and administration of such a fund;
- (d) The participation requirements.

Division (A)(2) requires the Superintendent to submit a copy of a preliminary report by March 3, 2003, with a final report by May 1, 2003, to the Governor, the Speaker of the Ohio House of Representatives, the President of the Ohio Senate, and the chairpersons of the committees of the Ohio General Assembly with jurisdiction over issues relating to medical malpractice liability. The final report is to include the Superintendent's recommendations for implementing the Patient's Compensation Fund.

Division (B) provides that the Superintendent of the Ohio Department of Insurance is to make recommendations for the operation of a Patient's Compensation Fund designed to assist health care practitioners in satisfying medical malpractice awards above designated amounts. The purpose of the study is to be to consider the feasibility of the Fund satisfying that portion of the awards for damages for noneconomic loss under division (A)(2) of section 2323.43 of the Ohio Revised Code resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of \$350,000 to a maximum of \$500,000. The recommendations are also to provide for the satisfaction of the awards for damages for noneconomic loss under division (A)(3) of section 2323.43 of the Ohio Revised Code resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of \$500,000 to a maximum of \$1 million dollars.

Division (C) sets forth that the Superintendent's recommendations are to include sources of revenues for the Fund and a mechanism for making, and the assessment of, claims against the Fund.

Section 6 – Applicability

Section 6 of the temporary language in division (A) provides that Sections 1751.67, 2117.06, 2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, and 5111.018 of the Ohio Revised Code, as amended by this Act, and sections 2303.23, 2305.113, 2323.41, 2323.42, 2323.43, and 2323.55 of the Ohio Revised Code, as enacted by this Act, apply to civil actions upon a medical claim, dental claim, optometric claim, or chiropractic claim in which the act or omission that constitutes the alleged basis of the claim occurs on or after the effective date of this act.

Section 7 – Severability

Section 7 of the temporary language provides that if any item of law that constitutes the whole or part of a section of law contained in this Act, or if any application of any item of law that constitutes the whole or part of a section of law contained in this Act, is held invalid, the invalidity does not affect other items of law or applications of items of law that can be given effect without the invalid item of law or application. To this end, the items of law of which the sections contained in this Act are composed, and their applications, are independent and severable.

Section 8 – Preemption by Federal Law

Section 8 of the temporary language sets forth that if any item of law that constitutes the whole or part of a section of law contained in this Act, or if any application of any item of law contained in this Act, is held to be preempted by federal law, the preemption of the item of law or its application does not affect other items of law or applications that can be given effect. The items of law of which the sections of this Act are composed, and their applications, are independent and severable.