



Aida S. Montano

*Bill Analysis*  
*Legislative Service Commission*

## **Sub. S.B. 281\***

124th General Assembly  
(As Reported by H. Civil and Commercial Law)

**Sens. Goodman, Coughlin, Randy Gardner, Nein, Wachtmann, Mead, Hottinger, Harris, Spada, Armbruster, Austria, Amstutz, Mumper, Robert Gardner**

---

### **BILL SUMMARY**

- Enacts additional exceptions to the current statute of repose in which an action upon a medical, dental, optometric, or chiropractic claim may not be commenced more than four years after the act or omission that is the basis of the claim occurs.
- Enacts procedures in civil actions upon a medical, dental, optometric, or chiropractic claim in which a court must determine, upon a defendant's motion, whether or not there is a reasonable good faith basis upon which the particular claim is asserted against that defendant, and the court must award the defendant certain court costs and attorneys' fees if no reasonable good faith basis is found.
- Limits the noneconomic damages that may be awarded in medical, dental, optometric, and chiropractic claims as follows:
  - (1) Generally, the greater of \$250,000 or an amount equal to three times the plaintiff's economic loss, up to a maximum of \$500,000;
  - (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 plaintiff from being able to independently care for self and perform life-sustaining activities,

---

\* This analysis was prepared before the report of the House Civil and Commercial Law Committee appeared in the House Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

the greater of \$1 million or an amount equal to \$15,000 times the number of years remaining in the plaintiff's expected life.

- Provides that a court of common pleas has no jurisdiction to enter judgment on an award of damages for noneconomic loss in excess of those limits.
- Regulates the award of future damages exceeding \$50,000 in medical, dental, optometric, and chiropractic actions, including, but not limited to, the use of periodic payments plans.
- Permits defendants in civil actions upon medical, dental, optometric, and chiropractic claims 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.
- Revises the law governing arbitration agreements between a patient and a physician or hospital, by, among other things, expanding its scope to govern arbitration agreements with other healthcare providers.
- Requires every clerk of a court of common pleas to send to the Department of Insurance a quarterly report containing specified information relating to each civil action upon a medical, dental, optometric, or chiropractic claim that was filed or is pending in the court and requires the court to collect an additional filing fee of \$5 to pay the costs of making the reports.
- Creates the Ohio Medical Malpractice Commission consisting of seven members, to study the effects of the act, investigate the problems and issues surrounding medical malpractice, and submit a report to the General Assembly not later than two years after the act's effective date.
- Requires the Superintendent of Insurance to study the feasibility of a Patient Compensation Fund to cover medical malpractice claims, including the financial responsibility of providers covered in the act and the Fund, the identification of the methods of funding, and the Fund's operation and participation requirements and to submit a preliminary report by March 3, 2003, and a final report by May 1, 2003.

- Requires the Department of Insurance to provide the General Assembly annual reports on medical malpractice insurance rates, the number of medical malpractice insurers, and the number of insurer applications seeking rate increases and the Department's decisions on those requests.
- Includes in uncodified language statements of the General Assembly's findings in relation to medical malpractice insurance, and of its intent, based upon these findings, in enacting the bill.

---

## TABLE OF CONTENTS

Commencement of medical, dental, optometric, and chiropractic claims; definitions; conforming changes.....	4
Reasonable good faith basis for medical, dental, optometric, or chiropractic claims .....	6
Good faith motion .....	6
Award to defendant .....	7
Limitation on noneconomic damages in medical, dental, optometric, and chiropractic civil actions .....	8
Procedure.....	8
Future damages in medical, dental, optometric, and chiropractic civil actions; periodic payments.....	10
Collateral benefits.....	13
Arbitration of medical disputes.....	14
Expert testimony .....	15
Reporting of malpractice actions .....	15
Miscellaneous.....	16

## UNCODIFIED PROVISIONS

Saving clauses; Intent.....	17
Ohio Medical Malpractice Commission.....	18
Feasibility of Patient Compensation Fund .....	18
Department of Insurance report .....	20
Applicability.....	20

---

## CONTENT AND OPERATION

### Commencement of medical, dental, optometric, and chiropractic claims; definitions; conforming changes

Chapter 2305. of the Revised Code contains statutes of limitations on civil actions. Claimants are required to commence a civil action within the periods set by statutes of limitations.

Currently, section 2305.11 of the Revised Code sets limitations upon the commencement of a number of actions, including, but not limited to, libel, false imprisonment, unlawful abortion, and medical, dental, optometric, and chiropractic claims. The bill repeals the provisions in section 2305.11 of the Revised Code relating to the commencement of medical, dental, optometric, and chiropractic actions and enacts section 2305.113 of the Revised Code to regulate the commencement of these actions. The bill also repeals related definitions currently in section 2305.11 of the Revised Code and enacts these definitions in section 2305.113 of the Revised Code.

A "medical claim," as used in both the current section 2305.11 and enacted section 2305.113 of the Revised Code, is any claim asserted in a civil action against any person in a listed category of health care practitioners, arising out of medical diagnosis, care, or treatment. The bill includes more categories of health care practitioners under section 2305.113 of the Revised Code than section 2305.11 of the Revised Code currently does. Currently, a "medical claim," includes claims against physicians, podiatrists, hospitals, homes, and residential facilities, and employees and agents of physicians, podiatrists, hospitals, homes, and residential facilities, and against registered nurses and physical therapists. The bill defines a "medical claim" to also include claims against licensed practical nurses and advanced practice nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic. An "advanced practice nurse," as defined by the bill, 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 Revised Code. "Licensed practical nurse" means any person who is licensed to practice as a licensed practical nurse by the State Board of Nursing pursuant to R.C. Chapter 4723. "Physician assistant" means any person who holds a valid certificate of registration or temporary certificate of registration issued pursuant to R.C. Chapter 4730. Emergency medical technician-basic, emergency medical technician-intermediate, and emergency medical technician-paramedic means any person who is certified under R.C. Chapter 4765. as that type of emergency medical technician. (R.C. 2305.113(E)(3), (16), (17), (18), and (19).)

Section 2305.11 of Revised Code currently requires an action upon a medical, dental, optometric, or chiropractic claim to be commenced within one year after the cause of action accrued. The bill retains the one-year limit for the commencement of these actions.

Section 2305.11 of the Revised Code currently allows a person who is considering bringing an action upon a medical, dental, optometric, or chiropractic claim, if that person has given written notice to the person who is the subject of the claim prior to the expiration of the one-year statute of limitations stating that the claimant is considering bringing an action upon the claim, to commence the action at any time within 180 days after the notice is given. The bill retains this provision, and prohibits an insurance company from considering the existence or nonexistence of such a written notice in setting the liability insurance premium rates that the company may charge the company's insured person who was notified. (R.C. 2305.11(B)(1) and 2305.113(B).)

As in current section 2305.11 of the Revised Code, the bill precludes an action upon a medical, dental, optometric, or chiropractic claim from being commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the claim, except as to persons within the age of minority or of unsound mind (R.C. 2305.113(C)). The bill adds the following exceptions to this statute of repose (R.C. 2305.113(D)):

(1) If a person making a medical, dental, optometric, or chiropractic 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 that 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, dental, optometric, or chiropractic 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.

A person who commences an action upon a medical, dental, optometric, or chiropractic claim under the circumstances described above in paragraph (1) or (2) has the affirmative burden of proving, 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 in paragraph (1) or within the one-year period described in paragraph (2), whichever is applicable.

The bill also amends sections 2117.06 and 2305.15 of the Revised Code to reflect the bill's movement, by repeal and reenactment, of provisions on medical, dental, optometric, and chiropractic claims from section 2305.11 to section 2305.113 of the Revised Code.

Section 2117.06 of the Revised Code, pertaining to creditors' claims against estates, states that its provisions are not to be construed to reduce the time periods allowed under the Revised Code for the commencement of specified civil actions, including the time periods set by section 2305.11 of the Revised Code. The bill adds a reference to section 2305.113 in the list of sections currently referenced by section 2117.06. Section 2305.15 of the Revised Code, pertaining to civil claims against prisoners, provides that the time of a person's imprisonment is not counted as part of the time periods allowed under sections of the Revised Code for the commencement of specified civil actions, including the time periods set by section 2305.11 of the Revised Code. The bill adds a reference to section 2305.113 in the list of sections currently referenced by section 2305.15.

**Reasonable good faith basis for medical, dental, optometric, or chiropractic claims**

**Good faith motion**

Upon the motion of any defendant in a civil action based upon a medical claim, dental claim, optometric claim, or chiropractic claim, the court must 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 must file the motion not earlier than the close of discovery in the action and not later than 30 days after the court or jury renders any verdict or award in the action. After the motion is filed, the plaintiff has not less than 14 days to respond to the motion. Upon good cause shown by the plaintiff, the court must 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. (R.C. 2323.42(A).)

At the request of any party to the good faith motion described in the preceding paragraph, the court must order the motion to be heard at an oral hearing and must 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 must take into consideration, in addition to the facts of the underlying claim, whether the plaintiff did any of the following (R.C. 2323.42(B)):

(1) Obtained a reasonably timely review of the merits of the particular claim by a qualified medical, dental, optometric, or chiropractic 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;

(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.

Prior to filing a good faith motion, any defendant that intends to file that type of motion must serve a "Notice of Demand for Dismissal and Intention to File a Good Faith Motion." If, within 14 days of service of that notice, the plaintiff dismisses the defendant from the action, the defendant after the dismissal is precluded from filing a good faith motion as to any attorneys' fees and other costs subsequent to the dismissal. (R.C. 2323.42(D).)

### **Award to 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 must award all of the following in favor of the moving defendant (R.C. 2323.42(C)):

(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.

**Limitation on noneconomic damages in medical, dental, optometric, and chiropractic civil actions**

Section 2323.43 of the Revised Code, as enacted by the bill, limits the damages that may be awarded in a civil action upon a medical, dental, optometric, or chiropractic claim for damages for injury, death, or loss to person or property. The bill limits the recovery of those compensatory damages that represent each plaintiff's noneconomic loss. Such compensatory damages generally cannot exceed the greater of \$250,000 or an amount equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of \$500,000. However, if the noneconomic losses of the plaintiff 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, then the amount recoverable for noneconomic losses is limited to the greater of \$1 million or an amount equal to \$15,000 times the number of years remaining in the plaintiff's expected life. In contrast, the bill prohibits limitations on the award of compensatory damages that represent a plaintiff's economic loss. (R.C. 2323.43(A)(1), (2), and (3).)

**Procedure**

If a trial is conducted in the civil action upon a medical, dental, optometric, or chiropractic claim and a plaintiff prevails with respect to that claim, the court in a nonjury trial must make findings of fact, and the jury in a jury trial must return a general verdict accompanied by answers to interrogatories, that must specify all of the following (R.C. 2323.43(B)):

- (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.

After the trier of fact complies with the above requirements, the court must enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to (2), above, and a judgment in favor of the plaintiff for compensatory damages for noneconomic loss subject to the bill's provision 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 the bill.

In no event may a judgment for compensatory damages for noneconomic loss exceed the maximum recoverable amount that represents damages for noneconomic loss as provided in the bill. The limits must be applied in a jury trial only after the jury has made its factual findings and determination as to the damages. (R.C. 2323.43(C)(1) and (D)(1).)

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 with the applicable limits. If the trier of fact is a jury, the court must not instruct the jury with respect to the limit on compensatory damages for noneconomic loss, and neither counsel for any party nor a witness may inform the jury or potential jurors of that limit. (R.C. 2323.43(C)(2) and (D)(2).)

Any excess amount of compensatory damages for noneconomic loss that is greater than the applicable amount of the limits cannot 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 (R.C. 2323.43(E)).

For purposes of this section, an "economic loss" means any of the following types of pecuniary harm:

- (1) All lost wages, salaries, or other compensation;
- (2) All expenditures for medical care or treatment, rehabilitation services, and other care, treatment, services, products, or accommodations, resulting from injury, death, or loss to person or property, that is the subject of the civil action;
- (3) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is the subject of the civil action, other than attorney's fees incurred in connection with the action.

A "noneconomic loss" means any nonpecuniary harm incurred, 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. (R.C. 2323.43(G)(1), and (3).)

This section does not apply to civil actions upon medical, dental, optometric, or chiropractic claims that are either: (1) brought against the state in the Court of Claims, including, but not limited to, actions in which a state university or college is a defendant, or (2) brought against political subdivisions, if the action is commenced under or subject to Chapter 2744. of the Revised Code (which regulates the liability of political subdivisions in tort actions). This section

does not apply to wrongful death actions brought pursuant to Chapter 2125. of the Revised Code. (R.C. 2323.43(F).)

Section 2305.234 of the Revised Code currently provides immunity in tort and other civil actions to many health care professionals who volunteer their services. For purposes of this section, "health care professional" includes physicians, registered and licensed practical nurses, physician assistants, dentists and dental hygienists, physical therapists, chiropractors, optometrists, podiatrists, dietitians, and pharmacists. The bill expands this definition to include advanced practice nurses and emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under R.C. Chapter 4765.

**Future damages in medical, dental, optometric, and chiropractic civil actions; periodic payments**

Current law, section 2323.57 of the Revised Code, which would be repealed by the bill, regulates the award of future damages in excess of \$200,000 in a medical, dental, optometric, or chiropractic action. The bill enacts section 2323.55 of the Revised Code to govern the award of future damages in these actions.<sup>1</sup> The bill's provisions apply to future damages in excess of \$50,000.

Provisions in section 2323.57 of the Revised Code that are repealed and similar provisions enacted in section 2323.55 of the Revised Code require a trier of fact to return a general verdict upon the motion of the plaintiff or defendant in an action in which a plaintiff makes a good faith claim for future damages in excess of the statutory minimum. If that verdict is in favor of the plaintiff, the trier of fact must return interrogatories or findings of fact regarding the plaintiff's damages (see below).

Currently, section 2323.57 permits a plaintiff or defendant to file a motion with the court, at any time after the verdict or determination in favor of the plaintiff but prior to the entry of judgment, requesting the court to order future damages determined to be in excess of \$200,000 to be paid in periodic payments rather than a lump sum. If timely filed, the court is required to order that future damages in excess of \$200,000 be used to fund a series of periodic payments.

---

<sup>1</sup> As in current law, the bill defines "future damages" as any damages resulting 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 will accrue after the verdict or determination of liability is rendered by the trier of fact. The bill specifies that "future damages" includes both economic and noneconomic loss. (R.C. 2323.55(A)(2).)

The bill permits a plaintiff or defendant to file a motion with the court within this same time period, when recoverable future damages exceeds \$50,000. The motion seeks a determination as to whether all or any part of the future damages recoverable by the plaintiff should be received as a series of periodic payments. If timely filed, the court is required to set a date for a hearing on the subject of the periodic payment of future damages and to provide notice of the date of the hearing to the parties involved and their counsel of record. At the hearing, the court is required to allow the parties involved to present relevant evidence. In determining whether all or any part of recoverable future damages should be received by the plaintiff in a series of periodic payments, the court must consider all of the following factors: the purposes for which future damages are awarded; the business or occupational experience of the plaintiff; the plaintiff's age; the physical and mental condition of the plaintiff; whether the plaintiff, or the parent, guardian, or custodian of the plaintiff, is able to competently manage the future damages; and any other circumstance that relates to whether the injury sustained by the plaintiff would be better compensated by the payment of the future damages in a lump sum or as a series of periodic payments. After this hearing and prior to the entry of judgment, the court is required to determine, in its discretion, whether to order all or any part of the future damages in excess of \$50,000 to be paid in a series of periodic payments. (R.C. 2323.55(C) and (D).)

While current law, in determining the amount of future damages, requires the trier of fact to specify the portions of the future damages that represent noneconomic loss and each of three types of economic loss, the bill does not require the trier of fact to differentiate between types of future damages. Current law provides that no plaintiff who is the subject of an approved periodic payments plan may receive less than \$200,000, plus the plaintiff's cost of litigation, including attorney's fees, in a lump sum payment. Unlike current law, the bill does not address the inclusion of the cost of litigation in a periodic payments plan.

Both current law, section 2323.57 of the Revised Code, and the bill, enacted section 2323.55 of the Revised Code, require a plaintiff to submit a periodic payments plan to the court, either alone or jointly with the defendant. The time for filing a periodic payments plan, however, varies between current law and the bill. Current law requires periodic payments plans to be filed within 20 days after the motion requesting the payment of future damages in a series of periodic payments is filed with the court. The bill requires the periodic payments plans to be filed within 20 days after the court's determination in favor of paying future damages in a series of periodic payments.

If a joint periodic payments plan is not filed, both current law and the bill permit a defendant to submit its own plan within the same time given the plaintiff. Further, a defendant who has not submitted a plan either alone or jointly with the

plaintiff may submit written comments to the court about the plaintiff's plan within ten days after the plaintiff files the plan; if a defendant submits a separate plan, the plaintiff may submit written comments on that plan to the court within ten days after its filing. All periodic payments plans, both currently and under the bill, may include, but are not limited to, a provision for a trust or an annuity. (R.C. 2323.55(E), (F), and (H).)

Both current law and the bill allow the court to modify, approve, or reject any submitted periodic payments plan. However, the bill requires the court to require interest on the judgment in accordance with section 1343.03 of the Commercial Transactions Law, Title XIII of the Revised Code. The bill also specifies that 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. The periodic payments plan may provide for irregular or varied payments, or graduated payments over the duration of the plan.

As in current law, the bill requires the court to include in any approved periodic payments plan adequate security to insure that the plaintiff will receive all of the periodic payments. If the approved periodic payments plan includes a provision for an annuity, both current law and the bill require the defendant to purchase the annuity from either:

(1) 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;

(2) An insurance company that the Superintendent of Insurance, under rules adopted pursuant to the Administrative Procedure Act, determines is licensed to do business in this state, is stable, and issues annuities that are both safe and desirable. In making this determination, the Superintendent is to consider a company's financial condition, general standing, operating results, profitability, leverage, liquidity, amount and soundness of reinsurance, adequacy of reserves, and management. The Superintendent may also 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.

The bill gives the court discretion, if an approved periodic payments plan provides payments over a period of five years or more, to include a provision in the plan that gives the court continuing jurisdiction over the plan, including jurisdiction to review and modify the plan. Current law does not explicitly permit the court to retain jurisdiction. (R.C. 2323.55(G).)

Current law provides rules governing the payment of future damages when a plaintiff dies prior to the receipt of all payments under a periodic payments plan. The bill also contains provisions on this topic, but there are differences from current law.

The bill provides that if a plaintiff dies prior to the receipt of all future damages, the liability for the unpaid portion of those damages that is not yet due at the time of the plaintiff's death continue, but the payments are paid to the plaintiff's heirs as scheduled in and otherwise in accordance with the approved periodic payments plan. If the plan does not contain a relevant provision, the court is to determine how payments are to be made. (R.C. 2323.55(I).)

Current law provides that liability for the future economic loss representing expenditures for medical care or treatment, rehabilitation service, or other care, treatment, services, products, or accommodations resulting from injury, death or loss to person or property, as well as future noneconomic loss, that is not due at the time of the plaintiff's death, ceases at the time of death. Under current law all other liability payments continue, and, as in the bill, the payments are paid to the plaintiff's heirs as scheduled in and otherwise in accordance with the approved periodic payments plan, or, if the plan does not contain a relevant provision, as determined by the court.

Both current law and the bill state that nothing precludes a plaintiff and a defendant from mutually agreeing to a settlement of the action. Also, neither current law or the bill increase the time for filing any motion or notice of appeal or taking any other action relative to the civil action, alter the amount of any verdict or determination of damages by the trier of fact, or alter the liability of any party to pay or satisfy the verdict or determination. These provisions do not apply to tort actions brought against political subdivisions and commenced or subject to Chapter 2744. of the Revised Code (Sovereign Immunity Law), or to tort actions brought against the state in the Court of Claims. (R.C. 2323.55(J) and (K).)

### **Collateral benefits**

The bill repeals section 2305.27 of the Revised Code, which currently contains language on collateral recovery and subrogation in connection with awards on medical claims. The bill enacts section 2323.41 of the Revised Code to govern collateral recovery and subrogation in connection with civil actions upon medical, dental, optometric, and chiropractic claims.

The bill permits a defendant to introduce evidence of any amount payable as a benefit to the plaintiff as a result of damages that result from an injury, death, or loss to person or property that is the subject of the claim, except if the source of

collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation.

If a defendant introduces evidence of a plaintiff's right to receive collateral benefits, the plaintiff may introduce evidence of any amount the plaintiff has paid or contributed to secure any benefits which the defendant has introduced into evidence. A source of collateral benefits, of which evidence is introduced by the defendant, is prohibited from recovering any amount against the plaintiff and may not be subrogated to the plaintiff's rights against a defendant. (R.C. 2323.41.)

Currently, section 2305.27 of the Revised Code provides that an award of damages in a medical claim is not to be reduced by insurance proceeds, payments, or other benefits paid under any insurance policy or contract paid for by the plaintiff, the plaintiff's employer, or both, but is to be reduced by any other collateral recovery for medical and hospital care, custodial care or rehabilitation services, and loss of earned income. This section also provides that a collateral source of indemnity is not to be subrogated to the claimant against a physician, podiatrist, or hospital, unless otherwise expressly provided by statute.

#### **Arbitration of medical disputes**

Currently, section 2711.22 of the Revised Code provides that a written contract between a patient and a hospital or physician to use binding arbitration to settle any dispute or controversy arising out of the diagnosis, treatment, or care rendered, whether entered into prior to or subsequent to the diagnosis, treatment, or care, is valid, irrevocable, and enforceable, except upon such grounds as exist at law or in equity for the revocation of any contract.

The bill expands the scope of this section to include written contracts entered into with other groups of healthcare providers. For purposes of the bill's arbitration provisions, "healthcare provider" includes podiatrists, dentists, licensed practical nurses, registered nurses, advanced practice nurses, chiropractors, optometrists, physician assistants, emergency medical technicians, and physical therapists, as well as physicians, as those professions are defined in section 2305.113 of the Revised Code. The contract agreeing to binding arbitration must be entered into prior to the diagnosis, treatment, or care of the patient. The contract is valid, irrevocable, and enforceable once the contract is signed by all parties, and 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 if the patient is incapacitated or a minor. (R.C. 2711.22.)

To be valid and enforceable, current law, section 2711.23 of the Revised Code, requires an arbitration agreement involving hospital or medical care, diagnosis, or treatment, that is entered into prior to care, diagnosis, or treatment, to provide that the medical or hospital care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate. The agreement must also provide that the patient, or in the event of the patient's death or incapacity, the patient's spouse, or the personal representative of the patient's estate, has the right to withdraw from the arbitration agreement by providing written notification to a physician or hospital within 60 days after the patient's discharge from a hospital or the termination of a physician-patient relationship for the condition involved.

The bill expands the scope of the application of this section to include arbitration agreements involving medical, dental, chiropractic, and optometric claims entered into prior to a patient receiving any care, diagnosis, or treatment. The bill shortens the time for withdrawal from an arbitration agreement, providing that the right to withdraw from an agreement must be exercised by a patient, the patient's spouse, or the representative of the patient's estate, within 30 days after the patient's signing of the agreement. As in current law, the filing of a claim within the period provided for withdrawal, 30 days under the bill, is deemed to be a withdrawal from the agreement. (R.C. 2711.23(A), (B), and (I).)

The bill's provisions amending the persons subject to the law on arbitration agreements and the maximum time for withdrawal from arbitration agreements are reflected in the bill's amendments to section 2323.24 of the Revised Code, which regulates the standard form for an arbitration agreement. The current references in the form to physicians and hospitals are changed to "healthcare providers."

### **Expert testimony**

Current law provides that no person is deemed competent to give expert testimony on liability issues in a medical claim unless the person is licensed to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery by the State Medical Board or by the licensing authority of any state and such person devotes  $\frac{3}{4}$  of the person's professional time to its active clinical practice or to its instruction in an accredited university. The bill includes the same provision as in current law, and provides that that provision is not 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 (R.C. 2743.43(A) and (C)).

### **Reporting of malpractice actions**

Before the 15th day of January, April, July, and October of each year, every clerk of a court of common pleas in Ohio must send to the Department of

Insurance a quarterly report containing all of the following information relating to each civil action upon a medical, dental, optometric, or chiropractic claim that was filed or is pending in that court of common pleas:

- (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 compensatory damages that represent economic and noneconomic loss, and the date of entry of the judgment;
- (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.

If a report that relates to a specific civil action includes the information described in (6) and (7), above, with respect to that action or if the parties have agreed on a settlement, the succeeding quarterly report that the clerk of the court sends to the Department of Insurance no longer may include all of the above information with respect to that action.

For the purpose of paying the costs of implementing the reporting requirements, the court of common pleas must collect the sum of \$5 as additional filing fees in each civil action upon a medical, dental, optometric, or chiropractic claim that is filed in the court. (R.C. 2303.23.)

### **Miscellaneous**

The bill amends various sections of the Revised Code to reflect the movement of the definitions of "hospital," "physician," "medical claim," "podiatrist," "dentist," "dental claim," "derivative claim for relief," "registered nurse," "chiropractic claim," "chiropractor," "optometric claim," "optometrist," and "physical therapist," from section 2305.11 to section 2305.113 of the Revised Code.<sup>2</sup> References to the definitions currently found in section 2305.11 are

---

<sup>2</sup> R.C. secs. 1751.67, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21 to 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, 4705.15, and 5111.018.

amended to refer to section 2305.113 of the Revised Code. The definitions of "medical claim," "dental claim," "optometric claim," "chiropractic claim," "advanced practice nurse," "licensed practical nurse," "physician assistant," and "emergency medical technician-basic," "emergency medical technician-intermediate," and "emergency medical technician-paramedic" in section 2305.113 of the Revised Code are also referenced in the other sections enacted by the bill, sections 2303.23, 2323.41, 2323.43, and 2323.55 of the Revised Code and in other sections amended by the bill.

## UNCODIFIED PROVISIONS

### **Saving clauses; Intent**

Uncodified language in the bill provides a saving clause. The bill states that if any item of law that constitutes the whole or part of a section of law contained in the act, or if any application of any item of law that constitutes the whole or part of a section of law contained in the act, is held invalid, the invalidity does not affect other items of law or applications that can be given effect without the invalid item of law or application. The items of law in the act, and their applications, are declared to be independent and severable. A similar saving clause, declaring the items of law and their applications to be independent and severable, is also provided in uncodified language for provisions in the act, or their applications, that are preempted by federal law. (Sections 8 and 9.)

Uncodified language in the bill provides statements of the General Assembly's findings in relation to medical malpractice insurance, and of its intent, based upon these findings, in enacting the bill.

The General Assembly states, in part, that medical malpractice awards to plaintiffs have increased dramatically. The cost of these awards is reflected in large increases in medical malpractice insurance premiums. Medical malpractice insurers have left the Ohio market as they faced losses, largely as a consequence of the increased awards. Health care practitioners are having a difficult time finding affordable medical malpractice insurance, and the increase in medical malpractice insurance premiums is reflected in rising health care costs to consumers. 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 General Assembly further states that limits on damages have been upheld by other state supreme courts (citing cases from California, Indiana, and Alaska).

In consideration of its findings, the General Assembly provides statements of its intent to stem the increase in medical malpractice insurance premiums and health care costs in Ohio. The General Assembly provides statements of its intent



to address its concerns with past holdings of the Ohio Supreme Court on collateral source benefits, statutes of repose, and caps on damage awards. Further, the General Assembly states that it is its intent 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. (Section 3.)

### **Ohio Medical Malpractice Commission**

The bill creates the Ohio Medical Malpractice Commission consisting of seven members appointed as follows: (1) three appointed by President of the Senate, (2) three appointed by the Speaker of the House of Representatives, and (3) one who is the Director of the Department of Insurance or the Director's designee. Of the six members appointed by the Senate President and the House Speaker, one must represent the Ohio State Bar Association, one must represent the Ohio State Medical Association, and one must represent the insurance companies in Ohio, and all of them must have expertise in medical malpractice insurance issues.

The Commission must do all of the following: (1) study the effects of the act, (2) investigate the problems posed by, and the issues surrounding, medical malpractice, and (3) submit a report of its findings to the General Assembly not later than two years after the act's effective date.

Any vacancy in the membership of the Commission must be filled in the same manner in which the original appointment was made. The members of the Commission, by majority vote, must elect a chairperson from among themselves. Each member must be reimbursed by the Department of Insurance for expenses that are actually and necessarily incurred in the performance of the member's duties.

The Department of Insurance must provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties. (Section 4.)

### **Feasibility of Patient Compensation Fund**

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 Insurance must study the feasibility of a Patient Compensation Fund to cover medical malpractice claims, including, but not limited to the following:

(1) The financial responsibility limits for providers that are covered in Sub. Senate Bill 281 of the 124th General Assembly, and the Patient Compensation Fund;

(2) The identification of methods of funding, which include, but are not limited to, surcharges on providers and all insurers authorized to write and engaged in writing liability insurance policies including insurers covering such perils in multiple peril package policies;

(3) The operation and administration of such a fund;

(4) The participation requirements.

The Superintendent must 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 General Assembly with jurisdiction over issues relating to medical malpractice liability. The final report must include the Superintendent's recommendations for implementing the Patient's Compensation Fund which the General Assembly must implement not later than July 1, 2003.

The Superintendent must 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 Fund must be designed and funded as necessary to satisfy that portion of the awards for damages for noneconomic loss under R.C. 2323.43(A)(2) 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 must also provide for the satisfaction of the awards for damages for noneconomic loss under R.C. 2323.43(A)(3) resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of \$500,000 to a maximum of the greater of \$1 million or \$15,000 times the number of years remaining in the plaintiff's expected life. The Fund must act to satisfy awards for damages in the above amounts only as to awards made after the implementation of the Fund's operation.

In order to create a source of money for the Fund sufficient to satisfy claims made against it for that portion of medical malpractice awards identified in the preceding paragraph, the Superintendent must also make recommendations for another source of state or private money for the Fund. The money in the Fund and any income from the Fund must be used solely for the satisfaction of claims made against the Fund and the expenses of administering the Fund. The Superintendent's recommendations must include a mechanism for making, and the assessment of, claims against the Fund. (Section 5.)

**Department of Insurance report**

The Department of Insurance must annually, beginning with information relative to the year 2002, provide the Ohio General Assembly with a report on all of the following: (1) medical malpractice insurance rates in Ohio, (2) the number of insurers offering medical malpractice insurance in Ohio, and (3) the number of insurer applications submitted to the Department of Insurance seeking rate increases for medical malpractice insurance, and the Department's decisions on those requests. The Department must provide the annual report to the Speaker and minority leader of the House of Representatives, the President and minority leader of the Senate, the chairperson and ranking minority member of the insurance committees of both houses, and the Ohio Medical Malpractice Commission, on or before the 31st day of March of each year. (Section 6.)

**Applicability**

The bill provides that the sections of the Revised Code, as amended or enacted by this act, apply to civil actions upon a medical, dental, optometric, or chiropractic claim in which the act or omission that constitutes the alleged basis of the claim occurs on or after the act's effective date (Section 7).

---

**HISTORY**

ACTION	DATE	JOURNAL ENTRY
Introduced	06-18-02	p. 1916
Reported, S. Insurance, Commerce and Labor	11-21-02	p. 2156
Passed Senate (22-9)	11-21-02	pp. 2162-2168
Reported, H. Civil and Commercial Law	---	---

S0281-RH.124/ss

