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Bill Analysis
Legislative Service Commission

Sub. S.B. 281*

124th General Assembly

(As Reported by S. Insurance, Commerce and Labor)

Sens. Goodman, Coughlin, Randy Gardner, Nein, Wachtmann, Mead, Hottinger, Harris, Spada

BILL SUMMARY

- Enacts a new statute of limitations governing medical, dental, optometric, and chiropractic claims that includes a new requirement to provide notice to a defendant prior to bringing an action.
- Limits the noneconomic damages that may be awarded in medical, dental, optometric, and chiropractic claims.
- 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.
- 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.
- Limits attorney contingency fees specifically in connection with medical, dental, optometric, and chiropractic claims.

* *This analysis was prepared before the report of the Senate Insurance, Commerce and Labor Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.*

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CONTENT AND OPERATION

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

(secs. 2305.11 and 2305.113)

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, and emergency medical technicians. 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.

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 but places a new requirement on their commencement. The bill requires written notice of a claimant's intent to bring an action be provided to the person to be named in the action at least 90 days prior to the commencement of the action. The notice must state the legal basis of the claim, the type of loss sustained, and, with specificity, the nature of the injuries suffered.

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 they are considering bringing an action upon the claim, to commence the action at any time within 180 days after the notice is given. The bill permits a claimant that has provided written notice of their intent to commence an action within 90 days prior to the expiration of the one-year limit for the commencement of the action to commence an action up to 90 days from the date of the service of this notice. This appears to shorten the current time frame a person potentially has to bring such an action by 90 days.

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.

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

(secs. 2305.234 and 2323.43)

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 in a tort action that represent the plaintiff's noneconomic loss. Such compensatory damages, in most cases, 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 related to a permanent and substantial physical deformity, loss of limb, or loss of a bodily organ system, or to a permanent physical functional injury that prevents the plaintiff from being able to independently care for himself or herself and perform life-sustaining activities, then the amount recoverable for noneconomic losses is limited to the greater of \$750,000 or an amount equal to \$35,000 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.

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

1. All lost wages, salaries, and other compensation;
2. All expenditures for medical care or treatment, rehabilitation services, and other care, treatment, services, products, and 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.

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's caps on noneconomic damage awards do not apply to wrongful death actions brought pursuant to Chapter 2125. of the Revised Code.

This section also prohibits the reallocation of noneconomic damages allocated to an immune tortfeasor or to a tortfeasor whose liability is limited by law to any other tortfeasor.

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.

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

(sec. 2323.55)

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. 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 minimums. If that verdict is in favor of the plaintiff, the trier 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.

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.

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 their 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.

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 take into consideration 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.

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.

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.

Collateral benefits

(sec. 2323.41)

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, from any of the following sources:

1. The United States Social Security Act;
2. Any state or federal income disability or workers' 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.

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 insurance benefit 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.

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

(secs. 2711.21 to 2711.24)

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.

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 care. 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.

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."

Attorney's contingency fees

(sec. 4705.15)

Current law regulates contingent fee agreements in connection with claims that are or may become the basis of a tort action. For this purpose, a contingent fee agreement is an agreement for the provision of legal services under which the attorney's compensation is contingent, in whole or part, upon a judgment being rendered in favor of or a settlement being obtained for the client; the compensation may be a fixed amount or may be formulized.

The bill adds provisions to specifically and separately regulate attorney-client contracts for the provision of legal services in connection with a medical claim, dental claim, optometric claim, or chiropractic claim that may become the basis of a tort action, when the contract includes a contingent fee agreement. The bill places limits on the contingency fees permitted in these contracts, prohibiting an agreement for the payment of a fee, and an attorney's collection of a fee, exceeding: 35% of the first \$100,000 recovered, 25% of the next \$500,000 recovered, and 15% on any amounts recovered over \$600,000. These limits apply regardless of whether the recovery is by settlement, arbitration, or judgment or whether the person for whom the recovery is made is a responsible adult, infant, or a person of unsound mind. As is currently the law with regard to other contingent fee agreements, prior to receiving compensation under a contingent fee agreement connected with a medical claim, dental claim, optometric claim, or chiropractic claim, an attorney must provide the client with a copy of a signed statement that specifies the manner in which the attorney's compensation was determined pursuant to the agreement.

For purposes of this section, the bill defines "recovered" as the net sum recovered on a claim after deducting any disbursements, costs, and expenses incurred in connection with the prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office overhead costs or charges are not deductible disbursements or costs for this purpose.

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.¹ References to the definitions currently found in section 2305.11 are amended to refer to section 2305.113 of the Revised Code. The definitions of "medical claim," "dental claim," "optometric claim," "chiropractic claim," and "advanced practice nurse" in section 2305.113 of the Revised Code are also referenced in the other sections enacted by the bill, sections 2323.41, 2323.43, and 2323.55 of the Revised Code (sec. 2323.43 separately defines "medical claim," excluding nursing homes and residential facilities from the definition used elsewhere in the bill).

UNCODIFIED PROVISIONS

Saving clauses; Intent

(Sections 3, 4, and 5)

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 that are preempted by federal law.

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.

¹ 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.

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. Further, 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.

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	06-18-02	p. 1916
Reported, S. Insurance, Commerce and Labor	---	---

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