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Conference Committee Synopsis

Legislative Service Commission

Comparative Synopsis of Sub. S.B. 281 of the 124th General Assembly, As Passed by the Senate,
 Am. Sub. S.B. 281 of the 124th General Assembly, As Passed by the House,
 and the Conference Committee Report

Topic	Sub. S.B. 281 (As Passed by the Senate)	Am. Sub. S.B. 281 (As Passed by the House)	Conference Committee Report
Reporting of malpractice actions	No comparable provision.	Requires every clerk of a court of common pleas in Ohio, before the fifteenth day of January, April, July, and October of each year, to 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 its filing, (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, (6) whether or not a judgment has been	Same as in the House passed version, but instead of filing a quarterly report, the clerk of the court of common pleas must file an annual report before the 15th day of January of each year (<i>R.C. 2303.23</i>).

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		<p>rendered, the nature of the judgment, including the amounts of compensatory damages representing economic and noneconomic loss, and the date of its entry, and (7) if a judgment has been rendered, whether or not a notice of appeal has been filed or whether the time for filing an appeal has expired.</p> <p>If a report that relates to a specific civil action includes the information specified in (6) and (7), above, or if the parties have agreed on a settlement with respect to that action, the succeeding quarterly report no longer should include all of the information described in the preceding paragraph with respect to that action.</p> <p>For the purpose of paying the costs of the above reporting provision, the court of common pleas must collect \$5 as additional filing fee in each civil action upon a medical, dental, optometric, or chiropractic claim that is filed</p>	



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		in the court. (R.C. 2303.23.)	
<p>Notice of intent to commence action upon medical claim, dental claim, optometric claim, or chiropractic claim</p>	<p>Requires written notice of a person's intent to bring an action upon a medical, dental, optometric, or chiropractic claim to be provided to the person whose act or omission is the basis of the claim at least 90 days before bringing 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. Permits a person that has given such notice within 90 days prior to the expiration of the one-year limitation for the commencement of the action to commence an action up to 90 days from the date of service of the notice. (R.C. 2305.113(B).)</p> <p>No comparable provision.</p>	<p>Provides that if prior to the expiration of the one-year period of limitations for commencing an action upon a medical, dental, optometric, or chiropractic claim a claimant gives to the person who is the subject of the claim written notice that the claimant is considering bringing an action, that action may be commenced against the person notified within 180 days after the notice is given (same as in current law). (R.C. 2305.113(B)(1).)</p> <p>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.</p>	<p>Same as in the House passed version.</p> <p>Same as in the House passed version.</p>



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<p>Statute of repose</p>	<p>Provides that except as to persons within the age of minority or of unsound mind, both of the following apply (R.C. 2305.113(C)):</p> <p>(1) No action upon a medical, dental, optometric, or chiropractic claim may be commenced more than four years after the occurrence of the act or omission constituting the basis of the claim.</p> <p>(2) If such an action is not commenced within that four-year period, then, <i>notwithstanding the time when the action is determined to accrue under the statute of limitations</i>, any action upon that claim is barred.</p> <p>No comparable provision.</p>	<p>2305.113(B)(2.)</p> <p>Provides that except as to persons within the age of minority or of unsound mind <i>and except as described below</i>, both of the following apply (R.C. 2305.113(C)):</p> <p>(1) The same provision as in (1) in the column to the left.</p> <p>(2) If an action is not commenced within the four-year period, then, any action upon that claim is barred (the bill deletes <i>notwithstanding the time when the action is determined to accrue under the statute of limitations</i>).</p> <p>The additional exceptions are (R.C. 2305.113(D)(1) and (2)):</p> <p>(a) If the claimant, in the</p>	<p>Same as in the House passed version.</p> <p>The additional exceptions to the statute of repose are (R.C. 2305.113(D)(1) and (2)):</p> <p>(a) Same as in (b) in the</p>



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	No comparable provision.	<p>exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission within the four-year period, the claimant may commence an action not later than one year after the claimant, in the exercise of reasonable care and diligence, discovered or should have discovered the injury.</p> <p>(b) If the claimant, in the exercise of reasonable care and diligence, could not have discovered the injury within three years after the act or omission but, in the exercise of reasonable care and diligence, discovers the injury before the expiration of the above four-year period, the claimant may commence an action not later than one year after the injury is discovered.</p> <p>Provides that a person who commences an action under the circumstances described above in (a) or (b) has the affirmative</p>	<p>immediately preceding column to the left.</p> <p>(b) If the alleged basis of the 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.</p> <p>Provides that a person who commences an action under the circumstances described in (a) or (b), above, has the</p>



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		burden of proving, <u>by clear and convincing evidence</u> , that the person, with reasonable care and diligence, could not have discovered the injury resulting from the act or omission within the four-year period under (a) or the three-year period under (b), above, whichever is applicable (<i>R.C. 2305.113(D)(3)</i>).	affirmative burden of proving, <u>by clear and convincing evidence</u> , that the person, with reasonable care and diligence, could not have discovered the injury resulting from the act or omission within the three-year period under (a) or within the one-year period under (b), whichever is applicable.
Definitions related to general definition of "medical claim"	Includes in the definition of "medical claim" a claim that is asserted against a licensed practical nurse, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, and emergency medical technician-paramedic, among other health care practitioners in current law (<i>R.C. 2305.113(E)(3)</i>). No comparable provision.	Includes the same types of medical professionals described in the column to the left and defines them as follows (<i>R.C. 2305.113(E)(17), (18), and (19)</i>): "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	Includes the same types of medical professionals added in the Senate and House passed versions and defines them in the same manner as in the House passed version.



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		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.	
Collateral benefits	Permits a defendant to introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages from the following sources (<i>R.C. 2323.41(A)</i>): (1) The U.S. 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	Permits a defendant to introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages, <i>except</i> 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 (<i>R.C. 2323.41(A)</i>).	Same as in the House passed version.



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	<p>provides health benefits, or income disability coverage;</p> <p>(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.</p> <p>Provides that if the defendant elects to introduce that evidence, the plaintiff may introduce evidence of any amount the plaintiff has paid or contributed to secure the right to receive the <i>insurance</i> benefits of which the defendant has introduced evidence (R.C. 2323.41(B)).</p>	<p>Provides that if the defendant elects to introduce that evidence, the plaintiff may introduce evidence of any amount the plaintiff has paid or contributed to secure the right to receive the benefits (the House passed version deletes <i>insurance</i>) of which the defendant has introduced evidence (R.C. 2323.41(B)).</p>	<p>Same as in the House passed version.</p>
<p>Reasonable good faith basis for medical, dental, optometric, or chiropractic claims</p>	<p>No comparable provision.</p>	<p>Provides the following procedures upon a defendant's motion to determine the existence or nonexistence of a reasonable good faith basis for the plaintiff's claim (a "good faith motion") that must be filed not earlier than the close</p>	<p>Same as in the House passed version.</p>



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		<p>of discovery and not later than 30 days after the verdict or award is rendered (<i>R.C. 2323.42</i>):</p> <p>(1) The plaintiff has not less than 14 days to respond but, upon good cause shown, the court must grant an extension as necessary for the plaintiff to obtain evidence.</p> <p>(2) The court must conduct a hearing, which must be an oral hearing at the parties' request, regarding the existence or nonexistence of a reasonable good faith basis upon which the claim is asserted against the defendant.</p> <p>(3) In making its determination, the court must consider the facts of the underlying claim and whether the plaintiff: (a) obtained timely review of the merits of the claim by a qualified expert, (b) reasonably relied upon the results of the review in supporting the claim, (c) had an opportunity to conduct a pre-</p>	



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		<p>suit investigation or was afforded full discovery during litigation, (d) reasonably relied upon evidence discovered during the litigation in support of the claim, or (e) took appropriate and reasonable steps to timely dismiss any defendant on behalf of whom it was alleged or determined that no reasonable good faith existed for continued assertion of the claim.</p> <p>(4) Any defendant that intends to file a good faith motion must first serve a "Notice of Demand for Dismissal and Intention to File a Good Faith Motion." If within 14 days of service, the plaintiff dismisses the defendant, the defendant is precluded from filing a good faith motion as to any attorney's fees and costs after the dismissal.</p> <p>(5) If the court determines that no reasonable good faith basis existed for the claim or that, at some point in the litigation, the</p>	



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		<p>plaintiff lacked a good faith basis for continuing the claim, the court must award all of the following to the defendant: (a) all costs incurred by the defendant, (b) reasonable attorney's fees in defense of the claim after the court's determination that no reasonable good faith basis existed for the claim, and (c) reasonable attorney's fees incurred in support of the good faith motion.</p>	
<p>Limits on damages for noneconomic loss</p>	<p>Limits the damages for <i>noneconomic loss</i> that may be awarded in a civil action upon a medical, dental, optometric, or chiropractic claim as follows (R.C. 2323.43(A)(2)):</p> <p>(1) Generally, 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;</p>	<p>Limits the damages for <i>each plaintiff's noneconomic loss</i> that may be awarded in a civil action upon a medical, dental, optometric, or chiropractic claim, <i>which includes related derivative claims</i>, as follows (R.C. 2323.43(A)):</p> <p>(1) The same limits as in (1) in the column to the left;</p>	<p>Limits the amount of noncompensatory damages for <i>noneconomic loss</i> that is recoverable in a civil action under this provision as follows (R.C. 2323.43(A)(2) and (3)):</p> <p>(1) Generally, 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 \$350,000 for each plaintiff or a maximum of \$500,000 for each occurrence;</p>



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	<p>(2) The greater of \$750,000 or an amount equal to \$35,000 times the number of years remaining in the <i>plaintiff's</i> expected life, if the noneconomic losses of the plaintiff are for permanent and substantial physical deformity, loss of use of a limb, loss of a bodily organ system, or permanent physical functional injury that permanently prevents the plaintiff from being able to independently care for self and perform life sustaining activities.</p> <p>Defines "medical claim" for use with the cap on noneconomic loss provisions of the bill to mean any claim that is asserted in any civil action against a physician, podiatrist, or hospital, against any employee or agent of a physician, podiatrist, or hospital, or against a licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, physician assistant, or emergency medical</p>	<p>(2) The greater of \$1 million or an amount equal to \$15,000 times the number of years remaining in the <i>injured person's</i> expected life, if the noneconomic losses of the plaintiff are of the same type of injuries as described in (2) in the column to the left.</p> <p>Defines "medical claim" for use with the cap on noneconomic loss provisions of the bill to have the same meaning as used in the other provisions of the bill and to mean a claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a licensed practical nurse,</p>	<p>(2) \$500,000 for each plaintiff or \$1 million for each occurrence, if the noneconomic losses of the plaintiff are of the same type of injuries as described in both the Senate and House passed versions.</p> <p>Defines "medical claim" as in the House passed version.</p>



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	<p>technician, and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person (R.C. 2323.43(C)(4)).</p>	<p>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:</p> <p>(1) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person;</p> <p>(2) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies:</p> <p>(a) The claim results from acts or omissions in providing medical care.</p> <p>(b) The claim results from the hiring, training, supervision, retention, or termination of</p>	



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		<p>caregivers providing medical diagnosis, care, or treatment.</p> <p>(3) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under R.C. 3721.17 (R.C. 2323.43(F)(2) and 2305.113(E)(3)).</p>	
<p>Procedures regarding limitation on noneconomic damages</p>	<p>No comparable provision.</p>	<p>Provides the following procedures regarding the award of damages in a civil action upon a medical, dental, optometric, or chiropractic claim:</p> <p>(1) If a trial is conducted and the plaintiff prevails with respect to a medical, dental, optometric, or chiropractic 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: (a) the total compensatory damages recoverable by the plaintiff, (b) the portion of the</p>	<p>Provides the same procedures as in the House passed version.</p>



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		<p>total compensatory damages representing economic loss, and (c) the portion of the total compensatory damages representing noneconomic loss. <i>(R.C. 2323.43(B).)</i></p> <p>(2) The court must enter a judgment for the plaintiff for compensatory damages for economic loss in the amount determined in (1)(b), above, and for compensatory damages for noneconomic loss subject to the 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 above. In no event may a judgment for noneconomic damages exceed the maximum amount recoverable pursuant to the limits on those damages. The provisions regarding the recovery of damages must be applied in a jury trial only after the jury has made its factual findings and determination as to the damages. <i>(R.C.</i></p>	



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		<p>2323.43(C)(1) and (D)(1).)</p> <p>(3) Prior to the trial, 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 for the nature of the injury (R.C. 2323.43(C)(2)).</p> <p>(4) If the trier of fact is a jury, the court must not instruct the jury with respect to the limits on the noneconomic damages, and neither counsel for any party nor a witness may inform the jury or potential jurors of that limit (R.C. 2323.43(D)(2)).</p>	
Reallocation of noneconomic damages precluded	Provides that noneconomic damages allocated to an immune tortfeasor or to a tortfeasor whose liability is limited by law may not be reallocated to any other tortfeasor (R.C. 2323.43(A)(3)).	Provides that any excess amount of compensatory damages for noneconomic loss that is greater than the applicable limits may not be reallocated to any other tortfeasor beyond the amount of compensatory damages that that tortfeasor would otherwise be responsible for under Ohio law (R.C. 2323.43(E)).	Same as in the House passed version.



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	<p>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. (R.C. 4705.15(A)(4).)</p>		<p>amount of the attorney's fees under the contingency fee agreement. The application must include the proposed distribution of the amount of the judgment or settlement.</p> <p>(2) The attorney must 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 retains jurisdiction over the settlement, allocation, and distribution of the claim.</p> <p>(3) The application must state the arrangements, if any, that have been made with respect to the attorney's fees. The attorney's fees are subject to the approval of the probate court.</p>
<p>Periodic payments of future damages</p>	<p>Defines "past damages" as damages resulting from an injury, death, or loss to person or property that is a subject of a</p>	<p>Defines "past damages" in the same manner and additionally states that "past damages" includes both economic loss</p>	<p>Same as in the House passed version.</p>



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	<p>civil action upon a medical, dental, optometric, or chiropractic claim and that have accrued by the time that the verdict or the determination of liability is rendered by the trier of fact (R.C. 2323.55(A)(5)).</p> <p>Requires the court, in approving a periodic payments plan, <i>to take into consideration</i> interest on the judgment in question in accordance with R.C. 1343.03 (R.C. 2323.55(G)(1)).</p>	<p>and noneconomic loss (R.C. 2323.55(A)(5)).</p> <p>Requires the court, in approving a periodic payments plan, <i>to require</i> interest on the judgment in question in accordance with R.C. 1343.03 (R.C. 2323.55(G)(1)).</p>	<p>Same as in the House passed version.</p>
Expert testimony	<p>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</p>	<p>Includes the same provision as in the column to the left, 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)).</p>	<p>Same as in the House passed version.</p>



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	accredited university (<i>R.C. 2743.43(A)</i>).		
Insurance company filings	No comparable provision.	Requires every insurance company in Ohio to file with the Department of Insurance all information about the salaries, bonuses, or other compensation of executive officers of and members of the boards of directors of the company, and provides that such filed information is open to public inspection under the Public Records Law (<i>R.C. 3929.88</i>).	No comparable provision.
Ohio Medical Malpractice Commission	No comparable provision.	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	Same as in the House passed version but provides that the Commission consists of nine, instead of seven, members and that the two additional members are appointed each by the minority leader of the Senate and the minority leader of the House. The Committee report deleted the requirement in the House passed version that the Department of Insurance reimburse each member for actual and necessary expenses. (<i>Section 4.</i>)



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		<p>State Medical Association, and one must represent the insurance companies in Ohio, and all of them must have expertise in medical malpractice insurance issues.</p> <p>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.</p> <p>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</p>	



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		<p>performance of the member's duties.</p> <p>The Department of Insurance must provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties. <i>(Section 4.)</i></p>	
<p>Patient Compensation Fund feasibility study</p>	<p>No comparable provision.</p>	<p>Requires the Superintendent of Insurance to study the feasibility of a Patient Compensation Fund to cover medical malpractice claims, including, but not limited to: (1) the financial responsibility limits for providers that are covered in Sub. S.B. 281, and the Patient Compensation Fund, (2) the identification of methods of funding to include, but not be 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 maintenance of such a fund,</p>	<p>Requires the Superintendent of Insurance to study the feasibility of a Patient Compensation Fund to cover medical malpractice claims, including, but not limited to: (1) the financial responsibility limits for providers that are covered in Am. Sub. S.B. 281, and the Patient Compensation Fund, (2) the identification of methods of funding, <i>excluding any tax on consumers</i>, (3) the operation and administration of such a fund, and (4) the participation requirements.</p>



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		<p>and (4) the participation requirements.</p> <p>States that this requirement is 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.</p> <p>Requires the Superintendent to make recommendations for the operation of the 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 generally for noneconomic loss in excess of \$350,000 to a maximum of \$500,000 and for the satisfaction of the awards for noneconomic loss for the more serious types of injuries described in the bill in excess of \$500,000 to a maximum of the greater of \$1 million or</p>	<p>States that this requirement is 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.</p> <p>Requires the Superintendent to make recommendations for the operation of the Fund designed to assist health care practitioners in satisfying medical malpractice awards above designated amounts. <i>The purpose of the study is to consider the feasibility of the Fund satisfying that portion of the awards generally for noneconomic loss in excess of \$350,000 to a maximum of \$500,000 and for the satisfaction of the awards for noneconomic loss for the more serious types of injuries described in the bill in excess of \$500,000 to a maximum of</i></p>



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		<p>\$15,000 times the number of years remaining in the injured person's expected life. The Fund must act to satisfy awards only as to awards made after the implementation of the Fund's operation.</p> <p>Requires the Superintendent to submit a preliminary report by March 3, 2003, and a final report by May 1, 2003, to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the chairpersons of the General Assembly committees with jurisdiction over medical malpractice liability issues. The final report must include the recommendations for implementing the Fund, which the General Assembly must implement not later than July 1, 2003.</p> <p>Requires the Superintendent to also make recommendations for any other source of state or private money for the Fund and for a mechanism for making,</p>	<p>\$1 million.</p> <p>Requires the Superintendent to submit a preliminary report by March 3, 2003, and a final report by May 1, 2003, to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the chairpersons of the General Assembly committees with jurisdiction over medical malpractice liability issues. The final report must include the recommendations for implementing the Fund.</p> <p>Requires the Superintendent's recommendations to include sources of revenue for the Fund and a mechanism for making, and the assessment of, claims</p>



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		and the assessment of, claims against the Fund. The money and income from the Fund must be used solely for the satisfaction of the claims made against it and the expenses of its administration. <i>(Section 5.)</i>	against the Fund. <i>(Section 5.)</i>
Department of Insurance reports	No comparable provision.	<p>Requires the Department of Insurance annually, beginning with information relative to the years 2002, to provide the 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.</p> <p>Requires the Department of Insurance to provide the annual report to the Speaker and minority leader of the House of Representatives, the President</p>	No comparable provision.



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		and minority leader of the Senate, the chairperson and ranking minority member of the insurance committees of both houses, and the Medical Malpractice Commission, on or before the 31st day of March of each year. <i>(Section 6.)</i>	
Statements of General Assembly findings and intent	<p>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.</p> <p>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</p>	Provides the same statements of the General Assembly's findings and intent as described in the column to the left <i>(Section 3.)</i>	Provides the same statements of the General Assembly's findings and intent as in the Senate and House passed versions <i>(Section 3.)</i>



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	<p>insurance, and the increase in medical malpractice insurance premiums is reflected in rising health care costs to consumers.</p> <p>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. <i>(Section 3.)</i></p> <p>No comparable provision.</p>	<p>Provides the additional statements of the General Assembly's findings as follows: (1) 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 <i>(Section 3(A)(3))</i>.</p>	<p>Provides the additional statements of the General Assembly's findings as in the House passed version. <i>(Section 3.)</i></p>



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		<p>(2) In <i>Evans v. State</i> (Sup. Ct. Alaska 2002), the Alaska Supreme Court held that Alaska's damages caps do not violate the rights to a trial by jury granted by the Alaska Constitution and the Seventh Amendment to the United States Constitution, and relied on a Third Circuit Court of Appeal's holding in <i>Davis v. Omitowaju</i> (3rd Cir. 1989), 883 F. 2d 1155, that the 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.</p> <p>It is the intent of the 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. (Section 3(A)(4)(c).)</p>	



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		<p>(3) Limits on damages have been upheld by other state supreme courts (citing cases from California, Indiana, and Alaska (<i>Section 3(A)(4)(d)</i>).</p> <p>(4) This legislation addresses the aspects of current law's statute of repose, the application of which was found by the Ohio Supreme Court to be unconstitutional in <i>Gaines v. Preterm-Cleveland, Inc.</i> (1987), 33 Ohio St.3d 54. Citing <i>Dunn v. St. Francis Hospital, Inc.</i> (Del. 1982), 401 Atl.2d 77, it states that the Delaware Supreme Court found the Delaware three-years statute of repose constitutional as not violative of the Delaware Constitution's open courts provision. (<i>Section 3(A)(6)(f)</i>.)</p>	
Applicability	No comparable provision.	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	Same as in the House passed version.



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		act or omission that constitutes the alleged basis of the claim occurs on or after the act's effective date (<i>Section 7</i>).	

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