



*Synopsis of House Committee Amendments**

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Legislative Service Commission

Sub. S.B. 281

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(H. Civil and Commercial Law)

Statute of limitations and statute of repose

The Committee made the following changes to the Senate passed version:

(1) It deleted the provisions pertaining to the 90-day notice of a person's intent to bring an action upon a medical, dental, optometric, or chiropractic claim and substituted current law's 180-day notice (a person who gives a written notice prior to the expiration of the one-year statute of limitations has 180 days after the notice is given to commence an action) and added a prohibition against an insurance company considering the existence or nonexistence of such notice in setting the liability insurance premium rates for the insured person who was notified (R.C. 2305.113(B)).

(2) It added the following exceptions to the four-year statute of repose: (a) if a claimant could not have discovered the injury within three years after the occurrence of the act or omission constituting the alleged basis of the claim, but, in the exercise of reasonable care and diligence, discovers the injury before the expiration of the four-year period, the person may commence an action not later than one year after the discovery of the injury and (b) if the alleged basis of the claim is an act or omission that involves a foreign object left in the body of the claimant, the claimant may commence an action not later than one year after the claimant discovered or with reasonable care and diligence should have discovered the foreign object. In either case, the person 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 within the applicable period. (R.C. 2305.113(D).)

Collateral benefits

The Committee retained the provision permitting a defendant to introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages, deleted the list of types of sources of those benefits, and provided an exception to their

* This synopsis does not address amendments that may have been adopted on the House floor.

introduction in evidence if the source of the benefits has a mandatory self-effectuating federal right of subrogation or a contractual or statutory right of subrogation (R.C. 2323.41(A)). The Committee revised the provision with respect to the plaintiff introducing evidence of any amount the plaintiff has paid or contributed to secure the right to receive the benefits (not limited to *insurance* benefits as in the Senate passed version) (R.C. 2323.41(B)).

Reasonable good faith basis

The Committee added procedures in civil actions upon a medical, dental, optometric, or chiropractic claim in which a court must determine, upon a defendant's motion filed not earlier than the close of discovery and not later than 30 days after the verdict or award is rendered, whether or not there is a reasonable good faith basis upon which the particular claim is asserted against that defendant. The court must conduct a hearing and, in making its determination, must consider the facts of the underlying claim and whether the plaintiff performed certain specified actions with respect to the claim. The court must award certain court costs and attorneys' fees if no reasonable good faith basis for the claim is found. (R.C. 2323.42.)

Limits on damages for noneconomic loss

The Committee modified the Senate passed version as follows:

(1) It limited the amount of compensatory damages recoverable *by each plaintiff* (added by the Committee) in the civil action for noneconomic loss and imposed a maximum recoverable amount of the greater of \$1 million or \$15,000 times the number of years remaining in the plaintiff's expected life if the noneconomic losses are for the more serious types of injuries described in both versions (R.C. 2323.43(A)(2) and (3)).

(2) It deleted the definition of "medical claim" in the Senate passed version for use with the cap on noneconomic loss provisions (this definition excluded claims against nursing homes or residential facilities) and defined "medical claim" for use with those provisions to have the same meaning as used in the other provisions of the bill (R.C. 2323.43(G)(2) and 2305.113(E)(3)).

(3) It provided the following procedures regarding the award of damages: (a) if a trial is conducted and the plaintiff prevails, 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 the total compensatory damages recoverable, the portion representing economic loss, and the portion representing noneconomic loss, (b) the court must enter a judgment for economic loss in the amount as determined and a judgment for noneconomic loss subject to the provision that a court of common pleas has no jurisdiction to enter judgment on an award of damages for noneconomic loss in excess of the limits, (c) the recovery of damages provisions must be applied in a jury trial only after the jury has made its factual findings and determination as to the damages, (d) prior

to trial, any party may seek summary judgment with respect to the nature of the alleged injury or loss, seeking a determination of the damages for the nature of the injury, and (e) if the trier of fact is a jury, the court must not instruct the jury with respect to the limits on 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(B), (C), and (D)).

(4) It replaced the non-allocation provision in the Senate passed version with the provision that any excess amount of noneconomic loss that is greater than the applicable limits cannot be reallocated to any other tortfeasor beyond the amount of damages that the tortfeasor would otherwise be responsible for under Ohio law (R.C. 2323.43(E)).

Other changes

The Committee further modified the Senate passed version in the following manners:

(1) It provided that the court, in approving a periodic payments plan for future damages, must *require* (instead of *take into consideration*) interest on the judgment (R.C. 2323.55(G)(1)).

(2) It added a provision in current law on expert testimony that current law is not to be construed to limit the trial court's power to allow testimony of any other expert witness that is relevant to the medical claim involved (R.C. 2743.43(C)).

(3) It removed all of the provisions regarding the limits on contingency fees permitted in attorney-client contingent fee agreements in connection with a medical, dental, optometric, or chiropractic claim.

(4) It added provisions requiring 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 requiring the court to collect an additional filing fee of \$5 to pay the costs of making the reports (R.C. 2303.23).

(5) It created 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 (Section 4).

(6) It added uncodified provisions requiring 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 (Section 5).

(7) It added an uncodified provision requiring 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 (Section 6).

(8) It added an uncodified provision that the sections of the Revised Code, as amended or enacted by the act, apply to civil actions upon a medical, dental, optometric, or chiropractic claim in which the act or omission that is the alleged basis of the claim occurs on or after the act's effective date (Section 7).

(9) It included additional uncodified statements of findings and intent of the General Assembly, including citations of cases from California, Indiana, and Alaska in which the state supreme courts upheld limits on damages and a statement of its intent that as a matter of policy, the bill's limits on noneconomic damages are applied after a jury's determination of the factual question of damages (Section 3).

(10) It added definitions for "licensed practical nurse," "physician assistant," "emergency medical technician-basic," "emergency medical technician-intermediate," and "emergency medical technician-paramedic," all of which are included in both bill's definitions of "medical claim."

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