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

**REPRESENTATIVES Cates, Calvert, Grendell, Schmidt, Raga, Niehaus,
Evans, Hoops, Faber, Olman, Aslanides, Collier, Hollister, Carey, Flowers,
Lendrum, Wolpert, Gilb, Reidelbach, Latta, Carmichael, Jolivette, Williams,
G. Smith, Schneider, Clancy, Husted, Setzer, Schaffer, White, Peterson**

A B I L L

To amend sections 1751.67, 2117.06, 2305.11, 2305.15,	1
2305.234, 2317.02, 2317.54, 2323.56, 2711.21,	2
2711.22, 2711.23, 2711.24, 2743.02, 2743.43,	3
2919.16, 3923.63, 3923.64, 3929.71, and 5111.018,	4
to enact sections 2303.23, 2305.113, 2323.41,	5
2323.42, 2323.43, and 2323.55, and to repeal	6
sections 2305.27 and 2323.57 of the Revised Code	7
relative to medical claims, dental claims,	8
optometric claims, and chiropractic claims.	9

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1751.67, 2117.06, 2305.11, 2305.15,	10
2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23,	11
2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, and	12
5111.018 be amended and sections 2303.23, 2305.113, 2323.41,	13
2323.42, 2323.43, and 2323.55 of the Revised Code be enacted to	14

read as follows: 15

Sec. 1751.67. (A) Each individual or group health insuring 16
corporation policy, contract, or agreement delivered, issued for 17
delivery, or renewed in this state that provides maternity 18
benefits shall provide coverage of inpatient care and follow-up 19
care for a mother and her newborn as follows: 20

(1) The policy, contract, or agreement shall cover a minimum 21
of forty-eight hours of inpatient care following a normal vaginal 22
delivery and a minimum of ninety-six hours of inpatient care 23
following a cesarean delivery. Services covered as inpatient care 24
shall include medical, educational, and any other services that 25
are consistent with the inpatient care recommended in the 26
protocols and guidelines developed by national organizations that 27
represent pediatric, obstetric, and nursing professionals. 28

(2) The policy, contract, or agreement shall cover a 29
physician-directed source of follow-up care. Services covered as 30
follow-up care shall include physical assessment of the mother and 31
newborn, parent education, assistance and training in breast or 32
bottle feeding, assessment of the home support system, performance 33
of any medically necessary and appropriate clinical tests, and any 34
other services that are consistent with the follow-up care 35
recommended in the protocols and guidelines developed by national 36
organizations that represent pediatric, obstetric, and nursing 37
professionals. The coverage shall apply to services provided in a 38
medical setting or through home health care visits. The coverage 39
shall apply to a home health care visit only if the provider who 40
conducts the visit is knowledgeable and experienced in maternity 41
and newborn care. 42

When a decision is made in accordance with division (B) of 43
this section to discharge a mother or newborn prior to the 44
expiration of the applicable number of hours of inpatient care 45

required to be covered, the coverage of follow-up care shall apply
to all follow-up care that is provided within seventy-two hours
after discharge. When a mother or newborn receives at least the
number of hours of inpatient care required to be covered, the
coverage of follow-up care shall apply to follow-up care that is
determined to be medically necessary by the provider responsible
for discharging the mother or newborn.

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(B) Any decision to shorten the length of inpatient stay to
less than that specified under division (A)(1) of this section
shall be made by the physician attending the mother or newborn,
except that if a nurse-midwife is attending the mother in
collaboration with a physician, the decision may be made by the
nurse-midwife. Decisions regarding early discharge shall be made
only after conferring with the mother or a person responsible for
the mother or newborn. For purposes of this division, a person
responsible for the mother or newborn may include a parent,
guardian, or any other person with authority to make medical
decisions for the mother or newborn.

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(C)(1) No health insuring corporation may do either of the
following:

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(a) Terminate the participation of a provider or health care
facility in an individual or group health care plan solely for
making recommendations for inpatient or follow-up care for a
particular mother or newborn that are consistent with the care
required to be covered by this section;

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(b) Establish or offer monetary or other financial incentives
for the purpose of encouraging a person to decline the inpatient
or follow-up care required to be covered by this section.

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(2) Whoever violates division (C)(1)(a) or (b) of this
section has engaged in an unfair and deceptive act or practice in

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the business of insurance under sections 3901.19 to 3901.26 of the
Revised Code.

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(D) This section does not do any of the following:

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(1) Require a policy, contract, or agreement to cover
inpatient or follow-up care that is not received in accordance
with the policy's, contract's, or agreement's terms pertaining to
the providers and facilities from which an individual is
authorized to receive health care services;

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(2) Require a mother or newborn to stay in a hospital or
other inpatient setting for a fixed period of time following
delivery;

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(3) Require a child to be delivered in a hospital or other
inpatient setting;

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(4) Authorize a nurse-midwife to practice beyond the
authority to practice nurse-midwifery in accordance with Chapter
4723. of the Revised Code;

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(5) Establish minimum standards of medical diagnosis, care,
or treatment for inpatient or follow-up care for a mother or
newborn. A deviation from the care required to be covered under
this section shall not, solely on the basis of this section, give
rise to a medical claim or to derivative claims for relief, as
those terms are defined in section ~~2305.11~~ 2305.113 of the Revised
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Sec. 2117.06. (A) All creditors having claims against an
estate, including claims arising out of contract, out of tort, on
cognovit notes, or on judgments, whether due or not due, secured
or unsecured, liquidated or unliquidated, shall present their
claims in one of the following manners:

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(1) To the executor or administrator in a writing;

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(2) To the executor or administrator in a writing, and to the probate court by filing a copy of the writing with it;

(3) In a writing that is sent by ordinary mail addressed to the decedent and that is actually received by the executor or administrator within the appropriate time specified in division (B) of this section. For purposes of this division, if an executor or administrator is not a natural person, the writing shall be considered as being actually received by the executor or administrator only if the person charged with the primary responsibility of administering the estate of the decedent actually receives the writing within the appropriate time specified in division (B) of this section.

(B) All claims shall be presented within one year after the death of the decedent, whether or not the estate is released from administration or an executor or administrator is appointed during that one-year period. Every claim presented shall set forth the claimant's address.

(C) A claim that is not presented within one year after the death of the decedent shall be forever barred as to all parties, including, but not limited to, devisees, legatees, and distributees. No payment shall be made on the claim and no action shall be maintained on the claim, except as otherwise provided in sections 2117.37 to 2117.42 of the Revised Code with reference to contingent claims.

(D) In the absence of any prior demand for allowance, the executor or administrator shall allow or reject all claims, except tax assessment claims, within thirty days after their presentation, provided that failure of the executor or administrator to allow or reject within that time shall not prevent the executor or administrator from doing so after that time and shall not prejudice the rights of any claimant. Upon the allowance of a claim, the executor or the administrator, on demand

of the creditor, shall furnish the creditor with a written 138
statement or memorandum of the fact and date of the allowance. 139

(E) If the executor or administrator has actual knowledge of 140
a pending action commenced against the decedent prior to the 141
decedent's death in a court of record in this state, the executor 142
or administrator shall file a notice of ~~his~~ the appointment of the 143
executor or administrator in the pending action within ten days 144
after acquiring that knowledge. If the administrator or executor 145
is not a natural person, actual knowledge of a pending suit 146
against the decedent shall be limited to the actual knowledge of 147
the person charged with the primary responsibility of 148
administering the estate of the decedent. Failure to file the 149
notice within the ten-day period does not extend the claim period 150
established by this section. 151

(F) This section applies to any person who is required to 152
give written notice to the executor or administrator of a motion 153
or application to revive an action pending against the decedent at 154
the date of the death of the decedent. 155

(G) Nothing in this section or in section 2117.07 of the 156
Revised Code shall be construed to reduce the time mentioned in 157
section 2125.02, 2305.09, 2305.10, 2305.11, 2305.113, or 2305.12 158
of the Revised Code, provided that no portion of any recovery on a 159
claim brought pursuant to any of those sections shall come from 160
the assets of an estate unless the claim has been presented 161
against the estate in accordance with Chapter 2117. of the Revised 162
Code. 163

(H) Any person whose claim has been presented and has not 164
been rejected after presentment is a creditor as that term is used 165
in Chapters 2113. to 2125. of the Revised Code. Claims that are 166
contingent need not be presented except as provided in sections 167
2117.37 to 2117.42 of the Revised Code, but, whether presented 168
pursuant to those sections or this section, contingent claims may 169

be presented in any of the manners described in division (A) of 170
this section. 171

(I) If a creditor presents a claim against an estate in 172
accordance with division (A)(2) of this section, the probate court 173
shall not close the administration of the estate until that claim 174
is allowed or rejected. 175

(J) The probate court shall not require an executor or 176
administrator to make and return into the court a schedule of 177
claims against the estate. 178

(K) If the executor or administrator makes a distribution of 179
the assets of the estate prior to the expiration of the time for 180
the filing of claims as set forth in this section, the executor or 181
administrator shall provide notice on the account delivered to 182
each distributee that the distributee may be liable to the estate 183
up to the value of the distribution and may be required to return 184
all or any part of the value of the distribution if a valid claim 185
is subsequently made against the estate within the time permitted 186
under this section. 187

Sec. 2303.23. (A) Before the fifteenth day of January of each 188
year, every clerk of a court of common pleas in this state shall 189
send to the department of insurance an annual report containing 190
all of the following information relating to each civil action 191
upon a medical claim, dental claim, optometric claim, or 192
chiropractic claim that was filed or is pending in that court of 193
common pleas: 194

(1) The style and number of the case; 195

(2) The date of the filing of the case; 196

(3) Whether or not there has been a trial and the dates of 197
the trial if there was a trial; 198

(4) The current status of the case; 199

(5) Whether or not the parties have agreed on a settlement of the case; 200
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(6) Whether or not a judgment has been rendered, the nature of the judgment, including the amounts of the compensatory damages that represent economic loss and noneconomic loss, and the date of entry of the judgment; 202
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(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. 206
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(B) If a report that relates to a specific civil action as described in division (A) of this section includes the information specified in divisions (A)(6) and (7) of this section with respect to that action or if the parties have agreed on a settlement, the succeeding annual report that the clerk of the court sends to the department of insurance no longer shall include the information described in division (A) of this section with respect to that action. 209
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(C) For the purpose of paying the costs of implementing division (A) of this section, the court of common pleas shall collect the sum of five dollars as additional filing fees in each civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim that is filed in the court. 217
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(D) As used in this section, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code. 222
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Sec. 2305.11. (A) An action for libel, slander, malicious prosecution, or false imprisonment, an action for malpractice other than an action upon a medical, dental, optometric, or chiropractic claim, or an action upon a statute for a penalty or forfeiture shall be commenced within one year after the cause of 225
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action accrued, provided that an action by an employee for the 230
payment of unpaid minimum wages, unpaid overtime compensation, or 231
liquidated damages by reason of the nonpayment of minimum wages or 232
overtime compensation shall be commenced within two years after 233
the cause of action accrued. 234

~~(B)(1) Subject to division (B)(2) of this section, an action 235
upon a medical, dental, optometric, or chiropractic claim shall be 236
commenced within one year after the cause of action accrued, 237
except that, if prior to the expiration of that one-year period, a 238
claimant who allegedly possesses a medical, dental, optometric, or 239
chiropractic claim gives to the person who is the subject of that 240
claim written notice that the claimant is considering bringing an 241
action upon that claim, that action may be commenced against the 242
person notified at any time within one hundred eighty days after 243
the notice is so given. 244~~

~~(2) Except as to persons within the age of minority or of 245
unsound mind, as provided by section 2305.16 of the Revised Code: 246~~

~~(a) In no event shall any action upon a medical, dental, 247
optometric, or chiropractic claim be commenced more than four 248
years after the occurrence of the act or omission constituting the 249
alleged basis of the medical, dental, optometric, or chiropractic 250
claim. 251~~

~~(b) If an action upon a medical, dental, optometric, or 252
chiropractic claim is not commenced within four years after the 253
occurrence of the act or omission constituting the alleged basis 254
of the medical, dental, optometric, or chiropractic claim, then, 255
notwithstanding the time when the action is determined to accrue 256
under division (B)(1) of this section, any action upon that claim 257
is barred. 258~~

~~(c) A civil action for unlawful abortion pursuant to section 259
2919.12 of the Revised Code, a civil action authorized by division 260~~

(H) of section 2317.56 of the Revised Code, a civil action 261
pursuant to division (B)(1) or (2) of section 2307.51 of the 262
Revised Code for performing a dilation and extraction procedure or 263
attempting to perform a dilation and extraction procedure in 264
violation of section 2919.15 of the Revised Code, and a civil 265
action pursuant to division (B)(1) or (2) of section 2307.52 of 266
the Revised Code for terminating or attempting to terminate a 267
human pregnancy after viability in violation of division (A) or 268
(B) of section 2919.17 of the Revised Code shall be commenced 269
within one year after the performance or inducement of the 270
abortion, within one year after the attempt to perform or induce 271
the abortion in violation of division (A) or (B) of section 272
2919.17 of the Revised Code, within one year after the performance 273
of the dilation and extraction procedure, or, in the case of a 274
civil action pursuant to division (B)(2) of section 2307.51 of the 275
Revised Code, within one year after the attempt to perform the 276
dilation and extraction procedure. 277

~~(D)(C)~~ As used in this section: 278

~~(1) "Hospital" includes any person, corporation, association,~~ 279
~~board, or authority that is responsible for the operation of any~~ 280
~~hospital licensed or registered in the state, including, but not~~ 281
~~limited to, those that are owned or operated by the state,~~ 282
~~political subdivisions, any person, any corporation, or any~~ 283
~~combination thereof. "Hospital" also includes any person,~~ 284
~~corporation, association, board, entity, or authority that is~~ 285
~~responsible for the operation of any clinic that employs a~~ 286
~~full-time staff of physicians practicing in more than one~~ 287
~~recognized medical specialty and rendering advice, diagnosis,~~ 288
~~care, and treatment to individuals. "Hospital" does not include~~ 289
~~any hospital operated by the government of the United States or~~ 290
~~any of its branches.~~ 291

~~(2) "Physician" means a person who is licensed to practice~~ 292

~~medicine and surgery or osteopathic medicine and surgery by the
state medical board or a person who otherwise is authorized to
practice medicine and surgery or osteopathic medicine and surgery
in this state.~~ 293
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~~(3) "Medical claim" means any 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 registered nurse or physical therapist, and that arises
out of the medical diagnosis, care, or treatment of any person.
"Medical claim" includes the following:~~ 297
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~~(a) Derivative claims for relief that arise from the medical
diagnosis, care, or treatment of a person;~~ 304
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~~(b) Claims that arise out of the medical diagnosis, care, or
treatment of any person and to which either of the following
apply:~~ 306
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~~(i) The claim results from acts or omissions in providing
medical care.~~ 309
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~~(ii) The claim results from the hiring, training,
supervision, retention, or termination of caregivers providing
medical diagnosis, care, or treatment.~~ 311
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~~(c) Claims that arise out of the medical diagnosis, care, or
treatment of any person and that are brought under section 3721.17
of the Revised Code.~~ 314
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~~(4) "Podiatrist" means any person who is licensed to practice
podiatric medicine and surgery by the state medical board.~~ 317
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~~(5) "Dentist" means any person who is licensed to practice
dentistry by the state dental board.~~ 319
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~~(6) "Dental claim" means any claim that is asserted in any
civil action against a dentist, or against any employee or agent~~ 321
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~~of a dentist, and that arises out of a dental operation or the
dental diagnosis, care, or treatment of any person. "Dental claim"
includes derivative claims for relief that arise from a dental
operation or the dental diagnosis, care, or treatment of a person.~~

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

~~(a) Loss of society, consortium, companionship, care,
assistance, attention, protection, advice, guidance, counsel,
instruction, training, or education, or any other intangible loss
that was sustained by the parent, guardian, custodian, or spouse;~~

~~(b) Expenditures of the parent, guardian, custodian, or
spouse for medical, dental, optometric, or chiropractic care or
treatment, for rehabilitation services, or for other care,
treatment, services, products, or accommodations provided to the
individual who was the subject of the medical diagnosis, care, or
treatment, the dental diagnosis, care, or treatment, the dental
operation, the optometric diagnosis, care, or treatment, or the
chiropractic diagnosis, care, or treatment.~~

~~(8) "Registered nurse" means any person who is licensed to
practice nursing as a registered nurse by the state board of
nursing.~~

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

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~~"Chiropractic claim" includes derivative claims for relief that
arise from the chiropractic diagnosis, care, or treatment of a
person.~~ 354
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~~(10) "Chiropractor" means any person who is licensed to
practice chiropractic by the chiropractic examining board.~~ 357
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~~(11) "Optometric claim" means any claim that is asserted in
any civil action against an optometrist, or against any employee
or agent of an optometrist, and that arises out of the optometric
diagnosis, care, or treatment of any person. "Optometric claim"
includes derivative claims for relief that arise from the
optometric diagnosis, care, or treatment of a person.~~ 359
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~~(12) "Optometrist" means any person licensed to practice
optometry by the state board of optometry.~~ 365
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~~(13) "Physical therapist" means any person who is licensed to
practice physical therapy under Chapter 4755. of the Revised Code.~~ 367
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~~(14) "Home" has the same meaning as in section 3721.10 of the
Revised Code.~~ 369
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~~(15) "Residential facility" means a facility licensed under
section 5123.19 of the Revised Code, "medical claim," "dental
claim," "optometric claim," and "chiropractic claim" have the same
meanings as in section 2305.113 of the Revised Code.~~ 371
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Sec. 2305.113. (A) Except as otherwise provided in this 375
section, an action upon a medical, dental, optometric, or 376
chiropractic claim shall be commenced within one year after the 377
cause of action accrued. 378

(B)(1) If prior to the expiration of the one-year period 379
specified in division (A) of this section, a claimant who 380
allegedly possesses a medical, dental, optometric, or chiropractic 381
claim gives to the person who is the subject of that claim written 382
notice that the claimant is considering bringing an action upon 383

that claim, that action may be commenced against the person 384
notified at any time within one hundred eighty days after the 385
notice is so given. 386

(2) An insurance company shall not consider the existence or 387
nonexistence of a written notice described in division (B)(1) of 388
this section in setting the liability insurance premium rates that 389
the company may charge the company's insured person who is 390
notified by that written notice. 391

(C) Except as to persons within the age of minority or of 392
unsound mind as provided by section 2305.16 of the Revised Code, 393
and except as provided in division (D) of this section, both of 394
the following apply: 395

(1) No action upon a medical, dental, optometric, or 396
chiropractic claim shall be commenced more than four years after 397
the occurrence of the act or omission constituting the alleged 398
basis of the medical, dental, optometric, or chiropractic claim. 399

(2) If an action upon a medical, dental, optometric, or 400
chiropractic claim is not commenced within four years after the 401
occurrence of the act or omission constituting the alleged basis 402
of the medical, dental, optometric, or chiropractic claim, then, 403
any action upon that claim is barred. 404

(D)(1) If a person making a medical claim, dental claim, 405
optometric claim, or chiropractic claim, in the exercise of 406
reasonable care and diligence, could not have discovered the 407
injury resulting from the act or omission constituting the alleged 408
basis of the claim within three years after the occurrence of the 409
act or omission, but, in the exercise of reasonable care and 410
diligence, discovers the injury resulting from that act or 411
omission before the expiration of the four-year period specified 412
in division (C)(1) of this section, the person may commence an 413
action upon the claim not later than one year after the person 414

discovers the injury resulting from that act or omission.

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(2) If the alleged basis of a medical claim, dental claim, optometric claim, 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.

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(3) A person who commences an action upon a medical claim, dental claim, optometric claim, or chiropractic claim under the circumstances described in division (D)(1) or (2) of this section 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 division (D)(1) of this section or within the one-year period described in division (D)(2) of this section, whichever is applicable.

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(E) As used in this section:

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(1) "Hospital" includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including, but not limited to, those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination of the state, political subdivisions, persons, and corporations. "Hospital" also includes any person, corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. "Hospital" does not include any hospital operated by

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the government of the United States or any of its branches.

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(2) "Physician" means a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the state medical board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in this state.

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(3) "Medical claim" means any 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, 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:

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(a) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person;

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(b) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies:

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(i) The claim results from acts or omissions in providing medical care.

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(ii) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

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(c) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under section 3721.17 of the Revised Code.

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(4) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the state medical board. 477
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(5) "Dentist" means any person who is licensed to practice dentistry by the state dental board. 479
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(6) "Dental claim" means any claim that is asserted in any civil action against a dentist, or against any employee or agent of a dentist, and that arises out of a dental operation or the dental diagnosis, care, or treatment of any person. "Dental claim" includes derivative claims for relief that arise from a dental operation or the dental diagnosis, care, or treatment of a person. 481
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(7) "Derivative claims for relief" include, but are not limited to, claims of a parent, guardian, custodian, or spouse of an individual who was the subject of any medical diagnosis, care, or treatment, dental diagnosis, care, or treatment, dental operation, optometric diagnosis, care, or treatment, or chiropractic diagnosis, care, or treatment, that arise from that diagnosis, care, treatment, or operation, and that seek the recovery of damages for any of the following: 487
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(a) Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or spouse; 495
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(b) Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment. 499
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(8) "Registered nurse" means any person who is licensed to 507

practice nursing as a registered nurse by the state board of 508
nursing. 509

(9) "Chiropractic claim" means any claim that is asserted in 510
any civil action against a chiropractor, or against any employee 511
or agent of a chiropractor, and that arises out of the 512
chiropractic diagnosis, care, or treatment of any person. 513
"Chiropractic claim" includes derivative claims for relief that 514
arise from the chiropractic diagnosis, care, or treatment of a 515
person. 516

(10) "Chiropractor" means any person who is licensed to 517
practice chiropractic by the chiropractic examining board. 518

(11) "Optometric claim" means any claim that is asserted in 519
any civil action against an optometrist, or against any employee 520
or agent of an optometrist, and that arises out of the optometric 521
diagnosis, care, or treatment of any person. "Optometric claim" 522
includes derivative claims for relief that arise from the 523
optometric diagnosis, care, or treatment of a person. 524

(12) "Optometrist" means any person licensed to practice 525
optometry by the state board of optometry. 526

(13) "Physical therapist" means any person who is licensed to 527
practice physical therapy under Chapter 4755. of the Revised Code. 528

(14) "Home" has the same meaning as in section 3721.10 of the 529
Revised Code. 530

(15) "Residential facility" means a facility licensed under 531
section 5123.19 of the Revised Code. 532

(16) "Advanced practice nurse" means any certified nurse 533
practitioner, clinical nurse specialist, or certified registered 534
nurse anesthetist, or a certified nurse-midwife certified by the 535
board of nursing under section 4723.41 of the Revised Code. 536

(17) "Licensed practical nurse" means any person who is 537

licensed to practice nursing as a licensed practical nurse by the 538
state board of nursing pursuant to Chapter 4723. of the Revised 539
Code. 540

(18) "Physician assistant" means any person who holds a valid 541
certificate of registration or temporary certificate of 542
registration issued pursuant to Chapter 4730. of the Revised Code. 543

(19) "Emergency medical technician-basic," "emergency medical 544
technician-intermediate," and "emergency medical 545
technician-paramedic" means any person who is certified under 546
Chapter 4765. of the Revised Code as an emergency medical 547
technician-basic, emergency medical technician-intermediate, or 548
emergency medical technician-paramedic, whichever is applicable. 549

Sec. 2305.15. (A) When a cause of action accrues against a 550
person, if ~~he~~ the person is out of the state, has absconded, or 551
conceals ~~himself~~ self, the period of limitation for the 552
commencement of the action as provided in sections 2305.04 to 553
2305.14, 1302.98, and 1304.35 of the Revised Code does not begin 554
to run until ~~he~~ the person comes into the state or while ~~he~~ the 555
person is so absconded or concealed. After the cause of action 556
accrues if ~~he~~ the person departs from the state, absconds, or 557
conceals ~~himself~~ self, the time of ~~his~~ the person's absence or 558
concealment shall not be computed as any part of a period within 559
which the action must be brought. 560

(B) When a person is imprisoned for the commission of any 561
offense, the time of ~~his~~ the person's imprisonment shall not be 562
computed as any part of any period of limitation, as provided in 563
section 2305.09, 2305.10, 2305.11, 2305.113, or 2305.14 of the 564
Revised Code, within which any person must bring any action 565
against the imprisoned person. 566

Sec. 2305.234. (A) As used in this section: 567

(1) "Chiropractic claim," "medical claim," and "optometric claim" have the same meanings as in section 2305.11 <u>2305.113</u> of the Revised Code.	568 569 570
(2) "Dental claim" has the same meaning as in section 2305.11 <u>2305.113</u> of the Revised Code, except that it does not include any claim arising out of a dental operation or any derivative claim for relief that arises out of a dental operation.	571 572 573 574
(3) "Governmental health care program" has the same meaning as in section 4731.65 of the Revised Code.	575 576
(4) "Health care professional" means any of the following who provide medical, dental, or other health-related diagnosis, care, or treatment:	577 578 579
(a) Physicians authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;	580 581 582
(b) Registered nurses, <u>advanced practice nurses</u> , and licensed practical nurses licensed under Chapter 4723. of the Revised Code;	583 584 585
(c) Physician assistants authorized to practice under Chapter 4730. of the Revised Code;	586 587
(d) Dentists and dental hygienists licensed under Chapter 4715. of the Revised Code;	588 589
(e) Physical therapists licensed under Chapter 4755. of the Revised Code;	590 591
(f) Chiropractors licensed under Chapter 4734. of the Revised Code;	592 593
(g) Optometrists licensed under Chapter 4725. of the Revised Code;	594 595
(h) Podiatrists authorized under Chapter 4731. of the Revised	596

Code to practice podiatry;	597
(i) Dietitians licensed under Chapter 4759. of the Revised Code;	598 599
(j) Pharmacists licensed under Chapter 4729. of the Revised Code;	600 601
(k) <u>Emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under Chapter 4765. of the Revised Code.</u>	602 603 604 605
(5) "Health care worker" means a person other than a health care professional who provides medical, dental, or other health-related care or treatment under the direction of a health care professional with the authority to direct that individual's activities, including medical technicians, medical assistants, dental assistants, orderlies, aides, and individuals acting in similar capacities.	606 607 608 609 610 611 612
(6) "Indigent and uninsured person" means a person who meets all of the following requirements:	613 614
(a) The person's income is not greater than one hundred fifty per cent of the current poverty line as defined by the United States office of management and budget and revised in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C. 9902, as amended.	615 616 617 618 619 620
(b) The person is not eligible to receive medical assistance under Chapter 5111., disability assistance medical assistance under Chapter 5115. of the Revised Code, or assistance under any other governmental health care program.	621 622 623 624
(c) Either of the following applies:	625
(i) The person is not a policyholder, certificate holder,	626

insured, contract holder, subscriber, enrollee, member, 627
beneficiary, or other covered individual under a health insurance 628
or health care policy, contract, or plan. 629

(ii) The person is a policyholder, certificate holder, 630
insured, contract holder, subscriber, enrollee, member, 631
beneficiary, or other covered individual under a health insurance 632
or health care policy, contract, or plan, but the insurer, policy, 633
contract, or plan denies coverage or is the subject of insolvency 634
or bankruptcy proceedings in any jurisdiction. 635

(7) "Operation" means any procedure that involves cutting or 636
otherwise infiltrating human tissue by mechanical means, including 637
surgery, laser surgery, ionizing radiation, therapeutic 638
ultrasound, or the removal of intraocular foreign bodies. 639
"Operation" does not include the administration of medication by 640
injection, unless the injection is administered in conjunction 641
with a procedure infiltrating human tissue by mechanical means 642
other than the administration of medicine by injection. 643

(8) "Nonprofit shelter or health care facility" means a 644
charitable nonprofit corporation organized and operated pursuant 645
to Chapter 1702. of the Revised Code, or any charitable 646
organization not organized and not operated for profit, that 647
provides shelter, health care services, or shelter and health care 648
services to indigent and uninsured persons, except that "shelter 649
or health care facility" does not include a hospital as defined in 650
section 3727.01 of the Revised Code, a facility licensed under 651
Chapter 3721. of the Revised Code, or a medical facility that is 652
operated for profit. 653

(9) "Tort action" means a civil action for damages for 654
injury, death, or loss to person or property other than a civil 655
action for damages for a breach of contract or another agreement 656
between persons or government entities. 657

(10) "Volunteer" means an individual who provides any 658
medical, dental, or other health-care related diagnosis, care, or 659
treatment without the expectation of receiving and without receipt 660
of any compensation or other form of remuneration from an indigent 661
and uninsured person, another person on behalf of an indigent and 662
uninsured person, any shelter or health care facility, or any 663
other person or government entity. 664

(B)(1) Subject to divisions (E) and (F)(3) of this section, a 665
health care professional who is a volunteer and complies with 666
division (B)(2) of this section is not liable in damages to any 667
person or government entity in a tort or other civil action, 668
including an action on a medical, dental, chiropractic, 669
optometric, or other health-related claim, for injury, death, or 670
loss to person or property that allegedly arises from an action or 671
omission of the volunteer in the provision at a nonprofit shelter 672
or health care facility to an indigent and uninsured person of 673
medical, dental, or other health-related diagnosis, care, or 674
treatment, including the provision of samples of medicine and 675
other medical products, unless the action or omission constitutes 676
willful or wanton misconduct. 677

(2) To qualify for the immunity described in division (B)(1) 678
of this section, a health care professional shall do all of the 679
following prior to providing diagnosis, care, or treatment: 680

(a) Determine, in good faith, that the indigent and uninsured 681
person is mentally capable of giving informed consent to the 682
provision of the diagnosis, care, or treatment and is not subject 683
to duress or under undue influence; 684

(b) Inform the person of the provisions of this section; 685

(c) Obtain the informed consent of the person and a written 686
waiver, signed by the person or by another individual on behalf of 687
and in the presence of the person, that states that the person is 688

mentally competent to give informed consent and, without being 689
subject to duress or under undue influence, gives informed consent 690
to the provision of the diagnosis, care, or treatment subject to 691
the provisions of this section. 692

(3) A physician or podiatrist who is not covered by medical 693
malpractice insurance, but complies with division (B)(2) of this 694
section, is not required to comply with division (A) of section 695
4731.143 of the Revised Code. 696

(C) Subject to divisions (E) and (F)(3) of this section, 697
health care workers who are volunteers are not liable in damages 698
to any person or government entity in a tort or other civil 699
action, including an action upon a medical, dental, chiropractic, 700
optometric, or other health-related claim, for injury, death, or 701
loss to person or property that allegedly arises from an action or 702
omission of the health care worker in the provision at a nonprofit 703
shelter or health care facility to an indigent and uninsured 704
person of medical, dental, or other health-related diagnosis, 705
care, or treatment, unless the action or omission constitutes 706
willful or wanton misconduct. 707

(D) Subject to divisions (E) and (F)(3) of this section and 708
section 3701.071 of the Revised Code, a nonprofit shelter or 709
health care facility associated with a health care professional 710
described in division (B)(1) of this section or a health care 711
worker described in division (C) of this section is not liable in 712
damages to any person or government entity in a tort or other 713
civil action, including an action on a medical, dental, 714
chiropractic, optometric, or other health-related claim, for 715
injury, death, or loss to person or property that allegedly arises 716
from an action or omission of the health care professional or 717
worker in providing for the shelter or facility medical, dental, 718
or other health-related diagnosis, care, or treatment to an 719
indigent and uninsured person, unless the action or omission 720

constitutes willful or wanton misconduct. 721

(E)(1) Except as provided in division (E)(2) of this section, 722
the immunities provided by divisions (B), (C), and (D) of this 723
section are not available to an individual or to a nonprofit 724
shelter or health care facility if, at the time of an alleged 725
injury, death, or loss to person or property, the individuals 726
involved are providing one of the following: 727

(a) Any medical, dental, or other health-related diagnosis, 728
care, or treatment pursuant to a community service work order 729
entered by a court under division (F) of section 2951.02 of the 730
Revised Code as a condition of probation or other suspension of a 731
term of imprisonment or imposed by a court as a community control 732
sanction pursuant to sections 2929.15 and 2929.17 of the Revised 733
Code. 734

(b) Performance of an operation. 735

(c) Delivery of a baby. 736

(2) Division (E)(1) of this section does not apply to an 737
individual who provides, or a nonprofit shelter or health care 738
facility at which the individual provides, diagnosis, care, or 739
treatment that is necessary to preserve the life of a person in a 740
medical emergency. 741

(F)(1) This section does not create a new cause of action or 742
substantive legal right against a health care professional, health 743
care worker, or nonprofit shelter or health care facility. 744

(2) This section does not affect any immunities from civil 745
liability or defenses established by another section of the 746
Revised Code or available at common law to which an individual or 747
a nonprofit shelter or health care facility may be entitled in 748
connection with the provision of emergency or other diagnosis, 749
care, or treatment. 750

(3) This section does not grant an immunity from tort or 751
other civil liability to an individual or a nonprofit shelter or 752
health care facility for actions that are outside the scope of 753
authority of health care professionals or health care workers. 754

(4) This section does not affect any legal responsibility of 755
a health care professional or health care worker to comply with 756
any applicable law of this state or rule of an agency of this 757
state. 758

(5) This section does not affect any legal responsibility of 759
a nonprofit shelter or health care facility to comply with any 760
applicable law of this state, rule of an agency of this state, or 761
local code, ordinance, or regulation that pertains to or regulates 762
building, housing, air pollution, water pollution, sanitation, 763
health, fire, zoning, or safety. 764

Sec. 2317.02. The following persons shall not testify in 765
certain respects: 766

(A) An attorney, concerning a communication made to the 767
attorney by a client in that relation or the attorney's advice to 768
a client, except that the attorney may testify by express consent 769
of the client or, if the client is deceased, by the express 770
consent of the surviving spouse or the executor or administrator 771
of the estate of the deceased client and except that, if the 772
client voluntarily testifies or is deemed by section 2151.421 of 773
the Revised Code to have waived any testimonial privilege under 774
this division, the attorney may be compelled to testify on the 775
same subject; 776

(B)(1) A physician or a dentist concerning a communication 777
made to the physician or dentist by a patient in that relation or 778
the physician's or dentist's advice to a patient, except as 779
otherwise provided in this division, division (B)(2), and division 780
(B)(3) of this section, and except that, if the patient is deemed 781

by section 2151.421 of the Revised Code to have waived any 782
testimonial privilege under this division, the physician may be 783
compelled to testify on the same subject. 784

The testimonial privilege established under this division 785
does not apply, and a physician or dentist may testify or may be 786
compelled to testify, in any of the following circumstances: 787

(a) In any civil action, in accordance with the discovery 788
provisions of the Rules of Civil Procedure in connection with a 789
civil action, or in connection with a claim under Chapter 4123. of 790
the Revised Code, under any of the following circumstances: 791

(i) If the patient or the guardian or other legal 792
representative of the patient gives express consent; 793

(ii) If the patient is deceased, the spouse of the patient or 794
the executor or administrator of the patient's estate gives 795
express consent; 796

(iii) If a medical claim, dental claim, chiropractic claim, 797
or optometric claim, as defined in section ~~2305.11~~ 2305.113 of the 798
Revised Code, an action for wrongful death, any other type of 799
civil action, or a claim under Chapter 4123. of the Revised Code 800
is filed by the patient, the personal representative of the estate 801
of the patient if deceased, or the patient's guardian or other 802
legal representative. 803

(b) In any civil action concerning court-ordered treatment or 804
services received by a patient, if the court-ordered treatment or 805
services were ordered as part of a case plan journalized under 806
section 2151.412 of the Revised Code or the court-ordered 807
treatment or services are necessary or relevant to dependency, 808
neglect, or abuse or temporary or permanent custody proceedings 809
under Chapter 2151. of the Revised Code. 810

(c) In any criminal action concerning any test or the results 811
of any test that determines the presence or concentration of 812

alcohol, a drug of abuse, or alcohol and a drug of abuse in the 813
patient's blood, breath, urine, or other bodily substance at any 814
time relevant to the criminal offense in question. 815

(d) In any criminal action against a physician or dentist. In 816
such an action, the testimonial privilege established under this 817
division does not prohibit the admission into evidence, in 818
accordance with the Rules of Evidence, of a patient's medical or 819
dental records or other communications between a patient and the 820
physician or dentist that are related to the action and obtained 821
by subpoena, search warrant, or other lawful means. A court that 822
permits or compels a physician or dentist to testify in such an 823
action or permits the introduction into evidence of patient 824
records or other communications in such an action shall require 825
that appropriate measures be taken to ensure that the 826
confidentiality of any patient named or otherwise identified in 827
the records is maintained. Measures to ensure confidentiality that 828
may be taken by the court include sealing its records or deleting 829
specific information from its records. 830

(2)(a) If any law enforcement officer submits a written 831
statement to a health care provider that states that an official 832
criminal investigation has begun regarding a specified person or 833
that a criminal action or proceeding has been commenced against a 834
specified person, that requests the provider to supply to the 835
officer copies of any records the provider possesses that pertain 836
to any test or the results of any test administered to the 837
specified person to determine the presence or concentration of 838
alcohol, a drug of abuse, or alcohol and a drug of abuse in the 839
person's blood, breath, or urine at any time relevant to the 840
criminal offense in question, and that conforms to section 841
2317.022 of the Revised Code, the provider, except to the extent 842
specifically prohibited by any law of this state or of the United 843
States, shall supply to the officer a copy of any of the requested 844

records the provider possesses. If the health care provider does
not possess any of the requested records, the provider shall give
the officer a written statement that indicates that the provider
does not possess any of the requested records.

(b) If a health care provider possesses any records of the
type described in division (B)(2)(a) of this section regarding the
person in question at any time relevant to the criminal offense in
question, in lieu of personally testifying as to the results of
the test in question, the custodian of the records may submit a
certified copy of the records, and, upon its submission, the
certified copy is qualified as authentic evidence and may be
admitted as evidence in accordance with the Rules of Evidence.
Division (A) of section 2317.422 of the Revised Code does not
apply to any certified copy of records submitted in accordance
with this division. Nothing in this division shall be construed to
limit the right of any party to call as a witness the person who
administered the test to which the records pertain, the person
under whose supervision the test was administered, the custodian
of the records, the person who made the records, or the person
under whose supervision the records were made.

(3)(a) If the testimonial privilege described in division
(B)(1) of this section does not apply as provided in division
(B)(1)(a)(iii) of this section, a physician or dentist may be
compelled to testify or to submit to discovery under the Rules of
Civil Procedure only as to a communication made to the physician
or dentist by the patient in question in that relation, or the
physician's or dentist's advice to the patient in question, that
related causally or historically to physical or mental injuries
that are relevant to issues in the medical claim, dental claim,
chiropractic claim, or optometric claim, action for wrongful
death, other civil action, or claim under Chapter 4123. of the
Revised Code.

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(b) If the testimonial privilege described in division (B)(1) 877
of this section does not apply to a physician or dentist as 878
provided in division (B)(1)(c) of this section, the physician or 879
dentist, in lieu of personally testifying as to the results of the 880
test in question, may submit a certified copy of those results, 881
and, upon its submission, the certified copy is qualified as 882
authentic evidence and may be admitted as evidence in accordance 883
with the Rules of Evidence. Division (A) of section 2317.422 of 884
the Revised Code does not apply to any certified copy of results 885
submitted in accordance with this division. Nothing in this 886
division shall be construed to limit the right of any party to 887
call as a witness the person who administered the test in 888
question, the person under whose supervision the test was 889
administered, the custodian of the results of the test, the person 890
who compiled the results, or the person under whose supervision 891
the results were compiled. 892

(4) The testimonial privilege described in division (B)(1) of 893
this section is not waived when a communication is made by a 894
physician to a pharmacist or when there is communication between a 895
patient and a pharmacist in furtherance of the physician-patient 896
relation. 897

(5)(a) As used in divisions (B)(1) to (4) of this section, 898
"communication" means acquiring, recording, or transmitting any 899
information, in any manner, concerning any facts, opinions, or 900
statements necessary to enable a physician or dentist to diagnose, 901
treat, prescribe, or act for a patient. A "communication" may 902
include, but is not limited to, any medical or dental, office, or 903
hospital communication such as a record, chart, letter, 904
memorandum, laboratory test and results, x-ray, photograph, 905
financial statement, diagnosis, or prognosis. 906

(b) As used in division (B)(2) of this section, "health care 907
provider" means a hospital, ambulatory care facility, long-term 908

care facility, pharmacy, emergency facility, or health care
practitioner. 909
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(c) As used in division (B)(5)(b) of this section: 911

(i) "Ambulatory care facility" means a facility that provides 912
medical, diagnostic, or surgical treatment to patients who do not 913
require hospitalization, including a dialysis center, ambulatory 914
surgical facility, cardiac catheterization facility, diagnostic 915
imaging center, extracorporeal shock wave lithotripsy center, home 916
health agency, inpatient hospice, birthing center, radiation 917
therapy center, emergency facility, and an urgent care center. 918
"Ambulatory health care facility" does not include the private 919
office of a physician or dentist, whether the office is for an 920
individual or group practice. 921

(ii) "Emergency facility" means a hospital emergency 922
department or any other facility that provides emergency medical 923
services. 924

(iii) "Health care practitioner" has the same meaning as in 925
section 4769.01 of the Revised Code. 926

(iv) "Hospital" has the same meaning as in section 3727.01 of 927
the Revised Code. 928

(v) "Long-term care facility" means a nursing home, 929
residential care facility, or home for the aging, as those terms 930
are defined in section 3721.01 of the Revised Code; an adult care 931
facility, as defined in section 3722.01 of the Revised Code; a 932
nursing facility or intermediate care facility for the mentally 933
retarded, as those terms are defined in section 5111.20 of the 934
Revised Code; a facility or portion of a facility certified as a 935
skilled nursing facility under Title XVIII of the "Social Security 936
Act," 49 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended. 937

(vi) "Pharmacy" has the same meaning as in section 4729.01 of 938
the Revised Code. 939

(6) Divisions (B)(1), (2), (3), (4), and (5) of this section 940
apply to doctors of medicine, doctors of osteopathic medicine, 941
doctors of podiatry, and dentists. 942

(7) Nothing in divisions (B)(1) to (6) of this section 943
affects, or shall be construed as affecting, the immunity from 944
civil liability conferred by section 307.628 or 2305.33 of the 945
Revised Code upon physicians who report an employee's use of a 946
drug of abuse, or a condition of an employee other than one 947
involving the use of a drug of abuse, to the employer of the 948
employee in accordance with division (B) of that section. As used 949
in division (B)(7) of this section, "employee," "employer," and 950
"physician" have the same meanings as in section 2305.33 of the 951
Revised Code. 952

(C) A member of the clergy, rabbi, priest, or regularly 953
ordained, accredited, or licensed minister of an established and 954
legally cognizable church, denomination, or sect, when the member 955
of the clergy, rabbi, priest, or minister remains accountable to 956
the authority of that church, denomination, or sect, concerning a 957
confession made, or any information confidentially communicated, 958
to the member of the clergy, rabbi, priest, or minister for a 959
religious counseling purpose in the member of the clergy's, 960
rabbi's, priest's, or minister's professional character; however, 961
the member of the clergy, rabbi, priest, or minister may testify 962
by express consent of the person making the communication, except 963
when the disclosure of the information is in violation of a sacred 964
trust; 965

(D) Husband or wife, concerning any communication made by one 966
to the other, or an act done by either in the presence of the 967
other, during coverture, unless the communication was made, or act 968
done, in the known presence or hearing of a third person competent 969
to be a witness; and such rule is the same if the marital relation 970
has ceased to exist; 971

(E) A person who assigns a claim or interest, concerning any matter in respect to which the person would not, if a party, be permitted to testify; 972
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(F) A person who, if a party, would be restricted under section 2317.03 of the Revised Code, when the property or thing is sold or transferred by an executor, administrator, guardian, trustee, heir, devisee, or legatee, shall be restricted in the same manner in any action or proceeding concerning the property or thing. 975
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(G)(1) A school guidance counselor who holds a valid educator license from the state board of education as provided for in section 3319.22 of the Revised Code, a person licensed under Chapter 4757. of the Revised Code as a professional clinical counselor, professional counselor, social worker, or independent social worker, or registered under Chapter 4757. of the Revised Code as a social work assistant concerning a confidential communication received from a client in that relation or the person's advice to a client unless any of the following applies: 981
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(a) The communication or advice indicates clear and present danger to the client or other persons. For the purposes of this division, cases in which there are indications of present or past child abuse or neglect of the client constitute a clear and present danger. 990
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(b) The client gives express consent to the testimony. 995

(c) If the client is deceased, the surviving spouse or the executor or administrator of the estate of the deceased client gives express consent. 996
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(d) The client voluntarily testifies, in which case the school guidance counselor or person licensed or registered under Chapter 4757. of the Revised Code may be compelled to testify on the same subject. 999
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(e) The court in camera determines that the information 1003
communicated by the client is not germane to the counselor-client 1004
or social worker-client relationship. 1005

(f) A court, in an action brought against a school, its 1006
administration, or any of its personnel by the client, rules after 1007
an in-camera inspection that the testimony of the school guidance 1008
counselor is relevant to that action. 1009

(g) The testimony is sought in a civil action and concerns 1010
court-ordered treatment or services received by a patient as part 1011
of a case plan journalized under section 2151.412 of the Revised 1012
Code or the court-ordered treatment or services are necessary or 1013
relevant to dependency, neglect, or abuse or temporary or 1014
permanent custody proceedings under Chapter 2151. of the Revised 1015
Code. 1016

(2) Nothing in division (G)(1) of this section shall relieve 1017
a school guidance counselor or a person licensed or registered 1018
under Chapter 4757. of the Revised Code from the requirement to 1019
report information concerning child abuse or neglect under section 1020
2151.421 of the Revised Code. 1021

(H) A mediator acting under a mediation order issued under 1022
division (A) of section 3109.052 of the Revised Code or otherwise 1023
issued in any proceeding for divorce, dissolution, legal 1024
separation, annulment, or the allocation of parental rights and 1025
responsibilities for the care of children, in any action or 1026
proceeding, other than a criminal, delinquency, child abuse, child 1027
neglect, or dependent child action or proceeding, that is brought 1028
by or against either parent who takes part in mediation in 1029
accordance with the order and that pertains to the mediation 1030
process, to any information discussed or presented in the 1031
mediation process, to the allocation of parental rights and 1032
responsibilities for the care of the parents' children, or to the 1033
awarding of parenting time rights in relation to their children; 1034

(I) A communications assistant, acting within the scope of 1035
the communication assistant's authority, when providing 1036
telecommunications relay service pursuant to section 4931.35 of 1037
the Revised Code or Title II of the "Communications Act of 1934," 1038
104 Stat. 366 (1990), 47 U.S.C. 225, concerning a communication 1039
made through a telecommunications relay service. Nothing in this 1040
section shall limit the obligation of a communications assistant 1041
to divulge information or testify when mandated by federal law or 1042
regulation or pursuant to subpoena in a criminal proceeding. 1043

Nothing in this section shall limit any immunity or privilege 1044
granted under federal law or regulation. 1045

(J)(1) A chiropractor in a civil proceeding concerning a 1046
communication made to the chiropractor by a patient in that 1047
relation or the chiropractor's advice to a patient, except as 1048
otherwise provided in this division. The testimonial privilege 1049
established under this division does not apply, and a chiropractor 1050
may testify or may be compelled to testify, in any civil action, 1051
in accordance with the discovery provisions of the Rules of Civil 1052
Procedure in connection with a civil action, or in connection with 1053
a claim under Chapter 4123. of the Revised Code, under any of the 1054
following circumstances: 1055

(a) If the patient or the guardian or other legal 1056
representative of the patient gives express consent. 1057

(b) If the patient is deceased, the spouse of the patient or 1058
the executor or administrator of the patient's estate gives 1059
express consent. 1060

(c) If a medical claim, dental claim, chiropractic claim, or 1061
optometric claim, as defined in section ~~2305.11~~ 2305.113 of the 1062
Revised Code, an action for wrongful death, any other type of 1063
civil action, or a claim under Chapter 4123. of the Revised Code 1064
is filed by the patient, the personal representative of the estate 1065

of the patient if deceased, or the patient's guardian or other 1066
legal representative. 1067

(2) If the testimonial privilege described in division (J)(1) 1068
of this section does not apply as provided in division (J)(1)(c) 1069
of this section, a chiropractor may be compelled to testify or to 1070
submit to discovery under the Rules of Civil Procedure only as to 1071
a communication made to the chiropractor by the patient in 1072
question in that relation, or the chiropractor's advice to the 1073
patient in question, that related causally or historically to 1074
physical or mental injuries that are relevant to issues in the 1075
medical claim, dental claim, chiropractic claim, or optometric 1076
claim, action for wrongful death, other civil action, or claim 1077
under Chapter 4123. of the Revised Code. 1078

(3) The testimonial privilege established under this division 1079
does not apply, and a chiropractor may testify or be compelled to 1080
testify, in any criminal action or administrative proceeding. 1081
1082

(4) As used in this division, "communication" means 1083
acquiring, recording, or transmitting any information, in any 1084
manner, concerning any facts, opinions, or statements necessary to 1085
enable a chiropractor to ~~diagnosis~~ diagnose, treat, or act for a 1086
patient. A communication may include, but is not limited to, any 1087
chiropractic, office, or hospital communication such as a record, 1088
chart, letter, memorandum, laboratory test and results, x-ray, 1089
photograph, financial statement, diagnosis, or prognosis. 1090

Sec. 2317.54. No hospital, home health agency, ambulatory 1091
surgical facility, or provider of a hospice care program shall be 1092
held liable for a physician's failure to obtain an informed 1093
consent from the physician's patient prior to a surgical or 1094
medical procedure or course of procedures, unless the physician is 1095
an employee of the hospital, home health agency, ambulatory 1096

surgical facility, or provider of a hospice care program. 1097

Written consent to a surgical or medical procedure or course 1098
of procedures shall, to the extent that it fulfills all the 1099
requirements in divisions (A), (B), and (C) of this section, be 1100
presumed to be valid and effective, in the absence of proof by a 1101
preponderance of the evidence that the person who sought such 1102
consent was not acting in good faith, or that the execution of the 1103
consent was induced by fraudulent misrepresentation of material 1104
facts, or that the person executing the consent was not able to 1105
communicate effectively in spoken and written English or any other 1106
language in which the consent is written. Except as herein 1107
provided, no evidence shall be admissible to impeach, modify, or 1108
limit the authorization for performance of the procedure or 1109
procedures set forth in such written consent. 1110

(A) The consent sets forth in general terms the nature and 1111
purpose of the procedure or procedures, and what the procedures 1112
are expected to accomplish, together with the reasonably known 1113
risks, and, except in emergency situations, sets forth the names 1114
of the physicians who shall perform the intended surgical 1115
procedures. 1116

(B) The person making the consent acknowledges that such 1117
disclosure of information has been made and that all questions 1118
asked about the procedure or procedures have been answered in a 1119
satisfactory manner. 1120

(C) The consent is signed by the patient for whom the 1121
procedure is to be performed, or, if the patient for any reason 1122
including, but not limited to, competence, infancy, or the fact 1123
that, at the latest time that the consent is needed, the patient 1124
is under the influence of alcohol, hallucinogens, or drugs, lacks 1125
legal capacity to consent, by a person who has legal authority to 1126
consent on behalf of such patient in such circumstances. 1127

Any use of a consent form that fulfills the requirements 1128

stated in divisions (A), (B), and (C) of this section has no
effect on the common law rights and liabilities, including the
right of a physician to obtain the oral or implied consent of a
patient to a medical procedure, that may exist as between
physicians and patients on July 28, 1975.

As used in this section the term "hospital" has the same
meaning ~~set forth as~~ in division (D) of section 2305.11 2305.113
of the Revised Code; "home health agency" has the same meaning ~~set~~
~~forth as~~ in division (A) of former section 3701.88 5101.61 of the
Revised Code; "ambulatory surgical facility" has the meaning as in
division (A) of section 3702.30 of the Revised Code; and "hospice
care program" has the same meaning ~~set forth as~~ in division (A) of
section 3712.01 of the Revised Code. The provisions of this
division apply to hospitals, doctors of medicine, doctors of
osteopathic medicine, and doctors of podiatric medicine.

Sec. 2323.41. (A) In any civil action upon a medical, dental,
optometric, or chiropractic claim, the defendant may introduce
evidence of any amount payable as a benefit to the plaintiff as a
result of the damages that result from an injury, death, or loss
to person or property that is the subject of the claim, 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.

(B) If the defendant elects to introduce evidence described
in division (A) of this section, the plaintiff may introduce
evidence of any amount that the plaintiff has paid or contributed
to secure the plaintiff's right to receive the benefits of which
the defendant has introduced evidence.

(C) A source of collateral benefits of which evidence is
introduced pursuant to division (A) of this section shall not

recover any amount against the plaintiff nor shall it be 1160
subrogated to the rights of the plaintiff against a defendant. 1161

(D) As used in this section, "medical claim," "dental claim," 1162
"optometric claim," and "chiropractic claim" have the same 1163
meanings as in section 2305.113 of the Revised Code. 1164

Sec. 2323.42. (A) Upon the motion of any defendant in a civil 1165
action based upon a medical claim, dental claim, optometric claim, 1166
or chiropractic claim, the court shall conduct a hearing regarding 1167
the existence or nonexistence of a reasonable good faith basis 1168
upon which the particular claim is asserted against the moving 1169
defendant. The defendant shall file the motion not earlier than 1170
the close of discovery in the action and not later than thirty 1171
days after the court or jury renders any verdict or award in the 1172
action. After the motion is filed, the plaintiff shall have not 1173
less than fourteen days to respond to the motion. Upon good cause 1174
shown by the plaintiff, the court shall grant an extension of the 1175
time for the plaintiff to respond as necessary to obtain evidence 1176
demonstrating the existence of a reasonable good faith basis for 1177
the claim. 1178

(B) At the request of any party to the good faith motion 1179
described in division (A) of this section, the court shall order 1180
the motion to be heard at an oral hearing and shall consider all 1181
evidence and arguments submitted by the parties. In determining 1182
whether a plaintiff has a reasonable good faith basis upon which 1183
to assert the claim in question against the moving defendant, the 1184
court shall take into consideration, in addition to the facts of 1185
the underlying claim, whether the plaintiff did any of the 1186
following: 1187

(1) Obtained a reasonably timely review of the merits of the 1188
particular claim by a qualified medical, dental, optometric, or 1189
chiropractic expert, as appropriate; 1190

<u>(2) Reasonably relied upon the results of that review in</u>	1191
<u>supporting the assertion of the particular claim;</u>	1192
<u>(3) Had an opportunity to conduct a pre-suit investigation or</u>	1193
<u>was afforded by the defendant full and timely discovery during</u>	1194
<u>litigation;</u>	1195
<u>(4) Reasonably relied upon evidence discovered during the</u>	1196
<u>course of litigation in support of the assertion of the claim in</u>	1197
<u>question;</u>	1198
<u>(5) Took appropriate and reasonable steps to timely dismiss</u>	1199
<u>any defendant on behalf of whom it was alleged or determined that</u>	1200
<u>no reasonable good faith basis existed for continued assertion of</u>	1201
<u>the claim in question.</u>	1202
<u>(C) If the court determines that there was no reasonable good</u>	1203
<u>faith basis upon which the plaintiff asserted the claim in</u>	1204
<u>question against the moving defendant or that, at some point</u>	1205
<u>during the litigation, the plaintiff lacked a good faith basis for</u>	1206
<u>continuing to assert that claim, the court shall award all of the</u>	1207
<u>following in favor of the moving defendant:</u>	1208
<u>(1) All court costs incurred by the moving defendant;</u>	1209
<u>(2) Reasonable attorneys' fees incurred by the moving</u>	1210
<u>defendant in defense of the claim after the time that the court</u>	1211
<u>determines that no reasonable good faith basis existed upon which</u>	1212
<u>to assert or continue to assert the claim;</u>	1213
<u>(3) Reasonable attorneys' fees incurred in support of the</u>	1214
<u>good faith motion.</u>	1215
<u>(D) Prior to filing a good faith motion as described in</u>	1216
<u>division (A) of this section, any defendant that intends to file</u>	1217
<u>that type of motion shall serve a "notice of demand for dismissal</u>	1218
<u>and intention to file a good faith motion." If, within fourteen</u>	1219
<u>days of service of that notice, the plaintiff dismisses the</u>	1220

defendant from the action, the defendant after the dismissal shall 1221
be precluded from filing a good faith motion as to any attorneys' 1222
fees and other costs subsequent to the dismissal. 1223

(E) As used in this section, "medical claim," "dental claim," 1224
"optometric claim," and "chiropractic claim" have the same 1225
meanings as in section 2305.113 of the Revised Code. 1226

Sec. 2323.43. (A) In a civil action upon a medical, dental, 1227
optometric, or chiropractic claim to recover damages for injury, 1228
death, or loss to person or property, all of the following apply: 1229

(1) There shall not be any limitation on compensatory damages 1230
that represent the economic loss of the person who is awarded the 1231
damages in the civil action. 1232

(2) Except as otherwise provided in division (A)(3) of this 1233
section, the amount of compensatory damages that represents 1234
damages for noneconomic loss that is recoverable in a civil action 1235
under this section to recover damages for injury, death, or loss 1236
to person or property shall not exceed the greater of two hundred 1237
fifty thousand dollars or an amount that is equal to three times 1238
the plaintiff's economic loss, as determined by the trier of fact, 1239
to a maximum of three hundred fifty thousand dollars for each 1240
plaintiff or a maximum of five hundred thousand dollars for each 1241
occurrence. 1242

(3) The amount recoverable for noneconomic loss in a civil 1243
action under this section may exceed the amount described in 1244
division (A)(2) of this section but shall not exceed five hundred 1245
thousand dollars for each plaintiff or one million dollars for 1246
each occurrence if the noneconomic losses of the plaintiff are for 1247
either of the following: 1248

(a) Permanent and substantial physical deformity, loss of use 1249
of a limb, or loss of a bodily organ system; 1250

(b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life sustaining activities. 1251
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(B) If a trial is conducted in a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property and a plaintiff prevails with respect to that claim, the court in a nonjury trial shall make findings of fact, and the jury in a jury trial shall return a general verdict accompanied by answers to interrogatories, that shall specify all of the following: 1254
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(1) The total compensatory damages recoverable by the plaintiff; 1261
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(2) The portion of the total compensatory damages that represents damages for economic loss; 1263
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(3) The portion of the total compensatory damages that represents damages for noneconomic loss. 1265
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(C)(1) After the trier of fact in a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property complies with division (B) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to division (B)(2) of this section, and, subject to division (D)(1) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for noneconomic loss. In no event shall a judgment for compensatory damages for noneconomic loss exceed the maximum recoverable amount that represents damages for noneconomic loss as provided in divisions (A)(2) and (3) of this section. Division (A) of this section shall be applied in a jury trial only after the jury has made its factual findings and determination as to the damages. 1267
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(2) Prior to the trial in the civil action, any party may seek summary judgment with respect to the nature of the alleged injury or loss to person or property, seeking a determination of the damages as described in division (A)(2) or (3) of this section. 1282
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(D)(1) A court of common pleas has no jurisdiction to enter judgment on an award of compensatory damages for noneconomic loss in excess of the limits set forth in this section. 1287
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(2) If the trier of fact is a jury, the court shall not instruct the jury with respect to the limit on compensatory damages for noneconomic loss described in divisions (A)(2) and (3) of this section, and neither counsel for any party nor a witness shall inform the jury or potential jurors of that limit. 1290
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(E) Any excess amount of compensatory damages for noneconomic loss that is greater than the applicable amount specified in division (A)(2) or (3) of this section shall not be reallocated to any other tortfeasor beyond the amount of compensatory damages that that tortfeasor would otherwise be responsible for under the laws of this state. 1295
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(F)(1) If pursuant to a contingency fee agreement between an attorney and a plaintiff in a civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim, the amount of the attorney's fees exceed the applicable amount of the limits on compensatory damages for noneconomic loss as provided in division (A)(2) or (3) of this section, the attorney shall make an application in the probate court of the county in which the civil action was commenced or in which the settlement was entered. The application shall contain a statement of facts, including the amount to be allocated to the settlement of the claim, the amount of the settlement or judgment that represents the compensatory damages for economic loss and noneconomic loss, the relevant provision in the contingency fee agreement, and the dollar amount 1301
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of the attorney's fees under the contingency fee agreement. The 1314
application shall include the proposed distribution of the amount 1315
of the judgment or settlement. 1316

(2) The attorney shall give written notice of the hearing and 1317
a copy of the application to all interested persons who have not 1318
waived notice of the hearing. Notwithstanding the waivers and 1319
consents of the interested persons, the probate court shall retain 1320
jurisdiction over the settlement, allocation, and distribution of 1321
the claim. 1322

(3) The application shall state the arrangements, if any, 1323
that have been made with respect to the attorney's fees. The 1324
attorney's fees shall be subject to the approval of the probate 1325
court. 1326

(G) This section does not apply to any of the following: 1327

(1) Civil actions upon a medical, dental, optometric, or 1328
chiropractic claim that are brought against the state in the court 1329
of claims, including, but not limited to, those actions in which a 1330
state university or college is a defendant and to which division 1331
(B)(3) of section 3345.40 of the Revised Code applies; 1332

(2) Civil actions upon a medical, dental, optometric, or 1333
chiropractic claim that are brought against political subdivisions 1334
of this state and that are commenced under or are subject to 1335
Chapter 2744. of the Revised Code. Division (C) of section 2744.05 1336
of the Revised Code applies to recoverable damages in those 1337
actions; 1338

(3) Wrongful death actions brought pursuant to Chapter 2125. 1339
of the Revised Code. 1340

(H) As used in this section: 1341

(1) "Economic loss" means any of the following types of 1342
pecuniary harm: 1343

(a) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim; 1344
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(b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim; 1348
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(c) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, other than attorney's fees incurred in connection with that action. 1353
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(2) "Medical claim, dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code. 1358
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(3) "Noneconomic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss. 1361
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(4) "Trier of fact" means the jury or, in a nonjury action, the court. 1369
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Sec. 2323.55. (A) As used in this section: 1371

(1) "Economic loss" means any of the following types of pecuniary harm: 1372
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(a) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim; 1374
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(b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim; 1378
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(c) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, other than attorney's fees incurred in connection with that action. 1383
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(2) "Future damages" means any damages that result from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim and that will accrue after the verdict or determination of liability is rendered in that action by the trier of fact. "Future damages" includes both economic and noneconomic loss. 1388
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(3) "Medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code. 1394
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(4) "Noneconomic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss. 1397
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(5) "Past damages" means any damages that result from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim and that have accrued by the time that the verdict or determination of liability is rendered in that action by the trier of fact. "Past damages" include both economic loss and noneconomic loss. 1405
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(6) "Trier of fact" means the jury or, in a nonjury action, the court. 1412
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(B) In any civil action upon a medical, dental, optometric, or chiropractic claim in which a plaintiff makes a good faith claim against the defendant for future damages that exceed fifty thousand dollars, upon motion of that plaintiff or the defendant, the trier of fact shall return a general verdict and, if that verdict is in favor of that plaintiff, answers to interrogatories or findings of fact that specify both of the following: 1414
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(1) The past damages recoverable by that plaintiff; 1421

(2) The future damages recoverable by that plaintiff. 1422

(C) If answers to interrogatories are returned or findings of fact are made pursuant to division (B) of this section and if the future damages recoverable by that plaintiff exceeds fifty thousand dollars, the plaintiff or defendant may file a motion with the court that seeks a determination under division (D) of this section. The plaintiff or defendant shall file the motion at any time after the verdict or determination in favor of the plaintiff is rendered by the trier of fact but prior to the entry of judgment in accordance with Civil Rule 58. 1423
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(D)(1) Upon the filing of a motion pursuant to division (C) of this section and prior to the entry of judgment in accordance with Civil Rule 58, the court shall do all of the following: 1432
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(a) Set a date for a hearing to address whether all or any 1435

part of the future damages recoverable by the plaintiff shall be 1436
received by the plaintiff in a series of periodic payments rather 1437
than in a lump sum; 1438

(b) Give notice of the date of the hearing described in 1439
division (D)(1)(a) of this section to the parties involved and 1440
their counsel of record; 1441

(c) Conduct the hearing described in division (D)(1)(a) of 1442
this section, allow the parties involved to present any relevant 1443
evidence at the hearing, consider the factors described in 1444
division (D)(2) of this section in making its determination, and 1445
make its determination in accordance with division (D)(3) of this 1446
section. 1447

(2) In determining whether all or any part of the future 1448
damages recoverable by the plaintiff shall be received by the 1449
plaintiff in a series of periodic payments rather than in a lump 1450
sum, the court shall consider all of the following factors: 1451

(a) The purposes for which those portions of the future 1452
damages were awarded to that plaintiff; 1453

(b) The business or occupational experience of that 1454
plaintiff; 1455

(c) The age of that plaintiff; 1456

(d) The physical and mental condition of that plaintiff; 1457

(e) Whether that plaintiff or the parent, guardian, or 1458
custodian of that plaintiff is able to competently manage the 1459
future damages; 1460

(f) Any other circumstance that relates to whether the injury 1461
sustained by that plaintiff would be better compensated by the 1462
payment of the future damages in a lump sum or by their receipt in 1463
a series of periodic payments. 1464

(3) After the hearing described in division (D)(1) of this 1465

section and prior to the entry of judgment in accordance with 1466
Civil Rule 58, the court shall determine, in its discretion, 1467
whether all or any part of the future damages recoverable by the 1468
plaintiff shall be received by the plaintiff in a series of 1469
periodic payments rather than in a lump sum. If the court 1470
determines that a plaintiff shall receive the future damages 1471
recoverable by the plaintiff in a series of periodic payments, it 1472
may order the payments only as to the amount of the future damages 1473
recoverable by the plaintiff that exceeds fifty thousand dollars. 1474
If the court determines that the plaintiff shall receive the 1475
future damages recoverable by the plaintiff in a lump sum, the 1476
future damages shall be paid in a lump sum. 1477

(E) If the court determines pursuant to division (D) of this 1478
section that a plaintiff shall receive the future damages 1479
recoverable by the plaintiff in a series of periodic payments, 1480
both of the following apply: 1481

(1) Within twenty days after the court makes that 1482
determination, the plaintiff shall submit a periodic payments plan 1483
to the court. The plan may include, but is not limited to, a 1484
provision for a trust or an annuity and may be submitted by that 1485
plaintiff alone or by that plaintiff and the defendant. 1486

(2) Within twenty days after the court makes that 1487
determination, the defendant may submit to the court, alone or 1488
jointly with the plaintiff, a periodic payments plan. If the 1489
defendant submits a periodic payments plan, the plan may include, 1490
but is not limited to, a provision for a trust or an annuity. 1491

(F)(1) If the defendant and plaintiff do not jointly submit a 1492
periodic payments plan and if the defendant does not separately 1493
submit a periodic payments plan, then, within ten days after that 1494
plaintiff submits a plan, the defendant may submit to the court 1495
written comments relative to the periodic payments plan of the 1496
plaintiff. 1497

(2) If the defendant and plaintiff do not jointly submit a 1498
periodic payments plan and if the defendant separately submits a 1499
periodic payments plan, then, within ten days after the defendant 1500
submits the plan, the plaintiff may submit to the court written 1501
comments relative to the periodic payments plan of the defendant. 1502

(G)(1) The court, in its discretion, may modify, approve, or 1503
reject any submitted periodic payments plan. In approving any 1504
periodic payments plan, the court shall require interest on the 1505
judgment in question in accordance with section 1343.03 of the 1506
Revised Code. Additionally, in approving any periodic payments 1507
plan, the court is not required to ensure that payments under the 1508
periodic payments plan are equal in amount or that the total 1509
amount paid each year under the periodic payments plan is equal in 1510
amount to the total amount paid in other years under the plan; 1511
rather, a periodic payments plan may provide for payments to be 1512
made in irregular or varied amounts, or to be graduated upward or 1513
downward in amount over the duration of the periodic payments 1514
plan. 1515

(2) The court shall include in any approved periodic payments 1516
plan adequate security to insure that the plaintiff will receive 1517
all of the periodic payments under that plan. If the approved 1518
periodic payments plan includes a provision for an annuity as the 1519
adequate security or otherwise, the defendant shall purchase the 1520
annuity from either of the following types of insurance companies: 1521

(a) An insurance company that the A.M. Best Company, in its 1523
most recently published rating guide of life insurance companies, 1524
has rated A or better and has rated XII or higher as to financial 1525
size or strength; 1526

(b) An insurance company that the superintendent of 1527
insurance, under rules adopted pursuant to Chapter 119. of the 1528
Revised Code for purposes of implementing this division, 1529

determines is licensed to do business in this state and, 1530
considering the factors described in this division, is a stable 1531
insurance company that issues annuities that are safe and 1532
desirable. In making determinations as described in this division, 1533
the superintendent shall be guided by the principle that annuities 1534
should be safe and desirable for plaintiffs who are awarded 1535
damages. In making those determinations, the superintendent shall 1536
consider the financial condition, general standing, operating 1537
results, profitability, leverage, liquidity, amount and soundness 1538
of reinsurance, adequacy of reserves, and the management of any 1539
insurance company in question and also may consider ratings, 1540
grades, and classifications of any nationally recognized rating 1541
services of insurance companies and any other factors relevant to 1542
the making of such determinations. 1543

(3) If a periodic payments plan provides for periodic 1544
payments over a period of five years or more to the plaintiff, the 1545
court, in its discretion, may include in the approved periodic 1546
payments plan a provision in which it reserves to itself 1547
continuing jurisdiction over that plan, including jurisdiction to 1548
review and modify that plan. 1549

(4) The court shall specify in the entry of judgment in the 1550
tort action the determination made pursuant to division (D) of 1551
this section and, if applicable, the terms of any approved 1552
periodic payments plan. 1553

(H) After a periodic payments plan is approved, the future 1554
damages that are to be received in periodic payments shall be paid 1555
in accordance with the plan, including, if applicable, payment 1556
over to a trust or annuity provided for in the plan. 1557

(I) If a court orders a series of periodic payments of future 1558
damages in accordance with this section and the plaintiff dies 1559
prior to the receipt of all of the future damages, the liability 1560
for the unpaid portion of those damages that is not yet due at the 1561

time of the death of that plaintiff shall continue, but the 1562
payments shall be paid to the heirs of that plaintiff as scheduled 1563
in and otherwise in accordance with the approved periodic payments 1564
plan or, if the plan does not contain a relevant provision, as the 1565
court shall order. 1566

(J)(1) Nothing in this section precludes a plaintiff and a 1567
defendant from mutually agreeing to a settlement of the action. 1568

(2) Except as otherwise provided in this section, nothing in 1569
this section increases the time for filing any motion or notice of 1570
appeal or taking any other action relative to a civil action upon 1571
a medical, dental, optometric, or chiropractic claim, alters the 1572
amount of any verdict or determination of damages by the trier of 1573
fact in a civil action upon a medical, dental, optometric, or 1574
chiropractic claim, or alters the liability of any party to pay or 1575
satisfy the verdict or determination. 1576

(K) This section does not apply to tort actions that are 1577
brought against political subdivisions of this state and that are 1578
commenced under or are subject to Chapter 2744. of the Revised 1579
Code or to tort actions brought against the state in the court of 1580
claims. 1581

Sec. 2323.56. (A) As used in this section: 1582

(1) "Economic loss" means any of the following types of 1583
pecuniary harm: 1584

(a) All wages, salaries, or other compensation lost as a 1585
result of an injury to person that is a subject of a tort action; 1586

(b) All expenditures for medical care or treatment, 1587
rehabilitation services, or other care, treatment, services, 1588
products, or accommodations as a result of an injury to person 1589
that is a subject of a tort action; 1590

(c) Any other expenditures incurred as a result of an injury 1591

to person that is a subject of a tort action. 1592

(2) "Future damages" means any damages that result from an 1593
injury to person that is a subject of a tort action and that will 1594
accrue after the verdict or determination of liability by the 1595
trier of fact is rendered in that tort action. 1596

(3) "Medical claim," "dental claim," "optometric claim," and 1597
"chiropractic claim" have the same meanings as in section ~~2305.11~~ 1598
2305.113 of the Revised Code. 1599

(4) "Noneconomic loss" means nonpecuniary harm that results 1600
from an injury to person that is a subject of a tort action, 1601
including, but not limited to, pain and suffering, loss of 1602
society, consortium, companionship, care, assistance, attention, 1603
protection, advice, guidance, counsel, instruction, training, or 1604
education, mental anguish, and any other intangible loss. 1605

(5) "Past damages" means any damages that result from an 1606
injury to person that is a subject of a tort action and that have 1607
accrued by the time that the verdict or determination of liability 1608
by the trier of fact is rendered in that tort action, and any 1609
punitive or exemplary damages awarded. 1610

(6) "Tort action" means a civil action for damages for injury 1611
to person. "Tort action" includes a product liability claim for 1612
damages for injury to person that is subject to sections 2307.71 1613
to 2307.80 of the Revised Code, but does not include a civil 1614
action for damages for a breach of contract or another agreement 1615
between persons. 1616

(7) "Trier of fact" means the jury or, in a nonjury action, 1617
the court. 1618

(B)(1) In any tort action that is tried to a jury and in 1619
which a plaintiff makes a good faith claim against the defendant 1620
in question for future damages that exceed two hundred thousand 1621
dollars, upon motion of that plaintiff or the defendant in 1622

question, the court shall instruct the jury to return, and the jury shall return, a general verdict and, if that verdict is in favor of that plaintiff, answers to interrogatories that shall specify all of the following:

(a) The past damages recoverable by that plaintiff;

(b) The future damages recoverable by that plaintiff, and the portions of those future damages that represent each of the following:

(i) Noneconomic loss;

(ii) Economic loss;

(iii) Economic loss as described in division (A)(1)(a) of this section;

(iv) Economic loss as described in division (A)(1)(b) of this section;

(v) Economic loss as described in division (A)(1)(c) of this section.

(2) In any tort action that is tried to a court and in which a plaintiff makes a good faith claim against the defendant in question for future damages that exceed two hundred thousand dollars, upon motion of that plaintiff or the defendant in question, the court shall make its determination in the action and, if that determination is in favor of that plaintiff, make findings of fact that shall specify damages as provided in division (B)(1) of this section.

(C) If answers to interrogatories are returned or findings of fact are made pursuant to division (B) of this section and if the total of the portions of the future damages described in divisions (B)(1)(b)(i), (iv), and (v) of this section exceeds both two hundred thousand dollars and twenty-five per cent of the total of the damages described in divisions (B)(1)(a) and (b) of this

section, the plaintiff or defendant in question may file a motion
with the court that seeks a determination under division (D) of
this section. Such a motion shall be filed at any time after the
verdict or determination in favor of the plaintiff in question is
rendered by the trier of fact but prior to the entry of judgment
in accordance with Civil Rule 58.

(D)(1) Upon the filing of a motion pursuant to division (C)
of this section and prior to the entry of judgment in accordance
with Civil Rule 58, the court shall do all of the following:

(a) Set a date for a hearing to address whether all or any
part of the total of the portions of the future damages described
in divisions (B)(1)(b)(i), (iv), and (v) of this section shall be
received by the plaintiff in question in a series of periodic
payments rather than in a lump sum;

(b) Give notice of the date of the hearing described in
division (D)(1)(a) of this section to the parties involved and
their counsel of record;

(c) Conduct the hearing described in division (D)(1)(a) of
this section, allow the parties involved to present any relevant
evidence at the hearing, consider the factors described in
division (D)(2) of this section in making its determination, and
make its determination in accordance with division (D)(3) of this
section.

(2) In determining whether all or any part of the total of
the portions of the future damages described in divisions
(B)(1)(b)(i), (iv), and (v) of this section shall be received by
the plaintiff in question in a series of periodic payments rather
than in a lump sum, the court shall consider all of the following
factors:

(a) The purposes for which those portions of the future
damages were awarded to that plaintiff;

(b) The business or occupational experience of that plaintiff; 1684
1685

(c) The age of that plaintiff; 1686

(d) The physical and mental condition of that plaintiff; 1687

(e) Whether that plaintiff or the parent, guardian, or custodian of that plaintiff is able to competently manage those portions of the future damages; 1688
1689
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(f) Any other circumstance that relates to whether the injury sustained by that plaintiff would be better compensated by the payment of those portions of the future damages in a lump sum or by their receipt in a series of periodic payments. 1691
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(3) After the hearing described in division (D)(1) of this section and prior to the entry of judgment in accordance with Civil Rule 58, the court shall determine, in its discretion, whether all or any part of the total of the portions of the future damages described in divisions (B)(1)(b)(i), (iv), and (v) of this section shall be received by the plaintiff in question in a series of periodic payments rather than in a lump sum. If the court determines that a series of periodic payments shall be received by that plaintiff, it may order such payments only as to the amount of that total that exceeds both two hundred thousand dollars and twenty-five per cent of the total of the damages described in divisions (B)(1)(a) and (b) of this section. 1695
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(E)(1)(a) If the court determines pursuant to division (D) of this section that a series of periodic payments shall be received by the plaintiff in question, then, within twenty days after the court so determines, that plaintiff shall submit a periodic payments plan to the court. Such a plan may include, but is not limited to, a provision for a trust or an annuity, and may be submitted by that plaintiff alone or by that plaintiff and the defendant in question. 1707
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(b) If that defendant and that plaintiff do not jointly submit a periodic payments plan, then, within twenty days after the court makes its determination pursuant to division (D) of this section that a series of periodic payments shall be received by that plaintiff, that defendant may submit to the court a periodic payments plan. If ~~he~~ that defendant does so, it may include, but is not limited to, a provision for a trust or an annuity.

(c) If that defendant and that plaintiff do not jointly submit a periodic payments plan and if that defendant does not separately submit such a plan pursuant to division (E)(1)(b) of this section, then, within ten days after that plaintiff submits such a plan, that defendant may submit to the court written comments relative to the periodic payments plan of that plaintiff. If that defendant and that plaintiff do not jointly submit a periodic payments plan and if that defendant separately submits such a plan pursuant to division (E)(1)(b) of this section, then, within ten days after that defendant submits such a plan, that plaintiff may submit to the court written comments relative to the periodic payments plan of that defendant.

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

(e) The court shall include in any approved periodic payments 1747
plan adequate security to insure that the plaintiff in question 1748
will receive all of the periodic payments under that plan. If the 1749
approved periodic payments plan includes a provision for an 1750
annuity as the adequate security or otherwise, the defendant in 1751
question shall purchase the annuity from either of the following 1752
types of insurance companies: 1753

(i) An insurance company that the A.M. Best Company, in its 1754
most recently published rating guide of life insurance companies, 1755
has rated A or better and has rated XII or higher as to financial 1756
size or strength; 1757

(ii) An insurance company that the superintendent of 1758
insurance, under rules adopted pursuant to Chapter 119. of the 1759
Revised Code for purposes of implementing this division, 1760
determines is licensed to do business in this state and, 1761
considering the factors described in this division, is a stable 1762
insurance company that issues annuities that are safe and 1763
desirable. 1764

In making determinations as described in this division, the 1765
superintendent shall be guided by the principle that annuities 1766
should be safe and desirable for plaintiffs who are awarded 1767
damages. In making such determinations, the superintendent shall 1768
consider the financial condition, general standing, operating 1769
results, profitability, leverage, liquidity, amount and soundness 1770
of reinsurance, adequacy of reserves, and the management of any 1771
insurance company in question and also may consider ratings, 1772
grades, and classifications of any nationally recognized rating 1773
services of insurance companies and any other factors relevant to 1774
the making of such determinations. 1775

(f) If a periodic payments plan provides for periodic 1776
payments over a period of five years or more to the plaintiff in 1777
question, the court, in its discretion, may include in the 1778

approved periodic payments plan a provision in which it reserves 1779
to itself continuing jurisdiction over that plan, including 1780
jurisdiction to review and modify that plan. 1781

(g) After a periodic payments plan is approved, the future 1782
damages that are to be received in periodic payments shall be paid 1783
in accordance with the plan, including, if applicable, payment 1784
over to a trust or annuity provided for in the plan. 1785

(2) If the court determines pursuant to division (D) of this 1786
section that a series of periodic payments shall not be received 1787
by the plaintiff in question, the future damages described in 1788
divisions (B)(1)(b)(i), (iv), and (v) of this section shall be 1789
paid in a lump sum. 1790

(3) The court shall specify in the entry of judgment in the 1791
tort action the determination made pursuant to division (D) of 1792
this section and, if applicable, the terms of any approved 1793
periodic payments plan. 1794

(F) If a court orders a series of periodic payments of future 1795
damages in accordance with this section, the following rules shall 1796
govern those payments if the plaintiff in question dies prior to 1797
the receipt of all of them: 1798

(1) The liability for the portion of those payments that 1799
represents future economic loss as described in division 1800
(B)(1)(b)(iv) of this section and that is not due at the time of 1801
the death of that plaintiff shall cease at that time; 1802

(2) The liability for the portion of those payments that 1803
represents future noneconomic loss of that plaintiff as described 1804
in division (B)(1)(b)(i) of this section and that is not due at 1805
the time of the death of that plaintiff shall continue, but the 1806
payments shall be paid to the heirs of that plaintiff as scheduled 1807
in and otherwise in accordance with the approved periodic payments 1808
plan or, if the plan does not contain a relevant provision, as the 1809

court shall order; 1810

(3) The liability for the portion of those payments not 1811
described in division (F)(1) or (2) of this section shall 1812
continue, but the payments shall be paid as described in division 1813
(F)(2) of this section. 1814

(G)(1) Nothing in this section precludes a plaintiff in 1815
question and a defendant in question from mutually agreeing to a 1816
settlement of the action. 1817

(2) Except to the extent provided in divisions (A) to (F) of 1818
this section, nothing in those divisions increases the time for 1819
filing any motion or notice of appeal or taking any other action 1820
relative to a tort action, alters the amount of any verdict or 1821
determination of damages by the trier of fact in a tort action, or 1822
alters the liability of any party to pay or satisfy any such 1823
verdict or determination. 1824

(H) This section does not apply to tort actions against 1825
political subdivisions of this state that are commenced under or 1826
are subject to Chapter 2744. of the Revised Code or to tort 1827
actions against the state in the court of claims. This section 1828
also does not apply to a tort or other civil action upon a medical 1829
claim, dental claim, optometric claim, or chiropractic claim, and 1830
instead such an action shall be subject to section ~~2323.57~~ 2323.55 1831
of the Revised Code. 1832

Sec. 2711.21. (A) Upon the filing of any medical, dental, 1833
optometric, or chiropractic claim as defined in ~~division (D) of~~ 1834
section ~~2305.11~~ 2305.113 of the Revised Code, if all of the 1835
parties to the medical, dental, optometric, or chiropractic claim 1836
agree to submit it to nonbinding arbitration, the controversy 1837
shall be submitted to an arbitration board consisting of three 1838
arbitrators to be named by the court. The arbitration board shall 1839
consist of one person designated by the plaintiff or plaintiffs, 1840

one person designated by the defendant or defendants, and a person 1841
designated by the court. The person designated by the court shall 1842
serve as the ~~chairman~~ chairperson of the board. Each member of the 1843
board shall receive a reasonable compensation based on the extent 1844
and duration of actual service rendered, and shall be paid in 1845
equal proportions by the parties in interest. In a claim 1846
accompanied by a poverty affidavit, the cost of the arbitration 1847
shall be borne by the court. 1848

(B) The arbitration proceedings shall be conducted in 1849
accordance with sections 2711.06 to 2711.16 of the Revised Code 1850
insofar as they are applicable. Such proceedings shall be 1851
conducted in the county in which the trial is to be held. 1852

(C) If the decision of the arbitration board is not accepted 1853
by all parties to the medical, dental, optometric, or chiropractic 1854
claim, the claim shall proceed as if it had not been submitted to 1855
nonbinding arbitration pursuant to this section. The decision of 1856
the arbitration board and any dissenting opinion written by any 1857
board member are not admissible into evidence at the trial. 1858

(D) Nothing in this section shall be construed to limit the 1859
right of any person to enter into an agreement to submit a 1860
controversy underlying a medical, dental, optometric, or 1861
chiropractic claim to binding arbitration. 1862

Sec. 2711.22. ~~A (A) Except as otherwise provided in this~~ 1863
~~section, a~~ written contract between a patient and a hospital or 1864
~~physician~~ healthcare provider to settle by binding arbitration any 1865
dispute or controversy arising out of the diagnosis, treatment, or 1866
care of the patient rendered by a ~~physician~~ or hospital or 1867
healthcare provider, that is entered into prior to ~~or subsequent~~ 1868
~~to the rendering of such~~ diagnosis, treatment, or care of the 1869
patient is valid, irrevocable, and enforceable, ~~save upon such~~ 1870
~~grounds as exist at law or in equity for the revocation of any~~ 1871

contract once the contract is signed by all parties. The contract 1872
remains valid, irrevocable, and enforceable until or unless the 1873
patient or the patient's legal representative rescinds the 1874
contract by written notice within thirty days of the signing of 1875
the contract. A guardian or other legal representative of the 1876
patient may give written notice of the rescission of the contract 1877
if the patient is incapacitated or a minor. 1878

(B) As used in this section the terms "hospital" and 1879
"physician" shall have the meaning set forth in division (D) of 1880
section 2305.11 of the Revised Code. The provisions of this 1881
division apply to hospitals, doctors of medicine, doctors of 1882
osteopathic medicine, and doctors of podiatric medicine. and in 1883
sections 2711.23 and 2711.24 of the Revised Code: 1884

(1) "Healthcare provider" means a physician, podiatrist, 1885
dentist, licensed practical nurse, registered nurse, advanced 1886
practice nurse, chiropractor, optometrist, physician assistant, 1887
emergency medical technician-basic, emergency medical 1888
technician-intermediate, emergency medical technician-paramedic, 1889
or physical therapist. 1890

(2) "Hospital," "physician," "podiatrist," "dentist," 1891
"licensed practical nurse," "registered nurse," "advanced practice 1892
nurse," "chiropractor," "optometrist," "physician assistant," 1893
"emergency medical technician-basic," "emergency medical 1894
technician-intermediate," "emergency medical 1895
technician-paramedic," "physical therapist," "medical claim," 1896
"dental claim," "optometric claim," and "chiropractic claim" have 1897
the same meanings as in section 2305.113 of the Revised Code. 1898

Sec. 2711.23. To be valid and enforceable any arbitration 1899
agreements pursuant to sections 2711.01 and 2711.22 of the Revised 1900
Code for controversies involving hospital or a medical care, 1901
diagnosis, or treatment which are, dental, chiropractic, or 1902

optometric claim that is entered into prior to rendering such a 1903
patient receiving any care, diagnosis, or treatment shall include 1904
or be subject to the following conditions: 1905

(A) The agreement shall provide that ~~medical or hospital~~ the 1906
care, diagnosis, or treatment will be provided whether or not the 1907
patient signs the agreement to arbitrate; 1908

(B) The agreement shall provide that the patient, or the 1909
patient's spouse, or the personal representative of ~~his~~ the 1910
patient's estate in the event of the patient's death or 1911
incapacity, shall have a right to withdraw the patient's consent 1912
to arbitrate ~~his~~ the patient's claim by notifying the ~~physician~~ 1913
healthcare provider or hospital in writing within ~~sixty~~ thirty 1914
days after the patient's ~~discharge from the hospital for any claim~~ 1915
~~arising out of hospitalization, or within sixty days after the~~ 1916
~~termination of the physician-patient relationship for the physical~~ 1917
~~condition involved for any claim against a physician~~ signing of 1918
the agreement. Nothing in this division shall be construed to mean 1919
that the spouse of a competent patient can withdraw over the 1920
objection of the patient the consent of the patient to arbitrate; 1921

(C) The agreement shall provide that the decision whether or 1922
not to sign the agreement is solely a matter for the patient's 1923
determination without any influence ~~by the physician or hospital~~; 1924

(D) The agreement shall, if appropriate, provide that its 1925
terms constitute a waiver of any right to a trial in court, or a 1926
waiver of any right to a trial by jury; 1927

(E) The agreement shall provide that the arbitration expenses 1928
shall be divided equally between the parties to the agreement; 1929
1930

(F) Any arbitration panel shall consist of three persons, no 1931
more than one of whom shall be a physician or the representative 1932
of a hospital; 1933

(G) The arbitration agreement shall be separate from any 1934
other agreement, consent, or document; 1935

(H) The agreement shall not be submitted to a patient for 1936
approval when the patient's condition prevents the patient from 1937
making a rational decision whether or not to agree; 1938

(I) Filing of a medical, dental, chiropractic, or optometric 1939
~~claim, as defined in division (D) of section 2305.11 of the~~ 1940
~~Revised Code,~~ within the sixty thirty days provided for withdrawal 1941
of a patient from the arbitration agreement shall be deemed a 1942
withdrawal from ~~such~~ the agreement; 1943

(J) The agreement shall contain a separately stated notice 1944
that clearly informs the patient of ~~his~~ the patient's rights under 1945
division (B) of this section. 1946

~~As used in this section, the terms "hospital" and "physician"~~ 1947
~~shall have the meanings set forth in division (D) of section~~ 1948
~~2305.11 of the Revised Code.~~ 1949

~~The provisions of this division apply to hospitals, doctors~~ 1950
~~of medicine, doctors of osteopathic medicine, and doctors of~~ 1951
~~podiatric medicine.~~ 1952

Sec. 2711.24. To the extent it is in ten-point type and is 1953
executed in the following form, an arbitration agreement of the 1954
type stated in section 2711.23 of the Revised Code shall be 1955
presumed valid and enforceable in the absence of proof by a 1956
preponderance of the evidence that the execution of the agreement 1957
was induced by fraud, that the patient executed the agreement as a 1958
direct result of the willful or negligent disregard by the 1959
~~physician or hospital~~ healthcare provider of the patient's right 1960
not to so execute, or that the patient executing the agreement was 1961
not able to communicate effectively in spoken and written English 1962
or any other language in which the agreement is written: 1963

"AGREEMENT TO RESOLVE FUTURE MALPRACTICE 1964

CLAIM BY BINDING ARBITRATION 1965

In the event of any dispute or controversy arising out of the 1966
diagnosis, treatment, or care of the patient by the healthcare 1967
provider of ~~medical services~~, the dispute or controversy shall be 1968
submitted to binding arbitration. 1969

Within fifteen days after a party to this agreement has given 1970
written notice to the other of demand for arbitration of said 1971
dispute or controversy, the parties to the dispute or controversy 1972
shall each appoint an arbitrator and give notice of such 1973
appointment to the other. Within a reasonable time after such 1974
notices have been given the two arbitrators so selected shall 1975
select a neutral arbitrator and give notice of the selection 1976
thereof to the parties. The arbitrators shall hold a hearing 1977
within a reasonable time from the date of notice of selection of 1978
the neutral arbitrator. 1979

Expenses of the arbitration shall be shared equally by the 1980
parties to this agreement. 1981

The patient, by signing this agreement, also acknowledges 1982
that ~~he~~ the patient has been informed that: 1983

(1) ~~Medical or hospital care~~ Care, diagnosis, or treatment 1984
will be provided whether or not the patient signs the agreement to 1985
arbitrate; 1986

(2) The agreement may not even be submitted to a patient for 1987
approval when the patient's condition prevents the patient from 1988
making a rational decision whether or not to agree; 1989

(3) The decision whether or not to sign the agreement is 1990
solely a matter for the patient's determination without any 1991
influence ~~by the physician or hospital~~; 1992

(4) The agreement waives the patient's right to a trial in 1993
court for any future malpractice claim ~~he~~ the patient may have 1994

against the ~~physician or hospital~~ healthcare provider; 1995

(5) The patient must be furnished with two copies of this 1996
agreement. 1997

PATIENT'S RIGHT TO CANCEL 1998

HIS AGREEMENT TO ARBITRATE 1999

The patient, or the patient's spouse or the personal 2000
representative of ~~his~~ the patient's estate in the event of the 2001
patient's death or incapacity, has the right to cancel this 2002
agreement to arbitrate by notifying the ~~physician or hospital~~ 2003
healthcare provider in writing within ~~sixty~~ thirty days after the 2004
patient's ~~discharge from the hospital for any claim against a~~ 2005
~~hospital, or within sixty days after the termination of the~~ 2006
~~physician-patient relationship for the physical condition involved~~ 2007
~~for claims against physicians~~ signing of the agreement. The 2008
patient, or ~~his~~ the patient's spouse or representative, as 2009
appropriate, may cancel this agreement by merely writing 2010
"cancelled" on the face of one of ~~his~~ the patient's copies of the 2011
agreement, signing ~~his~~ the patient's name under such word, and 2012
mailing, by certified mail, return receipt requested, ~~such the~~ 2013
copy to the ~~physician or hospital~~ healthcare provider within ~~such~~ 2014
~~sixty-day~~ the thirty-day period. 2015

Filing of a medical claim in a court within the ~~sixty~~ thirty 2016
days provided for cancellation of the arbitration agreement by the 2017
patient will cancel the agreement without any further action by 2018
the patient. 2019

Date: 2020

..... 2021

Signature of Provider of Medical Services 2022

..... 2023

Signature of Patient " 2024

~~(B) As used in this section the terms "hospital" and~~ 2025

~~"physician" have the meanings set forth in division (D) of section 2305.11 of the Revised Code. The provisions of this division apply to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine.~~

Sec. 2743.02. (A)(1) The state hereby waives its immunity from liability and consents to be sued, and have its liability determined, in the court of claims created in this chapter in accordance with the same rules of law applicable to suits between private parties, except that the determination of liability is subject to the limitations set forth in this chapter and, in the case of state universities or colleges, in section 3345.40 of the Revised Code, and except as provided in division (A)(2) of this section. To the extent that the state has previously consented to be sued, this chapter has no applicability.

Except in the case of a civil action filed by the state, filing a civil action in the court of claims results in a complete waiver of any cause of action, based on the same act or omission, which the filing party has against any officer or employee, as defined in section 109.36 of the Revised Code. The waiver shall be void if the court determines that the act or omission was manifestly outside the scope of the officer's or employee's office or employment or that the officer or employee acted with malicious purpose, in bad faith, or in a wanton or reckless manner.

(2) If a claimant proves in the court of claims that an officer or employee, as defined in section 109.36 of the Revised Code, would have personal liability for his the officer's or employee's acts or omissions but for the fact that the officer or employee has personal immunity under section 9.86 of the Revised Code, the state shall be held liable in the court of claims in any action that is timely filed pursuant to section 2743.16 of the Revised Code and that is based upon the acts or omissions.

(B) The state hereby waives the immunity from liability of 2057
all hospitals owned or operated by one or more political 2058
subdivisions and consents for them to be sued, and to have their 2059
liability determined, in the court of common pleas, in accordance 2060
with the same rules of law applicable to suits between private 2061
parties, subject to the limitations set forth in this chapter. 2062
This division is also applicable to hospitals owned or operated by 2063
political subdivisions which have been determined by the supreme 2064
court to be subject to suit prior to July 28, 1975. 2065

(C) Any hospital, as defined ~~under~~ in section ~~2305.11~~ 2066
2305.113 of the Revised Code, may purchase liability insurance 2067
covering its operations and activities and its agents, employees, 2068
nurses, interns, residents, staff, and members of the governing 2069
board and committees, and, whether or not such insurance is 2070
purchased, may, to such extent as its governing board considers 2071
appropriate, indemnify or agree to indemnify and hold harmless any 2072
such person against expense, including attorney's fees, damage, 2073
loss, or other liability arising out of, or claimed to have arisen 2074
out of, the death, disease, or injury of any person as a result of 2075
the negligence, malpractice, or other action or inaction of the 2076
indemnified person while acting within the scope of ~~his~~ the 2077
indemnified person's duties or engaged in activities at the 2078
request or direction, or for the benefit, of the hospital. Any 2079
hospital electing to indemnify such persons, or to agree to so 2080
indemnify, shall reserve such funds as are necessary, in the 2081
exercise of sound and prudent actuarial judgment, to cover the 2082
potential expense, fees, damage, loss, or other liability. The 2083
superintendent of insurance may recommend, or, if such hospital 2084
requests ~~him~~ the superintendent to do so, the superintendent shall 2085
recommend, a specific amount for any period that, in ~~his~~ the 2086
superintendent's opinion, represents such a judgment. This 2087
authority is in addition to any authorization otherwise provided 2088

or permitted by law. 2089

(D) Recoveries against the state shall be reduced by the 2090
aggregate of insurance proceeds, disability award, or other 2091
collateral recovery received by the claimant. This division does 2092
not apply to civil actions in the court of claims against a state 2093
university or college under the circumstances described in section 2094
3345.40 of the Revised Code. The collateral benefits provisions of 2095
division (B)(2) of that section apply under those circumstances. 2096
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(E) The only defendant in original actions in the court of 2098
claims is the state. The state may file a third-party complaint or 2099
counterclaim in any civil action, except a civil action for two 2100
thousand five hundred dollars or less, that is filed in the court 2101
of claims. 2102

(F) A civil action against an officer or employee, as defined 2103
in section 109.36 of the Revised Code, that alleges that the 2104
officer's or employee's conduct was manifestly outside the scope 2105
of ~~his~~ the officer's or employee's employment or official 2106
responsibilities, or that the officer or employee acted with 2107
malicious purpose, in bad faith, or in a wanton or reckless manner 2108
shall first be filed against the state in the court of claims, 2109
which has exclusive, original jurisdiction to determine, 2110
initially, whether the officer or employee is entitled to personal 2111
immunity under section 9.86 of the Revised Code and whether the 2112
courts of common pleas have jurisdiction over the civil action. 2113

The filing of a claim against an officer or employee under 2114
this division tolls the running of the applicable statute of 2115
limitations until the court of claims determines whether the 2116
officer or employee is entitled to personal immunity under section 2117
9.86 of the Revised Code. 2118

(G) Whenever a claim lies against an officer or employee who 2119
is a member of the Ohio national guard, and the officer or 2120

employee was, at the time of the act or omission complained of, 2121
subject to the "Federal Tort Claims Act," 60 Stat. 842 (1946), 28 2122
U.S.C. 2671, et seq., then the Federal Tort Claims Act is the 2123
exclusive remedy of the claimant and the state has no liability 2124
under this section. 2125

Sec. 2743.43. (A) No person shall be deemed competent to give 2126
expert testimony on the liability issues in a medical claim, as 2127
defined in ~~division (D)(3) of section 2305.11~~ 2305.113 of the 2128
Revised Code, unless: 2129

(1) Such person is licensed to practice medicine and surgery, 2130
osteopathic medicine and surgery, or podiatric medicine and 2131
surgery by the state medical board or by the licensing authority 2132
of any state; 2133

(2) Such person devotes three-fourths of ~~his~~ the person's 2134
professional time to the active clinical practice of medicine or 2135
surgery, osteopathic medicine and surgery, or podiatric medicine 2136
and surgery, or to its instruction in an accredited university. 2137

(B) Nothing in division (A) of this section shall be 2138
construed to limit the power of the trial court to adjudge the 2139
testimony of any expert witness incompetent on any other ground. 2140

(C) Nothing in division (A) of this section shall be 2141
construed to limit the power of the trial court to allow the 2142
testimony of any other expert witness that is relevant to the 2143
medical claim involved. 2144

Sec. 2919.16. As used in sections 2919.16 to 2919.18 of the 2145
Revised Code: 2146

(A) "Fertilization" means the fusion of a human spermatozoon 2147
with a human ovum. 2148

(B) "Gestational age" means the age of an unborn human as 2149

calculated from the first day of the last menstrual period of a pregnant woman. 2150
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(C) "Health care facility" means a hospital, clinic, ambulatory surgical treatment center, other center, medical school, office of a physician, infirmary, dispensary, medical training institution, or other institution or location in or at which medical care, treatment, or diagnosis is provided to a person. 2152
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(D) "Hospital" has the same meanings as in sections 2108.01, 3701.01, and 5122.01 of the Revised Code. 2158
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(E) "Live birth" has the same meaning as in division (A) of section 3705.01 of the Revised Code. 2160
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(F) "Medical emergency" means a condition that a pregnant woman's physician determines, in good faith and in the exercise of reasonable medical judgment, so complicates the woman's pregnancy as to necessitate the immediate performance or inducement of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman that delay in the performance or inducement of the abortion would create. 2162
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(G) "Physician" has the same meaning as in section ~~2305.11~~ 2305.113 of the Revised Code. 2171
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(H) "Pregnant" means the human female reproductive condition, that commences with fertilization, of having a developing fetus. 2173
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(I) "Premature infant" means a human whose live birth occurs prior to thirty-eight weeks of gestational age. 2176
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(J) "Serious risk of the substantial and irreversible impairment of a major bodily function" means any medically 2178
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diagnosed condition that so complicates the pregnancy of the woman 2180
as to directly or indirectly cause the substantial and 2181
irreversible impairment of a major bodily function, including, but 2182
not limited to, the following conditions: 2183

(1) Pre-eclampsia; 2184

(2) Inevitable abortion; 2185

(3) Prematurely ruptured membrane; 2186

(4) Diabetes; 2187

(5) Multiple sclerosis. 2188

(K) "Unborn human" means an individual organism of the 2189
species homo sapiens from fertilization until live birth. 2190

(L) "Viable" means the stage of development of a human fetus 2191
at which in the determination of a physician, based on the 2192
particular facts of a woman's pregnancy that are known to the 2193
physician and in light of medical technology and information 2194
reasonably available to the physician, there is a realistic 2195
possibility of the maintaining and nourishing of a life outside of 2196
the womb with or without temporary artificial life-sustaining 2197
support. 2198

Sec. 3923.63. (A) Notwithstanding section 3901.71 of the 2199
Revised Code, each individual or group policy of sickness and 2200
accident insurance delivered, issued for delivery, or renewed in 2201
this state that provides maternity benefits shall provide coverage 2202
of inpatient care and follow-up care for a mother and her newborn 2203
as follows: 2204

(1) The policy shall cover a minimum of forty-eight hours of 2205
inpatient care following a normal vaginal delivery and a minimum 2206
of ninety-six hours of inpatient care following a cesarean 2207
delivery. Services covered as inpatient care shall include 2208

medical, educational, and any other services that are consistent 2209
with the inpatient care recommended in the protocols and 2210
guidelines developed by national organizations that represent 2211
pediatric, obstetric, and nursing professionals. 2212

(2) The policy shall cover a physician-directed source of 2213
follow-up care. Services covered as follow-up care shall include 2214
physical assessment of the mother and newborn, parent education, 2215
assistance and training in breast or bottle feeding, assessment of 2216
the home support system, performance of any medically necessary 2217
and appropriate clinical tests, and any other services that are 2218
consistent with the follow-up care recommended in the protocols 2219
and guidelines developed by national organizations that represent 2220
pediatric, obstetric, and nursing professionals. The coverage 2221
shall apply to services provided in a medical setting or through 2222
home health care visits. The coverage shall apply to a home health 2223
care visit only if the health care professional who conducts the 2224
visit is knowledgeable and experienced in maternity and newborn 2225
care. 2226

When a decision is made in accordance with division (B) of 2227
this section to discharge a mother or newborn prior to the 2228
expiration of the applicable number of hours of inpatient care 2229
required to be covered, the coverage of follow-up care shall apply 2230
to all follow-up care that is provided within seventy-two hours 2231
after discharge. When a mother or newborn receives at least the 2232
number of hours of inpatient care required to be covered, the 2233
coverage of follow-up care shall apply to follow-up care that is 2234
determined to be medically necessary by the health care 2235
professionals responsible for discharging the mother or newborn. 2236

(B) Any decision to shorten the length of inpatient stay to 2237
less than that specified under division (A)(1) of this section 2238
shall be made by the physician attending the mother or newborn, 2239
except that if a nurse-midwife is attending the mother in 2240

collaboration with a physician, the decision may be made by the
nurse-midwife. Decisions regarding early discharge shall be made
only after conferring with the mother or a person responsible for
the mother or newborn. For purposes of this division, a person
responsible for the mother or newborn may include a parent,
guardian, or any other person with authority to make medical
decisions for the mother or newborn.

(C)(1) No sickness and accident insurer may do either of the
following:

(a) Terminate the participation of a health care professional
or health care facility as a provider under a sickness and
accident insurance policy solely for making recommendations for
inpatient or follow-up care for a particular mother or newborn
that are consistent with the care required to be covered by this
section;

(b) Establish or offer monetary or other financial incentives
for the purpose of encouraging a person to decline the inpatient
or follow-up care required to be covered by this section.

(2) Whoever violates division (C)(1)(a) or (b) of this
section has engaged in an unfair and deceptive act or practice in
the business of insurance under sections 3901.19 to 3901.26 of the
Revised Code.

(D) This section does not do any of the following:

(1) Require a policy to cover inpatient or follow-up care
that is not received in accordance with the policy's terms
pertaining to the health care professionals and facilities from
which an individual is authorized to receive health care services;

(2) Require a mother or newborn to stay in a hospital or
other inpatient setting for a fixed period of time following
delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting; 2272
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(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code; 2274
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(5) Establish minimum standards of medical diagnosis, care or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, solely on the basis of this section, give rise to a medical claim or derivative medical claim, as those terms are defined in section ~~2305.11~~ 2305.113 of the Revised Code. 2277
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Sec. 3923.64. (A) Notwithstanding section 3901.71 of the Revised Code, each public employee benefit plan established or modified in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows: 2283
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(1) The plan shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. 2288
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(2) The plan shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols 2296
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and guidelines developed by national organizations that represent 2303
pediatric, obstetric, and nursing professionals. The coverage 2304
shall apply to services provided in a medical setting or through 2305
home health care visits. The coverage shall apply to a home health 2306
care visit only if the health care professional who conducts the 2307
visit is knowledgeable and experienced in maternity and newborn 2308
care. 2309

When a decision is made in accordance with division (B) of 2310
this section to discharge a mother or newborn prior to the 2311
expiration of the applicable number of hours of inpatient care 2312
required to be covered, the coverage of follow-up care shall apply 2313
to all follow-up care that is provided within seventy-two hours 2314
after discharge. When a mother or newborn receives at least the 2315
number of hours of inpatient care required to be covered, the 2316
coverage of follow-up care shall apply to follow-up care that is 2317
determined to be medically necessary by the health care 2318
professionals responsible for discharging the mother or newborn. 2319

(B) Any decision to shorten the length of inpatient stay to 2320
less than that specified under division (A)(1) of this section 2321
shall be made by the physician attending the mother or newborn, 2322
except that if a nurse-midwife is attending the mother in 2323
collaboration with a physician, the decision may be made by the 2324
nurse-midwife. Decisions regarding early discharge shall be made 2325
only after conferring with the mother or a person responsible for 2326
the mother or newborn. For purposes of this division, a person 2327
responsible for the mother or newborn may include a parent, 2328
guardian, or any other person with authority to make medical 2329
decisions for the mother or newborn. 2330

(C)(1) No public employer who offers an employee benefit plan 2331
may do either of the following: 2332

(a) Terminate the participation of a health care professional 2333
or health care facility as a provider under the plan solely for 2334

making recommendations for inpatient or follow-up care for a 2335
particular mother or newborn that are consistent with the care 2336
required to be covered by this section; 2337

(b) Establish or offer monetary or other financial incentives 2338
for the purpose of encouraging a person to decline the inpatient 2339
or follow-up care required to be covered by this section. 2340
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(2) Whoever violates division (C)(1)(a) or (b) of this 2342
section has engaged in an unfair and deceptive act or practice in 2343
the business of insurance under sections 3901.19 to 3901.26 of the 2344
Revised Code. 2345

(D) This section does not do any of the following: 2346

(1) Require a plan to cover inpatient or follow-up care that 2347
is not received in accordance with the plan's terms pertaining to 2348
the health care professionals and facilities from which an 2349
individual is authorized to receive health care services; 2350

(2) Require a mother or newborn to stay in a hospital or 2351
other inpatient setting for a fixed period of time following 2352
delivery; 2353

(3) Require a child to be delivered in a hospital or other 2354
inpatient setting; 2355

(4) Authorize a nurse-midwife to practice beyond the 2356
authority to practice nurse-midwifery in accordance with Chapter 2357
4723. of the Revised Code; 2358

(5) Establish minimum standards of medical diagnosis, care, 2359
or treatment for inpatient or follow-up care for a mother or 2360
newborn. A deviation from the care required to be covered under 2361
this section shall not, solely on the basis of this section, give 2362
rise to a medical claim or derivative medical claim, as those 2363
terms are defined in section ~~2305.11~~ 2305.113 of the Revised Code. 2364

Sec. 3929.71. As used in sections 3929.71 to 3929.85 of the Revised Code, or any rules adopted pursuant thereto:

(A) "Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death, disease, or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed physician, podiatrist, or hospital, as those terms are defined in section ~~2305.11~~ 2305.113 of the Revised Code.

(B) "Association" means the nonprofit unincorporated joint underwriting association established pursuant to section 3929.72 of the Revised Code.

(C) "Net direct premiums" means gross direct premiums written on liability insurance including the liability component of multiple peril package policies as computed by the superintendent of insurance less return premiums or the unused or unabsorbed portions of premium deposits.

Sec. 5111.018. (A) The provision of medical assistance under this chapter shall include coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1) The medical assistance program shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) The medical assistance program shall cover a physician-directed source of follow-up care. Services covered as

follow-up care shall include physical assessment of the mother and
newborn, parent education, assistance and training in breast or
bottle feeding, assessment of the home support system, performance
of any medically necessary and appropriate clinical tests, and any
other services that are consistent with the follow-up care
recommended in the protocols and guidelines developed by national
organizations that represent pediatric, obstetric, and nursing
professionals. The coverage shall apply to services provided in a
medical setting or through home health care visits. The coverage
shall apply to a home health care visit only if the health care
professional who conducts the visit is knowledgeable and
experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of
this section to discharge a mother or newborn prior to the
expiration of the applicable number of hours of inpatient care
required to be covered, the coverage of follow-up care shall apply
to all follow-up care that is provided within forty-eight hours
after discharge. When a mother or newborn receives at least the
number of hours of inpatient care required to be covered, the
coverage of follow-up care shall apply to follow-up care that is
determined to be medically necessary by the health care
professionals responsible for discharging the mother or newborn.

(B) Any decision to shorten the length of inpatient stay to
less than that specified under division (A)(1) of this section
shall be made by the physician attending the mother or newborn,
except that if a nurse-midwife is attending the mother in
collaboration with a physician, the decision may be made by the
nurse-midwife. Decisions regarding early discharge shall be made
only after conferring with the mother or a person responsible for
the mother or newborn. For purposes of this division, a person
responsible for the mother or newborn may include a parent,
guardian, or any other person with authority to make medical

decisions for the mother or newborn. 2427

(C) The department of job and family services, in 2428
administering the medical assistance program, may not do either of 2429
the following: 2430

(1) Terminate the participation of a health care professional 2431
or health care facility as a provider under the program solely for 2432
making recommendations for inpatient or follow-up care for a 2433
particular mother or newborn that are consistent with the care 2434
required to be covered by this section; 2435

(2) Establish or offer monetary or other financial incentives 2436
for the purpose of encouraging a person to decline the inpatient 2437
or follow-up care required to be covered by this section. 2438
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(D) This section does not do any of the following: 2440

(1) Require the medical assistance program to cover inpatient 2441
or follow-up care that is not received in accordance with the 2442
program's terms pertaining to the health care professionals and 2443
facilities from which an individual is authorized to receive 2444
health care services. 2445

(2) Require a mother or newborn to stay in a hospital or 2446
other inpatient setting for a fixed period of time following 2447
delivery; 2448

(3) Require a child to be delivered in a hospital or other 2449
inpatient setting; 2450

(4) Authorize a nurse-midwife to practice beyond the 2451
authority to practice nurse-midwifery in accordance with Chapter 2452
4723. of the Revised Code; 2453

(5) Establish minimum standards of medical diagnosis, care, 2454
or treatment for inpatient or follow-up care for a mother or 2455
newborn. A deviation from the care required to be covered under 2456

this section shall not, on the basis of this section, give rise to 2457
a medical claim or derivative medical claim, as those terms are 2458
defined in section ~~2305.11~~ 2305.113 of the Revised Code. 2459

Section 2. That existing sections 1751.67, 2117.06, 2305.11, 2460
2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2461
2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 2462
3929.71, and 5111.018, and sections 2305.27 and 2323.57 of the 2463
Revised Code are hereby repealed. 2464

Section 3. The General Assembly makes the following statement 2465
of findings and intent: 2466

(A) The General Assembly finds: 2467

(1) Medical malpractice litigation represents an increasing 2468
danger to the availability and quality of health care in Ohio. 2469

(2) The number of medical malpractice claims resulting in 2470
payments to plaintiffs has remained relatively constant. However, 2471
the average award to plaintiffs has risen dramatically. Payments 2472
to plaintiffs at or exceeding one million dollars have doubled in 2473
the past three years. 2474

(3) This state has a rational and legitimate state interest 2475
in stabilizing the cost of health care delivery by limiting the 2476
amount of compensatory damages representing noneconomic loss 2477
awards in medical malpractice actions. The overall cost of health 2478
care to the consumer has been driven up by the fact that 2479
malpractice litigation causes health care providers to over 2480
prescribe, over treat, and over test their patients. The General 2481
Assembly bases its finding on this state interest upon the 2482
following evidence: 2483

(a) The Superintendent of Insurance has stated that medical 2484
malpractice insurers' investments are not to blame for the 2485

increase in medical malpractice insurance premiums. The vast
majority of these insurers' assets are invested in bonds and other
fixed income investments, not in stocks. Investment income
declined by less than one per cent from 1996 to 2001.

(b) Many medical malpractice insurers left the Ohio market as
they faced increasing losses, largely as a consequence of rapidly
rising compensatory damages and noneconomic loss awards in medical
malpractice actions. The Department of Insurance reports that only
six admitted carriers continue to actively write coverage in Ohio
at this time.

(c) As insurers have left the market, physicians, hospitals,
and other health care practitioners have had an increasingly
difficult time finding affordable medical malpractice insurance.
Some health care practitioners, including a large number of
specialists, have been forced out of the practice of medicine
altogether as a consequence. The Ohio State Medical Association
reports fifteen per cent of Ohio's physicians are considering or
have already relocated their practices due to rising medical
malpractice insurance costs.

(d) As stated in testimony provided by Lawrence E. Smarr,
President of the Physician Insurers Association of America,
medical malpractice costs have increased even while sixty-one per
cent of all claims filed against individual practitioners are
dropped or dismissed by the court and even while the defendants
win eighty per cent of all claims that are continued through trial
to verdict.

(e) The U.S. Department of Health and Human Services
published a report in 2002 stating that health care practitioners
in states with effective caps on noneconomic damages are
experiencing premium increases in the twelve to fifteen per cent
range, as compared to an average forty-four per cent increase in
states that do not cap noneconomic damage awards.

(4)(a) The distinction among claimants with a permanent physical functional loss strikes a reasonable balance between potential plaintiffs and defendants in consideration of the intent of an award for noneconomic losses, while treating similar plaintiffs equally, acknowledging that such distinctions do not limit the award of actual economic damages.

(b) The limits on compensatory damages representing noneconomic loss as specified in section 2323.43 of the Revised Code, as enacted by this act, are based on testimony asking the members of the General Assembly to recognize these distinctions and stating that the cap amounts are similar to caps on awards adopted by other states.

(c) In *Evans v. State* (Sup. Ct. Alaska, August 30, 2002), No. 5618, 2002 Alas. LEXIS 135, one of the issues addressed by the Alaska Supreme Court is whether the caps on noneconomic and punitive damages constitute a violation of the right to a trial by jury granted by the Alaska Constitution and the Seventh Amendment to the United States Constitution. The Court held that the damages caps do not violate the constitutional right to a trial by jury and agreed with the reasoning by the Third Circuit Court of Appeals in *Davis v. Omitowaju* (3d Cir. 1989), 883 F.2d 1155, which interpreted the Seventh Amendment to the United States Constitution to allow damages caps. The Alaska Supreme Court relied on the *Davis* holding that a damages cap did not intrude on the jury's fact-finding function, because the cap was a "policy decision" applied after the jury's determination and did not constitute a re-examination of the factual question of damages. *Evans v. State, supra*, at pp. 11-12.

It is the intent of the General Assembly that as a matter of policy, the limits on compensatory damages for noneconomic loss are applied after a jury's determination of the factual question of damages.

(d) A report from the U.S. Department of Health and Human Services, *Update on the Medical Litigation Crisis: Not the Result of the Insurance Cycle* (Sept. 25, 2002), states that among states that have adopted a two hundred fifty thousand dollar cap on noneconomic damages are: Indiana, Colorado, California, Nebraska, Utah, and Montana. These states, as well as others that have imposed meaningful caps on noneconomic damages, report significantly lower increases in average premium rates than those states without caps. Limits on damages have been upheld by other state supreme courts, as in *Fein v. Permanente Medical Group* (1985), 38 Cal.3d 137, 695 P.2d 665, *Johnson v. St. Vincent Hospital, Inc.* (1980), 273 Ind. 374, 404 N.E.2d 585, and *Evans v. State, supra*.

(5) This legislation does not affect the award of economic damages, such as for lost wages and medical care.

(6)(a) That a statute of repose on medical, dental, optometric, and chiropractic claims strikes a rational balance between the rights of prospective claimants and the rights of hospitals and health care practitioners;

(b) Over time, the availability of relevant evidence pertaining to an incident and the availability of witnesses knowledgeable with respect to the diagnosis, care, or treatment of a prospective claimant becomes problematic.

(c) The maintenance of records and other documentation related to the delivery of medical services, for a period of time in excess of the time period presented in the statute of repose, presents an unacceptable burden to hospitals and health care practitioners.

(d) Over time, the standards of care pertaining to various health care services may change dramatically due to advances being made in health care, science, and technology, thereby making it

difficult for expert witnesses and triers of fact to discern the
standard of care relevant to the point in time when the relevant
health care services were delivered.

(e) This legislation precludes unfair and unconstitutional
aspects of state litigation but does not affect timely medical
malpractice actions brought to redress legitimate grievances.

(f) This legislation addresses the aspects of current
division (B) of section 2305.11 of the Revised Code, the
application of which was found by the Ohio Supreme Court to be
unconstitutional in *Gaines v. Preterm-Cleveland, Inc.* (1987), 33
Ohio St.3d 54. In *Dunn v. St. Francis Hospital, Inc.* (Del. 1982),
401 Atl.2d 77, the Delaware Supreme Court found the Delaware
three-year statute of repose constitutional as not violative of
the Delaware Constitution's open courts provision.

(B) In consideration of these findings, the General Assembly
declares its intent to accomplish all of the following by the
enactment of this act:

(1) To stem the exodus of medical malpractice insurers from
the Ohio market;

(2) To increase the availability of medical malpractice
insurance to Ohio's hospitals, physicians, and other health care
practitioners, thus ensuring the availability of quality health
care for the citizens of this state;

(3) To continue to hold negligent health care providers
accountable for their actions;

(4) To preserve the right of patients to seek legal recourse
for medical malpractice.

(5)(a) To abrogate the common law collateral source rules as
adopted by the Ohio Supreme Court in *Pryor v. Webber* (1970), 23
Ohio St.2d 104, and reaffirmed in *Sorrell v. Thevenir* (1994), 69

Ohio St.3d 415; 2611

(b) To address the aspects of former section 2317.45 of the 2612
Revised Code that the Supreme Court found in Sorrell v. Thevenir 2613
(1994), 69 Ohio St.3d 415, May v. Tandy Corp. (1994), 69 Ohio 2614
St.3d 415, and DePew v. Ogella (1994), 69 Ohio St.3d 610, to be 2615
unconstitutional as being violative of the equal protection 2616
provision of Section 2, the right to a trial by jury provision of 2617
Section 5, and the due course of law, right to a remedy, and open 2618
court provision of Section 16 of Article I of the Ohio 2619
Constitution. 2620

(C)(1) The Ohio General Assembly respectfully requests the 2621
Ohio Supreme Court to uphold this intent in the courts of Ohio, to 2622
reconsider its holding on damage caps in State v. Sheward (1999), 2623
Ohio St.3d 451, to reconsider its holding on the deductibility of 2624
collateral source benefits in Sorrel v. Thevenir (1994), 69 Ohio 2625
St.3d 415, and to reconsider its holding on statutes of repose in 2626
Sedar v. Knowlton Constr. Co. (1990), 49 Ohio St.3d 193, thereby 2627
providing health care practitioners with access to affordable 2628
medical malpractice insurance and maintaining the provision of 2629
quality health care in Ohio. 2630

(2) The General Assembly acknowledges the Court's authority 2631
in prescribing rules governing practice and procedure in the 2632
courts of this state as provided by Section 5 of Article IV of the 2633
Ohio Constitution. 2634

Section 4. (A) There is hereby created the Ohio Medical 2635
Malpractice Commission consisting of nine members. The President 2636
of the Senate shall appoint three of the members, and the Speaker 2637
of the House of Representatives shall appoint three of the 2638
members. The minority leader of the Senate shall appoint one 2639
member and the minority leader of the House of Representatives 2640
shall appoint one member. The Director of the Department of 2641

Insurance or the Director's designee shall be the ninth member of 2642
the Commission. Of the six members appointed by the President of 2643
the Senate and the Speaker of the House of Representatives, one 2644
shall represent the Ohio State Bar Association, one shall 2645
represent the Ohio State Medical Association, and one shall 2646
represent the insurance companies in Ohio, and all of them shall 2647
have expertise in medical malpractice insurance issues. 2648

(B) The Commission shall do all of the following: 2649

(1) Study the effects of this act; 2650

(2) Investigate the problems posed by, and the issues 2651
surrounding, medical malpractice; 2652

(3) Submit a report of its findings to the members of the 2653
General Assembly not later than two years after the effective date 2654
of this act. 2655

(C) Any vacancy in the membership of the Commission shall be 2656
filled in the same manner in which the original appointment was 2657
made. 2658

(D) The members of the Commission shall by majority vote 2659
elect a chairperson from among themselves. 2660

(E) The Department of Insurance shall provide any technical, 2661
professional, and clerical employees that are necessary for the 2662
Commission to perform its duties. 2663

Section 5. (A)(1) In recognition of the statewide concern 2664
over the rising cost of medical malpractice insurance and the 2665
difficulty that health care practitioners have in locating 2666
affordable medical malpractice insurance, the Superintendent of 2667
Insurance shall study the feasibility of a Patient Compensation 2668
Fund to cover medical malpractice claims, including, but not 2669
limited to the following: 2670

(a) The financial responsibility limits for providers that are covered in Am. Sub. Senate Bill 281 of the 124th General Assembly, and the Patient Compensation Fund;	2671 2672 2673
(b) The identification of methods of funding, excluding any tax on consumers;	2674 2675
(c) The operation and administration of such a fund;	2676
(d) The participation requirements.	2677
(2) The Superintendent shall 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 shall include the Superintendent's recommendations for implementing the Patient's Compensation Fund.	2678 2679 2680 2681 2682 2683 2684 2685
(B) The Superintendent of Insurance shall make recommendations for the operation of a Patient's Compensation Fund designed to assist health care practitioners in satisfying medical malpractice awards above designated amounts. The purpose of the study shall be to consider the feasibility of the Fund satisfying that portion of the awards for damages for noneconomic loss under division (A)(2) of section 2323.43 of the Revised Code resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of three hundred fifty thousand dollars to a maximum of five hundred thousand dollars. The recommendations shall also provide for the satisfaction of the awards for damages for noneconomic loss under division (A)(3) of section 2323.43 of the Revised Code resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of five hundred thousand dollars to a maximum of one million dollars.	2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701

(C) The Superintendent's recommendations shall include 2702
sources of revenues for the Fund and a mechanism for making, and 2703
the assessment of, claims against the Fund. 2704

Section 6. (A) Sections 1751.67, 2117.06, 2305.11, 2305.15, 2705
2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23, 2706
2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, and 2707
5111.018 of the Revised Code, as amended by this act, and sections 2708
2303.23, 2305.113, 2323.41, 2323.42, 2323.43, and 2323.55 of the 2709
Revised Code, as enacted by this act, apply to civil actions upon 2710
a medical claim, dental claim, optometric claim, or chiropractic 2711
claim in which the act or omission that constitutes the alleged 2712
basis of the claim occurs on or after the effective date of this 2713
act. 2714

(B) As used in this section, "medical claim," "dental claim," 2715
"optometric claim," and "chiropractic claim" have the same 2716
meanings as in section 2305.113 of the Revised Code. 2717

Section 7. If any item of law that constitutes the whole or 2718
part of a section of law contained in this act, or if any 2719
application of any item of law that constitutes the whole or part 2720
of a section of law contained in this act, is held invalid, the 2721
invalidity does not affect other items of law or applications of 2722
items of law that can be given effect without the invalid item of 2723
law or application. To this end, the items of law of which the 2724
sections contained in this act are composed, and their 2725
applications, are independent and severable. 2726

Section 8. If any item of law that constitutes the whole or 2727
part of a section of law contained in this act, or if any 2728
application of any item of law contained in this act, is held to 2729
be preempted by federal law, the preemption of the item of law or 2730
its application does not affect other items of law or applications 2731

that can be given affect. The items of law of which the sections 2732
of this act are composed, and their applications, are independent 2733
and severable. 2734

Section 9. Section 2117.06 of the Revised Code is presented 2735
in this act as a composite of the section as amended by both Sub. 2736
H.B. 85 and Sub. S.B. 108 of the 124th General Assembly. The 2737
General Assembly, applying the principle stated in division (B) of 2738
section 1.52 of the Revised Code that amendments are to be 2739
harmonized if reasonably capable of simultaneous operation, finds 2740
that the composite is the resulting version of the section in 2741
effect prior to the effective date of the section as presented in 2742
this act. 2743