As Introduced

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Senator Coughlin

Cosponsors: Senators Mumper, Amstutz, Schuring, Buehrer, Schaffer

A B I L L

To amend section 2305.113 and to enact sections 2339.01 to 2339.16 of the Revised Code to establish a pilot program mandating arbitration for claims of medical negligence prior to the filing of a complaint, to suspend, for nine years, sections 2711.21 to 2711.24 of the Revised Code as the sections apply to medical negligence claims, and to terminate the provisions of this act ten years after the effective date of this act by repealing sections 2339.01, 2339.02, 2339.03, 2339.04, 2339.05, 2339.06, 2339.07, 2339.08, 2339.09, 2339.10, 2339.11, 2339.12, 2339.13, 2339.14, 2339.15, and 2339.16 of the Revised Code on that date.

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

Section 1. That section 2305.113 be amended and sections 2339.01, 2339.02, 2339.03, 2339.04, 2339.05, 2339.06, 2339.07, 2339.08, 2339.09, 2339.10, 2339.11, 2339.12, 2339.13, 2339.14, 2339.15, and 2339.16 of the Revised Code be enacted to read as follows:

Sec. 2305.113. (A) Except as otherwise provided in this section and Chapter 2339. of the Revised Code, an action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued.

(B)(1)(a) If prior to the expiration of the one-year period specified in division (A) of this section, a claimant who allegedly possesses a medical, dental, optometric, or chiropractic claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within one hundred eighty days after the notice is so given.

(b) When Chapter 2339. of the Revised Code is applicable, an action upon a medical claim may be commenced by a claimant up to sixty days after one of the following occurs:

(i) The arbitration panel serves all parties to the claim with the panel's evaluation pursuant to section 2339.12 of the Revised Code.

(ii) Another alternative dispute resolution mechanism concludes if all parties to the claim agree to use that other mechanism.

(iii) The court enters judgment on a motion to vacate, modify, or correct the panel's evaluation under sections 2711.10 to 2711.16 of the Revised Code if such a motion is filed.

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

(C) Except as to persons within the age of minority or of

unsound mind as provided by section 2305.16 of the Revised Code, and except as provided in division (D) of this section, both of the following apply:

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

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

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

(2) If the alleged basis of a medical 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.

(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.

(E) As used in this section:

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

(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.

(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:

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

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

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

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

(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.

(4) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the state medical board.

(5) "Dentist" means any person who is licensed to practice dentistry by the state dental board.

(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.

(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 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. "Chiropractic claim" includes derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

(10) "Chiropractor" means any person who is licensed to

practice chiropractic by the state chiropractic board.

(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.

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

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

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

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

(16) "Advanced practice nurse" means any certified nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse-midwife who holds a certificate of authority issued by the board of nursing under Chapter 4723. of the Revised Code.

(17) "Licensed practical nurse" means any person who is licensed to practice nursing as a licensed practical nurse by the board of nursing pursuant to Chapter 4723. of the Revised Code.

(18) "Physician assistant" means any person who holds a valid certificate to practice issued pursuant to Chapter 4730. of the Revised Code.

(19) "Emergency medical technician-basic," "emergency medical technician-intermediate," and "emergency medical technician-paramedic" means any person who is certified under Chapter 4765. of the Revised Code as an emergency medical

technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, whichever is applicable.

Sec. 2339.01. As used in sections 2339.01 to 2339.16 of the Revised Code:

(A) "Affidavit of merit" means a statement, as described in Civil Rule 10, made by an expert witness that includes all of the following:

(1) A statement that the affiant has reviewed all medical records reasonably available to the claimant concerning the allegations contained in the claimant's notice of intent required under section 2339.03 of the Revised Code;

(2) A statement that the affiant is familiar with the applicable standard of care;

(3) The opinion of the affiant that the standard of care was breached by one or more of the respondents to claim and that the breach caused injury to the claimant.

(B) "Claimant" means a person who asserts a claim for medical negligence against a health care professional, hospital, or health care facility that is subject to this chapter.

(C) "Health care facility" means a clinic, ambulatory surgical facility, trauma facility, emergency department, office of a health care professional or associated group of health care professionals, training institution for health care professionals, or any other place where medical or other health-related diagnosis, care, or treatment is provided to persons.

(D) "Health care professional" means a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery, or podiatric medicine and surgery.

(E) "Hospital" means 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, 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 medical or other health-related advice, diagnosis, care, and treatment to individuals. "Hospital" does not include any hospital operated by the government of the United States or any of its branches.

(F) "Medical negligence" means a negligent act or an omission to act by a health care professional, hospital, or health care facility in the rendering of health care services that are within the scope of the services for which the health care professional, hospital, or health care facility is licensed or accredited which act or omission is the proximate cause of personal injury or wrongful death.

(G) "Respondent" means a health care professional, hospital, or health care facility that is the subject of a claim for medical negligence asserted by a claimant that is subject to this chapter.

Sec. 2339.02. (A) The superintendent of insurance, in collaboration with the supreme court of Ohio, shall establish a pilot program to determine the benefits of using arbitration in disputes as to the medical negligence of a health care professional, hospital, or health care facility.

(B) Five years after the effective date of sections 2339.01 to 2339.16 of the Revised Code, the superintendent and supreme court each shall submit a preliminary written report on the use of

arbitration panels by the pilot program and other alternative dispute resolution mechanisms agreed upon by all parties to a claim to the governor, the speaker of the house of representatives, and the president of the senate. The reports shall include the information submitted to the superintendent and supreme court pursuant to division (G) of section 2339.14 of the Revised Code, any other findings the superintendent or supreme court make concerning the results of arbitration under the pilot program, and any information the superintendent requires pursuant to rules the superintendent may adopt. Additionally, the supreme court shall include in its report information detailing the number of complaints alleging medical negligence that were filed after arbitration proceedings were held under the pilot program and any increases or decreases in the number of complaints filed alleging medical negligence after the effective date of the pilot program as compared to the number of such complaints filed before the effective date of the pilot program. The superintendent and supreme court each shall issue a final written report that shall include the same types of information as required in the preliminary reports within one year after the conclusion of the pilot program to the governor, the speaker of the house of representatives, and the president of the senate.

Sec. 2339.03. (A) Claims alleging medical negligence are subject to sections 2339.01 to 2339.16 of the Revised Code. A claimant shall not commence an action in Lorain, Erie, Huron, Cuyahoga, Summit, Lake, or Geauga counties alleging medical negligence against a respondent unless the claimant has given the respondent written notice pursuant to this section, not less than one hundred eighty days before commencing the action, of the claimant's intent to file a complaint. This required written notice shall be accompanied by an affidavit of merit or notice that the claimant is unable to obtain an affidavit of merit, the

name of an arbitrator to serve on the arbitration panel pursuant to section 2339.04 of the Revised Code, an authorization for the release of any medical records related to the claim that are not in the claimant's control but of which the claimant has knowledge, and any demands for discovery that may be answered in writing or by the furnishing of documents. The notice that the claimant is unable to obtain an affidavit of merit described in this division shall include an explanation of good cause why the claimant is unable to obtain the affidavit.

(B) The claimant shall mail the required written notice by certified mail to the last known business or residential address of the respondent. Proof of the receipt of the notice constitutes prima-facie evidence of the provision of the notice and compliance with this section. If a business or residential address reasonably cannot be ascertained, the claimant shall mail the notice via certified mail to the address where the applicable health care services were rendered.

(C)(1) The written notice required by this section shall contain all of the following information:

(a) The factual basis for the claim;

(b) The standard of practice or care alleged by the claimant to be applicable to the relevant health care services;

(c) The manner in which it is alleged that the applicable standard of practice or care was breached by the respondent;

(d) The action that allegedly should have been taken to achieve compliance with the stated standard of practice or care;

(e) The manner in which it is alleged that the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice;

(f) The names of all respondents that the claimant is

notifying under this section in relation to the claim.

(2) After serving the initial written notice on the respondents named in that notice, the claimant may give notice to additional respondents only if the claimant did not identify and could not reasonably have been expected to identify the additional respondents when the claimant served the initial written notice.

(D) After the initial written notice is given to a respondent pursuant to this section, no additional days shall be added to the one hundred eighty-day waiting period irrespective of the number of additional parties subsequently notified in regard to that claim.

(E) Within thirty days after receipt of a written notice under this section, a respondent, other than a respondent added pursuant to division (C)(2) of this section, shall notify the claimant or the claimant's attorney, in writing sent by certified mail, return receipt requested, of the name of an arbitrator to serve on the arbitration panel pursuant to section 2339.04 of the Revised Code. Within thirty days after receipt of a written notice under this section, a respondent may serve on the claimant any demands for discovery that may be answered in writing or by the furnishing of documents.

(F) A claimant or respondent shall serve copies of all notices and filings required by sections 2339.03 through 2339.16 of the Revised Code on all parties to a proceeding under those sections of which the claimant or respondent knows or has reason to know.

(G) The time periods for filings and responses set forth in sections 2339.03 and 2339.06 of the Revised Code do not alter or affect the minimum period described in division (A) of this section. This section does not affect the time limits placed on the commencement of actions under section 2305.113 of the Revised

Code.

Sec. 2339.04. (A) The arbitration panel shall consist of three members, one member selected by the claimant, one member selected by the respondent, and a third member, who shall serve as chairperson of the panel, agreed to by the members selected by the claimant and respondent. Within ten days after a respondent notifies a claimant of the name of an arbitrator pursuant to division (E) of section 2339.03 of the Revised Code, the arbitrators selected by the claimant and the respondent shall choose the chairperson of the arbitration panel. The chairperson shall have practiced law for at least eight years and be from the American health lawyers association alternative dispute resolution service, American arbitration association, or other similar dispute resolution service. The panel member selected by each party shall be a medical expert in the area of medicine that is the subject of the claim.

(B)(1) If multiple claimants are involved in a claim and those claimants cannot agree on a panel member, any claimant, within five days after learning of the disagreement, may ask the American health lawyers association alternative dispute resolution service to select the panel member.

(2) If multiple respondents are involved in a claim and those respondents cannot agree on a panel member, any claimant, within five days after the earlier of receipt of the last response required to be served under division (E) of section 2339.03 of the Revised Code or the expiration of the time for service of all responses under that division, may ask the American health lawyers association alternative dispute resolution service to select the panel member.

(3) If the panel members selected by or for the claimants and respondents cannot agree on a chairperson, they shall ask the

American health lawyers association alternative dispute resolution service to do so.

(4) In the event of a dispute over the selection of an arbitrator, the deadlines for subsequent actions required or permitted under sections 2339.05 and 2339.06 of the Revised Code shall be extended by the number of days after the expiration of the ten-day period that were required to resolve the dispute under this division.

(C) The grounds for disqualification of an arbitrator shall be the same as that provided by the Revised Code and court rules for the disqualification of a judge.

(D) Each party is responsible for the cost of the panel member selected by that party. The parties shall share all other costs of arbitration.

Sec. 2339.05. (A) Except as described in divisions (B) and (C) of this section, within fourteen days after the arbitration panel is completed, the panel shall determine whether the notice of claim and affidavit of merit establish a valid prima-facie claim for which damages may be awarded and serve notice and an explanation of its decision on all parties by certified mail, return receipt requested. If the panel finds that the claimant has made out a prima-facie claim for damages, the notice of decision shall be accompanied by both of the following, as determined by the chairperson:

(1) Notice of the time for the arbitration hearing, which shall begin not sooner than two hundred four days and not later than two hundred sixty-four days after service of the initial notice of claim pursuant to section 2339.03 of the Revised Code, and the place for the arbitration hearing;

(2) A case management schedule allowing time periods for

additional written discovery, depositions, and the exchange of expert reports.

(B) If, in place of an affidavit, the claimant gives a respondent notice that claimant was unable to obtain an affidavit of merit as permitted under section 2339.03 of the Revised Code, then the arbitration panel, within fourteen days after the panel is selected, shall determine whether the claimant had good cause to give the respondent such notice. The panel shall serve notice of the panel's good cause determination to all parties by certified mail, return receipt requested. The notice of the time for the arbitration hearing and the case management schedule described in divisions (A)(1) and (2) of this section shall accompany the panel's good cause determination. In determining whether good cause exists, the panel shall consider all of the following, as described in Civil Rule 10:

(1) A description of any information necessary in order to obtain an affidavit of merit;

(2) Whether the information is in the possession or control of a respondent or third party;

(3) The scope and type of discovery necessary to obtain the information;

(4) What efforts, if any, were taken to obtain the information;

(5) Any other facts or circumstances relevant to the ability of the claimant to obtain an affidavit of merit.

(C) If the panel determines that the claimant had good cause pursuant to division (B) of this section, the claimant shall have up to ninety additional days from the time the claimant gives the respondent notice that the claimant is unable to obtain an affidavit of merit pursuant to section 2339.03 of the Revised Code to give the respondent and the panel an affidavit of merit. Within

fourteen days after receiving the affidavit of merit, the panel shall determine whether the notice of claim and affidavit establish a valid prima-facie claim for which damages may be awarded and serve notice and an explanation of its decision on all parties by certified mail, return receipt requested. If the panel determines that the claimant has established a valid prima-facie claim, the arbitration process shall continue as specified in the case management schedule.

(D) If the panel determines that the claimant did not have good cause pursuant to division (B) of this section or if the panel determines that the claimant cannot establish a valid prima-facie claim pursuant to division (A) or (C) of this section, the claimant may commence an action in court upon posting a cash or surety bond, approved by the court, in the amount of fifty thousand dollars. If judgment is entered against the party who posted the bond, the bond shall be used to pay all reasonable costs incurred by the opposing parties as allowed by the Revised Code and rules of court, including reasonable attorney's fees.

(E) Discovery shall be completed not later than two hundred four days after service of the initial notice of claim pursuant to section 2339.03 of the Revised Code unless the panel decides, upon its own motion or motion of one of the parties made within the two-hundred-four-day period, that the case is complex. If the panel decides that the case is complex, it shall allow additional time for discovery and schedule the hearing to begin on or about a date three hundred twenty-four days after service of the initial notice of claim.

Sec. 2339.06. (A)(1) Within thirty days after receiving a notice from an arbitration panel under division (A) or (B) of section 2339.05 of the Revised Code, the respondent notified, or the respondent's attorney, if denying the claim, shall furnish a

written response to the claimant or the claimant's attorney and the arbitration panel that contains all of the following information and statements:

(a) The factual basis for any defense to the claim;

(b) The standard of practice or care that the respondent alleges to be applicable to the health care services rendered;

(c) A statement by the respondent that the applicable standard of practice or care was complied with and the manner in which compliance was achieved;

(d) The reason that the respondent contends that the claimant's alleged injury is unrelated to the health care services rendered.

(2) The response furnished by a respondent under division (A)(1) of this section may be accompanied by an affidavit of noninvolvement that meets the requirements of section 2323.45 of the Revised Code and a motion to dismiss the claim as to the respondent that served the affidavit. The response shall be accompanied by responses to any demands for discovery served with the notice of claim and with copies of or an offer of access to all of the medical records related to the claim that are in the respondent's control pursuant to division (C) of this section.

(B) Except as described in division (D) of this section, if the claimant or the claimant's attorney does not receive the written response required under division (A) of this section within the time prescribed, the claimant may thereafter commence an action alleging medical negligence against the health care professional, hospital, or health care facility.

(C) Within ten days after receiving the required written response pursuant to division (A) of this section, the claimant shall allow the respondent notified, or the respondent's attorney,

access to all of the medical records related to the claim that are in the claimant's control. Within ten days after receiving from the claimant access to medical records and releases pursuant to this division, the respondent shall allow the claimant or the claimant's attorney access to all medical records related to the claim that are in the respondent's control. This division does not restrict a respondent that receives notice pursuant to this section from communicating with other health care professionals, hospitals, or health care facilities and acquiring medical records as otherwise permitted by the Revised Code.

(D) If a claim is made alleging medical negligence, the respondent, instead of responding pursuant to division (A) of this section, may file, within fifteen days after receiving notice from the chairperson of the panel pursuant to division (A) or (B) of section 2339.05 of the Revised Code, a motion with the arbitration panel for dismissal of the claim, accompanied by an affidavit of noninvolvement. The procedures, rights and responsibilities of the parties, and responsibilities of the court concerning a motion for dismissal and affidavit of noninvolvement as set forth in section 2323.45 of the Revised Code shall be imposed on the parties to a medical negligence claim and the arbitration panel described under this division.

(E) The parties to a medical negligence claim, and their attorneys, may communicate with persons in order to obtain information relevant to the subject matter of the medical negligence claim. The parties to a medical negligence claim, and their attorneys, shall obtain discovery, including the conduct of any necessary interrogatories, request for production of documents, and depositions relating to the subject matter of the claim. Any person disclosing information pursuant to this division is not in violation of any duty or obligation owed to the parties under other provisions of the Revised Code.

Sec. 2339.07. No person shall be deemed competent to give expert testimony in a claim alleging medical negligence unless the person meets the requirements for an expert witness under section 2743.43 of the Revised Code.

Sec. 2339.08. No civil action against a health care professional, hospital, or health care facility based upon acts or omissions subject to sections 2339.01 to 2339.16 of the Revised Code, or against persons providing related health care or treatment, whether or not they are party to a medical negligence claim based on those acts or omissions, shall be taken except pursuant to sections 2339.01 to 2339.16 of the Revised Code. Prior to the filing of a complaint, a claim alleging medical negligence shall be arbitrated in accordance with sections 2339.01 to 2339.16 of the Revised Code or in accordance with another alternative dispute resolution mechanism agreed upon by all parties to the claim.

Sec. 2339.09. (A) If at any time a claimant alleging medical negligence enters into a settlement agreement with a respondent concerning the claim, whether or not the settlement agreement was entered into under court supervision, the claimant and respondent or the claimant's and respondent's attorneys shall jointly file a complete written copy of the settlement agreement with the superintendent of insurance. The filing shall be made within thirty days after the parties enter into the settlement agreement.

(B) Information filed with the superintendent under this section is confidential except for use by the department of insurance for general statistical purposes.

Sec. 2339.10. At least five days before the date of the arbitration hearing, the parties to the claim shall submit copies

of the filings made under section 2339.03 of the Revised Code to the chairperson of the arbitration panel, and five copies of a concise brief or summary setting forth each party's factual or legal position on the issues presented by the claim. Parties to the claim may submit additional documents pertaining to the issues to be arbitrated. In addition, one copy of each document and the brief or summary shall be served on each attorney of record in the action.

Sec. 2339.11. (A) A party to a medical negligence claim shall attend an arbitration hearing.

(B) The Ohio Rules of Evidence shall apply to arbitration hearings. If the supreme court of Ohio adopts rules regarding the applicability of the Rules of Civil Procedure to sections 2339.01 to 2339.16 of the Revised Code, those rules shall apply to arbitration under those sections. Factual information having a bearing on liability shall be supported by documentary evidence when possible. A stenographic record or tape recording and transcript of each arbitration hearing shall be maintained as part of the arbitration panel's official record.

(C) The panel's written evaluation is admissible in subsequent court proceedings, but the panel members shall not testify or provide depositions in subsequent court proceedings.

(D) To the extent permitted by the Rules of Evidence, an admission made by a party or a party's representative to the arbitration panel, and witness testimony and documentary evidence given at the arbitration hearing, shall be admissible in any subsequent court proceeding.

(E) Each party's testimony and each party's attorney's opening statement shall not exceed thirty minutes or another period of time that the panel determines.

(F) Unless the parties unanimously agree to one or more extensions of a specified number of days, an arbitration hearing shall not last longer than twenty-one days or, if the arbitration panels determines that the case is complex, twenty-eight days.

Sec. 2339.12. (A) Except as otherwise provided in division (B) of this section, an arbitration panel shall evaluate a claim within ten days after an arbitration hearing and shall serve each party with a copy of its evaluation. The evaluation shall include the panel's specific findings on the applicable standard of practice or care for the health care services rendered; if the respondent deviated from that standard of practice or care; and if that deviation was the proximate cause of the claimant's injuries. All dissenting opinions of members shall accompany the evaluation. The panel's findings shall not include damages, the value of the claim, or the extent, if any, of a claimant's disability or impairment.

(B) The evaluation shall state if the arbitration panel determines that a claim or defense is frivolous. If the claim proceeds to trial as described in division (C) of section 2339.14 of the Revised Code, the party who has been determined to have a frivolous claim or defense shall post a cash or surety bond, approved by the court, in the amount of fifty thousand dollars. If judgment is entered against the party who posted the bond, the bond shall be used to pay all reasonable costs incurred by the opposing parties as allowed by the Revised Code and rules of court, including reasonable attorney fees.

Sec. 2339.13. (A) Each party to a claim shall file a written acceptance or rejection of the arbitration panel's evaluation within twenty-eight days after being served with the panel's evaluation. A party's failure to file written acceptance or rejection within twenty-eight days shall constitute the party's

acceptance of the evaluation.

(B) In arbitrations involving multiple parties, the following rules shall apply:

(1) All of the parties on either side of the claim have the option of jointly accepting all of the arbitration panel's evaluation or of accepting part of the evaluation and rejecting other parts. However, as to any particular opposing party, the party either shall accept or reject that part of the evaluation in its entirety.

(2) A party that accepts all of the evaluation may indicate in the acceptance that the acceptance only is effective if all of the opposing parties accept the evaluation concerning the accepting party. If this limitation is not included in the acceptance, the accepting party shall be considered to have agreed to an entry of judgment as to that party and those of the opposing parties who have accepted all of the evaluation, with the action to continue as described in division (C) of section 2339.14 of the Revised Code between the accepting party and those opposing parties that have rejected the part of the evaluation concerning the accepting party. If the limitation is included in the acceptance and some of the opposing parties reject the part of the evaluation concerning the accepting party, the party including the limitation is considered to have rejected all of the evaluation even as to those individual opposing parties that have accepted all of the evaluation and the cost provisions of section 2339.15 of the Revised Code shall apply.

(C) Any party to a claim may file a motion with the court to vacate, modify, or correct the arbitration panel's evaluation in accordance with sections 2711.10 to 2711.16 of the Revised Code.

Sec. 2339.14. (A) A party's acceptance or rejection of the

arbitration panel's evaluation shall not be disclosed until the expiration of the twenty-eight-day period described in section 2339.13 of the Revised Code, at which time the chairperson of the panel shall mail a notice to all parties to the action indicating each party's acceptance or rejection of the panel's evaluation. The notice shall include a statement of all fees, costs, and interest to the date of the evaluation.

(B) In a case involving multiple parties, the chairperson of the panel shall mail copies of the parts of the evaluation to the parties that have accepted those parts of the evaluation that apply to them if not proscribed by division (B)(2) of section 2339.13 of the Revised Code.

(C) If all or part of the evaluation is rejected by opposing parties, the action shall proceed to trial to determine the standard of practice or care applicable to the claim; if the respondent deviated from that standard of practice or care; if that deviation was the proximate cause of the claimant's injuries; and damages to be awarded under the claim, subject to a party filing a complaint with the court within sixty days after being served with the panel's evaluation.

(D) At any time within one year after a party accepts an arbitration panel's evaluation, the party shall apply to the court for an order confirming the evaluation and for determining damages to be awarded under the claim. Thereupon the court shall grant such an order, determine damages, and enter judgment thereon, unless the evaluation is vacated, modified, or corrected as prescribed in sections 2711.10 to 2711.16 of the Revised Code. Written notice of the application shall be served upon the adverse parties and their attorneys five days before a hearing on the application.

(E) The chairperson of the panel shall place a copy of the

evaluation and the parties' acceptances and rejections in a sealed envelope and file the envelope with the clerk of the court in which a party filed a complaint pursuant to division (C) of this section or filed an order pursuant to division (D) of this section.

(F) Unless one or more parties accepts with limitation pursuant to division (B)(2) of section 2339.13 of the Revised Code, if opposing parties accept the arbitration panel's evaluation, the evaluation is binding on all accepting parties.

(G) After the chairperson of the panel sends copies of the parties acceptance or rejection as required under this section, the chairperson shall submit a report to the superintendent of insurance and supreme court of Ohio that includes a summary of the arbitration proceedings, the date the notice of intent to file a complaint was given pursuant to section 2339.03 of the Revised Code, and the date the panel rendered an evaluation pursuant to section 2339.12 of the Revised Code.

Sec. 2339.15. (A) If a party rejects all or any of the arbitration panel's evaluation, the claim proceeds to trial as described in division (C) of section 2339.14 of the Revised Code, and the court's verdict is not favorable to the rejecting party, the rejecting party shall pay an opposing party's actual costs in addition to any damages the court orders the rejecting party to pay.

(B) For purposes of this section, a verdict shall be adjusted by adding assessable costs and interest to the amount of the verdict from the date of filing of the complaint to the date of the evaluation's release.

(C) As used in this section, actual costs include, but are not limited to, those costs taxable in any civil action and reasonable attorney's fees.

Sec. 2339.16. If any person violates sections 2339.01 to 2339.15 of the Revised Code, the person aggrieved by the alleged violation may petition any court of common pleas having jurisdiction of the alleged violator for an order directing that the arbitration proceed in the manner provided for in sections 2339.01 to 2339.15 of the Revised Code. Five days' notice in writing of that petition shall be served upon the person allegedly in violation. Service of the notice shall be made in the manner provided for the service of a summons. If no jury trial is demanded as provided in this section, the court shall hear and determine if a violation occurred as alleged in the petition. Either party, on or before the return day of the notice of the petition, may demand a jury trial of the alleged violation. Upon the party's demand for a jury trial, the court shall make an order referring the alleged violation to a jury called and impaneled in the manner provided in civil actions. If the jury finds that the alleged violation did not occur, the proceeding shall be dismissed. If the jury finds that the alleged violation occurred, the court shall make an order summarily directing the parties to proceed with the arbitration in accordance with sections 2339.01 to 2339.15 of the Revised Code.

Section 2. That existing section 2305.113 of the Revised Code is hereby repealed.

Section 3. Sections 2339.01, 2339.02, 2339.03, 2339.04, 2339.05, 2339.06, 2339.07, 2339.08, 2339.09, 2339.10, 2339.11, 2339.12, 2339.13, 2339.14, 2339.15, and 2339.16 of the Revised Code are hereby repealed, effective ten years after the effective date of this act.

Section 4. In connection with all actions based upon medical negligence claims that accrue during a period commencing on the

effective date of this act and expiring nine years thereafter, the operation of sections 2711.21, 2711.22, 2711.23, and 2711.24 of the Revised Code is suspended. All actions based upon medical negligence claims accruing during this period shall be subject to the operation of Chapter 2339. of the Revised Code. Upon the expiration of such period of suspension, sections 2711.21, 2711.22, 2711.23, and 2711.24 of the Revised Code, in either the present form of such sections or as they are hereafter amended, again become fully operational as to all actions based upon medical negligence claims accruing after the period of suspension.

Section 5. The General Assembly hereby respectfully requests that the Supreme Court adopt rules regarding the applicability of the Rules of Civil Procedure to medical negligence arbitration under the provisions of this act.