IN THE SUPREME COURT OF OHIO

KATHLEEN MCCARTHY, et al., **Plaintiffs-Appellants,** **vs.** **PETER K. LEE, M.D., et al.,** **Defendants-Appellees.**	**Supreme Court Case No. 2022-0732** **On Appeal from the Franklin County Court of Appeals, Tenth Appellate District** **Court of Appeals Case No. 21AP-426**

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INTRODUCTION AND STATEMENT OF INTEREST OF AMICI CURIAE

The question at issue in this case is whether derivative loss of consortium claims, based upon an underlying medical negligence claim, can proceed against defendants where judgment has been granted in favor of defendants on the underlying medical negligence claim due to the medical claim statute of repose found at R.C. 2305.113(C). The Court's answer to this question will determine if Ohio should impose an unduly and unfair prolonged period of uncertainty upon its medical providers[1] which will have a significant, detrimental impact on those providers and, ultimately, on all Ohioans, a scenario that defeats the exact purpose of a statute of repose.

The Ohio Association of Civil Trial Attorneys (OACTA) is a statewide organization comprised attorneys, corporate executives, and managers who defend civil lawsuits. OACTA has a strong interest in obtaining certainty and finality as to potential litigation against medical providers, as well as business owners, who comprise an important portion of the clients represented and defended by its members. The Tenth District Court of Appeals' decision correctly held that such derivative loss of consortium claims cannot proceed against Appellees where judgment was granted in Appellees' favor on the underlying medical negligence claim based upon the medical claim statute of repose at R.C. 2305.113(C). *McCarthy v. Lee*, 10th Dist. No. 21AP-426, 2022-Ohio-1413. In so holding, certainty and finality relative to derivative loss of consortium claims against medical providers continues to be properly maintained under Ohio law.

However, a reversal of the Tenth District's decision will upend this certainty, subjecting Ohio's medical providers to the perpetual threat of litigation of loss of consortium claims dating back several decades and resulting in an adverse impact on them—and, ultimately, their patients—

[1] "Medical providers" as used herein refers to hospitals, health systems, physicians, medical residents, nurse practitioners, nurses, and other health care providers.

that cannot be overstated. Indeed, under this constant menace of litigation, the best and most talented medical providers may well choose to leave the state of Ohio and practice elsewhere, which will only serve to negatively impact the health care and quality of life of all Ohioans.

And the ramifications of reversing the Tenth District's decision will very likely not end with the medical claim statute of repose. It is not unreasonable to suggest that the door will be opened to a potential flood of derivative loss of consortium claims—dating back several decades—related to, for instance, the construction statute of repose and product liability statute of repose. If that were to happen, particularly in combination with an already unsteady and floundering economy, established businesses may choose to leave Ohio for other venues where they are not subject to an ongoing threat of litigation going back decades. Moreover, new business owners will be reluctant to open operations here, electing instead to start companies elsewhere. The unfortunate result will be the loss of economic growth and job opportunities for all Ohioans.

Therefore, and as outlined further below, Amici respectfully urges this Court to affirm the Tenth District's decision dismissing Appellants' claims.

STATEMENT OF THE CASE

Amici hereby respectfully defers to and adopts the Statement of the Case presented by Appellees.

STATEMENT OF FACTS

Amici hereby respectfully defers to and adopts the Statement of Facts presented by Appellees.

LAW AND ARGUMENT

AMICI PROPOSITION OF LAW NO. 1:

A derivative loss of consortium claim, based upon an underlying medical negligence claim, cannot proceed against a defendant where judgment has been granted in favor of said defendant on the underlying medical negligence claim due to the medical claim Statute of Repose found at R.C. 2305.113(C).

A. This Court's Affirmance of the Decision of the Tenth District Will Maintain the General Assembly's Meaningful Policy Goals Relative to the Medical Claim Statute of Repose.

In 2003, R.C. 2305.113(C) was enacted through Senate Bill 281, which outlines the General Assembly's policy considerations in so doing. The General Assembly noted 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 practitioners." Am.Sub.S.B. No. 281, Section 3(A)(6)(a). The General Assembly further listed various reasons why a medical claim statute of repose is critical and necessary for all Ohioans, including:

> (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 providers.
>
> (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.

Id. at Section 3(A)(6)(b)-(e).

This Court has previously recognized that a medical claim statute of repose is crucial because a constant threat of litigation against medical providers is unjust and unfair. As this Court opined in *Ruther v. Kaiser*, in which the medical claim statute of repose was held to be constitutional:

> **Just as a plaintiff is entitled to a meaningful time and opportunity to pursue a claim, a defendant is entitled to a reasonable time after which he or she can be assured that a defense will not have to be mounted for actions occurring years before. The statute of repose exists to give medical providers certainty with respect to the time within which a claim can be brought and a time after which they may be free from the fear of litigation.**

134 Ohio St. 3d 408, 2012-Ohio-5686, 983 N.E.2d 291 at ¶ 19. (Emphasis added.)

As also previously recognized by this Court in *Ruther*, forcing medical providers to defend against claims that go back several decades presents numerous and significant litigation concerns, including:

> [t]he risk that evidence is unavailable through the death or unknown whereabouts of witnesses, the possibility that pertinent documents were not retained, the likelihood that evidence would be untrustworthy due to faded memories, the potential that technology may have changed to create a different and more stringent standard of care not applicable to the earlier time, the risk that the medical providers' financial circumstances may have changed—i.e., that practitioners have retired and no longer carry liability insurance, the possibility that a practitioner's insurer has become insolvent, and the risk that the institutional medical provider may have closed.

Id. at ¶ 20.

All of the foregoing is as true today as it was when this Court decided *Ruther* and applies equally to derivative loss of consortium claims as to primary medical claims. In particular, the lightning speed with which advances in medicine, science, and technology have occurred in even

the last few years, let alone in the last few decades, is proof positive that a medical statute of repose remains critical to ensure justice and fairness for all Ohioans.

To allow otherwise will create an environment of chaos and crisis for medical providers that will hurt not only them but ultimately **all** Ohioans. At first glance, it may seem like a benefit to Ohio's citizens to be afforded extremely prolonged opportunities to bring lawsuits based upon derivative loss of consortium claims at any given time over a period of decades. However, the reality is that such a "benefit" will come at a significant price. First, it is reasonably foreseeable that physicians, physician assistants, and nurse practitioners who are currently practicing in Ohio may well seek to establish a practice in other locations where they are not subject to the perpetual threat of litigation regarding medical care that occurred years or even decades earlier. Second, new and innovative medical providers—be it physicians, nurse practitioners, and even state of the art hospitals—will think twice before establishing themselves in Ohio in order to avoid an excessively prolonged threat of uncertainty relative to potential litigation. As a result, Ohioans will be deprived of the cutting-edge medical care that they deserve and need.

Moreover, the ramifications of reversing the Tenth District's decision does not end with the medical claim Statute of Repose. The door will be opened to a potential flood of derivative loss of consortium claims—dating back several decades—related to the construction Statute of Repose and product liability Statute of Repose. The resulting havoc that will be wreaked on Ohio's judicial system, as well as Ohio's business owners, suppliers, and manufacturers—and again, the citizens of Ohio—cannot be overstated. Under such circumstances, as with medical providers, it is very likely that businesses will leave Ohio for locations where they are not subject to litigation going back decades and new business owners will be unwilling to open operations here, resulting in economic losses for all Ohioans.

Amici respectfully urges this Court to consider the foregoing when reviewing the legal bases outlined below, which are succinctly outlined in even further detail in Appellees' Merit Brief, in support of an affirmance of the decision of the Tenth District.

B. The Failure of the Primary Claim Necessarily Results in the Failure of the Derivative Claim.

This Court has consistently held over the last fifty-plus years that a loss of consortium claim, no matter who brings the claim, is derivative of the underlying, primary claim. See *Whitehead v. Gen. Tel. Co.*, 20 Ohio St.2d 108, 112-13 (1969) (holding that a single wrong created, *inter alia*, "a derivative action in favor of the parents of the child for the loss of her services and her medical expenses"), *overruled on other grounds*, *Grava v. Parkman Township*, 73 Ohio St. 3d 379 (1995); see also *Tomlinson v. Skolnik*, 44 Ohio St.3d 11, 14 (1989) ("A claim for loss of consortium is a derivative action, deriving from a spouse's claim for bodily injury") (emphasis omitted), *overruled on other grounds*, *Schaefer v. Allstate Ins. Co.*, 76 Ohio St.3d 553 (1996). Under Ohio law, a derivative claim arises from or out of the existence of another claim. See, e.g., *Fehrenbach v. O'Malley*, 113 Ohio St.3d 18, 2007-Ohio-971, ¶ 11 (describing a loss of consortium claim as "a derivative action, arising from the same occurrence that produced the alleged injury to the other familial party"); see also, *Cross v. Cincinnati Ins. Co.*, 4th Dist. No. 02CA758, 2004-Ohio-328, ¶ 44 ("A 'derivative' action is one that derives from or is based on another claim. In other words, a 'derivative' claim is one that is said to 'arise from' or 'arise out of' the existence of another claim," quoting *Merriam-Websters Online Thesaurus*, 2002).

Because it is a derivative claim, a loss of consortium claim is dependent on the existence of the underlying, primary claim. As specifically held by this Court, "[a] derivative action clearly stems from a single accident or occurrence. **Indeed, the derivative actions would not exist but for the primary action.**" *Tomlinson*, *supra,* at 14. (Emphasis added.) See also, *Fehrenbach*,

supra, at ¶ 21 (holding that parents "cannot recover damages from defendants if defendants are found not to be liable for [the minor's] injury"); *Grindell v. Huber*, 28 Ohio St.2d 71, 75 (1971) ("Here, the action of the parent for medical expenses has been joined with the action of the minor for damages for personal injuries. Inasmuch as the parent's action is derivative, a defendant, if he is not liable for the minor's injuries, cannot be held accountable for the medical expenses arising therefrom.").

Accordingly, a derivative claim cannot grant greater rights than the primary claim. *Gearing v. Nationwide Ins. Co.*, 76 Ohio St.3d 34, 40-41 (1996) (holding that, because the parents' loss of consortium claims derived from the primary claim of their children, "[t]he parents' claims of insurance coverage are thus no greater than those of the . . . minors themselves"). As explained in detail in Appellees' Merit Brief, **each and every Ohio Appellate Court district has consistently applied these legal principles, resulting in the dismissal of a loss of consortium claim when the primary claim failed.** See, *McFadden v. Butler*, 1st Dist. No. C-120140, 2012 Ohio App. LEXIS 5326, at *4 (Dec. 26, 2012); *Miller v. Xenia*, 2d Dist. No. 2001 CA 82, 2002 Ohio App. LEXIS 1315, at *9 (Mar. 22, 2002); *Voisard v. Noble*, 3d Dist. No. 2-88-21, 1990 Ohio App. LEXIS 666, at *15 (Feb. 23, 1990); *Mender v. Village of Chauncey*, 2015-Ohio-4105, 41 N.E.3d 1289, ¶ 2 (4th Dist.); *Burchard v. Ashland Cty. Bd. of Dev. Disabilities*, 2018-Ohio-4408, 122 N.E.3d 266, ¶ 33 (5th Dist.); *Hurt v. Cyclops Corp.*, 6th Dist. No. L-90-163, 1991 Ohio App. LEXIS 1167, at *4 (Mar. 22, 1991); *Schneider v. Morse*, 7th Dist. No. 637, 1995 Ohio App. LEXIS 3604, at *11 (Aug. 30, 1995); *Turk v. Novacare Rehab. of Ohio*, 8th Dist. No. 94635, 2010-Ohio-6477, ¶ 39; *Young v. Zukowski*, 9th Dist. No. 25146, 2010-Ohio-3491, ¶ 13; *Keller v. Foster Wheel Energy Corp.*, 163 Ohio App.3d 325, 2005-Ohio-4821, ¶ 19 (10th Dist.); *Baker v. J.I.G.S. Invests.,*

Inc., 11th Dist. No. 2010-T-0045, 2010-Ohio-5180, ¶ 27; *Cramton v. Brock*, 12th Dist. No. CA91-05-011, 1992 Ohio App. LEXIS 1285, at *15 (Mar. 23, 1992).

Here, the primary claim upon which Appellants' loss of parental consortium claim derives was properly dismissed pursuant to the medical claim Statute of Repose. Under long-standing Ohio law, without the requisite primary claim, which was dismissed and is not on appeal here, Appellants' derivative claims for loss of parental consortium are barred from proceeding. Accordingly, this Court should affirm the decision of the Tenth District Court of Appeals.

C. Despite Appellants' Claims Otherwise, Res Judicata, the Statute of Limitations, and Contractual Releases Are Not Exceptions to the General Rule that Failure of the Primary Claim Necessarily Results in the Failure of the Derivative Claim.

Despite Appellants' contentions to the contrary, and as outlined below, res judicata, the statute of limitations, and contractual releases are not exceptions or limitations to the general rule that a derivate claim fails when a primary claim fails.

1. Res Judicata Is Not at Issue Here and Moreover Does Not Create an Exception to the General Rule.

Res judicata is not at issue in this matter. Nonetheless, Appellants attempt to utilize the concept of res judicata, arguing that where a primary claim fails due to res judicata, a loss of consortium claim may continue, and citing to the case of *Kraut v. Cleveland Ry. Co.*, 132 Ohio St. 125 (1936) as instructive. In *Kraut*, a married woman filed suit against the defendant for alleged injuries incurred while riding a rail car; the defendant prevailed at trial. Thereafter, her husband filed a claim for "loss of services and medical expenses" arising from the rail car accident. Under the doctrine of res judicata, the Court held that the husband's claims were not barred because the husband and wife had presented separate causes of action and no privity existed between them.

Id. at 127. Despite Appellants' contentions otherwise, and in light of subsequent case law that is explained below, the *Kraut* holdings are questionable at best.

First, in *Whitehead, supra,* the issue of a derivative loss of consortium claim in the context of res judicata was examined. This Court held that a judgment extinguishing a parental loss of child consortium claim did not bar, on res judicata or collateral estoppel grounds, the primary claim of the child, and that the parent-child relationship did not create privity for res judicata purposes. 20 Ohio St.2d 108 (1969) at syl. ¶¶ 4-5, *overruled on other grounds, Grava v. Parkman Township*, 73 Ohio St. 3d 379 (1995).

Second, in *Grava, supra,* this Court ruled that "[a] valid, final judgment rendered upon the merits bars all subsequent actions based upon ***any claim*** arising out of the transaction or occurrence that was the subject matter of the previous action." *Id.* at syl. (Emphasis added.) Res judicata applies both to those in privity with the litigants and also "to those who could have entered the proceeding but did not avail themselves of the opportunity." *State ex rel. Schachter v. Ohio Pub. Emples. Retirement Bd.*, 121 Ohio St.3d 526, 2009-Ohio-1704 ¶ 35 (quoting *Howell v. Richardson*, 45 Ohio St.3d 365, 367 (1989)). Privity includes the concept of mutuality of interest, including an identity of a desired result. *Id.* ¶ 34.

As such, the holding of *Kraut* is in serious question. Certainly, the husband and wife in that matter shared a mutuality of interest of the desired result, i.e., a finding of the defendant's negligence, and certainly their claims, while separate and distinct, arose from the same transaction and occurrence, i.e., the alleged injuries incurred by the wife while riding the rail car. Indeed, as this Court held in *Fehrenbach v. O'Malley*, primary and derivative claims holders have a shared interest in the underlying claim as the parents "cannot recover damages from defendants if defendants are found not to be liable for" the child's injury. 113 Ohio St.3d 18, 2007-Ohio-971 at

¶ 21. Moreover, Civil Rule 19.1requires that derivative claims for loss of consortium be filed with the primary claim, including a loss of parental consortium claim. *Id.* at ¶¶ 17-20; *see also* Civ.R. 19.1(A).

Accordingly, *Kraut* simply does not create an exception or limitation to the general rule that a derivative claim fails where the primary claim fails. Even assuming, *arguendo*, that it did, *Kraut* has been overruled by subsequent case law that Appellants have completely overlooked (or ignored) in their analysis. And, even if *Kraut* remained good law (which it does not), the decision fails to support Appellants because the concepts of res judicata are simply not at issue here.

2. The Statute of Limitations Does Not Create an Exception to the General Rule.

As explained below, a derivative claim for loss of consortium does not have a different statute of limitations than the primary claim. And, even assuming, *arguendo*, that it did, such an exception to the general rule would inapplicable here because the primary claim in this case failed due to the statute of repose.

The statute of repose was amended to include derivative claims for loss of consortium within the definition of a "medical claim" for purposes of the one-year statute of limitations. See *Shadler v. Purdy*, 64 Ohio App.3d 98, 104 (6th Dist. 1989).[2] The current version of R.C. 2305.113 also includes derivative claims within the definition of medical claims. *See* R.C. 2305.113(E)(3)(a). Under the plain language of the statute, both the primary and derivative claims relative to medical claims must be filed within one year of the accrual date. R.C. 2305.113(A). See *Flowers v. Walker*, 63 Ohio St.3d 546, 547 n.1 (1992); see also *Hershberger v. Akron City Hosp.*, 34 Ohio St.3d 1, 6 (1987).

[2] The appellate court in *Shadler* noted that, prior to this amendment, derivative claims had a different statute of limitation than primary medical claims. 64 Ohio App.3d at 104.

Appellants contend that, because the statute of repose does not specifically denote "minors" in the list of those persons whose claims comprise derivative claims for relief, then a minor's loss of parental consortium claim is thereby excluded as a derivative claim for relief. However, R.C. 2305.113(E)(7) defines "derivative claims for relief" as follows:

> (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.

Id. 7(a)-(b) (emphasis added). The statutory phrase of "including but not limited to" is key in the analysis of the statute, as under Ohio law, that phrase "means that the examples expressly given are 'a non-exhaustive list of examples.'" *State ex rel. Clay v. Cuyahoga Cnty. Med. Exam'rs Office*, 152 Ohio St. 3d 163, 2017-Ohio-8714 at ¶ 35. Such "[e]xamples are typically intended to provide illustrations of a term defined in the statute, ***but do not act as limitations on that term***." *Colbert v. City of Cleveland*, 99 Ohio St.3d 215, 2003-Ohio-3319, ¶ 14. (Emphasis added.) (Citation and punctuation omitted.)

Moreover, this Court has defined a loss of parental consortium claim to include the same types of damages that are set forth under R.C. 2305.113(E)(7)(a). In *Gallimore v. Children's Hosp. Med. Ctr.*, 67 Ohio St.3d 244, 255 (1993), the Court stated that ". . . a minor child has a cause of action for loss of parental consortium . . . [which] includes society, companionship, affection, comfort, guidance and counsel." Similarly, in R.C. 2305.113(E)(7)(a), the damages include "[l]oss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss. . ."). See also *Barley v. Hearth & Care of Greenfield, LLC*, 4th Dist. No. 12CA13, 2013-Ohio-279, ¶ 16.

As such, it is axiomatic that a minor's claim for loss of parental consortium would constitute a derivative claim for relief under R.C. 2305.113(E)(7) and, therefore, constitute a medical claim under the statute. Thus, pursuant to R.C. 2305.113(A), a primary medical claim and a derivative claim for loss of consortium – whether brought by, *inter alios*, a parent, spouse, child, or minor – both have the same statute of limitations period. This holding is in harmony with the concept expressed by this Court that a minor's claim for loss of parental consortium must be brought with the parent's primary claim. *Fehrenbach*, *supra,* 113 Ohio St.3d ¶ 17.

Accordingly, Appellants have not—and indeed, cannot—point to any scenario in which a derivative claim for loss of consortium will have a different statute of limitation than the primary claim. Even if the Court determines otherwise, this case does not rest upon such an issue because the primary claim in this case failed due to the statute of repose.

3. Contractual Releases Are Not at Issue Here and Moreover Do Not Create an Exception to the General Rule.

A contractual release is not at issue here. Despite that fact, Appellants mistakenly argue that a contractual release is an exception to the general rule that the failure of the primary claim results in the failure of a derivative claim.

In making their arguments in this regard, Appellants rely on the case of *Bowen v. Kil-Kare, Inc.*, 63 Ohio St.3d 84 (1992). As aptly explained by Appellees in their Merit Brief, which Amici respectfully defers to and adopts herein, the statements regarding the impact of the release/waiver to the loss of consortium claims in *Bowen* were dicta or advisory in nature and thus lack precedential authority. Accordingly, *Bowen* does not create an exception to the general rule related to primary and derivative claims. And, even if the holding in *Bowen* was not dicta, this case does not involve a contractual release/waiver, so such an exception has no role in this matter.

D. Even If Exceptions or Limitations Exist to the General Rule, They Are Inapplicable When the Primary Claim Is Dismissed Under the Statute of Repose.

Even if exceptions or limitations to the General Rule exist, including an exception/limitation related to the statute of limitation, when a primary claim is dismissed under the statute of repose, a derivative claim should be subject to dismissal as a matter of law because 1) the express language of the statute of repose makes it applicable to a derivative claim for loss of consortium (including a minor's loss of parental consortium claim) and 2) the statute of repose and the statute of limitations are not the same in function or effect.

1. The Plain Language of the Statute of Repose Makes Clear that It Applies to Derivative Claims for Loss of Consortium.

The plain language of the medical claim statute of repose makes clear that it is applicable to a derivative claim for loss of consortium:

> (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 . . . claim ***shall be commenced more than four years after the occurrence of the act or omission*** constituting the alleged basis of the medical . . . claim.

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

R.C. 2305.113 (Emphasis added.) As this Court has held, the medical claim statute of repose "is clear, unambiguous, and **means what it says**." *Antoon v. Cleveland Clinic Found.*, 148 Ohio St.3d 483, 2016-Ohio-7432 at ¶ 23. (Emphasis added.) As such, when the statute clearly and unambiguously says that "no action" upon a medical claim "shall be commenced" more than four years after the alleged negligent act, then that is precisely what the statute means. *Id.* Further, when the statute clearly and unambiguously says that, if a medical claim is not commenced within four years of the date of the alleged negligent act, then "any action upon that claim is barred," then that is precisely what the statute means. *Id.*

A derivative claim for loss of consortium, including a minor's loss of parental consortium claim, constitutes a medical claim, and as such, it is axiomatic that Appellants' claims are barred under R.C. 2305.113(C)(1). Further, even if the Court determines that a minor's derivative claim for loss of parental consortium is a not a medical claim, a claim for loss of parental consortium unquestionably constitutes "any action upon" a medical claim, thereby barring the claim under R.C. 2305.113(C)(2) if it is filed beyond four years after the alleged negligent act.

The first phrase of R.C. 2305.113(C) states "[e]xcept as to persons within the age of minority . . . as provided by section 2305.16 of the Revised Code," which Appellants argue results in an exception to the application of the medical statute of repose to a minor's claim for loss of parental consortium. However, this argument is incorrect. Rather, this language within the statute only applies to a **primary claim** held by a minor, **not a derivative claim** for loss of parental consortium held by a minor. As noted by the Tenth District, "[t]he fact that the medical claim statute of repose would not bar a principal medical claim brought by a minor is of no consequence

here" where the minors "asserted a derivative claim based upon their mother's underlying medical claim." *McCarthy*, 2022-Ohio-1413, ¶ 11.

While the General Assembly created an exception to the medical claim statute of repose with respect to a minor's ***primary claim*****,** Ohio law is clear that ***a derivative claim cannot grant greater rights than the primary claim***. See *Wilson v. Durrani*, 164 Ohio St. 3d 419, 2020-Ohio-6827, 173 N.E.3d 448 at ¶ 29; see also *Gearing*, *supra,* 76 Ohio St.3d at 40-41. Without a primary claim, there cannot be a derivative claim. *Cross, supra*, 2004-Ohio-328 at ¶ 44. Accordingly, Appellants' claim is barred because (i) the primary claim was barred by the medical claim statute of repose, (ii) Appellants' claim is derivative of the primary claim, and (iii) a derivative claim cannot survive once the primary claim is extinguished.

2. The Statute of Repose and the Statute of Limitations Are Different.

Despite Appellants' contentions otherwise, the statutes of repose and limitation are different in both function and effect. This Court should thus refuse to limit or create an exception or limitation to the general rule where the primary claim is dismissed due to the statute of repose.

This Court has previously distinguished the statute of repose from the statute of limitations, which are "distinct" from each other. *Wilson, supra,* at ¶ 7. The statutes "operate differently and have distinct applications." *Id.* ¶ 8. A statute of limitation "operates on the remedy, not on the existence of the cause of action itself;" a statute of repose "bars the claim – the right of action – itself" even if application of the statute of repose "ends before the plaintiff has suffered a resulting injury" *Id.* ¶ 9 (citation omitted). *See also Mominee v. Scherbarth*, 28 Ohio St.3d 270, 290 n.17 (1986) (Douglas, J., concurring) ("A statute of repose . . . is an absolute bar to a cause of action ever arising."). A statute of limitations requires diligence on the part of a plaintiff, whereas a statute of repose "emphasize[s] a defendant's entitlement to be free from liability after a

legislatively determined time." *Wilson*, *supra,* ¶ 10. Indeed, "[a] statute of repose confers on a defendant a personal privilege of sorts, in the form of an immunity from further liability." *Elliot v. Durrani*, 2021-Ohio-3055, 178 N.E.3d 977, ¶ 24 (1st Dist.) (quoting *Secy., United States Dept. of Labor v. Preston*, 873 F.3d 877, 884 (11th Cir. 2017)); see also *Mominee*, *supra,* at 290 (Douglas, J., concurring) ("The effect of a statute of repose, at least in the medical malpractice area, is to reduce the doctor's exposure to liability by granting to him immunity from suit after the limitations period has run.").

A claim for loss of consortium depends upon "the defendant's having committed a legally cognizable tort upon the spouse who suffers bodily injury." *Bowen,* 63 Ohio St.3d at 93. "Cognizable" has been defined as "[c]apable of being judicially tried or examined before a designated tribunal; within the court's jurisdiction." *Black's Law Dictionary* 253 (7th Ed. 1999). Where a primary claim fails as a matter of law, there is no longer a "legally cognizable tort" upon which a derivative claim can be based because the primary claim is no longer capable of being heard or decided by a court. See *McClary v. M/I Schottenstein Homes, Inc.*, 10th Dist. No. 03AP-777, 2004-Ohio-7047, ¶ 64 (finding that defendant owed no legal duty to plaintiff and, therefore, under *Bowen* the loss of consortium claim failed). See also *Johnson v. Ohio Dept. of Rehab. & Correction*, 10th Dist. No. 02AP-1428, 2003-Ohio-4512, ¶ 19 ("Because plaintiffs failed to prove ODRC committed a tort against plaintiff, their consortium claim also fails."); see also *Ma v. Bon Appétit Mgt. Co.,* 785 Fed. App'x 293, 294 n.1 (6th Cir. 2019) (citing *Bowen* and dismissing loss of consortium claim because the primary claim was dismissed as a matter of law) and *Courie v. Alcoa Wheel & Forged Prods.*, 577 F.3d 625, 633 (6th Cir. 2009) (citing *Bowen* and dismissing loss of consortium claim because "we have rejected all of Mr. Courie's other tort claims").

When a primary claim is barred by the statute of repose, a "legally cognizable tort" no longer exists. As this Court stated in *Wilson, supra,* the statute of repose bars the right of action itself. 164 Ohio St.3d ¶ 9. Justice Douglas went further in *Mominee, supra,* stating that the statute of repose bars the cause of action from "ever arising." 28 Ohio St.3d at 290. Accordingly, then, the primary claim cannot result in a legally cognizable tort – the claim will never be or become capable of adjudication by a court. Therefore, under *Bowen*, a derivative claim for loss of consortium is untenable. The Tenth District recognized this precise outcome based upon this Court's definition of the impact of the statute of repose:

> [T]he statute of repose eliminates the cause of action. Without a primary claim, there can be no derivative loss of consortium claim. Permitting a derivative loss of consortium claim where the underlying claim from which it is derived no longer exists would be inconsistent with this basic [principle]."

McCarthy, 2022-Ohio-1413, ¶ 9.

Therefore, even if other exceptions or limitations to the general rule exist, this Court should decline to create another one where the primary claim fails due to the statute of repose.

CONCLUSION

For all of the foregoing reasons, Amici respectfully urges this Court to affirm the decision of the Tenth District Court of Appeals in *McCarthy v. Lee,* 10th Dist. No. 21AP-426, 2022-Ohio-1413, and reject Appellants' arguments. As Appellants' primary claim was dismissed as a matter of law pursuant to the medical claim statute of repose, Appellants' derivative claim for loss of parental consortium likewise fails, and no exceptions or other limitations apply to change this outcome.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing has been sent, via electronic mail, on this 29th day of November 2022, to the following counsel of record:

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APPENDIX

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(124th General Assembly)
(Amended Substitute Senate Bill Number 281)

AN ACT

To amend sections 1751.67, 2117.06, 2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, and 5111.018, to enact sections 2303.23, 2305.113, 2323.41, 2323.42, 2323.43, 2323.55, 3929.88, and to repeal sections 2305.27 and 2323.57 of the Revised Code relative to medical claims, dental claims, optometric claims, and chiropractic claims.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 1751.67, 2117.06, 2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, and 5111.018 be amended and sections 2303.23, 2305.113, 2323.41, 2323.42, 2323.43, 2323.55, and 3929.88 of the Revised Code be enacted to read as follows:

Sec. 1751.67. (A) Each individual or group health insuring corporation policy, contract, or agreement delivered, issued for delivery, or renewed 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:

(1) The policy, contract, or agreement 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 policy, contract, or agreement 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 provider 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 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.

(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.

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

(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;

(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, 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;

(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;

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

(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 Code.

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:

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

(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 statement or memorandum of the fact and date of the allowance.

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

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

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

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

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

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

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

Sec. 2303.23. (A) Before the fifteenth day of January, April, July, and October of each year, every clerk of a court of common pleas in this state shall send to the department of insurance a quarterly report containing all of the following information relating to each civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim that was filed or is pending in that court of common pleas:

(1) The style and number of the case;

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

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

(4) The current status of the case;

(5) Whether or not the parties have agreed on a settlement of the case;

(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;

(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.

(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 quarterly 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.

(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.

(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.

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 action accrued, provided that an action by an employee for the payment of unpaid minimum wages, unpaid overtime compensation, or liquidated damages by reason of the nonpayment of minimum wages or overtime compensation shall be commenced within two years after the cause of action accrued.

(B)~~(1) Subject to division (B)(2) of this section, an action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued, except that, if prior to the expiration of that one-year period, 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.~~

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

~~(a) In no event shall any action upon a medical, dental, optometric, or chiropractic claim 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.~~

~~(b) 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, notwithstanding the time when the action is determined to accrue under division (B)(1) of this section, any action upon that claim is barred.~~

~~(C)~~ A civil action for unlawful abortion pursuant to section 2919.12 of the Revised Code, a civil action authorized by division (H) of section 2317.56 of the Revised Code, a civil action pursuant to division (B)(1) or (2) of section 2307.51 of the Revised Code for performing a dilation and extraction procedure or attempting to perform a dilation and extraction procedure in violation of section 2919.15 of the Revised Code, and a civil action pursuant to division (B)(1) or (2) of section 2307.52 of the Revised Code for terminating or attempting to terminate a human pregnancy after viability in violation of division (A) or (B) of section 2919.17 of the Revised Code shall be commenced within one year after the performance or

inducement of the abortion, within one year after the attempt to perform or induce the abortion in violation of division (A) or (B) of section 2919.17 of the Revised Code, within one year after the performance of the dilation and extraction procedure, or, in the case of a civil action pursuant to division (B)(2) of section 2307.51 of the Revised Code, within one year after the attempt to perform the dilation and extraction procedure.

~~(D)~~(C) 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 thereof. "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 registered nurse or physical therapist, 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 apply:~~

~~(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 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. "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 chiropractic examining 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~~, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

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

(B)(1) 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.

(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) Subject to division (D)(2) of this section, 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 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, in the exercise of reasonable care and diligence, discovered or should have discovered the injury resulting from that act or omission.

(2) 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.

(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 four-year period described in division (D)(1) of this section or the three-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 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. "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 chiropractic examining 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, or certified registered nurse anesthetist, or a certified nurse-midwife certified by the board of nursing under section 4723.41 of the Revised Code.

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

(18) "Physician assistant" means any person who holds a valid certificate of registration or temporary certificate of registration 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. 2305.15. (A) When a cause of action accrues against a person, if ~~he~~ the person is out of the state, has absconded, or conceals ~~himself~~ self, the period of limitation for the commencement of the action as provided in sections 2305.04 to 2305.14, 1302.98, and 1304.35 of the Revised Code does not begin to run until ~~he~~ the person comes into the state or while ~~he~~ the person is so absconded or concealed. After the cause of action accrues if ~~he~~ the person departs from the state, absconds, or conceals ~~himself~~ self, the time of ~~his~~ the person's absence or concealment shall not be computed as any part of a period within which the action must be brought.

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

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

(1) "Chiropractic claim," "medical claim," and "optometric claim" have the same meanings as in section ~~2305.11~~ 2305.113 of the Revised Code.

(2) "Dental claim" has the same meaning as in section ~~2305.11~~ 2305.113 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.

(3) "Governmental health care program" has the same meaning as in section 4731.65 of the Revised Code.

(4) "Health care professional" means any of the following who provide medical, dental, or other health-related diagnosis, care, or treatment:

(a) Physicians authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(b) Registered nurses, advanced practice nurses, and licensed practical nurses licensed under Chapter 4723. of the Revised Code;

(c) Physician assistants authorized to practice under Chapter 4730. of the Revised Code;

(d) Dentists and dental hygienists licensed under Chapter 4715. of the Revised Code;

(e) Physical therapists licensed under Chapter 4755. of the Revised Code;

(f) Chiropractors licensed under Chapter 4734. of the Revised Code;

(g) Optometrists licensed under Chapter 4725. of the Revised Code;

(h) Podiatrists authorized under Chapter 4731. of the Revised Code to practice podiatry;

(i) Dietitians licensed under Chapter 4759. of the Revised Code;

(j) Pharmacists licensed under Chapter 4729. of the Revised Code;

(k) Emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under Chapter 4765. of the Revised Code.

(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.

(6) "Indigent and uninsured person" means a person who meets all of the following requirements:

(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.

(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.

(c) Either of the following applies:

(i) The person is not a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan.

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

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

(8) "Nonprofit shelter or health care facility" means a charitable nonprofit corporation organized and operated pursuant to Chapter 1702. of

he Revised Code, or any charitable organization not organized and not operated for profit, that provides shelter, health care services, or shelter and health care services to indigent and uninsured persons, except that "shelter or health care facility" does not include a hospital as defined in section 3727.01 of the Revised Code, a facility licensed under Chapter 3721. of the Revised Code, or a medical facility that is operated for profit.

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

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

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

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

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

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

(c) Obtain the informed consent of the person and a written waiver, signed by the person or by another individual on behalf of and in the presence of the person, that states that the person is mentally competent to give informed consent and, without being subject to duress or under undue influence, gives informed consent to the provision of the diagnosis, care, or treatment subject to the provisions of this section.

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

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

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

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

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

(b) Performance of an operation.

(c) Delivery of a baby.

(2) Division (E)(1) of this section does not apply to an individual who provides, or a nonprofit shelter or health care facility at which the individual provides, diagnosis, care, or treatment that is necessary to preserve the life

of a person in a medical emergency.

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

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

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

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

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

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

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

(B)(1) A physician or a dentist concerning a communication made to the physician or dentist by a patient in that relation or the physician's or dentist's advice to a patient, except as otherwise provided in this division, division (B)(2), and division (B)(3) of this section, and except that, if the patient is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the physician may be compelled to testify on the same subject.

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

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

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

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

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

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

(c) In any criminal action concerning any test or the results of any test that determines the presence or concentration of alcohol, a drug of abuse, or alcohol and a drug of abuse in the patient's blood, breath, urine, or other bodily substance at any time relevant to the criminal offense in question.

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

(2)(a) If any law enforcement officer submits a written statement to a health care provider that states that an official criminal investigation has begun regarding a specified person or that a criminal action or proceeding

has been commenced against a specified person, that requests the provider to supply to the officer copies of any records the provider possesses that pertain to any test or the results of any test administered to the specified person to determine the presence or concentration of alcohol, a drug of abuse, or alcohol and a drug of abuse in the person's blood, breath, or urine at any time relevant to the criminal offense in question, and that conforms to section 2317.022 of the Revised Code, the provider, except to the extent specifically prohibited by any law of this state or of the United States, shall supply to the officer a copy of any of the requested 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.

(b) If the testimonial privilege described in division (B)(1) of this section does not apply to a physician or dentist as provided in division (B)(1)(c) of this section, the physician or dentist, in lieu of personally testifying as to the results of the test in question, may submit a certified copy

of those results, 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 results 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 in question, the person under whose supervision the test was administered, the custodian of the results of the test, the person who compiled the results, or the person under whose supervision the results were compiled.

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

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

(b) As used in division (B)(2) of this section, "health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.

(c) As used in division (B)(5)(b) of this section:

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

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

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

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

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

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

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

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

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

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

(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;

(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.

(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:

(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.

(b) The client gives express consent to the testimony.

(c) If the client is deceased, the surviving spouse or the executor or administrator of the estate of the deceased client gives express consent.

(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.

(e) The court in camera determines that the information communicated by the client is not germane to the counselor-client or social worker-client relationship.

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

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

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

(H) A mediator acting under a mediation order issued under division (A) of section 3109.052 of the Revised Code or otherwise issued in any

oceeding for divorce, dissolution, legal separation, annulment, or the allocation of parental rights and responsibilities for the care of children, in any action or proceeding, other than a criminal, delinquency, child abuse, child neglect, or dependent child action or proceeding, that is brought by or against either parent who takes part in mediation in accordance with the order and that pertains to the mediation process, to any information discussed or presented in the mediation process, to the allocation of parental rights and responsibilities for the care of the parents' children, or to the awarding of parenting time rights in relation to their children;

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

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

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

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

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

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

(2) If the testimonial privilege described in division (J)(1) of this section

does not apply as provided in division (J)(1)(c) of this section, a chiropractor may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the chiropractor by the patient in question in that relation, or the chiropractor'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.

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

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

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

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

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

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

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

Any use of a consent form that fulfills the requirements 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 same 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 subrogated to the rights of the plaintiff against a defendant.

(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.

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

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

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

(2) Reasonably relied upon the results of that review in supporting the assertion of the particular claim;

(3) Had an opportunity to conduct a pre-suit investigation or was afforded by the defendant full and timely discovery during litigation;

(4) Reasonably relied upon evidence discovered during the course of litigation in support of the assertion of the claim in question;

(5) Took appropriate and reasonable steps to timely dismiss any defendant on behalf of whom it was alleged or determined that no reasonable good faith basis existed for continued assertion of the claim in question.

(C) If the court determines that there was no reasonable good faith basis upon which the plaintiff asserted the claim in question against the moving defendant or that, at some point during the litigation, the plaintiff lacked a good faith basis for continuing to assert that claim, the court shall award all of the following in favor of the moving defendant:

(1) All court costs incurred by the moving defendant;

(2) Reasonable attorneys' fees incurred by the moving defendant in

defense of the claim after the time that the court determines that no reasonable good faith basis existed upon which to assert or continue to assert the claim;

(3) Reasonable attorneys' fees incurred in support of the good faith motion.

(D) Prior to filing a good faith motion as described in division (A) of this section, any defendant that intends to file that type of motion shall serve a "notice of demand for dismissal and intention to file a good faith motion." If, within fourteen days of service of that notice, the plaintiff dismisses the defendant from the action, the defendant after the dismissal shall be precluded from filing a good faith motion as to any attorneys' fees and other costs subsequent to the dismissal.

(E) 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.

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

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

(2) Except as otherwise provided in division (A)(3) of this section, the amount of compensatory damages that represents damages for noneconomic loss that is recoverable by each plaintiff in a civil action upon a medical, dental, optometric, or chiropractic claim, which includes related derivative claims, to recover damages for injury, death, or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of five hundred thousand dollars.

(3) The amount recoverable for noneconomic losses by each plaintiff for each medical claim, dental claim, optometric claim, or chiropractic claim, which includes related derivative claims, may exceed the amount described in division (A)(2) of this section but shall not exceed the greater of one million dollars or fifteen thousand dollars times the number of years remaining in the injured person's expected life if the noneconomic losses of the plaintiff are for either of the following:

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

(b) Permanent physical functional injury that permanently prevents the

injured person from being able to independently care for the injured person's self and perform life sustaining activities.

(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:

(1) The total compensatory damages recoverable by the plaintiff;

(2) The portion of the total compensatory damages that represents damages for economic loss;

(3) The portion of the total compensatory damages that represents damages for noneconomic loss.

(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.

(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.

(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.

(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.

mount of compensatory damages that that tortfeasor would otherwise be responsible for under the laws of this state.

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

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

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

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

(G) As used in this section:

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

(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;

(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;

(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.

(2) "Medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

(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.

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

Sec. 2323.55. (A) As used in this section:

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

(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;

(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;

(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.

(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.

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

(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.

(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.

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

(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:

(1) The past damages recoverable by that plaintiff;

(2) The future damages recoverable by that plaintiff.

(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.

(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 future damages recoverable by the plaintiff shall be received by the plaintiff 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 future damages recoverable by the plaintiff shall be received by the plaintiff 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;

(c) The age of that plaintiff;

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

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

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

(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 future damages recoverable by the plaintiff shall be received by the plaintiff in a series of periodic payments rather than in a lump sum. If the court determines that a plaintiff shall receive the future damages recoverable by the plaintiff in a series of periodic payments, it may order the payments only as to the amount of the future damages recoverable by the plaintiff that exceeds fifty thousand dollars. If the court determines that the plaintiff shall receive the future damages recoverable by the plaintiff in a lump sum, the future damages shall be paid in a lump sum.

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

(1) Within twenty days after the court makes that determination, the plaintiff shall submit a periodic payments plan to the court. The 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.

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

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

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

(G)(1) The court, in its discretion, may modify, approve, or reject any submitted periodic payments plan. In approving any periodic payments plan, the court shall require 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.

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

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

(b) An insurance company that the superintendent of insurance, under rules adopted pursuant to Chapter 119. of the Revised Code for purposes of implementing this division, determines is licensed to do business in this state and, considering the factors described in this division, is a stable insurance company that issues annuities that are safe and desirable. In making determinations as described in this division, the superintendent shall be guided by the principle that annuities should be safe and desirable for plaintiffs who are awarded damages. In making those determinations, the superintendent shall consider the financial condition, general standing, operating results, profitability, leverage, liquidity, amount and soundness of reinsurance, adequacy of reserves, and the management of any insurance company in question and also may consider ratings, grades, and classifications of any nationally recognized rating services of insurance companies and any other factors relevant to the making of such determinations.

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

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

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

(I) If a court orders a series of periodic payments of future damages in

accordance with this section and the plaintiff dies prior to the receipt of all of the future damages, the liability for the unpaid portion of those damages that is not yet due at the time of the death of that plaintiff shall continue, but the payments shall be paid to the heirs of that plaintiff as scheduled in and otherwise in accordance with the approved periodic payments plan or, if the plan does not contain a relevant provision, as the court shall order.

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

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

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

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

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

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

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

(c) Any other expenditures incurred as a result of an injury to person that is a subject of a tort action.

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

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

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

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

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

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

(B)(1) In any tort action that is tried to a jury 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 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;

(c) The age of that plaintiff;

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

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

(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.

(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

dred thousand dollars and twenty-five per cent of the total of the damages described in divisions (B)(1)(a) and (b) of this section.

(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.

(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 plan adequate security to insure that the plaintiff in question will receive all of the periodic payments under that plan. If the approved periodic payments plan includes a provision for an annuity as the adequate security or

otherwise, the defendant in question shall purchase the annuity from either of the following types of insurance companies:

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

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

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

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

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

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

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

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

(1) The liability for the portion of those payments that represents future

economic loss as described in division (B)(1)(b)(iv) of this section and that is not due at the time of the death of that plaintiff shall cease at that time;

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

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

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

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

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

Sec. 2711.21. (A) Upon the filing of any medical, dental, optometric, or chiropractic claim as defined in ~~division (D) of~~ section ~~2305.11~~ 2305.113 of the Revised Code, if all of the parties to the medical, dental, optometric, or chiropractic claim agree to submit it to nonbinding arbitration, the controversy shall be submitted to an arbitration board consisting of three arbitrators to be named by the court. The arbitration board shall consist of one person designated by the plaintiff or plaintiffs, one person designated by the defendant or defendants, and a person designated by the court. The person designated by the court shall serve as the ~~chairman~~ chairperson of the board. Each member of the board shall receive a reasonable compensation based on the extent and duration of actual service rendered, and shall be paid in equal proportions by the parties in interest. In a claim accompanied by a poverty affidavit, the cost of the arbitration shall be borne by the court.

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

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

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

Sec. 2711.22. ~~A~~ (A) Except as otherwise provided in this section, a written contract between a patient and a hospital or ~~physician~~ healthcare provider to settle by binding arbitration any dispute or controversy arising out of the diagnosis, treatment, or care of the patient rendered by a ~~physician or~~ hospital~~,~~ or healthcare provider that is entered into prior to ~~or subsequent to~~ the ~~rendering of such~~ diagnosis, treatment, or care of the patient is valid, irrevocable, and enforceable~~, save upon such grounds as exist at law or in equity for the revocation of any contract~~ once the contract is signed by all parties. The contract remains valid, irrevocable, and enforceable until or unless the patient or the patient's legal representative rescinds the contract by written notice within thirty days of the signing of the contract. A guardian or other legal representative of the patient may give written notice of the rescission of the contract if the patient is incapacitated or a minor.

(B) As used in this section ~~the terms "hospital" and "physician" shall have the meaning 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.~~ and in sections 2711.23 and 2711.24 of the Revised Code:

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

(2) "Hospital," "physician," "podiatrist," "dentist," "licensed practical nurse," "registered nurse," "advanced practice nurse," "chiropractor," "optometrist," "physician assistant," "emergency medical technician-basic," "emergency medical technician-intermediate," "emergency medical technician-paramedic," "physical therapist," "medical claim," "dental

claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

Sec. 2711.23. To be valid and enforceable any arbitration agreements pursuant to sections 2711.01 and 2711.22 of the Revised Code for controversies involving ~~hospital or~~ a medical ~~care, diagnosis, or treatment which are~~, dental, chiropractic, or optometric claim that is entered into prior to ~~rendering such~~ a patient receiving any care, diagnosis, or treatment shall include or be subject to the following conditions:

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

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

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

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

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

(F) Any arbitration panel shall consist of three persons, no more than one of whom shall be a ~~physician~~ health care provider or the representative of a hospital;

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

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

(I) Filing of a medical, dental, chiropractic, or optometric claim~~, as~~

~~ined in division (D) of section 2305.11 of the Revised Code,~~ within the ~~sixty~~ thirty days provided for withdrawal of a patient from the arbitration agreement shall be deemed a withdrawal from ~~such~~ the agreement;

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

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

"AGREEMENT TO RESOLVE FUTURE MALPRACTICE
CLAIM BY BINDING ARBITRATION

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

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

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

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

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

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

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

(4) The agreement waives the patient's right to a trial in court for any future malpractice claim ~~he~~ the patient may have against the ~~physician or hospital~~ healthcare provider;

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

PATIENT'S RIGHT TO CANCEL
~~HIS~~ AGREEMENT TO ARBITRATE

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

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

Date:

.....

Signature of Provider of Medical Services

.....

Signature of Patient"

~~(B) As used in this section the terms "hospital" and "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 all hospitals owned or operated by one or more political subdivisions and consents for them to be sued, and to have their liability determined, in the court of common pleas, in accordance with the same rules of law applicable to suits between private parties, subject to the limitations set forth in this chapter. This division is also applicable to hospitals owned or operated by political subdivisions which have been determined by the supreme court to be subject to suit prior to July 28, 1975.

(C) Any hospital, as defined ~~under~~ in section ~~2305.11~~ 2305.113 of the Revised Code, may purchase liability insurance covering its operations and activities and its agents, employees, nurses, interns, residents, staff, and members of the governing board and committees, and, whether or not such insurance is purchased, may, to such extent as its governing board considers appropriate, indemnify or agree to indemnify and hold harmless any such person against expense, including attorney's fees, damage, loss, or other liability arising out of, or claimed to have arisen out of, the death, disease, or injury of any person as a result of the negligence, malpractice, or other action or inaction of the indemnified person while acting within the scope of ~~his~~ the indemnified person's duties or engaged in activities at the request or direction, or for the benefit, of the hospital. Any hospital electing to

nify such persons, or to agree to so indemnify, shall reserve such funds as are necessary, in the exercise of sound and prudent actuarial judgment, to cover the potential expense, fees, damage, loss, or other liability. The superintendent of insurance may recommend, or, if such hospital requests ~~him~~ the superintendent to do so, the superintendent shall recommend, a specific amount for any period that, in ~~his~~ the superintendent's opinion, represents such a judgment. This authority is in addition to any authorization otherwise provided or permitted by law.

(D) Recoveries against the state shall be reduced by the aggregate of insurance proceeds, disability award, or other collateral recovery received by the claimant. This division does not apply to civil actions in the court of claims against a state university or college under the circumstances described in section 3345.40 of the Revised Code. The collateral benefits provisions of division (B)(2) of that section apply under those circumstances.

(E) The only defendant in original actions in the court of claims is the state. The state may file a third-party complaint or counterclaim in any civil action, except a civil action for two thousand five hundred dollars or less, that is filed in the court of claims.

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

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

(G) Whenever a claim lies against an officer or employee who is a member of the Ohio national guard, and the officer or employee was, at the time of the act or omission complained of, subject to the "Federal Tort Claims Act," 60 Stat. 842 (1946), 28 U.S.C. 2671, et seq., then the Federal Tort Claims Act is the exclusive remedy of the claimant and the state has no liability under this section.

Sec. 2743.43. (A) No person shall be deemed competent to give expert testimony on the liability issues in a medical claim, as defined in ~~division~~

~~(D)(3) of~~ section ~~2305.11~~ 2305.113 of the Revised Code, unless:

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

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

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

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

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

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

(B) "Gestational age" means the age of an unborn human as calculated from the first day of the last menstrual period of a pregnant woman.

(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.

(D) "Hospital" has the same meanings as in sections 2108.01, 3701.01, and 5122.01 of the Revised Code.

(E) "Live birth" has the same meaning as in division (A) of section 3705.01 of the Revised Code.

(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.

(G) "Physician" has the same meaning as in section ~~2305.11~~ 2305.113 of the Revised Code.

(H) "Pregnant" means the human female reproductive condition, that

mmences with fertilization, of having a developing fetus.

(I) "Premature infant" means a human whose live birth occurs prior to thirty-eight weeks of gestational age.

(J) "Serious risk of the substantial and irreversible impairment of a major bodily function" means any medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function, including, but not limited to, the following conditions:

(1) Pre-eclampsia;

(2) Inevitable abortion;

(3) Prematurely ruptured membrane;

(4) Diabetes;

(5) Multiple sclerosis.

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

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

Sec. 3923.63. (A) Notwithstanding section 3901.71 of the Revised Code, each individual or group policy of sickness and accident insurance delivered, issued for delivery, or renewed 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:

(1) The policy 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 policy 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 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 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.

(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;

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

(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.

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:

(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.

(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 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

enty-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 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.

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

(a) Terminate the participation of a health care professional or health care facility as a provider under the 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;

(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 plan to cover inpatient or follow-up care that is not received in accordance with the plan'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;

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

(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.

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. 3929.88. Every insurance company in this state shall file with the department of insurance all information about the salaries, bonuses, or other compensation of executive officers of and members of the boards of directors of the company. Any information that is filed with the department under this section is open to public inspection under section 149.43 of the Revised Code.

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.

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

(1) Terminate the participation of a health care professional or health care facility as a provider under the program 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;

(2) 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.

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

(1) Require the medical assistance program to cover inpatient or follow-up care that is not received in accordance with the program's terms

ertaining 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;

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

(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, 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.

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

SECTION 3. The General Assembly makes the following statement of findings and intent:

(A) The General Assembly finds:

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

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

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

(a) The Superintendent of Insurance has stated that medical malpractice insurers' investments are not to blame for the 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 limit on compensatory damages representing noneconomic loss to the greater of two hundred fifty thousand dollars, or an amount equal to three times the plaintiff's economic loss to a maximum of five hundred thousand dollars, and the limit on the amount recoverable for noneconomic losses to the greater of one million dollars or fifteen thousand dollars times the number of years remaining in the injured person's expected life for certain permanent and substantial injuries and deformity, is 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. Omitowoju* (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;

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

(C)(1) The Ohio General Assembly respectfully requests the Ohio

Supreme Court to uphold this intent in the courts of Ohio, to reconsider its holding on damage caps in *State v. Sheward* (1999), Ohio St.3d 451, to reconsider its holding on the deductibility of collateral source benefits in *Sorrel v. Thevenir* (1994), 69 Ohio St.3d 415, and to reconsider its holding on statutes of repose in *Sedar v. Knowlton Constr. Co.* (1990), 49 Ohio St.3d 193, thereby providing health care practitioners with access to affordable medical malpractice insurance and maintaining the provision of quality health care in Ohio.

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

SECTION 4. (A) There is hereby created the Ohio Medical Malpractice Commission consisting of seven members. The President of the Senate shall appoint three of the members, and the Speaker of the House of Representatives shall appoint three of the members. The Director of the Department of Insurance or the Director's designee shall be the seventh member of the Commission. Of the six members appointed by the President of the Senate and the Speaker of the House of Representatives, one shall represent the Ohio State Bar Association, one shall represent the Ohio State Medical Association, and one shall represent the insurance companies in Ohio, and all of them shall have expertise in medical malpractice insurance issues.

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

(1) Study the effects of this act;

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

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

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

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

(E) Each member of the Commission shall be reimbursed by the Department of Insurance for expenses that are actually and necessarily incurred in the performance of the duties of the member.

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

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

(a) The financial responsibility limits for providers that are covered in Sub. Senate Bill 281 of the 124th General Assembly, and the Patient Compensation Fund;

(b) The identification of methods of funding, which include, but are not limited to, surcharges on providers and all insurers authorized to write and engaged in writing liability insurance policies including insurers covering such perils in multiple peril package policies;

(c) The operation and administration of such a fund;

(d) The participation requirements.

(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 which the General Assembly shall implement not later than July 1, 2003.

(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 Fund shall be designed and funded as necessary to satisfy 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 the greater of one million dollars or fifteen thousand dollars times the number of years remaining in the injured person's expected life. The Fund shall act to satisfy awards for damages in the amounts provided in this

division only as to awards made after the implementation of the Fund's operation.

(C) In order to create a source of money for the Fund sufficient to satisfy claims made against it for that portion of medical malpractice awards identified in division (B) of this section, the Superintendent shall also make recommendations for another source of state or private money for the Fund. The money in the Fund and any income from the Fund shall be used solely for the satisfaction of claims made against the Fund and the expenses of administering the Fund. The Superintendent's recommendations shall include a mechanism for making, and the assessment of, claims against the Fund.

SECTION 6. The Department of Insurance shall annually, beginning with information relative to the year 2002, provide the Ohio General Assembly with a report on all of the following: (1) medical malpractice insurance rates in Ohio; (2) the number of insurers offering medical malpractice insurance in Ohio; and (3) the number of insurer applications submitted to the Department of Insurance seeking rate increases for medical malpractice insurance, and the Department's decisions on those requests. The Department of Insurance shall provide the annual report to the Speaker and minority leader of the House of Representatives, the President and minority leader of the Senate, the chairperson and ranking minority member of the insurance committees of both houses, and the Ohio Medical Malpractice Commission, on or before the thirty-first day of March of each year.

SECTION 7. (A) Sections 1751.67, 2117.06, 2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, and 5111.018 of the Revised Code, as amended by this act, and sections 2303.23, 2305.113, 2323.41, 2323.42, 2323.43, and 2323.55 of the Revised Code, as enacted by this act, apply to civil actions upon a medical claim, dental claim, optometric claim, or chiropractic claim in which the act or omission that constitutes the alleged basis of the claim occurs on or after the effective date of this act.

(B) 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.

SECTION 8. If any item of law that constitutes the whole or part of a

ction of law contained in this act, or if any application of any item of law that constitutes the whole or part of a section of law contained in this act, is held invalid, the invalidity does not affect other items of law or applications of items of law that can be given effect without the invalid item of law or application. To this end, the items of law of which the sections contained in this act are composed, and their applications, are independent and severable.

SECTION 9. If any item of law that constitutes the whole or part of a section of law contained in this act, or if any application of any item of law contained in this act, is held to be preempted by federal law, the preemption of the item of law or its application does not affect other items of law or applications that can be given affect. The items of law of which the sections of this act are composed, and their applications, are independent and severable.

SECTION 10. Section 2117.06 of the Revised Code is presented in this act as a composite of the section as amended by both Sub. H.B. 85 and Sub. S.B. 108 of the 124th General Assembly. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the composite is the resulting version of the section in effect prior to the effective date of the section as presented in this act.

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Speaker _____ *of the House of Representatives.*

_____

President _____ *of the Senate.*

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

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Secretary of State.

File No. _____ Effective Date _____