



# OHIO LEGISLATIVE SERVICE COMMISSION

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## Bill Analysis

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### **Sub. H.B. 7**

132nd General Assembly  
(As Passed by the House)

**Reps.** Cupp, Becker, Hambley, R. Smith, Huffman, Schaffer, Stein, Anielski, Ginter, Green, Lang, Pelanda, Reineke, Roegner, Romanchuk, Scherer, Schuring, Seitz, Wiggam, Young

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## **BILL SUMMARY**

### **Qualified immunity for health care providers and EMTs in a disaster**

- Generally grants qualified civil immunity to specific types of health care providers and to emergency medical technicians (EMTs) that provide emergency medical services, first-aid treatment, or other emergency professional care as a result of a disaster.
- Provides that the bill does not create a new cause of action or substantive right against a health care provider or EMT and does not affect any civil immunities or defenses to which a health care provider or EMT may be entitled in the provision of those services or that treatment or care.
- Provides that the bill does not grant immunity from tort or other civil liability to a health care provider or EMT for actions that are outside the provider's or EMT's authority and does not affect a provider's or EMT's legal responsibility to comply with any applicable Ohio law or agency rule.
- Specifies that the immunity applies only to the provision of emergency medical services, first-aid treatment, or other emergency professional care by a health care provider or EMT as a result of a disaster and through the duration of the disaster.
- Specifies that the immunity under the bill does not apply to a tort action alleging wrongful death against a health care provider or EMT who provides emergency medical services, first-aid treatment, or other emergency professional care as a result of a disaster.

## **Immunity for behavior of mental health patients**

- Grants immunity to certain health care professionals or hospitals for failing to discharge from a facility a patient whom the professional or hospital believes in the good faith exercise of professional judgment according to appropriate standards of professional practice has a mental health condition threatening the safety of the patient or others.
- Grants immunity to certain health care professionals or hospitals for discharging a patient whom the professional or hospital believes in the good faith exercise of professional judgment according to appropriate standards of professional practice not to have a mental health condition that threatens the safety of the patient or others.

## **Medical Malpractice Law**

- Clarifies the definition of "medical claim" and applies the provisions described in the following dot points to civil actions based on a medical claim.

### **Complaint asserting a medical claim**

- Specifies the manner of sending, prior to the expiration of the limitation period for the claim, to a person who is the subject of a medical claim the written notice under current law of the claimant's intent to bring that claim.
- Specifically requires the plaintiff to file with the complaint, pursuant to Civil Rule 10(D), an affidavit of merit as to each defendant or a motion to extend the period to file such affidavit.
- Permits the parties, within the period described in the second succeeding dot point, to seek to discover potential medical claims or defendants not included in the complaint.
- Permits the plaintiff, within the period described in the succeeding dot point, to join any additional claim or defendant if the one-year limitation period for that claim had not expired prior to the filing of the original claim.
- Provides that if a complaint is filed prior to the one-year limitation period, the period in which the parties may conduct discovery and the plaintiff may join any additional claim or defendant under the preceding two dot points is equal to the balance of any days remaining from the filing of the complaint to the expiration of that limitation period, plus 180 days from the filing of the complaint.

- Specifies that R.C. 2323.451, which provides for additional claims does not modify or affect any Revised Code provision, common law rule, or Rule of Civil Procedure that applies to the commencement of the limitation period for medical claims asserted after the 180-day period specified in the preceding dot point.
- Provides that R.C. 2323.451, which provides for additional claims *after* filing the original complaint, may be used in lieu of, and not in addition to, R.C. 2305.113(B)(1) which provides that an action may be brought against a person notified by a claimant considering bringing an action, within 180 days after the notice is given.

### **Unanticipated outcome of medical care**

- Renders inadmissible as evidence of an admission of liability a health care provider's, employee's, or representative's statements expressing error or fault made to the victim of an unanticipated outcome of medical care or the victim's relative or representative that relate to the victim's suffering, injury, or death.
- Provides that if any statements described in the preceding dot point or any statements of apology in continuing law are included in the medical record of the victim, only the portions of the medical record that include those statements are inadmissible as evidence of an admission of liability.
- Generally renders inadmissible as evidence any communications between a health care provider, employee, or representative and a victim, victim's relative, acquaintance, or representative following an unanticipated outcome of medical care and made as part of a good faith review into the cause of the unanticipated outcome.

### **Standards in federal laws not admissible as evidence in medical claim**

- Provides that any guideline or standard under the "Patient Protection and Affordable Care Act" or the "Social Security Act" dealing with Medicare and Medicaid cannot be construed to establish a health care provider's standard or duty of care owed to a patient and is not admissible as evidence in a medical claim.

### **Insurer's reimbursement policies not admissible as evidence in medical claim**

- Provides that any insurer's reimbursement policies or determinations or regulations of the United States Centers for Medicare and Medicaid Services or the Ohio Department of Medicaid regarding the health care services provided to a patient are not admissible as evidence and may not be used to establish a standard of care.

## Peer review proceedings

- Permits the Director of Health, during inspection of records from a health care entity, to have on-site access to peer review committee records or, if required by law, to obtain copies of them with the redaction of any patient identifying information or health care provider or entity information.

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## CONTENT AND OPERATION

### HEALTH CARE IMMUNITIES

#### Qualified immunity for health care providers and EMTs in a disaster

The bill generally provides that a "physician," "physician assistant," "dentist," "optometrist," "advanced practice registered nurse," "registered nurse," "pharmacist," or



"hospital" (all included in the bill's definition of "health care provider"<sup>1</sup>) and an "emergency medical technician"<sup>2</sup> (EMT) that provides emergency medical services, first-aid treatment, or other emergency professional care, including the provision of any medication or medical product, as a result of a "disaster" is not liable in damages to any person in a "tort action" for injury, death, or loss to person or property allegedly arising from the health care provider's or EMT's act or omission in providing those services or that treatment or care if the act or omission does not constitute "reckless disregard" for the consequences so as to affect the life or health of the patient (see "**Immunity in disasters – definitions**").<sup>3</sup> This provision is subject to the third bullet point under "**Conditions**," below.

### Conditions

The bill provides the following conditions and exceptions regarding the above immunity of health care providers and EMTs:<sup>4</sup>

- It does not create a new cause of action or substantive legal right against a health care provider or EMT.
- It 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 a health care provider or EMT may be entitled in providing emergency medical services, first-aid treatment, or other emergency professional care.
- It does not grant immunity from tort or other civil liability to a health care provider or EMT for actions that are outside the provider's or EMT's scope of authority.
- It does not affect any legal responsibility of a health care provider or EMT to comply with any applicable Ohio law or Ohio agency rule.
- It applies only to the provision of emergency medical services, first-aid treatment, or other emergency professional care, including the provision of medication or other medical product, by a health care provider or EMT as a result of a disaster and through the duration of the disaster.

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<sup>1</sup> R.C. 2305.2311(A)(7).

<sup>2</sup> R.C. 2305.2311(A)(4).

<sup>3</sup> R.C. 2305.2311(B).

<sup>4</sup> R.C. 2305.2311(C).



## Exception for wrongful death actions

The immunity provided by the bill does not apply to a tort action alleging wrongful death against a health care provider or EMT that provides emergency medical services, first-aid treatment, or other emergency professional care, including the provision of any medication or medical product, that allegedly arises from the provider's or EMT's act or omission in providing those services or that treatment or care as a result of a disaster.<sup>5</sup>

## Immunity in disasters – definitions

The bill defines "advanced practice registered nurse," "registered nurse," "pharmacist," "dentist," "optometrist," "physician," and "physician assistant" as persons who are licensed or authorized to practice their respective professions under the applicable licensing or regulatory statutes.<sup>6</sup> It defines "hospital" and "medical claim" as in the existing Medical Malpractice Law, as modified by the bill (see "**Application of bill's provisions to medical claims**," below).<sup>7</sup> The bill defines "emergency medical technician" as an "EMT-basic," an "EMT-I," or a "paramedic," and defines each of the latter three terms as an individual who holds a current, valid certificate issued under the regulatory statute to practice respectively as an EMT-basic, EMT-intermediate, or EMT-paramedic.<sup>8</sup>

The bill further defines the following terms:<sup>9</sup>

**"Disaster"** means any occurrence of widespread personal injury or loss of life that results from any natural or technological phenomenon or act of a human, or an epidemic and is declared to be a disaster by the federal government, state government, or a political subdivision of Ohio.

**"Reckless disregard"** as it applies to a given health care provider or EMT rendering emergency medical services, first-aid treatment, or other emergency professional care, including the provision of medication or other medical product, means conduct that such a health care provider or EMT knew or should have known, at the time those services or that treatment or care were rendered, created an unreasonable

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<sup>5</sup> R.C. 2305.2311(D).

<sup>6</sup> R.C. 2305.2311(A)(1) and (15) by reference to R.C. Chapter 4723., (A)(2) by reference to R.C. 2305.231, and (A)(9), (11), (12), and (13) by reference to R.C. Chapters 4725., 4729., 4731., and 4730., respectively.

<sup>7</sup> R.C. 2305.2311(A)(8).

<sup>8</sup> R.C. 2305.2311(A)(4), (5), (6), and (10) by reference to R.C. 4765.30.

<sup>9</sup> R.C. 2305.2311(A)(3), 14, and 16.



risk of injury, death, or loss to person or property so as to affect the life or health of another and that risk was substantially greater than that which is necessary to make the conduct negligent.

**"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 other agreement between persons or governmental entities, and includes an action on a "medical claim."

### **Immunity for behavior of mental health patients**

The bill provides that, notwithstanding any other provision of the Revised Code, a "physician," "physician assistant," "advanced practice registered nurse," (hereafter health care professional) or "hospital" is not liable in damages in a civil action, and cannot be subject to disciplinary action by any entity with licensing or regulatory authority, for doing either of the following (see **"Immunity for behavior of mental health patients – definitions"**):<sup>10</sup>

- Failing to discharge or to allow a patient to leave the facility if the health care professional or hospital believes in the good faith exercise of professional medical, advanced practice registered nursing, or physician assistant judgment according to appropriate standards of professional practice that the patient has a mental health condition that threatens the safety of the patient or others;
- Discharging a patient whom the health care professional or hospital believes in the good faith exercise of professional medical, advanced practice registered nursing, or physician assistant judgment according to appropriate standards of professional practice not to have a mental health condition that threatens the safety of the patient or others.

These immunities from civil liability and disciplinary action are in addition to and not in limitation of any immunity conferred on such health care professional or hospital by another section of the Revised Code or by judicial precedent.<sup>11</sup>

### **Immunity for behavior of mental health patients – definitions**

The bill defines "advanced practice registered nurse," "physician," and "physician assistant" as persons who are licensed or authorized to practice their respective

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<sup>10</sup> R.C. 2305.51(D).

<sup>11</sup> R.C. 2305.51(E).

professions under the applicable licensing or regulatory statutes.<sup>12</sup> It defines "hospital" as in the Peer Review Committee Law.<sup>13</sup>

## MEDICAL MALPRACTICE LAW

### Application of bill's provisions to medical claims

The bill's provisions modifying the Medical Malpractice Law primarily pertain to civil actions based upon a "medical claim," defined in current law as modified by the bill. Current law defines "**medical claim**" as any claim asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility or an employee or agent of such person or facility, or against a licensed practical nurse, registered nurse, advanced practice registered 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, as modified by the bill:<sup>14</sup>

- Derivative claims for relief that arise from the medical diagnosis, care (instead of plan of care in current law), or treatment of a person;
- Derivative claims for relief that arise from the plan of care prepared for a resident of a home (added by the bill);
- Claims that arise out of the medical diagnosis, care (instead of plan of care), or treatment of any person or "claims that arise out of the plan of care prepared for a resident of a home" (clarified by the bill) and to which both types of claims either of the following applies: the claim results from acts or omissions in providing medical care; or the claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment;
- Claims that arise out of the plan of care, medical diagnosis, or treatment of any person and are brought under the grievance procedure for violation of the rights of a nursing home resident;
- Claims that arise out of skilled nursing care or personal care services provided in a home pursuant to the plan of care, medical diagnosis, or treatment.

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<sup>12</sup> R.C. 2305.51(A)(1)(g), (i), and (j), by reference to R.C. 4723.01 and 4730.01 and R.C. Chapter 4731.

<sup>13</sup> R.C. 2305.51(A)(1)(h).

<sup>14</sup> R.C. 2305.113(E)(3).



## **Notice of intent to bring an action on a medical claim**

Current law provides that, if prior to the expiration of the one-year period of limitations for filing an action upon a medical, dental, optometric, or chiropractic claim a claimant who allegedly possesses such a claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action, that action may be commenced against the person notified at any time within 180 days after the notice is given.<sup>15</sup> The bill requires a claimant who allegedly possesses a "medical claim" (see above definition) and intends to give to the person who is the subject of that claim the written notice described above, to send the notice by certified mail, return receipt requested, addressed to any of the following: the person's residence, the person's professional practice, the person's employer, or the address of the person on file with the State Medical Board or other appropriate agency that issued the person's professional license.<sup>16</sup>

## **Complaint asserting a medical claim**

The bill specifies that at the time of filing a complaint asserting a "medical claim," the plaintiff must file with the complaint, pursuant to Civil Rule 10(D) (see "**Background – affidavit of merit**," below), an affidavit of merit relative to each defendant named in the complaint or a motion to extend the period of time to file an affidavit of merit.<sup>17</sup>

## **Discovery and joinder of additional medical claims or defendants**

The bill provides that the parties may conduct discovery as permitted by the Rules of Civil Procedure. Additionally, for the period described in the following paragraph, the parties may seek to discover the existence or identity of other potential medical claims or defendants that are not included or named in the complaint. All parties must provide such discovery in accordance with the Rules of Civil Procedure.<sup>18</sup> Within the period described in the following paragraph, the plaintiff, in an amendment to the complaint pursuant to Civil Rule 15, may join in the action any additional medical claim or defendant if the original one-year period of limitation applicable to

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<sup>15</sup> R.C. 2305.113(B)(1).

<sup>16</sup> R.C. 2305.113(B)(2).

<sup>17</sup> R.C. 2323.451(B).

<sup>18</sup> R.C. 2323.451(C).



that additional medical claim or defendant had not expired prior to the date the original complaint was filed.<sup>19</sup>

If a complaint is filed prior to the expiration of the one-year period of limitation applicable to medical claims, then the period in which the parties may conduct discovery and in which the plaintiff may join any additional medical claim or defendant as described above must be equal to the balance of any days remaining from the filing of the complaint to the expiration of that one-year period of limitation, plus 180 days from the filing of the complaint.<sup>20</sup>

The plaintiff must file an affidavit of merit supporting the joinder of the additional claim or defendant or a motion to extend the period of time to file an affidavit of merit pursuant to Civil Rule 10(D) with the amendment to the complaint.<sup>21</sup>

### **Nonjoinder of additional medical claim or defendant; other laws and rules not affected**

After the expiration of 180 days following the filing of a complaint asserting a medical claim, the bill prohibits the plaintiff from joining any additional medical claim or defendant to the action unless the medical claim is for wrongful death and the period of limitation for the claim under the Wrongful Death Law (generally within two years after the decedent's death) has not expired. The bill provides that R.C. 2323.451 (all the provisions discussed under "**Complaint asserting a medical claim**" and its subheadings above) does not modify or affect and is not to be construed as modifying or affecting any provision of the Revised Code, rule of common law, or Ohio Rules of Civil Procedure that applies to the commencement of the period of limitation for medical claims that are asserted or defendants that are joined after the expiration of the 180-day period described in the 2nd to the last paragraph under "**Discovery and joinder of additional medical claims or defendants**" above.<sup>22</sup>

### **Separate proceedings**

The bill provides that R.C. 2323.451 (provisions pertaining to the filing of additional claims *after* filing the original complaint) may be used in lieu of, and not in addition to, R.C. 2305.113(B)(1), which provides in relevant part that if prior to the expiration of the one-year period of limitation for filing an action upon a medical claim,

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<sup>19</sup> R.C. 2323.451(D)(1).

<sup>20</sup> R.C. 2323.451(D)(2).

<sup>21</sup> R.C. 2323.451(D)(1).

<sup>22</sup> R.C. 2323.451(E).

a claimant gives to the person subject to that claim written notice that the claimant is *considering* bringing an action, that action may be brought against the person notified at any time within 180 days after the notice is given.<sup>23</sup>

### **Background – affidavit of merit**

Under Civil Rule 10(D), a complaint that contains a medical claim, dental claim, optometric claim, or chiropractic claim generally must include one or more affidavits of merit relative to each defendant named in the complaint for whom expert testimony is necessary to establish liability. Affidavits of merit must be provided by an expert witness, and must include all of the following:

- A statement that the affiant has reviewed all medical records reasonably available to the plaintiff concerning the allegations in the complaint;
- A statement that the affiant is familiar with the applicable standard of care;
- The affiant's opinion that the standard of care was breached by one or more of the defendants to the action and that the breach caused injury to the plaintiff.

### **Applicability**

The bill provides that its provisions pertaining to the above procedures on discovery and joinder of additional claims upon filing a medical claim applies to a civil action based on a medical claim that is filed on or after the act's effective date.<sup>24</sup>

### **Unanticipated outcome of medical care**

#### **Defendant's expressions of error or fault**

The bill expands current law by providing that in any civil action brought by an alleged victim of an "unanticipated outcome" of medical care or in any arbitration proceeding related to such civil action, any and all statements, affirmations, gestures, or conduct expressing error or fault that are made by a health care provider, that provider's employee, or a "representative of a health care provider" to the alleged victim, the victim's relative, or a "representative of the alleged victim," and that relate to the discomfort, pain, suffering, injury, or death of the victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of

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<sup>23</sup> R.C. 2323.451(A)(2).

<sup>24</sup> Section 3.

liability or of an admission against interest. (See "**Unanticipated outcome – definitions.**")<sup>25</sup> Current law provides that in any civil action or arbitration proceeding described above, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence made by a health care provider or provider's employee to the alleged victim or the victim's relative or representative, and that relate to the discomfort, pain, suffering, injury, or death of the victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or of an admission against interest.<sup>26</sup>

The bill provides that if any statements, affirmations, gestures, or conduct described in current law and the bill or any reference to them are included in the medical record pertaining to the victim, only the portions of the medical record that include those statements, affirmations, gestures, or conduct or any reference to them are inadmissible as evidence of an admission of liability or an admission against interest.<sup>27</sup>

### **Communications made in a review**

The bill provides that when made as part of a "review" conducted in good faith by the health care provider or the provider's employee or representative into the cause of or reasons for an unanticipated outcome of medical care, the following communications are inadmissible as evidence in any civil action brought by an alleged victim of such unanticipated outcome, any related arbitration proceeding, or any other civil proceeding, unless the communications are recorded in the victim's medical record:<sup>28</sup>

- Any communications made by a health care provider or the provider's employee or representative to the alleged victim, the victim's relative or acquaintance, or the victim's representative;
- Any communications made by an alleged victim, the victim's relative or acquaintance, or the victim's representative to the health care provider or the provider's employee or representative.

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<sup>25</sup> R.C. 2317.43(A)(1).

<sup>26</sup> Current R.C. 2317.43(A).

<sup>27</sup> R.C. 2317.43(A)(2).

<sup>28</sup> R.C. 2317.43(B)(1).



The above provisions do not require a review to be conducted.<sup>29</sup>

### **Unanticipated outcome – definitions**

The bill expands the definition in current law of "**unanticipated outcome**" to include any outcome that is adverse or not satisfactory to the patient. Current law defines "**unanticipated outcome**" as the outcome of a medical treatment or procedure that differs from an expected result.<sup>30</sup>

Current law, retained by the bill, defines "**health care provider**" as a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.<sup>31</sup> The bill also retains the current definition of "representative" and clarifies that the defined term is "representative of an alleged victim" to distinguish it from the new defined term "representative of a health care provider" below.<sup>32</sup>

The bill defines the following additional terms:<sup>33</sup>

**"Representative of a health care provider"** means an attorney, health care provider, employee of a health care provider, or other person designated by a health care provider or employee to participate in a review conducted by a provider or employee.

**"Review"** means the policy, procedures, and activities undertaken by or at the direction of a health care provider, the provider's employee, or person designated by the provider or employee with the purpose of determining the cause of or reasons for an unanticipated outcome, and initiated and completed during the first 45 days following the occurrence or discovery of an unanticipated outcome. A review must be initiated by verbal communication to the patient or a relative or representative of the patient by the health care provider, the provider's employee, or person designated by the provider or employee. The verbal communication must be followed by a written document explaining the review process. A review may be extended for a longer period if necessary upon written notice to the patient or the patient's relative or representative.

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<sup>29</sup> R.C. 2317.43(B)(2).

<sup>30</sup> R.C. 2317.43(C)(6).

<sup>31</sup> R.C. 2317.43(C), by reference to R.C. 2317.02(B)(5), which is not in the bill.

<sup>32</sup> R.C. 2317.43(C)(3).

<sup>33</sup> R.C. 2317.43(C)(4) and (5).

## Standards in federal laws not admissible as evidence in medical claim

The bill provides that any guideline, regulation, or other standard under any provision of the "Patient Protection and Affordable Care Act," or Title XVIII or XIX of the "Social Security Act" (Medicare and Medicaid) cannot be construed to establish the standard or duty of care owed by a "health care provider" (defined as any person or entity against whom a medical claim may be asserted in a civil action) to a patient in a "medical claim" and is not admissible as evidence for or against any party in any civil action based on the medical claim or in any civil or administrative action involving the licensing or licensure status of the health care provider.<sup>34</sup>

## Insurer's reimbursement policies not admissible as evidence in medical claim

The bill provides that any "insurer's" "reimbursement policies" or "reimbursement determination" (see "**Insurer's policies – definitions**") or regulations issued by the United States Centers for Medicare and Medicaid Services or the Ohio Department of Medicaid regarding the health care services provided to the patient in any civil action based on a "medical claim" are not admissible as evidence for or against any party in the action and may not be used to establish a standard of care or breach of that standard of care in the action.<sup>35</sup>

### Insurer's policies – definitions

The bill defines the following terms for purposes of the above provisions:<sup>36</sup>

**"Insurer"** means any public or private entity doing or authorized to do any insurance business in Ohio, and includes a self-insuring employer and the United States Centers for Medicare and Medicaid Services.

**"Reimbursement determination"** means an insurer's determination of whether the insurer will reimburse a "health care provider" (see definition in "**Standards in federal laws not admissible as evidence in medical claim,**" above) for health care services and the amount of that reimbursement.

**"Reimbursement policies"** means an insurer's policies and procedures governing its decisions on the reimbursement of a health care provider for health care services and the method of reimbursement.

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<sup>34</sup> R.C. 2317.44.

<sup>35</sup> R.C. 2317.45(B).

<sup>36</sup> R.C. 2317.45(A).

## PEER REVIEW PROCEEDINGS

### Access to peer review and other health care entity records by Director of Health

The bill provides that when inspections authorized by the Director of Health pursuant to specified applicable laws seek records or documents from a health care entity, the Director must be permitted access to those records or documents, including records or documents within the scope of a peer review committee of such entity the confidentiality of which is protected under continuing law. Generally, the Director's access to those records or documents must be limited to an on-site review of them. However, if the Director is required by any Revised Code provision to obtain copies of those records or documents, any patient identifying information and any information on an individual health care provider and the health care entity that provides the health care must be redacted from those copies. The Director's access to, or receipt of copies of, records or documents does not affect the confidentiality of the records or documents or the information contained in them under the continuing law providing their confidentiality.<sup>37</sup>

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### HISTORY

ACTION	DATE
Introduced	02-01-17
Reported, H. Civil Justice	05-29-18
Passed House (76-18)	06-27-18

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<sup>37</sup> R.C. 2305.252(C).

