RESOLUTION 05-01-2026

TEXT OF RESOLUTION

RESOLVED that the Conference of California Bar Associations recommends that legislation be sponsored to amend Business and Professions Code section 801.1, to read as follows:

§801.01

(a) A complete report shall be sent to the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board with respect to a licensee of the board as to the following:

(1) A settlement over ~~thirty~~ one hundred thousand dollars ($~~30~~100,000) or arbitration award of any amount or a civil judgment of any amount, whether or not vacated by a settlement after entry of the judgment, that was not reversed on appeal, of a claim or action for damages for death or personal injury caused by the licensee's alleged negligence, error, or omission in practice, or by the licensee's rendering of unauthorized professional services.

(2) A settlement over ~~thirty~~ one hundred thousand dollars ($~~30~~100,000), if the settlement is based on the licensee's alleged negligence, error, or omission in practice, or on the licensee's rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee.

(b) The report shall be sent by any of the following:

(1) The insurer providing professional liability insurance to the licensee.

(2) The licensee, or the licensee's counsel.

(3) A state or local governmental agency that self-insures the licensee. For purposes of this section, "state governmental agency" includes, but is not limited to, the University of California.

(c) The entity, person, or licensee obligated to report pursuant to subdivision (b) shall send the complete report if the judgment, settlement agreement, or arbitration award is entered against or paid by the employer of the licensee and not entered against or paid by the licensee. "Employer," as used in this paragraph, means a professional corporation, a group practice, a health care facility or clinic licensed or exempt from licensure under the Health and Safety Code, a licensed health care service plan, a medical care foundation, an educational institution, a professional institution, a professional school or college, a general law corporation, a public entity, or a nonprofit organization that employs, retains, or contracts with a licensee referred to in this section. Nothing in this paragraph shall be construed to authorize the employment of, or contracting with, any licensee in violation of Section 2400.

(d) The report shall be sent to the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board as appropriate, within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto, within 30 days after service of the arbitration award on the parties, or within 30 days after the date of entry of the civil judgment.

(e) The entity, person, or licensee required to report under subdivision (b) shall notify the claimant or the claimant's counsel, if the claimant is represented by counsel, that the report has been sent to the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board. If the claimant or the claimant's counsel has not received this notice within 45 days after the settlement was reduced to

writing and signed by all of the parties or the arbitration award was served on the parties or the date of entry of the civil judgment, the claimant or the claimant's counsel shall make the report to the appropriate board.

(f) Failure to substantially comply with this section is a public offense punishable by a fine of not less than five hundred dollars ($500) and not more than five thousand dollars ($5,000).

(g)(1) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board may develop a prescribed form for the report.

(2) The report shall be deemed complete only if it includes the following information:

(A) The name and last known business and residential addresses of every plaintiff or claimant involved in the matter, whether or not the person received an award under the settlement, arbitration, or judgment.

(B) The name and last known business and residential addresses of every licensee who was alleged to have acted improperly, whether or not that person was a named defendant in the action and whether or not that person was required to pay any damages pursuant to the settlement, arbitration award, or judgment.

(C) The name, address, and principal place of business of every insurer providing professional liability insurance to any person described in subparagraph (B), and the insured's policy number.

(D) The name of the court in which the action or any part of the action was filed, and the date of filing and case number of each action.

(E) A description or summary of the facts of each claim, charge, or allegation, including the date of occurrence and the licensee's role in the care or professional services provided to the patient with respect to those services at issue in the claim or action.

(F) The name and last known business address of each attorney who represented a party in the settlement, arbitration, or civil action, including the name of the client the attorney represented.

(G) The amount of the judgment, the date of its entry, and a copy of the judgment; the amount of the arbitration award, the date of its service on the parties, and a copy of the award document; or the amount of the settlement and the date it was reduced to writing and signed by all parties and a copy of the settlement agreement. If an otherwise reportable settlement is entered into after a reportable judgment or arbitration award is issued, the report shall include both a copy of the settlement agreement and a copy of the judgment or award.

(H) The specialty or subspecialty of the licensee who was the subject of the claim or action.

(I) Any other information the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board may, by regulation, require.

(3) Every professional liability insurer, self-insured governmental agency, or licensee or the licensee's counsel that makes a report under this section and has received a copy of any written or electronic patient medical or hospital records prepared by the treating physician and surgeon, podiatrist, or physician assistant, or the staff of the treating physician and surgeon, podiatrist, or hospital, describing the medical condition, history, care, or treatment of the person whose death or injury is the subject of the report, or a copy of any deposition in the matter that discusses the care, treatment, or medical condition of the person, shall include with the report, copies of the records and depositions, subject to reasonable costs to be paid by the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board. If confidentiality is required by court order and, as a result, the reporter is unable to provide the records and depositions, documentation to that effect

shall accompany the original report. The applicable board may, upon prior notification of the parties to the action, petition the appropriate court for modification of any protective order to permit disclosure to the board. A professional liability insurer, self-insured governmental agency, or licensee or the licensee's counsel shall maintain the records and depositions referred to in this paragraph for at least one year from the date of filing of the report required by this section.
(h) If the board, within 60 days of its receipt of a report filed under this section, notifies a person named in the report, that person shall maintain for the period of three years from the date of filing of the report any records that person has as to the matter in question and shall make those records available upon request to the board to which the report was sent.
(i) Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without that written consent. The requirement of written consent shall only be waived by both the insured and the insurer.
(j)(1) A state or local governmental agency that self-insures licensees shall, prior to sending a report pursuant to this section, do all of the following with respect to each licensee who will be identified in the report:
(A) Before deciding that a licensee will be identified, provide written notice to the licensee that the agency intends to submit a report in which the licensee may be identified, based on the licensee's role in the care or professional services provided to the patient that were at issue in the claim or action. This notice shall describe the reasons for notifying the licensee. The agency shall include with this notice a reasonable opportunity for the licensee to review a copy of records to be used by the agency in deciding whether to identify the licensee in the report.
(B) Provide the licensee with a reasonable opportunity to provide a written response to the agency and written materials in support of the licensee's position. If the licensee is identified in the report, the agency shall include this response and materials in the report submitted to a board under this section if requested by the licensee.
(C) At least 10 days prior to the expiration of the 30-day reporting requirement under subdivision (d), provide the licensee with the opportunity to present arguments to the body that will make the final decision or to that body's designee. The body shall review the care or professional services provided to the patient with respect to those services at issue in the claim or action and determine the licensee or licensees to be identified in the report and the amount of the settlement to be apportioned to the licensee.
(2) Nothing in this subdivision shall be construed to modify either the content of a report required under this section or the timeframe for filing that report.
(k) For purposes of this section, “licensee” means a licensee of the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board.

(Proposed new language underlined; language to be deleted stricken)

PROPONENT: ORANGE COUNTY BAR ASSOCIATION

STATEMENT OF REASONS

The Problem (including Existing Law): Outdated Malpractice Reporting Threshold Burdens Regulatory System

Business and Professions Code section 801.01 requires reporting to the Medical Board of California when malpractice settlements exceed $30,000. This threshold has remained unchanged for decades despite significant inflation that has substantially eroded its real-world value.
The low threshold generates substantial reports for minor settlements that do not indicate serious quality-of-care concerns or negligence patterns requiring regulatory scrutiny. This administrative burden diverts Medical Board resources from investigating significant cases that genuinely threaten public safety. Healthcare providers, insurers, and self-insured entities must likewise dedicate staff time to filing reports on modest settlements falling far below MICRA damages caps.
The reporting requirement was intended to identify physicians whose malpractice history suggests substandard care warranting board attention. However, the outdated threshold now captures routine settlements reflecting ordinary litigation defense costs rather than meaningful indicators of physician competence. Many settlements below $100,000 are made for economic reasons unrelated to actual negligence—including expert witness costs, discovery, and trial preparation expenses that can exceed the settlement amount itself.
Updating this threshold would focus regulatory resources on cases presenting genuine public safety concerns while reducing unnecessary administrative burdens on the healthcare system..

The Solution: This resolution addresses the problem by raising the reporting threshold from thirty thousand dollars to one hundred thousand dollars. This adjustment better reflects current economic realities and focuses regulatory attention on settlements and verdicts that more reliably indicate potential quality-of-care issues requiring Medical Board investigation. The proposed one-hundred-thousand-dollar threshold maintains robust public protection while reducing unnecessary administrative burden. Medical Board enforcement resources can be concentrated on reviewing settlements and verdicts of sufficient magnitude to warrant serious scrutiny, rather than processing reports on minor settlements that rarely lead to disciplinary action. Healthcare providers and insurers benefit from reduced compliance costs, allowing them to allocate resources more efficiently. This adjustment aligns the reporting threshold more closely with MICRA damage caps, which begin at three hundred fifty thousand dollars for noneconomic damages as of 2023 and increase annually. By raising the reporting threshold to one hundred thousand dollars, the statute will capture settlements representing a meaningful percentage of potential damages rather than the lowest tier of routine settlements. The change maintains transparency and accountability while ensuring the Medical Board focuses its limited investigative resources on matters most likely to affect patient safety and healthcare quality.

IMPACT STATEMENT
This resolution does not affect any other law, statute, or rule. This resolution affects Business and Professions Code section 803.2, which cross-references section 801.01 and applies the same thirty-thousand-dollar reporting threshold to employers of physicians. If this resolution is approved, section 803.2 should be similarly amended to maintain consistency. The resolution does not affect reporting requirements for arbitration awards or civil judgments of any amount, which remain reportable regardless of amount under section 801.01(a)(1).

CURRENT OR PRIOR RELATED LEGISLATION

Assem. Bill No. 35 (2021-2022 Reg. Sess.) significantly amended MICRA provisions including damage caps and attorney fee limitations but did not address the thirty-thousand-dollar reporting threshold in Business and Professions Code section 801.01. No current legislation proposes to adjust this reporting threshold.

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