RESOLUTION 06-01-2026

TEXT OF RESOLUTION

RESOLVED that the Conference of California Bar Associations recommends that legislation be sponsored to amend add Evidence Code section 1154.5, to read as follows:

§ 1154.5. Inadmissibility of Third-Party Medical Lien Compromises Without Plaintiff Consent

(a) Evidence that a health care provider who rendered services to a person with a claim or potential claim against a tortfeasor or the tortfeasor's insurer has accepted a compromise, settlement, reduction, or discount of the medical provider's lien, charges, or invoices before trial or judgment is inadmissible to prove the reasonable value of medical services or the amount of damages unless:
(1) The injured person and the person's attorney, if represented, have agreed in writing to the compromise, settlement, reduction, or discount; or
(2) The compromise, settlement, reduction, or discount was negotiated and approved by the injured person's attorney in the course of representing the injured person's interests.
(b) If subdivision (a) applies, the health care provider's original charges or invoices shall be admissible as evidence of the reasonable value of medical services provided, subject to challenge as to reasonableness pursuant to applicable law. In no event shall evidence of the compromise, settlement, reduction, or discount be presented to the trier of fact or argued to the jury.
(c) If the injured person proceeds to trial and obtains a judgment, and if the tortfeasor or tortfeasor's insurer made pretrial payments to compromise a health care provider's lien without compliance with subdivision (a), the court shall, upon motion of the injured person, determine the manner of adjusting the judgment to account for such payments, including but not limited to ordering restitution of payments made to the health care provider, awarding the full judgment amount to the injured person, or imposing sanctions as appropriate.
(d) This section does not apply to:
(1) Compromises, settlements, reductions, or discounts negotiated by the injured person's attorney in the course of settlement of the entire claim;
(2) Reductions required by statute, regulation, or contractual obligation of the health care provider;
(3) An action for breach of the covenant of good faith and fair dealing or violation of subdivision (h) of Section 790.03 of the Insurance Code, where such evidence may be admissible to prove bad faith or unfair practices; or
(4) Liens subject to Medicare, Medicaid (Medi-Cal), or other federal statutory lien rights governed by federal law.
(e) As used in this section:
(1) "Health care provider" has the same meaning as in Section 56.05 of the Civil Code.
(2) "Tortfeasor" means a person or entity alleged to be liable for the injured person's damages.

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

PROPONENT: Orange County Bar Association

STATEMENT OF REASONS

The Problem (including Existing Law): Insurance companies are systematically negotiating with medical providers to reduce liens without plaintiffs' knowledge or consent. Through third-party companies like ClaimTECH, insurers contact providers directly, offering "prompt payment" for 40-60% discounts—bypassing injured plaintiffs and their attorneys entirely.
This exploits California's Howell v. Hamilton Meats ruling, which limits recovery to amounts actually paid. By secretly settling a $50,000 lien for $20,000, insurers manufacture an artificially low damage ceiling—regardless of the care's true value.
The practice violates fundamental legal principles. It interferes with the attorney-client relationship by settling damage components without plaintiff consent. It weaponizes settlement privilege policies meant to encourage fair negotiation. It incentivizes litigation delays while insurers systematically reduce liens. It misleads providers who unknowingly undermine their patients' cases. And it shifts costs to taxpayers when inadequately compensated plaintiffs turn to public assistance.
This is not isolated conduct. The emergence of specialized lien reduction companies demonstrates intentional, systematic design. Insurers are deliberately gaming evidentiary rules by creating artificially suppressed "amounts paid" through secret settlements with uninformed providers—undermining justice for injured Californians while subsidizing their own profits.
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The Solution: This resolution adds Evidence Code section 1154.5, making inadmissible any evidence of medical lien compromises negotiated without the injured plaintiff's and plaintiff attorney's written consent. The provision addresses a specific abuse while preserving legitimate settlement practices and statutory lien schemes. **Core Evidentiary Rule (Subdivision a)** Lien compromises negotiated by third parties—insurance companies or their representatives—without plaintiff consent are inadmissible to prove the reasonable value of medical services or damages. Plaintiffs retain control over whether to consent to such compromises, protecting their right to preserve full documentation of medical expenses for presentation to the trier of fact. **Preserving Original Medical Bills (Subdivision b)** When third-party lien compromises are excluded, original medical bills remain admissible as evidence of reasonable value, subject to the defendant's right to challenge reasonableness through expert testimony or other evidence. This preserves the adversarial process—defendants can argue bills are excessive, but cannot manufacture artificially low values through secret settlements. **Remedies for Unauthorized Payments (Subdivision c)** When insurance companies have already paid to settle liens without authorization, courts have discretion to adjust judgments appropriately, including ordering restitution of unauthorized payments or awarding plaintiffs the full judgment amount. This provides meaningful remedies and deters future misconduct. **Critical Exceptions (Subdivision d)** The proposal preserves legitimate practices through four exceptions: (1) settlements negotiated by plaintiff's counsel during global settlement remain unaffected—attorneys can still negotiate resolutions including lien compromises; (2) statutory or contractual reductions such as Medicare/Medicaid rates, insurance plan discounts, or provider fee schedules remain valid; (3) evidence of bad faith settlements may still be used in insurance bad faith cases under existing Evidence Code exceptions; and (4) federal statutory liens are excluded to avoid conflicts with federal law. **Narrow Tailoring** The proposal addresses the specific abuse without disrupting legitimate settlement negotiations, statutory lien schemes, or contractual obligations. It does not

prevent medical providers from accepting discounts—it simply requires that discounts negotiated by insurance companies cannot reduce plaintiffs' recovery unless plaintiffs consent. Providers remain free to negotiate, but insurers cannot use those negotiations to manipulate trial evidence. **Consistency with Existing Policy** This protection aligns with existing Evidence Code policy. Section 1152 protects settlement offers from proving liability. Section 1154 protects settlement acceptances from proving claim invalidity. Section 1154.5 extends these principles to prevent insurers from using covert settlements with medical providers to diminish plaintiffs' damage evidence. All three provisions share the same underlying policy: settlement discussions should facilitate fair resolution, not create evidentiary traps undermining legitimate claims. **Protecting the Attorney-Client Relationship** California law prohibits attorneys from settling cases without client consent. This resolution prevents insurance companies from accomplishing indirectly—through lien settlements—what plaintiff attorneys cannot do directly. It ensures decisions about presenting and proving damages remain within plaintiffs' control, consistent with fundamental principles of agency and professional responsibility.

IMPACT STATEMENT

This resolution does not affect any other law, statute, or rule. Click or tap here to enter text if additional explanation is necessary.

CURRENT OR PRIOR RELATED LEGISLATION

This section extends the policies underlying Evidence Code sections 1152 and 1154 to address third-party medical lien settlements. The resolution interacts with several bodies of law: First, it complements Howell v. Hamilton Meats & Provisions, Inc., 52 Cal.4th 541 (2011), which limits recovery to amounts paid or incurred. Howell remains good law, but plaintiffs retain the right to prevent insurance companies from artificially suppressing "amounts paid" through unauthorized settlements. Second, it affects insurance company litigation practices by prohibiting use of secret lien reductions to diminish damage awards. Insurance companies may still challenge the reasonableness of medical bills through expert testimony and other evidence, but cannot manufacture low values through covert settlements. Third, it preserves plaintiff attorney authority to negotiate lien reductions in the context of overall settlement. Subdivision (d)(1) explicitly excludes settlements negotiated by plaintiff counsel, ensuring attorneys can still resolve cases efficiently. Fourth, it does not affect Medicare, Medicaid (Medi-Cal), or other federal statutory liens, which remain governed by federal law. Subdivision (d)(4) explicitly excludes such liens. Fifth, it may require amendments to California Rules of Court regarding pretrial statements and damage calculations, but such changes are procedural and ministerial. Sixth, evidence of secret lien settlements may still be admissible in bad faith cases under Evidence Code section 1152(b), which already permits such evidence in actions for breach of good faith and fair dealing or Insurance Code violations. The resolution does not affect medical provider lien rights, contractual discount obligations, or statutory fee schedules. Providers remain free to negotiate reductions—the statute only restricts use of unauthorized settlements as evidence in the plaintiff's case.

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