Personal Injury Made Easy
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To State and National Physician, Chiropractic, Physical Therapy, Pain Medicine, Surgical, and Other Independent Healthcare Associations Across America:

This letter is not really about California.

It is a warning *from* California.

If you represent independent physicians and healthcare providers anywhere in America, whether chiropractors, pain physicians, physical therapists, surgeons, neurologists, psychologists, imaging providers, ASCs, or multidisciplinary medical practices, I believe you need to understand what just happened here.

Because California's SB 623 may have created something much bigger than a rideshare personal injury law.

It may have created a roadmap.

A roadmap showing large corporate defendants, transportation companies, insurers, and tort-reform advocates how to pursue changes to the personal injury system without directly defeating the plaintiffs' bar.

And if that strategy works?

Independent medicine may become the path of least resistance.

That should concern every healthcare association in America.

What Happened in California Should Get Your Attention

Uber wanted significant tort reform.

Its proposed ballot initiative included provisions aimed at the economics of personal injury litigation, including attorney contingency fees.

California's Legal Lobby mobilized. That was predictable. Attorney fees are the economic engine of the plaintiffs' bar. Threaten them and you threaten the profession's business model.

A political confrontation followed. Then came compromise.

The ballot fight disappeared. SB 623 became law.

Uber obtained important protections. The Legal Lobby protected important interests of its own. And the Governor removed two ballot initiatives that would have taken the focus off of his own ballot priorities.

But significant burdens arising from the compromise landed elsewhere:

On medical providers and physicians.

Medical billing. Medical liens. Medical funding. Referral disclosures. Provider declarations. And ultimately, the economics of providing healthcare to PI patients on delayed payment.

If you lead a healthcare association outside California, don't simply ask: **“What does California's new rideshare law say?”**

Ask the more important strategic question: **“What did everyone learn from how this deal got done?”**

Because that lesson can travel across state lines.

Uber May Have Discovered the Legal Lobby's Pressure Point

This is where I believe provider associations need to wake up.

Large corporations and insurers have fought tort reform battles for decades.

Plaintiffs' attorneys have become extremely sophisticated at opposing them.

They organize. They lobby. They contribute politically. They litigate. They communicate with consumers.

And they defend contingency fees aggressively because contingency fees fund the entire system.

California demonstrated what can happen when that economic model itself becomes vulnerable.

Put enough pressure on attorney fees and the plaintiffs' bar has an enormous incentive to negotiate.

There is nothing inherently improper about that.

Every industry protects its interests.

But what happens during the negotiation?

If corporate defendants want reform...and attorneys want to preserve their economics...where can the burdens go?

Medicine.

That is the danger.

Not because every attorney wants to hurt doctors. Not because every corporation wants to hurt patients.

But because in a political negotiation among powerful stakeholders, the party without an equally powerful voice can become the easiest place to put the compromise.

Across much of America, that party may be: **The independent medical provider.**

Do Not Assume Your State Is Different

Your state's laws may be completely different from California's.

Your lien laws may be different. Your evidentiary rules may be different. Your collateral-source rules may be different. Your tort environment may be different. Your medical-funding industry may be different. Your attorney-fee laws may be different. Your political environment may be different.

I understand all of that.

But strategies travel. Ballot language travels. Model legislation travels. Lobbyists travel. Political consultants travel. Industry groups compare notes. Insurers operate across state lines. Transportation companies operate nationally.

And when one jurisdiction develops a mechanism that successfully reduces tort exposure, **others notice.**

So don't wait for a bill number to appear in your state legislature before you start paying attention.

By then, someone else may already have defined the problem, framed the solution, built the coalition, and decided where medicine fits.

Usually at the receiving end.

Today's Rideshare Law Can Become Tomorrow's Broader PI Reform in Your State

This is one of my central concerns about SB 623.

Today, it applies within a defined rideshare context.

But once a special liability or medical-damages framework exists, other defendants have an obvious question: **Why don't we get it too?**

Why not another transportation company? Why not a delivery company? Why not a commercial fleet? Why not a municipality? Why not another corporate defendant? Why not insurers more broadly?

And eventually: **Why should two people with the same injury, receiving the same medical care, be subject to different standards simply because one crash involved a rideshare vehicle?**

That question will not be unique to California.

If this framework proves effective in reducing exposure, versions of it can be proposed elsewhere.

And the eventual objective may no longer be rideshare reform.

It may become PI reform.

That is why healthcare associations should study California now.

Your Members May Think This Isn't Their Problem

This is another danger.

Ask a chiropractor in another state about California SB 623 and the response may understandably be: **“Why should I care?”**

Ask a pain physician. A physical therapist. A surgeon. An ASC owner. A neurologist.

The answer may be the same.

They are busy treating patients and running practices.

They are not monitoring tort-reform strategy across America.

That is why they have associations.

This is your job.

Not merely reacting when reimbursement is cut. Not merely fighting scope battles. Not merely monitoring licensure. Not merely lobbying after legislation has already been drafted.

Your members need you to identify threats **before those threats become laws.**

California is giving you that opportunity.

Understand What PI Healthcare Actually Is Before Someone Else Defines It For You

One of the great problems I see is that policymakers often evaluate PI healthcare as though it were simply another form of conventional insurance reimbursement.

It isn't.

An independent provider may treat a PI patient today and wait: A year. Two years. Often longer.

The practice still pays staff. Rent. Malpractice insurance. Equipment. Supplies. Technology. Taxes. Compliance. And all the costs of running an independent healthcare business.

Meanwhile, the provider assumes: Payment risk. Liability risk. Policy-limit risk. Settlement risk. Litigation delay. Case abandonment. Case defeat. And eventual lien negotiation.

Sometimes the provider receives substantially less than billed. Sometimes nothing.

That risk has economic value.

It does not excuse unreasonable billing. It does not excuse unnecessary treatment.

But neither should policymakers compare a delayed, contingent PI receivable with a conventional health-insurance reimbursement and pretend they are economically identical.

Healthcare associations need to understand that distinction well enough to **teach it.**

Because if you don't explain PI medicine to legislators, insurers, regulators, and the public … **someone else will explain it for you.**

And Their Version May Simply Be: "The Medical Bills Are Too High."

That is politically easy.

It is also incomplete.

A bill can be unreasonable. Attack it.

A procedure can be unnecessary. Stop it.

A provider can commit fraud. Prosecute it.

But a higher charge for specialized treatment involving substantial payment delay and collection risk is not automatically evidence of abuse.

The correct question is: **Was the care medically necessary, was the charge reasonable considering the circumstances, and was the transaction transparent?**

That is a far more intelligent standard than simply asking whether the provider's bill exceeds an insurance reimbursement benchmark.

Trial Evidence and Medical Economics Are Not the Same Thing

Healthcare associations across America should understand this distinction before it reaches your state.

If policymakers believe large medical specials are being presented to juries and artificially increasing verdicts, they can regulate **what evidence the jury sees.**

That is an evidentiary issue.

But that does not automatically require government to dictate the underlying economic arrangement between the provider and patient outside of the courthouse.

Those are different questions:

What should a jury consider? … versus … What may a provider reasonably charge and recover for medically necessary care delivered with years of financial risk?

California's experience should teach every healthcare association to insist that those issues be analyzed separately.

Control the courtroom problem in the courtroom.

Don't unnecessarily use it to regulate the entire healthcare transaction outside of it.

Medical Funding Is Another Area You Need to Understand

Your members may not love medical funding companies.

Some may not understand them. Others may never use them. But consider the patient who needs medically necessary surgery and cannot obtain it through conventional insurance.

The surgeon may be willing to operate but unwilling, or financially unable, to finance a $50,000, $75,000, or $100,000+ procedure for several years.

The surgeon is a healer. The surgeon is not a bank.

A responsible funding company can provide the capital that makes treatment possible.

Does that industry need accountability? Absolutely.

Reasonable risk deserves a reasonable profit. Unreasonable profiteering should be attacked.

Transparency should be required.

But if medical funding is eliminated or made economically impossible, your members may discover that the real loser is not the funding company.

It is the patient who cannot get the procedure.

Healthcare associations should understand these businesses before legislation affecting them arrives.

But Medicine Must Clean Its Own House

I am not asking healthcare associations to circle the wagons and defend everything their members do.

Quite the opposite.

Your credibility depends upon refusing to defend bad medicine.

If providers overtreat, address it.

If they bill amounts that cannot reasonably be defended, address it.

If treatment is being driven by lawsuit value rather than patient need, condemn it.

If surgeons recommend procedures they know are unnecessary, stop defending them.

If chiropractic or physical therapy continues simply because a claim remains open, stop it.

If documentation is templated nonsense rather than an honest account of the patient's condition, improve it.

If improper attorney-provider financial relationships exist, expose them.

Bad providers make every good provider politically vulnerable.

The strongest position medicine can take is not: **Leave our members alone.**

It is: **Hold our members accountable for medically necessary care and reasonable billing, and hold every other participant in the PI ecosystem to equally high standards.**

That is a position worth defending.

Every Industry Should Carry Its Own Burden

This principle should become part of every provider association's PI policy.

If an attorney makes the referral, the attorney should disclose it.

If a provider overtreats, hold the provider responsible.

If a funding company charges unreasonable returns, regulate that funding company.

If an insurer improperly delays a legitimate claim, hold the insurer accountable.

If a transportation company engages in wrongful conduct, hold it accountable.

If medical charges are being improperly used before a jury, address the evidence.

Don't transfer one stakeholder's burden onto another simply because that stakeholder has less political power.

Independent medicine should not become the dumping ground for compromises between larger, better-funded industries.

And Don't Wait Until Your Members Start Saying "I Don't Take PI."

This is the end result provider associations should fear.

A physician does not have to treat PI patients. Neither does a chiropractor. Neither does a physical therapist. Neither does a surgeon.

If the legal environment becomes too risky or economically irrational, the easiest solution is: **Stop taking the cases.**

That protects the practice. But what happens to the injured patient?

Who treats the patient who cannot afford care today? Who provides the specialist evaluation? Who performs the surgery? Who documents the injury? Who tells the patient's pain-and-suffering journey? Who provides the credible medical evidence necessary to distinguish a legitimate claim from an exaggerated one?

Quality providers disappear. **And the patient loses.**

That is why provider associations need to frame PI reform as more than a reimbursement issue.

It is an access-to-care issue.

Independent Medicine Is Already Under Enough Pressure

Across America, independent medical practices face increasing pressure.

Declining reimbursements. Rising labor costs. Rising malpractice costs. Rising technology costs. Rising compliance costs. Administrative burdens. Consolidation. Private-equity pressures. Hospital-system competition. Insurer leverage. Physician burnout.

And **increasing difficulty maintaining independent practices.**

Personal injury can be one of the remaining areas where independent providers have an opportunity to be compensated based upon the value, complexity, risk, and economics of the care they actually provide rather than merely accepting a predetermined insurance reimbursement.

That does not give medicine permission to abuse the system.

But provider associations should think very carefully before allowing another viable segment of independent medicine to be economically weakened without understanding the long-term consequences.

Healthcare Associations Need a National Early-Warning System

This is one of my strongest recommendations.

Stop treating PI legislation as purely local.

State medical associations should communicate with one another.

Chiropractic associations should communicate across states, and through **ChiroCongress, the Chiropractic Strategic Plan, and the Chiropractic Summit perhaps do the best national job of that. Others should follow.**

Pain societies should coordinate. Physical therapy organizations should coordinate. Surgical organizations and ASC associations should coordinate.

National healthcare organizations should track: Rideshare tort reform. Medical lien legislation. Medical-damages evidentiary changes. Attorney referral and settlement disclosure laws. Medical-funding restrictions. Collateral-source changes. Limitations on billed medical expenses. Restrictions affecting provider collection rights. And proposals that alter what injured patients remain obligated to pay.

Build an early-warning network.

When something emerges in one state, tell the others.

When ballot language appears, analyze it.

When a bill appears, understand who drafted it and why.

When an industry proposes reform, ask what legitimate problem it is trying to solve.

Then determine whether the proposed solution actually targets that problem, or simply shifts the burden onto medicine.

Do Not Automatically Oppose Tort Reform

This is equally important.

Provider associations should not become reflexively anti-reform.

That destroys credibility.

There are legitimate abuses.

Help fix them.

If medical bills are artificially driving verdicts, support reasonable evidentiary solutions. If providers are overtreating, support accountability. If referral relationships are improper, support transparency. If funding profits are abusive, support reasonable regulation. If fraud exists, help eliminate it.

Be part of the solution.

But insist on a scalpel. Not a shotgun.

That is what I am advocating in California through the **Surgical Strike.**

Reform the Abuse. Preserve the Value. Protect the Consumer-Patient.

California Can Become Either a Warning or a Blueprint

This is where all of you come in.

If California surgically repairs SB 623, we may create a model for something positive: **Tort reform that addresses abuse.**

Protects legitimate defendants. Preserves legitimate legal representation. Maintains access to quality healthcare. Allows providers to earn reasonable compensation. Allows responsible funding to earn reasonable returns. Encourages insurers to resolve legitimate claims efficiently.

And punishes bad actors regardless of which industry they occupy.

That is a model worth copying.

But if California does not repair it and the current framework spreads?

Then California may instead provide the roadmap for transferring more and more of the economic burden of PI reform onto independent medicine.

That is the model I am warning you about.

My Ask of Every Healthcare Association Outside California

Start paying attention now.

Study what happened here.

Understand the Uber initiative. Understand the political pressure created by the proposed attorney-fee restrictions. Understand how the compromise was reached. Understand SB 623. Understand which provisions affect medicine. Understand the Surgical Repair I am advocating.

Then look at your own state.

Know your provider-lien laws. Know your collateral-source laws. Know your medical-damages rules. Know your funding environment. Know your attorney-fee environment. Know who your transportation lobbyists are. Know who your tort-reform organizations are. Know who represents the plaintiffs' bar.

And most importantly: **Know who will represent independent medicine competently if those groups sit down to negotiate.**

If the answer is: **“We're not sure.”**

Fix that now.

Get to the Table Before You Are on the Menu

That may be the simplest way I can say it.

California should be a wake-up call.

Independent medicine cannot afford to learn about major PI reform after the compromise has already been negotiated.

Your members need a seat at the table.

Not because medicine deserves special treatment. But because the people actually providing healthcare should have a voice when government changes the economics of providing that healthcare.

And when you get that seat, don't simply defend your members' money.

Defend an ethical system. Defend medically necessary care. Defend reasonable billing. Defend transparency. Defend accountability. Defend legitimate medical funding. Defend quality providers.

And above all: **Defend the injured patient's ability to get quality care when they need it.**

Because the greatest threat isn't that your members earn less on a PI case. The greatest threat is that enough good providers decide the answer is simply: “**I don't take personal injury.”**

That harms medicine. It harms legitimate attorneys. It harms insurers trying to evaluate claims accurately. It harms defendants trying to distinguish legitimate claims from exaggerated ones.

But most importantly … **it harms the patient.**

California has given you a warning.

Please don't wait until it becomes your state's law to hear it.

Reform the Abuse. Preserve the Value. Protect the Consumer-Patient.

And if you aren't at the table, you will be on the menu.

And pursue the outcomes every stakeholder should want:

Better Patient Outcomes.
Better Provider Outcomes.
Better Case Outcomes.
Better Claim Outcomes.

Respectfully,

Michael Coates
Michael Coates, Esq.
President, Personal Injury Made Easy

PS: If you lead a healthcare association outside California, I encourage you to ask your legislative team one question this week: **"If a California-style SB 623 proposal were introduced in our state tomorrow, do we understand it well enough—and have the relationships and strategy in place—to protect both our members and their patients?"** If the answer is no, California has already given you the time to prepare. Use it.