Cardiovascular Summit

Restrictive Covenants: Should They Be Loosened?

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- Legal basics of covenants, components
- Variation in states: Where legal, where limited, where illegal
- Tips for negotiation
  - Language
  - Landmines
  - Only restricted where work
  - Time/distance
Legal basics of covenants, components

• Restricted Activities: Limits on the ability of an individual to engage in certain activities
  • Typically, applies to employment or sale of a business
  • Should be tied to the same or similar line of business
  • Non-compete
  • Non-solicitation (patients, employees, referral sources)

• Restricted Area: Geographic area in which Restricted Activities are prohibited
  • Should be tied to areas in which the employer/purchaser provides services
Legal basics of covenants, components (continued)

- Time of Restriction: Length of time in which Restricted Activities are prohibited
  - 1-2 years post-employment
  - Up to 5 years following the sale of a business
- Protectable Business Interest
- Elements of Restricted Covenants vary by state
Variation in states: Where legal, where limited, where illegal

- Certain states prohibit non-competes against physicians (ex. Alabama, California)
- Certain states have specific statutes that authorize restrictive covenants within defined statutory limits (ex. Tennessee, Texas)
- Certain states rely on the courts to develop the terms of enforceable non-competes (ex., Kentucky, Mississippi)
Tips for negotiation

• Language/Landmines
  • Identify the goal – protecting the individual physician vs. protecting the employer/group
  • Restricting employment or affiliation with another competing system versus a return to private practice
    • Address private equity affiliations
    • Address ownership in ASCs or other outpatient service lines
    • Address the ability to participate in ACOs or CINs
    • Address the ability to participate in non-clinical works (directorships, medical staff positions, co-management)
Tips for negotiation (continued)

- Carve-out/exclusions:
  - Non-renewal
    - Require fair market value renewal offer
  - Termination by employer without cause
    - What if termination is approved by the other employed physicians?
  - Termination by physician for cause or good reason
  - Material change in compensation
  - Sale of Hospital/Employer
  - Buyout
  - Group unwind (Disintegration)
Tips for negotiation (continued)

• Landmines
  • Struggle of protecting the physician versus protecting the group
  • Establish equal playing field for renegotiation

• Only restricted where work
  • Primary practice location(s)
  • Secondary practice locations
    • Define the level or amount of work at a location that would cause it to become a secondary practice location
    • Older locations should fall away
      • Ex., Limit secondary locations to only those at which the physician regularly provided services during the 12 month period prior to termination
J. Jeffrey Marshall, MD, FACC

- BOG Workgroup – rationale and output

- Arguments for retaining RCs as a business practice

- Arguments for limiting or eliminating RCs
  - Physician perspective
  - Health System perspective
  - Public and patient perspective
Rationale for ACC BOG Convening a Restrictive Covenant Workgroup:
Cardiologist’s Practices are Changing

• AMA and MedAxiom report that for the first time that more than 50% of all physicians are employed, not in private practices

• That percentage is even higher in Cardiology

• Healthcare Systems are growing exponentially, some say even becoming monopolies

• Several FACCs were experiencing changes in practice and asking for advice employed to private practice, private practice to employed, PSA to employed
Cardiology Practices are Changing

- Key Trigger: Imaging Reimbursement Cuts in the 2005 Budget Reconciliation Act (took effect 2008)
- Employer reliance on non-compete agreements steadily increased since 2008 – valuation process for “employing” Cardiologists
- When Cardiologists were mostly in private practice restrictive covenants/non-competes protected Cardiologists, now they protect large Healthcare Systems
Our Committee’s Charge:
To Advise the BOG, HAC and BOT on what the BOG would desire to change in Restrictive Covenants in light of the changing dynamics of the practice of Cardiology

• Define current status (usual geography, timing, terms, State Laws) of restrictive covenants (RCs)

• What are the key arguments in favor of retaining RC from all stakeholder’s perspectives?

• What are the key arguments against retaining (i.e. eliminating or restricting) RC, from all stakeholder’s perspectives?
Arguments for Retaining RCs

• 1. Protect the Clinical Practice
   A. Spin off groups may take patients, new referrals, and hospital contracts from established practices, even if employed.
   B. For smaller groups, non-competes help prevent newly recruited talent from being pulled into larger systems (who often provide higher up front salaries).

• 2. Allow for Practice Expansion
   A. Employers more comfortable expanding practices knowing the investment is protected from future competition by current cardiologists.

• 3. Protect the Business
   A. Primarily proprietary business techniques (billing, payment methods).

• 4. Foster Training and Mentorship
   A. Practices may want to protect the investment in the training it provides, especially for those fresh out of fellowship
Arguments for Retaining RCs

• Limit the scope of non-competes for when they make the most sense:
  
  A. Limit RC to new hires for the first 2-3 years - after this period, the hires have “paid off” their debt.
  
  B. Allow smaller independent group practices to retain RC to protect against members being poached to larger systems, avoid significant disruptions to provider work-pools, or risk defaulting on hospital service-line management contracts.
  
  C. Allow for limited RC within a large organization to situations where institutions make a large capital investment to support the services of a new hire (e.g., building a new EP lab at a location where no EP services were previously offered).
    
    A. A limited non-compete allows the hospital or system to make the investment more confidently.

• Special Considerations:

  • Need to consider the situation of large systems spanning multiple states, each with their own RC laws. What is the role of the federal government? How is access to care affected, especially in underserved areas?
Arguments for Limiting or Eliminating RCs:

**Physician Perspective**

1. **Physician Autonomy** – RC’s limit cardiologists ability to do business, stay in an area, and continue to evolve competitively for the betterment of their patients; lack of autonomy is a major contributor to physician burnout, which ultimately tracks with physician shortages and mental health.

2. **Negotiation Limitations** – Physicians can try to negotiate for better pay, more support, programmatic investment, or other important considerations, but have no/limited recourse if these are not met sufficiently.

3. **Breeds Complacency and Hinders Innovation** – RC’s breed complacency and risk aversion as there is no competitive advantage to doing better since these cannot be used to their best ability for negotiation internally or to a different employer.

4. **Buyout Option** – Physicians should at least have an option to eliminate their RC through a financial or other liquidation of potential losses to the employer (with a reasonable cap determined by the State); expired contracts should not have the RC carry-over without renegotiation.

5. **More Focused RC is needed** – RC’s are written extremely broad, even when geographic and time limits are used, since practices and systems grow, acquire new practices and hospitals, and the geographic limitation applies to larger swaths of the region than originally intended; RC’s should be limited to the primary (> 50% of time) location of clinical work.
Arguments for Limiting or Eliminating RCs
Health System Perspective

1. **Forces Innovation in Order to Retain Talent** – Fosters investment in physicians in an ongoing fashion, to offer a competitive advantage and prevent them from wanting to leave; avoids complacency in health care which over time improves quality; the best health systems invest in their talent and that investment keeps them at the top.

2. **Ability to Attract Talent** – The ability to attract the best talent from the region to build new or top tier programs, enhance volume and patient catchment.

3. **Nationwide Competition Drives Quality and Innovation** – All organizations do better when forced to be in the free-market, competing for talent.
Arguments for Limiting or Eliminating RCs

Patient Perspective

1. **Continuity of Care** – patients should be able to follow the physician who knows them, their history and has developed a long-term trusting and therapeutic relationship with them; improves patient and physician satisfaction, quality and cost of care (less unnecessary testing);

2. **Patient Access to Diversity of Care** – patients may not find the type of physician (race, gender, ethnicity, expertise or skill set, experience) they require or desire in the physicians remaining after their physician leaves;

3. **Patient Access to Better Care** – physicians may leave to a more innovative, progressive, practice with better services and offerings, and patients should be given the choice of following their physician for the same reasons;

4. **Full Transparency** – Patients have a right know where their physician went, so that they can make an informed decision about following their physician or not, which may in some cases mean changing insurance companies/networks
Joseph E. Marine, MD, FACC

• Results of ACC BOG and MedAxiom surveys
ACC BOG and MedAxiom RC Surveys: Methods

- Questions formulated by BOG Workgroup
- BOG surveyed x 1 week September 2021
  - N=39
- Requested MedAxiom post on their listserv x 2 weeks, Sept. 2021
  - N=60
BOG Survey (N=39)

Have RC in current contract
- Yes: 68.4%
- No: 31.6%

Successful in modifying RC
- Yes: 46.2%
- No: 43.6%
- N/A: 10.3%
BOG Survey (N=39)

ACC Chapters should support legislation that would limit or ban RCs

- 65.8% Strongly agree
- 28.9% Agree
- Neutral

95% Agree or strongly agree
MA Survey: N=60

“I have been successful in modifying RC in my contract”
MA Survey (N=60)

Support legislation that would limit or ban RCs

- Strongly agree: 38%
- Agree: 28%
- Neutral: 12%
- Disagree: 12%
- Strongly disagree: 10%

66% Agree or strongly agree
MA: Reasons to retain RCs

- They protect the legitimate economic interests of health systems and physician practices.
- They provide stability to the healthcare system by limiting the movement of physicians between practices.
- They benefit physician stakeholders in practices by limiting partners and associates’ ability to exit.
- They increase the value of a practice to private equity firms, thereby increasing the value of the practice to physician partners/shareholders.
- They benefit patients by limiting physician’s ability to exit a practice.
- Other - Write In