MEMO

To: MMA Policy Council

From: Teresa Knoedler

Re: Restrictive Covenants

Date: October 7, 2015

The MMA has considered restrictive covenants or non-compete clauses on several occasions over the last five years. Most recently, the issue was considered as part of the MMA Policy Council's April 2015 Policy Conference. The following memo provides additional background information on this issue and a proposed policy statement for the Council's consideration.

A resolution from the 2011 MMA House of Delegates called for legislation prohibiting the use of restrictive covenants in physician contracting. That resolution was considered by the MMA Ethics and Medical-Legal Affairs Committee in 2012 and 2013. The committee was unable to reach consensus or majority vote on the resolution. Some committee members felt that restrictive covenants undermine patient choice and unduly burden physicians; others felt that restrictive covenants are important tools for independent physician practices to manage human capital investments.

Per the Ethics Committee and the MMA Board of Trustees, the MMA Delegation to the AMA House of Delegates brought a resolution to the AMA in 2013, requesting that the AMA Council on Ethical and Judicial Affairs (CEJA) review its policy on restrictive covenants. That policy, last reaffirmed in 1998, "discouraged" the use of restrictive covenants in physician contracting and stated that restrictive covenants "may be unethical" if not reasonable in scope. CEJA review was already undertaking a review of the policy and, in 2014 revised the policy to read in part:

> Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.
>
> Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.
>
> Physicians should not enter into covenants that:
> (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and

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(b) do not make reasonable accommodation for patients' choice of physician.

After this updated policy was issued, the Ethics Committee once again discussed restrictive covenants. Once again the committee was unable to reach consensus.

In April 2015, the MMA Policy Council convened a Policy Conference to address various threats to the physician-patient relationship. One session focused on restrictive covenants. An attorney familiar with restrictive covenants in physician contracting presented on the issue and fielded questions from the audience. At the end of the session, the audience was polled. 68.8% of respondents indicated that restrictive covenants were a "moderate" or "significant" threat to the physician-patient relationship. 51.5% indicated that geographic location was the most onerous aspect of a restrictive covenant, and 39.4 indicated that time limitations were the most onerous aspect. When asked what action the MMA should take on restrictive covenants, 30.3% responded "strongly oppose", and 60.6% said "do not oppose, but work to define 'reasonable restrictions'".

In light of the prolonged and difficult-to-resolve conversations within the MMA the last 5 years, combined with the results from the policy conference favoring efforts to define "reasonable restrictions," MMA staff is presenting draft language for the Policy Council's consideration as to what is a "reasonable" restrictive covenant.

In Minnesota, restrictive covenants are measured by their "reasonableness". Minnesota courts closely scrutinize restrictive covenants for fairness, which is generally examined by the geographical scope of the restriction, the length of the restriction, and the scope of the restricted practice. Many restrictive covenants contain a liquidated damages provision that may permit a physician to "buy out" the restrictions; this is usually an enormously large sum of money.

"Reasonable" for physicians may be different from "reasonable" for other professions who are regularly subject to restrictive covenants. Possible reasonable terms should address geographical scope, duration, and practice scope. There is very little precedent in other states to define this.

An initial proposal for MMA policy to define "reasonableness" is as follows:

> For physicians licensed under Minn. Stat. Ch. 147, a restrictive covenant contained within an employment, partnership, or other contracting agreement shall be void if the restriction:
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> 1) Prohibits practice for longer than one year;
> 2) Applies to sites which were not the primary practice site of the restricted physician ("primary practice" to be defined to include only one site);
> 3) Prohibits practice for a distance greater than 10 miles from the primary practice site;

4) Applies to services the restricted physician was not contracted with to provide (i.e., applies to family medicine if the restricted physician was employed as a thoracic surgeon)
5) Prevents a patient from obtaining information from the employer about the restricted physician's new practice.

Some questions to consider:

- Does "reasonable" mean the same thing within Minneapolis as it means in Mankato?
- Should this apply equally to "employed" physicians as to physicians who own private practices?
- Are there any specialties that should not be included, that is, should not be subject to restrictive covenants in any circumstances?
- Is it logical that this reasonableness applies to other healthcare professionals, beyond physicians?

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