PHYSICIAN NON-COMPETE AGREEMENTS

AND THE ANTI-KICKBACK AND PHYSICIAN SELF-REFERRAL LAWS

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It is common practice for a hospital to require a physician to sign a non-compete agreement whenever the hospital employs the physician or acquires the physician's medical practice. In certain respects, that is to be expected. Non-compete agreements are a common feature in employment agreements and business acquisition documents across all industries and therefore it makes sense that they would be prevalent in the healthcare industry, too. However, the healthcare industry is different; uniquely so. Among other things, the healthcare industry is subject to state and federal laws and regulations that prohibit physicians from referring patients in exchange for compensation (collectively, the "anti-kickback and physician self-referral laws"). The focus of this article is on the interplay between those anti-kickback and physician self-referral laws and hospital-physician non-compete agreements. Specifically, this article explores whether there really is a rightful place for non-compete agreements in hospital-physician employment and practice acquisition agreements given the regulatory constraints imposed by the anti-kickback and physician self-referral laws.

The Anti-Kickback and Physician Self-Referral Laws.

Central to the federal anti-kickback and physician self-referral regulatory regime are the federal anti-kickback statute[2] and the Stark law[3], adopted in 1972 and 1989, respectively, together with the regulations thereunder, as those laws and regulations have been amended from time to time. At the time they were adopted, those laws were designed to address two glaring concerns in the healthcare industry: (i) the runaway cost increases in the Medicare and Medicaid programs, and (ii) the undeniable correlation between the amount of cash and non-cash incentives hospitals paid to their referring physicians and the volume of referrals those physicians made to the hospitals. Simply put, independent industry data irrefutably substantiated the fact that the more the physicians received the more they referred, and the more they referred the more it cost the federal government and the American taxpayers under the Medicare and Medicaid programs. Once that problem was recognized, the chosen legislative solution was to prohibit physician referrals in exchange for cash and non-cash consideration, and for the past 40+ years the interpretation, clarification, expansion, application and enforcement of that basic prohibition has grown into a full-fledged industry rooted in thousands and thousands of pages of ever-evolving and expanding federal laws and regulations.

Current Contracting Practices.

Reflecting the current regulatory regime, conventional practice in the healthcare industry now dictates that hospitals and physicians affirmatively acknowledge and agree in all hospital-physician employment and practice acquisition agreements that the physicians are not agreeing to refer their patients to the hospital in exchange for compensation. In addition, while these agreements do typically require the physicians to refer their patients to the contracting hospital, these agreements also typically recognize that (i) the physician is free to refer his patients to other hospitals under certain limited circumstances, (ii) the physician's compensation under the agreement is not based on the volume of the physician's referrals, but rather is based on the fair market value of the goods and services provided by the physician, and (iii) the physician's compensation will not be adjusted, up or down, based on the volume of the physician's referrals to the hospital or its affiliates. In this way, most current hospital-physician employment and practice acquisition agreements pay great lip service to the basic tenets of the anti-kickback and physician self-referral laws.

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[1] 42 U.S. Code § 1320a–7b(b)
[2] 42 U.S. Code § 1395nn.

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In addition to the foregoing, most current hospital-physician employment and practice acquisition agreements also include a physician non-compete agreement. These non-compete agreements typically provide that the physician will not provide medical services competitive with the hospital to any patients within X miles of the hospital for a period of Y years following either the termination of the physician's employment with the hospital or the effective date of the practice acquisition transaction, as the case may be. Stated affirmatively, these non-compete agreements can be viewed in the alternative as providing that the physician will only provide healthcare services to patients within the stipulated geographic area and time period if those healthcare services are not competitive with the hospital (i.e., in cases where the patients are either referred to or shared with the hospital).

The Purpose Behind Non-Compete Agreements.

Historically, non-compete agreements have been used in various industries to protect the interests of employers and the purchasers of businesses. Where an employer provides specialized training and confidential information to an employee, it has long been recognized that the employer should have a right to restrict that employee from using that specialized training and confidential information to directly compete with the employer when the employment relationship ends. The non-compete agreements do not prohibit competition *in toto* in perpetuity, but rather impose reasonable geographic and time limitations on the employee's right to compete. Similarly, non-compete agreements have been used to protect the interests of those who buy businesses. The conventional thinking here is that a buyer who pays a business owner to purchase his business has a right to prevent the former business owner from immediately re-entering the business in direct competition with the buyer. Again, as is the case with employment based non-compete agreements, these non-compete agreements do not prohibit competition *in toto* in perpetuity, but rather impose reasonable geographic and time limitations on the former business owner's right to compete.

In keeping with the practice in other industries, the accepted justification for requiring non-compete agreements in the case of hospital-physician employment and practice acquisition agreements is that the hospitals have a right to protect their investment in their employed physicians and in the physician practices they acquire. In the case of employed physicians, the hospitals incur substantial time and expense in hiring and assimilating the employed physicians. They also provide the physicians with unique insights regarding the hospital and its business. In the case of the acquired physician practices, the hospitals simply pay the physicians for their practices. In both cases, the hospitals make a substantial investment in the physicians and their practices, and there is a general recognition that the hospitals have the right to try to protect that investment. Non-compete agreements are the preferred means of doing so. As in other industries, they are designed to protect the hospital from competitive interference from the physician for a specified period of time within a given geographic area in order to allow the hospital's investment to take root and flourish. Arguably, it would simply be unfair for the physician to accept cash payments and other non-cash benefits from the hospital under a hospital-physician employment or practice acquisition agreement and then immediately start competing with the hospital. That argument has general appeal in the healthcare industry and parallels the reasoning behind the use of non-compete agreements in other industries. Consequently, hospital-physician non-compete agreements have enjoyed wide acceptance and are generally recognized by the courts as being valid and enforceable, subject to certain reasonable limitations.

Notwithstanding its currency in the industry, the common justification for requiring non-compete agreements from physicians is somewhat suspect and is only part of the story. In reality, hospitals rarely provide unique training or truly "proprietary" information to their employed physicians. Physicians do receive years and years of extensive professional training, but not from the hospitals. And the internal operational insights that the employed physicians receive from the hospitals, while not generally available to others outside the hospital system, hardly rise to the level of confidential "proprietary" information that is critical to the successful operation of the hospital's business. Similarly, physicians that sell their practices to a hospital are rarely in a position to "compete" with the hospital; physicians actually have a symbiotic relationship with hospitals, not a competitive one. So the legitimate business concerns that are at the root of non-compete agreements in other industries really aren't that compelling in the case of hospital-physician employment and practice acquisition agreements. There is another reason, however, that hospitals insist on obtaining non-compete agreements from the physicians. The non-compete agreements effectively allow the hospitals to lock in exclusive access to the physicians' patient referrals. Patient referrals are the life blood of any hospital, and by prohibiting a physician from referring his patients to any other hospital within X miles of the contracting hospital, the contracting hospital can virtually guarantee that the physician will refer all of his patients to the hospital for the duration of the non-compete agreement. To do otherwise (i.e., to refer his patients for treatment to a hospital outside of the non-compete agreement's restricted geographic area) is simply impractical for the physician and presumably would be unacceptable to most patients given the immediate availability of the contracting hospital. Therefore, while the hospital's ability to control the physicians' patient referrals is rarely acknowledged as the reason for the non-compete agreements, it is arguably the real impetus behind the proliferation of physician non-compete agreements in hospital-physician employment and practice acquisition agreements.

Given the Focus of the Anti-Kickback and Physician Self-Referral Laws, Should Physician Non-Compete Agreements That Restrict Patient Referrals be Permitted?

As the anti-kickback and physician self-referral laws have been interpreted and applied over the years, healthcare professionals and lawyers working in the healthcare industry have grown to understand and accept that many business practices that are common and legal in other industries (e.g., price discounts, lease rental concessions, operating subsidies, etc.) are prohibited in the healthcare industry because they violate the anti-kickback and physician self-referral laws. The use of non-compete agreements in the healthcare industry is one of those common business practices that, to date, has not been challenged or restricted on such grounds. However, the use of non-compete agreements deserves to be re-examined in terms of its compliance with the anti-kickback and physician self-referral laws, particularly where the physician non-compete agreements are used in hospital-physician employment and physician practice acquisition agreements.

As noted above, the basic tenet of the anti-kickback and physician self-referral laws is that a hospital cannot contractually secure the exclusive right to a physician's patient referrals by compensating the physician for those referrals. In contrast, the core principle underlying a physician non-compete agreement (stated in the affirmative) is that, during the term of the non-compete agreement, the physician can only provide healthcare services within the restricted geographic area to patients that are either referred to or shared by the hospital. In other words, while the anti-kickback and physician self-referral laws dictate that the hospital cannot pay the physician for referrals, the physician non-compete agreement basically mandates that the physician can only refer his patients to the hospital. By any measure, that is effectively the same thing. Through contractual means, including the various incentives and agreements contained in the contracts, the hospitals acquire the preferential right to the physicians' referrals. By effectively prohibiting patient referrals to competing hospitals in the area, physician non-compete agreements facilitate exclusive (or virtually exclusive) referral patterns between the contracting hospital and physician, the very same arrangement that the anti-kickback and physician self-referral laws were designed to thwart.

Given the foregoing, it is difficult to reconcile the use of physician non-compete agreements in hospital-physician employment and practice acquisition agreements with the anti-kickback and physician self-referral laws. Simply put, they seem to be at odds with each other. The fact that a hospital can effectively accomplish indirectly and legally through a physician non-compete agreement that which it can't accomplish directly under the anti-kickback and physician self-referral laws, just doesn't seem right. That outcome clearly reflects the dominance of form over substance, which is both logically and legally troubling. So the ultimate question is: Should the use of physician non-compete agreements in hospital-physician employment and practice acquisition agreements be permitted? Or should their use be prohibited as a violation of the anti-kickback and physician self-referral laws? As this article suggests, while non-compete agreements currently enjoy wide use and regulatory acceptance in the healthcare industry, a good argument can be made that physician non-compete agreements actually violate the anti-kickback and physician self-referral laws and therefore should either be prohibited or further restricted in their use in connection with hospital-physician employment and practice acquisition agreements.

A Proposal for Reconciling the Use of Physician Non-Compete Agreements with the Anti-Kickback and Physician Self-Referral laws.

As highlighted above, non-compete agreements have long been recognized as serving a legitimate business purpose in many industries, and while the business concerns that compel the use of non-compete agreements in other industries may not be as prevalent or pronounced in the healthcare industry, there are still occasions where the use of non-compete agreements in the healthcare industry may be appropriate. Therefore, in attempting to address the conflict between the use of non-compete agreements and the anti-kickback and physician self-referral laws identified above, it would be wrong to simply prohibit the use of non-compete agreements in hospital-physician employment and practice acquisition agreements all together. Rather, the scope and application of the non-compete agreements should be specially tailored to the circumstances at hand on a case-by-case basis. For example, in the case of hospital-physician employment agreements, the hospital has every right to require the physician to refer his patients to the hospital during the term of the employment agreement. In that case, the physician is an employed member of the hospital staff and requiring an employed staff member to refer his patients to his employer during the term of his employment is entirely reasonable. In addition, where a hospital actually does provide unique training to an employed physician, or where a hospital does in fact provide the employed physician with confidential proprietary information that deserves protection, the hospital should be able to restrict the physician's ability to use that training or confidential information to compete with the hospital or otherwise use that training or confidential information to the hospital's detriment, both during the employment term and after the employment term for a reasonable period of time. That, too, is only fair. On the other hand, where a hospital does not provide specialized training or confidential proprietary information to the employed physician, the use of a non-compete agreement to restrict that physician's patient referrals after the employment term has ended is arguably inappropriate. Once the employment term ends, there is no reason that the physician should be required to maintain the prior exclusive referral arrangement with the hospital, and without specialized training or confidential proprietary information there is no basis for there being any unfair competition that needs to restricted through a non-compete agreement.

Where a hospital acquires a physician's practice, the analysis is even simpler. In that case, unless the selling physician owns or intends to own a controlling interest in a competing hospital or comparable facility after completion of the sale (in which case a non-compete agreement might be appropriate), the physician simply will not be in a position to compete with hospital. Physicians work collaboratively with hospitals, they do not compete with them. Therefore, where a hospital acquires a physician's practice, there is typically no potential for the physician to engage in unfair competition after completion of the sale. Similarly, there is no reason that, as a condition to the sale, the physician should be required to refer all of his patients to the hospital for a set period of time following the sale. For that reason, there is no need for the purchase agreement to include a non-compete agreement to restrict unfair competition after the sale. In fact, the use of a post-sale non-compete agreement under those circumstances should be prohibited because of the inherent conflict with the anti-kickback and physician self-referral laws. Of course selling physicians typically do enter into employment agreements with the purchasing hospitals, so it is conceivable that the physician's employment agreement may contain a non-compete agreement as discussed above, but that does not change the analysis with respect to the need for a separate non-compete agreement in the purchase agreement governing the acquisition of the physician's practice.

Conclusion.

As persuasive as the foregoing analysis may be, it is unlikely that the use of physician non-compete agreements in hospital-physician employment and practice acquisition agreements will be curtailed or found to violate the anti-kickback and physician self-referral laws any time soon. There are two principal reasons for that. First, the use of physician non-compete agreements in hospital-physician employment and practice acquisition agreements is supported by historical precedent and current industry

and regulatory practice. That alone is very difficult to overcome. Second, hospitals currently have a vested interest in preserving the role of non-compete agreements in hospital-physician employment and practice acquisition agreements because physician non-compete agreements clearly benefit the hospitals. Prior to the adoption and enforcement of the anti-kickback and physician self-referral laws, hospitals could (and routinely did) pay substantially more to acquire physician practices than they are legally permitted to pay today. In those instances, a significant portion of the purchase price was openly recognized as payment for "good will" (i.e., patient records and patient relationships a/k/a patient referrals). Today, however, that practice is prohibited by anti-kickback and physician self-referral laws. Consequently, the purchase prices for physician practices have dropped precipitously as compared to the past, and that works to the hospitals' financial advantage. Under today's regulatory regime, the hospitals spend less to acquire a physician's practice and yet they still effectively secure exclusive access to the physician's patient referrals through the use of a non-compete agreements. That is an undeniable win-win for the hospitals, and until the physicians' lobby out-organizes and outspends the hospital lobby, there is little reason to expect that any changes on the regulatory and enforcement front will be made to curtail the use of non-compete agreements in connection with hospital-physician employment and practice acquisition agreements.

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