Stark III

Did it Cripple Non-Competition Agreements in an Effort to Save Them?

by Thomas A. Lerner

At the end of 2007, the Department of Health and Human Services issued its third and final regulations governing physicians and health care entities with whom they have financial relationships. These regulations implement the 1995 legislation[1] named for its sponsoring congressman, Pete Stark of California. The statute could only have been more appropriately named had its sponsor been named Daunting or Burdensome.

Broadly put, the Stark statute and ensuing regulations were intended to police financial benefits flowing from referrals, where the payment for designated health services comes from Medicare or Medicaid. The economic relationships among physicians, suppliers of durable medical equipment, hospitals, and practice groups are complex, such that CMS (the Centers for Medicare and Medicaid Services) drafted regulations that reach into every aspect of physicians' working lives and their related finances. It is well beyond the scope of this article to address the full extent of these regulations. Indeed, the statute and regulations are of such complexity as to defy any effort to digest them in one fell swoop.

One small section of Stark III modifies restrictions that arise in the context of physician recruitment, and in particular, where a hospital is subsidizing the cost to a physician group of recruiting a new physician. In the prior iteration of the regulations (Stark II, in 2004) CMS had limited physician practices from imposing practice restrictions on recruited physicians, other than those related to quality of care. The breadth of this restriction drew much criticism, prompting CMS to modify the regulations to more closely resemble customary practice. The thrust of the public comments to the regulations was that Stark II precluded customary non-competition agreements, and therefore was an impediment to physician recruitment.

In issuing the new regulations, CMS expressed the government's intention to only preclude restrictions that "would have a substantial effect on the recruited physician's ability to remain and practice medicine in the hospital's geographic service area after leaving the physician practice or group practice."[2] Recall that these regulations are focused on physician recruitment contracts which are subsidized or funded by a hospital. CMS specifically stated that the following restrictions were permitted by the regulations:

- restrictions on moonlighting;
- prohibitions on soliciting patients and/or employees of the physician practice;
- requiring that the recruited physician treat Medicaid and indigent patients;
- requiring that a recruited physician not use confidential or proprietary information of the physician practice;
- requiring the recruited physician to repay losses of his or her practice that are absorbed by the physician practice in excess of any hospital recruitment payments; and
- requiring the recruited physician to pay a predetermined amount of reasonable damages (that is, *liquidated damages*) if the physician leaves the physician practice and remains in the community.[3]

Liquidated damage clauses are contract provisions which are predicated upon the agreement of the parties that proof of actual damages arising from a breach of the contract would be difficult to prove, such that the parties have negotiated a specific sum to represent "actual damages." If a liquidated damages clause provides some reasonable basis for projected damages, courts will enforce the provision. Liquidated damages clauses will not be enforced, however, if they are viewed by the courts as penalties for a contract breach.

In seeking to accommodate the concerns regarding obstacles to physician recruitment, CMS' stated goal was to preserve the opportunity for a physician to remain in the hospital's service area, even if the physician leaves the group that recruited them. To that end, the new regulation provides that "The

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1 The Stark Act, 42 USC 1395nn, as amended in 1995, arises under the Medicare statutes, and prohibits physician referrals for designated medical procedures (including clinical laboratory services, hospital inpatient and outpatient services) to entities in which the physician has interest.

2 72 Fed. Reg. 51053-54 (Sept. 5 2007)

3 72 Fed. Reg. 51054 (Sept. 5 2007)

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physician practice may not impose on the recruited physician any practice restrictions that unreasonably restrict the recruited physician's ability to practice medicine in the geographic area served by the hospital" which subsidized the recruitment.[4] Practice restrictions which do not comply with state law will likely be found to be unreasonable restrictions in violation of Stark.

In Washington, enforceability of noncompetition agreements is evaluated based upon whether the restrictions that they contain are reasonably necessary to protect the interests of the employer. To that end, the restrictions must be reasonable in time (e.g. two years after one leaves employment) and geographic scope (e.g. the area in which the employer does business). They must also not be contrary to public policy, even in light of their anti-competitive nature. Unlike other contracts, courts have the authority to modify overbroad noncompetition agreements to bring them within the scope of reasonableness.

In its Stark III revisions, CMS sought to defer to both state law and common practice. In restricting the scope of noncompetition agreements, CMS wanted to assure that physicians who had been recruited to serve a hospital's patient population would not be driven from the area by an overbroad noncompetition contract provision. By this means, however, the nose of the camel has been invited into the tent.

It is presently commonplace to see noncompetition agreements that are geographically expansive, such as encompassing an entire county or more. The very purpose of such covenants is to preclude a departing physician from serving the same patient population as the practice group from which they are departing. A noncompetition covenant with even a narrower geographic range may still have the effect of driving a physician from the community. A physician whose practice revolves around one

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hospital on the west side of Lake Washington, for example, typically would be geographically barred by the covenant from relocating their practice to serve their patients in the other hospitals on the same side of Lake Washington—and often on either side of the lake.

For physicians who have been recruited to join a physician group where the recruitment has been subsidized by a hospital, such broad noncompetition provisions are likely to run afoul of Stark III. At a minimum, those geographic restrictions will be of questionable enforcement. If the Court uses its authority to modify the geographic scope of the restrictions, it will have to do so in a manner that still preserves the departing physician's ability to serve patients at the same hospital. As a practical matter, one result is that the acceptable geographic scope of a noncompetition covenant is more likely to be measured in terms of proximity to the physician group's office rather than restrictions that impede access to the patient population served by the hospital.

The narrowing effect of Stark III is likely to impact state court enforcement of noncompetition provisions even where the contract falls outside of the specific Stark prohibition (e.g. if no hospital funds are involved in the recruitment). At the least, CMS has issued an express statement of public policy that geographically broad restrictions that impact access to care are contrary to public policy.

As such, this regulatory prohibition is an invitation to state courts to find geographically broad restrictions to be unreasonable, if the effect of those provisions is to drive the physician out of the hospital service area or even just away from the patient population that the physician serves.

This aspect of Stark III should have an impact on negotiations between a physician group and the physician being recruited. It may also require groups to re-evaluate existing noncompetition agreements to determine the extent to which they will remain fully enforceable. A group that relies on a broad noncompete as a constraint on a disgruntled group member's competitive departure may be disappointed. The new vulnerability of such agreements may be a spur for good group managers to address disharmony earlier, to stave off a departure.

But wait! CMS specifically provided that liquidated damages clauses as a remedy for a breach of a noncompetition agreement were not barred by the Stark III regulations. Thus, can't the group practice rely on financially onerous clauses to enforce the noncompetition agreement?

4 42 C.F.R 411.357(e)(4)(vi)

In reality, liquidated damages clause are routinely drafted with a view towards being as severe as possible, up to the point at which the amount will be viewed as a penalty. By illustration, a liquidated damages clause that is either based on the total compensation paid to a physician employee over the preceding year—or the total revenue generated by that physician in the year after their departure, are each overbroad. Total revenue is not a measure of lost income, and it is lost net income rather than revenue that relates to actual damages.

As with the geographic scope, however, CMS has imposed constraints on such clauses. Specifically, liquidated damages clauses that require "a *significant or unreasonable* payment by the [departing] physician . . . [and] have a substantial effect on the recruited physician's ability to remain in the recruiting hospital's geographic service area" will likely run afoul of the regulations.[5] There is ample room between what is a "significant" payment and one which may be "unreasonable." An unreasonable payment was likely unenforceable before, but a significant one was not.

CMS' broad language here also removes any potential for clear bright lines. For example, a $50,000 liquidated damages clause may be "significant" enough to prompt a physician who is early in practice or with a family to support to relocate, while a more seasoned physician with accrued assets or without major financial obligations might be better able to bear the load. Whether the liquidated damages clause runs afoul of Stark III can no longer be determined by focusing on the dollars involved, but may well turn on the individual circumstances of each individual physician. Two physicians working alongside each other could plausibly be subject to different outcomes with regard to whether the same liquidated damages clause, if enforced, would provoke their relocation—and therefore not be enforceable.

Although the AMA has long expressed the position that physician noncompete agreements have an adverse effect on health care and are contrary to the public interest, only a handful of states have statutes that preclude noncompete agreements for physicians. Prior to Stark III, the majority of states whose courts have decided the issue have enforced such agreements. While the new regulations do not make such agreements automatically unenforceable in Washington, the effect of those regulations is likely to narrow the scope of such provisions, and ameliorate the harshness of liquidated damages clauses.

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5 72 Fed. Reg. 51054 (Sept. 5 2007)