Chairpersons Rapp and Frankel and Honorable Members of the Committee, thank you for the opportunity to speak with you today about the critical issue of restrictive covenants and the impact they have on patients, physicians and the healthcare system in Pennsylvania. I am Jeremy Bonfini the Chief Executive Officer of the Allegheny County Medical Society. Our organization is united with many others to oppose the use of restrictive covenants, or "non-compete clauses," in physician contracts. Since 2008, it has been the policy of the Pennsylvania Medical Society to seek legislation to do away with restrictive covenants. This policy was reaffirmed by the House of Delegates in 2017.

Across Pennsylvania, physicians are increasingly opting for employment versus independent practice. Major economic factors have contributed to this trend. For young physicians, employment offers the allure of relief from crushing student debt without taking on even more debt to start a medical practice. Older, established independent physicians may transition to employment due to the ongoing burden of heavy government regulation and ever declining reimbursement from highly profitable third-party payers.

Restrictive covenants that control where and how physicians deliver care, violate the professional rights of physicians and potentially restrain them from effectively treating their patients. The threat of termination from a hospital medical staff where a restrictive covenant exists may prevent physicians from advocating for their patients if hospital management opposes such advocacy.

We believe that far-reaching restrictive covenants do not serve a legitimate business need for the hospital or employer. A restrictive covenant provides that upon termination of an

employment contract, a physician may not practice in a defined geographical location for a period which could last up to 2 years. With the growing consolidation of healthcare delivery organizations in Pennsylvania, restrictive covenants have a breathtakingly broad geographic reach. Instead of restricting a physician from leaving a private practice and opening a new practice just a few minutes away, the abusive restrictive covenants that we see more frequently now exclude a physician from being employed in entire regions, states and might even prohibit that physician from working in a hospital outside of the Country!

If an employer terminates a physician's contract, the impact on patients can be tremendous. Upon enforcing a restrictive covenant for just one physician, we have the potential of hundreds of patients, some of whom are our most vulnerable, forced to cope with losing the doctor who has cared for them for decades. The physician, who now must abandon the patients she has dedicated her career to care for, must also sell her home and move her family if she wants to continue practicing in the medical profession. This process of finding a new position and relocating could easily take six months. This constant threat hangs over the heads of our physicians and has contributed to record burn-out and suicide rates that are twice the national average of any other profession.

I'd like to share with the Committee a very real case provided by the American College of Surgeons that highlights the patient impact of enforced restrictive covenants. This story comes from a large Midwestern community within a state that had only five active, board-certified colorectal surgeons. In court proceedings, a major national insurance company testified that a lone colorectal surgeon would be unable to serve the needs of this population. The testimony indicated that the covenant's restrictions would leave the area with one

colorectal surgeon for 700,000 potential patients, a ratio that was characterized as dangerous.... Seriously ill patients would be faced with a three to four-week delay for surgery. This delay is considered unacceptable if the patient has colorectal cancer, rectal bleeding, or other acute colorectal disease. The court also heard testimony that patients who needed colorectal surgeries that were instead performed by general surgeons have higher death rates than those patients whose procedures were performed by colorectal surgeons.

Notably, restrictive covenants are prohibited amongst lawyers in the United States. In 1969, The American Bar Association adopted a professional code of conduct that included a disciplinary rule prohibiting restrictive covenants between attorneys, using the logic that restrictive covenants interfere with the client's freedom to choose a lawyer. In striking down a restrictive covenant against a physician, the Tennessee Supreme Court cited the prohibitions against restrictive covenants in the legal profession and profoundly stated that there was "no practical difference between the practice of law and the practice of medicine," and further determined that a patient's right to choose a physician is fundamental and cannot be denied by a restrictive covenant. It was also found that increased competition improves the quality of medical care and keeps costs affordable.

According to the late Peter M. Sfikas, a thought-leader on this topic and adjunct professor of law at Loyola University, the freedom of a patient to select their physician, the right to continue an ongoing relationship with a physician, and the benefits derived from having an increased number of physicians practicing in a community all outweigh the business interests of an employer.

Employers sometimes argue that since they expend considerable funds to educate or recruit physicians restrictive covenants protect their "investment." However, physicians receive their education during medical school and residency. This significant investment to educate and train physicians is paid for by the student and subsidized by the federal government's support for graduate medical education. Furthermore, medical education is also subsidized by Medicare and Medicaid payments to non-profit hospitals that have teaching and residency programs. Restrictive covenants by those same hospitals force physicians to leave the area and deprive the community of vital assets that are paid for with taxpayer dollars. If an employer expended funds to recruit a physician, a contract may reasonably require the physician to repay those funds if that physician terminates the contract within a defined period.

Many physicians assume that employers use restrictive covenants to prevent competition. However, preventing competition is only a legitimate business interest on a limited and reasonable basis. Preventing competition is particularly questionable for non-profit healthcare organizations as it is incongruent with the accepted mission of non-profits which is to provide a public good to our communities. We believe that physician healers belong to the community, not to the hospitals. Truly legitimate business interests supporting the use of restrictive covenants include the protection of (1) trade secrets, (2) referral sources, and (3) confidential information. Physicians almost never possess trade secrets and rarely disrupt referral patterns upon changing employer. Additionally, confidentiality laws and non-disclosure agreements can and do prevent physicians from divulging patient information or an employer's intellectual property. Several states have laws specifically banning restrictive covenants in physician contracts and some states have near-absolute bans. Courts in the remaining states,

like Pennsylvania, use the "rule of reason" to decide whether to uphold restrictive covenants. These courts reason that a party to a contract may compromise its legal rights under certain circumstances. These courts balance the public interest against the parties' freedom to contract. Thus, even though a physician signs a contract which includes a restrictive covenant, courts may decide not to enforce the restrictive covenant. However, it cannot be over emphasized that the mere threat of a legal action by an employer is typically more than enough to deter a physician from seeking relief from a restrictive covenant in the courts. Should a physician dedicate the significant time and financial resources to defend against an onslaught of legal actions, there are possible actions the courts may take. The courts may strike down restrictive covenants for several reasons, including the creation of a monopoly, illegal restraint of trade, and a general violation of the public interest. However, the daunting challenge that a lone physician faces in going up against a multi-billion-dollar healthcare organization is enough to ensure enforcement of a restrictive covenant even if it comes at tremendous impact to our communities, patients and physicians.

To summarize our position, the Allegheny County Medical Society condemns the use of restrictive covenants in physician contracts. We believe that restrictive covenants are broadly inapplicable and unconscionable in the massively consolidated healthcare industry in Pennsylvania. We take this position for the following reasons (1) when physicians move to another hospital, they do not take their patient records with them, (2) physicians almost never learn "trade secrets" from employers, (3) physicians do not take referral lists to another role, (4) physicians learn how to practice during their residencies, and do not learn office-management from employers, (5) Employers almost always use overly broad restrictive

covenants for the illegitimate purpose of restricting competition to the detriment of our communities, and (6) some employers use restrictive covenants as a means of controlling and exploiting physicians which may effectively prevent physicians from advocating and treating their patients.

In closing I wish to credit the American Academy of Emergency Medicine and the American College of Surgeons who have provided content for my testimony today. I also wish to acknowledge my esteemed physician leaders, Dr. Keith Kanel and Dr. Douglas Clough who have joined me today to address the Committee's questions. We appreciate the opportunity to provide this testimony to the Committee and are pleased to use the remaining time to engage in an interactive discussion.