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Getting a Pulse on Changes to Healthcare Non-Competes

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Texas permits non-competition provisions ("non-competes") under a general framework set out in Tex. Bus. & Com. Code § 15.50. Since 1989, non-competes that restrict physicians have had heightened requirements, reflecting the unique public interest in maintaining access to healthcare services and protecting patient-physician relationships. With the passage of Texas Senate Bill 1318 ("SB 1318") last year, this non-compete framework has been heavily modified. For practitioners advising healthcare clients on employment arrangements and covenant disputes, these changes mark a major shift in structuring and enforcing such agreements.

Background: The Previous Non-Competition Framework

For non-compete provisions to be enforceable under Texas law generally, they must be ancillary to or part of an otherwise enforceable agreement, contain reasonable limitations as to time, geographic area, and scope of activity, and not impose a greater restraint than necessary to protect the employer's legitimate business interest. Courts assess reasonableness based on the particular facts and circumstances of each case, and the Texas Supreme Court has declined to set bright-line rules for what temporal or geographic limits are permissible.

Non-competes in the physician context are subject to additional requirements. Under the previous version of Section 15.50, a non-compete restricting a physician was enforceable only if it included a provision allowing the physician to "buy out" the restriction at a reasonable price, allowed the physician access to certain patient information, and allowed the physician to provide continuing care and treatment to a specific patient during the course of an acute illness. This reflects the legislature's view that restricting a physician's ability to practice affects not just the physician but also patients who may lose access to their established care relationships. Before SB 1318, however, the statute did not specify what constituted a reasonable buyout amount, nor did it limit the permissible duration or geographic scope of physician non-competes.

What SB 1318 Changes

For contracts entered into or renewed on or after September 1, 2025, SB 1318 provides some specificity to existing restrictions, adds new restrictions to Section 15.50(b), and extends applicability of the statute to other types of healthcare practitioners. To elaborate:

- The previously unspecified “reasonable” buyout in Section 15.50(b)(2) is now capped at the physician's total annual salary and wages at the time of termination of the physician's employment or contract.
- The non-compete period may not last longer than one year after termination and the geographic scope may not exceed a five-mile radius from the physician's primary practice location.
- The agreement must now “clearly and conspicuously” set forth its terms and conditions in writing, adding a transparency requirement that should help practitioners understand what they are signing.
- New Section 15.501 extends these new requirements to dentists, licensed nurses (all types), and physician assistants, all of whom were previously unprotected by the non-compete requirements of Section 15.50.

The final significant change by SB 1318 is the addition of Section 15.50(d), which voids non-compete provisions if the physician is involuntarily discharged from contract or employment without “good cause.” The statute defines “good cause” as “a reasonable basis for discharge… that is directly related to the physician's conduct” (on the job or otherwise), including the physician's job performance and contract or employment record. In practical terms, this means that if an employer terminates a physician due to restructurings, financial pressures, or interpersonal conflicts with management, the non-compete would be unenforceable. Employers will need to document performance issues carefully and ensure that any termination decision can withstand scrutiny under this new standard.

Open Questions and Ambiguities

While SB 1318 provides more concrete limits than the prior framework, several ambiguities remain. How does the geographic restriction of five miles from where the physician “primarily practiced” apply to providers rotating among facilities, such as a hospitalist seeing patients at multiple hospitals or a rural physician who travels to several clinics each week? The statute also does not address non-competes tied to entity ownership. Section 15.50(c) exempts ownership interests in hospitals and ambulatory surgical centers, but what about a physician who owns a stake in a clinic located far from where the physician typically sees patients? The “good cause” standard for termination will likely generate disputes, as employers and practitioners may disagree about what constitutes a reasonable basis for discharge. And it remains unclear whether automatic extensions of contracts in place prior to September 1, 2025, count as “renewals” which trigger the new requirements under SB 1318. Given

these ambiguities, parties should seek experienced counsel when drafting or entering into non-compete provisions regarding healthcare professionals.

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