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Trends in Recent Healthcare Restrictive Covenant Laws

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State legislatures have accelerated efforts to limit restrictive covenants for healthcare professionals, creating a changing and fragmented legal landscape. To understand where we're headed, we reviewed state legislation around the country enacted over the past two years. Over this period of time, fourteen states have enacted laws limiting the use of restrictive covenants in the healthcare sector. The result is a patchwork quilt: these laws vary with respect to the practitioners they cover and the scope of prohibitions. Still, several overarching trends have emerged, which appear to reflect that while state legislatures disagree on precisely how far to restrict healthcare noncompetes, they increasingly agree that protecting patient access and continuity of care should take precedence over post-employment restraints.

Healthcare Noncompetes Are in the Crosshairs, But Approaches Vary

Some states have decided that healthcare noncompetes should simply disappear. Arkansas, Indiana, Utah, and Colorado have adopted categorical or near-categorical bans on noncompetes for healthcare practitioners. Arkansas and Indiana prohibit noncompetes for all physicians. Utah recently banned post-employment noncompete agreements for a broad range of healthcare practitioners. In 2025, Colorado banned all noncompete agreements for healthcare providers that restrict their ability to practice.

Pennsylvania, Maryland, and Texas have taken a narrower approach, requiring certain conditions to be met, rather than imposing a full ban on noncompetes for healthcare providers. Pennsylvania limited its prohibition to noncompetes lasting more than one year and in circumstances where the practitioner was terminated. Maryland has enacted a ban on noncompetes for licensed direct patient-care employees earning less than $350,000 but permits noncompetes for high earners that are effective up to one year and cover no more than a 10-mile geographic radius. In Texas, healthcare noncompetes are permitted so long as they are limited to one-year and a five-mile radius, and include a buy-out option capped at the equivalent of the employee's annual salary.

Although the statutory approaches differ, the direction of travel is consistent. States are moving away from traditional common-law reasonableness standards and toward healthcare-specific statutory frameworks that prescribe when, how, and whether restrictive covenants may be enforced.

The Protected Class Is Growing

State legislatures are also expanding *who* receives protection. Recent statutes increasingly focus on the worker's function rather than title alone.

Montana protects a broad group that includes certain behavioral-health practitioners, registered nurses, advanced practice registered nurses, and physician assistants. Rhode Island voids restrictions on advanced-practice registered nurses, subject to a sale-of-practice exception. Texas law applies to dentists, professional and vocational nurses, and physician assistants. Maryland separately covers veterinary practitioners and veterinary technicians. Illinois amended its general statute regulating noncompete agreements to include a complete ban on noncompetes for individuals providing mental health services to veterans and first responders when enforcement of the noncompete is likely to increase the cost or difficulty of obtaining care.

This evolution reflects a broader policy shift as legislatures expand the scope of who should receive coverage, suggesting that future reforms could continue to expand beyond to include other licensed healthcare professionals.

Legislatures Are Focused on Patient Choice and Continuity

Recent legislation has focused on preserving patient choice, continuity of care, and access to providers where services are needed. Maine requires any enforceable healthcare noncompete to recognize an individual's right to choose a healthcare practitioner. Colorado treats a covenant as restricting practice if it prohibits or materially limits a provider from informing existing patients of the provider's continuing practice, new contact information, or the patient's right to choose their provider. Utah voids non-solicitation provisions that prevent a healthcare worker from telling a patient where the worker currently works or will work. These provisions seek to ensure that a provider's transition does not sever established patient relationships or prevent patients from locating and continuing care with their chosen provider. They also reduce barriers to providers moving to practices or communities where their services may be needed.

Other states place affirmative obligations on the employer to minimize disruptions in care when a practitioner departs. Pennsylvania requires employers to notify patients of a practitioner's departure and, if a patient chooses to follow the practitioner, to provide information about transferring the patient's records. Pennsylvania employers must also explain that patients who remain with the employer's practice may be assigned to a new practitioner. Maryland requires certain employers, upon a patient's request, to provide the former provider's new practice location. Texas requires physician restrictive covenants to preserve the practitioner's access to patient lists and records from the prior year and permits continuing care during an acute illness. Montana and Rhode Island prohibit non-solicit agreements that restrict a provider from continuing to treat a patient or establishing a patient-provider relationship.

These provisions also illustrate that state legislatures consider restrictive covenants within healthcare as a broader public health policy issue. Rather than balancing only employer and employee interests, lawmakers are evaluating how restrictive covenants affect patient access, provider shortages, and continuity of care.

Bright-Line Rules are Replacing Judicial Flexibility

State legislatures increasingly specify the permissible duration, geographic scope, timing, and economics. Texas generally requires a buyout amount no greater than the employee's annual salary and wages, a maximum one-year term, a five-mile radius, and clearly and conspicuously stated terms for covered healthcare covenants. A physician covenant is also void if the physician is involuntarily discharged without good cause. Maryland imposes a one-year and 10-mile ceiling for covered direct-care employees above the $350,000 annual compensation threshold. Pennsylvania imposes a one-year limit, and requires that the healthcare provider was not terminated by the employer. Maine delays a covenant's enforceability until the later of one year of employment or six months after execution. In Louisiana, an initial contract may contain a noncompete for up to three years for a primary care physician and five years for other physicians, with the applicable period calculated from the date the agreement became effective.

If the initial contract ends during that period, any post-termination restraint is limited to specific parishes and to a duration of no more than two years.

For employers in these jurisdictions, these statutory requirements leave considerably less room for judicial interpretation and instead require compliance with specific legislative directions.

Protections for Certain Business Interests Remain

While noncompetes for healthcare practitioners are increasingly limited, legislatures have resisted wholly eliminating other traditional post-employment restrictions. Indiana permits nondisclosure agreements protecting confidential information and trade secrets, as well as limited employee non-solicitation provisions that do not restrict patient interactions, referrals, clinical collaboration, or professional relationships. Colorado has preserved reasonable confidentiality and trade secret provisions and permits noncompetes in the context of a purchase or sale of a business. Pennsylvania, Rhode Island, and Oregon have also maintained sale, ownership, or practice-purchase exceptions to healthcare restrictive covenants.

With this approach, state legislatures appear to be balancing patient choice with traditional business interests, such as confidential information, trade secrets, and ownership transactions.

What's Driving the Trends?

Why are legislatures treating healthcare differently than virtually every other industry? The foregoing suggests that they increasingly view restrictive covenants in the healthcare industry not merely as private contracts between employers and employees, but as agreements that can affect communities by influencing where healthcare professionals practice and whether patients can continue seeing the providers they've developed relationships with. In fact, restrictive covenants in healthcare have been subject to greater restrictions even in states that take a more lenient approach to enforcement of noncompetes in other industries. It appears that in numerous instances, patient choice is increasingly trumping contractual freedom. As healthcare labor shortages occur and access to care remains a legislative priority, restrictive covenant reform in this industry may be understood to have become part of broader public health policy rather than simply employment law.

What's Next?

If recent legislative activity is any indication, we can expect to see continued momentum toward broader restrictions. Future legislation may expand protections to additional licensed healthcare professionals, further regulate patient non-solicitation provisions, and continue replacing common-law reasonableness standards with detailed statutory requirements.

What Should Employers Consider Doing?

National or multi-state healthcare employers should consider implementing state-specific restrictive covenants rather than relying on one-size-fits-all approaches. Healthcare employers should also regularly review confidentiality, trade secret, and customer protection provisions as statutory restrictions continue to evolve.

More broadly, as noncompetes become more limited, employers may increasingly need to rely on competitive compensation, retention incentives, and carefully tailored confidentiality protections to retain key talent while protecting legitimate business interests.

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