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Advancing Health in America

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February 22, 2023

The Honorable Lina M. Khan
Chair
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, D.C. 20580

Re: Notice of Proposed Rulemaking, Federal Trade Commission; Non-Compete Clause Rule; 88 Fed. Reg. 3482 (RIN: 3084-AB74) (January 19, 2023)

Dear Chair Khan:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) opposes the Federal Trade Commission's (FTC) proposed Non-Compete Clause Rule in its current form.

The AHA respects the FTC's efforts to address issues of genuine unequal bargaining power between certain employers and certain types of workers. Hospitals and health systems employ a wide variety of personnel, from food service employees in their cafeterias, to nurses, translators and social workers in their patient rooms, to surgeons in their operating rooms. Some hospital employees are highly-trained; some are lower-skilled. Some are highly-compensated; some are lower-wage. But many of these hospital employees, especially physicians and senior executives, do not present the same considerations with respect to non-compete agreements as other types of employees. **The proposed regulation errs by seeking to create a one-size-fits-all rule for *all* employees across *all* industries, especially because Congress has not granted the FTC the authority to act in such a sweeping manner.**

Even if the FTC had the legal authority to issue this proposed rule, now is not the time to upend the health care labor markets with a rule like this. The COVID-19 pandemic exacerbated existing shortages of skilled health care workers, and these shortages will persist well beyond the pandemic. Data shows, for example, that nearly

one-quarter of health care workers say they are likely to leave the field soon.[1] Similarly, the United States will face a physician shortage of as many as 124,000 by 2034.[2] A sister federal agency – indeed, the federal agency with far more expertise with the health care workforce – has reached the same conclusion. Specifically, the Department of Health and Human Services (HHS) has observed that "[s]hortages and maldistribution of health care workers … were a major concern even before the pandemic."[3] The COVID-19 pandemic "put extreme stress on the health care workforce in the United States," causing many hospitals to report "critical staffing shortages."[4] And looking to the future, "many of the impacts the pandemic has had on the workforce are cumulative and may not resolve quickly," and "the longer-term workforce challenges remain."[5]

Despite these long-term workforce challenges, the proposed rule would profoundly transform the health care labor market – particularly for physicians and senior hospital executives. It would instantly invalidate millions of dollars of existing contracts, while exacerbating problems of health care labor scarcity, especially for medically underserved areas like rural communities. Perhaps most troubling, the FTC would take this monumental step on the apparent basis of economic research that does not actually support the proposed rule. It also would do so without a fulsome analysis of the benefits that these agreements bring to hospitals and health systems, and without any analysis of the consequences of applying the rule to only for-profit hospitals, as the law necessitates, when nearly 80% of for-profit hospitals operate in the same markets as non-profit hospitals with many of the same demands for highly-skilled labor and senior executives.

As noted, the proposed rule should be withdrawn because Congress has not given the FTC the power to promulgate it. But if the FTC chooses to proceed with a final rule, it cannot invalidate or ban non-compete agreements without far greater particularized study of the health care labor markets. At the very least, any rule that the FTC finalizes must specifically exempt physicians and senior hospital executives or, more generally, highly-skilled, highly-compensated employees using, for instance, categories that are already well-established in federal law under the exemptions from minimum wage and overtime pay provided by Section 13(a)(1) of the Fair Labor Standards Act.

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[1] *See* Kelly Kooch, *23% of healthcare workers likely to leave healthcare soon, poll finds*, Becker's Hospital Review, February 2, 2022. https://www.beckershospitalreview.com/workforce/23-of-healthcare-workers-likely-to-leave-healthcare-soon-poll-finds.html.
[2] *See The Complexities of Physician Supply and Demand: Projections from 2019 to 2034*, Association of American Medical Colleges, June 2021. https://www.aamc.org/media/54681/download.
[3] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Issue Brief: Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce* (May 3, 2022), *at* https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf.
[4] *Id*.
[5] *Id*.

A. THE FTC LACKS LEGAL AUTHORITY TO ISSUE THE PROPOSED RULE

Before turning to the AHA's hospital-specific policy concerns, it is critical to identify our legal objections to the proposed rule. **Put simply, the FTC has no statutory authority to issue a rule that would invalidate both existing and future non-compete agreements across the entire United States economy.**

The AHA's legal concerns have been well articulated by others, and so the AHA need not to repeat them in great detail here. It is nevertheless important to underscore the proposed rule's many legal shortcomings:

- ***First*, the proposed rule makes clear that the Commission would be acting under Sections 5 and 6(g) of the FTC Act. But those provisions do *not* authorize the agency to engage in rulemaking to prohibit business practices that the FTC deems an unfair method of competition.** Critically, the text of Section 6(g)'s rulemaking authority is limited to agency procedural rules, and Congress has been clear in other contexts (*e.g.*, Fairness to Contact Lens Consumers Act, Children's Online Privacy Protection Act, Telemarketing and Consumer Fraud and Abuse Prevention Act) when it intends to grant the FTC substantive rulemaking authority.[6] Similarly, Magnuson-Moss Act of 1975 expressly excluded rulemaking for unfair methods of competition, and the FTC has not attempted to promulgate such a rule in the nearly half-century since that legislation was enacted.[7] Taken together, statutory text, legislative history, and

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[6] *See generally* Thomas W. Merrill, Antitrust Rulemaking: The FTC's Delegation Deficit, *at* https://administrativestate.gmu.edu/wp-content/uploads/2022/09/Merrill_22-18.pdf ("As evinced by the drafting conventions at the time Congress passed the Federal Trade Commission Act, the original law was never intended to grant legislative rulemaking authority to the FTC. Likewise, Congress repeatedly ratified this interpretation by enacting limited grants of rulemaking power to the FTC in the decades after the original Act. The evidence that the FTC has the power to promulgate legislative rules regulating anti-competitive behavior consists of a single activist D.C. Circuit opinion and a plethora of arguments about why legislative rulemaking power would be a good thing. The Supreme Court should make quick work of these arguments if and when any upcoming rules are challenged."); Thomas W. Merrill and Kathryn Tongue Watts, *Agency Rules with the Force of Law: The Original Convention*), 116 HARV. L. REV. 467 (2002) (reviewing history and reaching same conclusion).

[7] *See, e.g.*, Am. Bar Ass'n, Comments of the Antitrust Law Section of the American Bar Association in Connection with the Federal Trade Commission Workshop on "Non-Competes in the Workplace: Examining Antitrust and Consumer Protection Issues" 57 (April 24, 2020), https://ourcuriousamalgam.com/wpcontent/uploads/Comment-on-Non-Competes-in-the-Workplace_Final_4.24.2020.pdf ("[G]iven that Magnuson-Moss was enacted to address concerns raised by *National Petroleum Refiners* and similar cases, it's hard to see Section 6(g), with its vague and broad language, as providing a firm footing for informal antitrust rulemaking by the Commission …. There have been no antitrust rules promulgated by the Commission post-Magnuson-Moss. Accordingly, the Section remains skeptical of the Commission's authority under Section 6(g) of the Federal Trade Commission Act

historical agency practice make it clear that the FTC cannot rely on Sections 5 and 6(g) to issue the proposed rule.

- ***Second*, even if the FTC had some rulemaking authority under those provisions, Congress has not granted it the authority to regulate such an extensive portion of the American economy in one fell swoop**. As a substantive matter, the FTC grounds its authority to act in Section 5's vague term "unfair method of competition." But "[e]xtraordinary grants of regulatory authority are rarely accomplished through words" like that.[8] And make no mistake, if the Commission were to issue anything remotely resembling the proposed rule, it would be an extraordinary exercise of regulatory authority over "'a significant portion of the American economy.'"[9] As the proposed rule itself observes, this rule would impact *one in five* workers, invalidating millions of private contracts across all American industries. The Commission "must point to clear congressional authorization for the power it claims" here.[10] There is none.

- ***Third*, even if the FTC had the extraordinary regulatory authority to prospectively prohibit *future* non-compete agreements, it lacks such authority to act to invalidate *existing* private contracts**. "Retroactivity is not favored in the law," and an agency may not issue retroactive rules without express congressional authorization.[11] **Here, there is no indication in the text, structure, or history of the FTC Act that Congress intended to grant the Commission the vast authority to retroactively upend millions of pre-existing private contracts, worth billions of dollars of negotiated value.** It is typically understood, moreover, that the consideration for a non-compete clause is the employment itself.[12] Put another way, employers have *already* performed their duty under the contract by hiring the employee; the employee, by contrast,

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to promulgate antitrust rules—in this case, one banning or limiting the use of non-compete clauses in employment agreements as an unfair method of competition. Antitrust problems are in general too fact-specific and context-specific to lend themselves to a broad sweeping rule. Assuming for the sake of argument that noncompete clauses can raise competition concerns, they would seem to do so only under particular circumstances and conditions, thereby requiring case-by-case adjudication instead of the issuance of a trade regulation rule.").

[8] *West Virginia v. EPA*, 142 S. Ct. 2587, 2609 (2022).

[9] *Id*. at 2608 (quoting *Utility Air Regulatory Group v. EPA*, 573 U. S. 302, 324 (2014).

[10] *Id*. at 2609.

[11] *Bowen v. Georgetown Univ. Hosp*., 488 U.S. 204, 208 (1988).

[12] *See, e.g*., *Socko v. Mid-Atlantic Sys. of CPA, Inc*., 633 Pa. 555, 126 A.3d 1266, 1275 (2015) ("If a noncompetition clause is executed at the inception of the employment, the consideration...may be the award of the position."); *Stone Legal Resources Group, Inc. v. Glebus*, No. CA025136, 2002 WL 35654421, at *5 (Mass. Super. Dec. 16, 2002) (there is sufficient consideration at the beginning of employment because the non-competition is signed in exchange for employment); *Farm Bureau Serv. Co. of Maynard v. Kohls*, 203 N.W.2d 209, (Iowa 1972) ("continuing employment for an indefinite period is sufficient consideration to support a covenant not to compete").

still has not completed her duty to abide by the non-compete agreement. As such, there are legitimate constitutional doubts under the Takings Clause because the FTC would be appropriating services by employees not yet rendered – namely, their agreement not to compete – even though those services had already been paid for.[13] Thus, to the extent the FTC can identify any statutory authority for the retrospective invalidation of agreed-upon contracts, or to the extent the Commission seeks to evade that characterization by inaccurately claiming it is merely halting the enforcement of future enforcement of contract provisions, these constitutional concerns should inform any statutory analysis.[14] **Ultimately, given these twin legal infirmities, the FTC, at the very least, should not act *retroactively* by invalidating existing non-compete agreements.**

- ***Fourth,* the FTC lacks legal authority to exercise its Section 5 powers with respect to non-profit entities, including non-profit hospitals and health systems.** Section 5 provides that the Commission is "empowered and directed to prevent persons, partnerships, or corporations." But the Act defines "corporations" as "any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members."[15] This text plainly does not include non-profit entities. **Although the proposed rule alludes to this legal limitation (88 Fed. Reg. at 3510), any final rule should unmistakably indicate that it does not apply to non-profits, including non-profit hospitals and health systems**.[16]

For all of these reasons, the proposed rule cannot survive legal scrutiny. The Commission should withdraw it.

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[13] *E.g.*, *Chang v. United States*, 859 F.2d 893, 895, 899 (Fed. Cir. 1988) ("[A]s the Supreme Court also recognized in *Connolly* [*v. Pension Benefit Guaranty Corp*, 475 U.S. 211, 224], "'[t]his is not to say that contractual rights are never property rights or that the Government may always take them for its own benefit without compensation."… Most importantly, the plaintiffs do not complain that the sanctions resulted in a loss of income for services *previously provided but not yet paid for*, merely the loss of the contingent right to future income for services yet to be rendered." (emphasis added)).

[14] *E.g.*, *Jennings v. Rodriguez*, 138 S.Ct. 830, 842 (2018) ("When 'a serious doubt' is raised about the constitutionality of an act of Congress, 'it is a cardinal principle that this Court will first ascertain whether a construction of the statute is fairly possible by which the question may be avoided.' (quoting *Crowell v. Benson*, 285 U.S. 22, 62 (1932))).

[15] 15 U.S.C. § 44.

[16] As explained below (at page 16), the consequences of this differential treatment between non-profit and for-profit hospitals requires further study by the Commission. Without additional study, any application of the proposed rule to the hospital field would be arbitrary and capricious.

Withdrawing the proposed rule *will not* mean that non-compete agreements will go unregulated. States have long demonstrated an ability to regulate non-compete agreements in a nuanced manner, consistent with local conditions and markets. In particular, states have demonstrated an ability to address non-compete agreements in the health care field in a thoughtful, finely-drawn manner. For example:

- Some state statutes regulate non-compete agreements only for low-wage workers[17];
- Some states exclude physicians from any restrictions on non-compete agreements[18];
- Texas allows non-compete agreements for physicians, but provides that all such agreements must allow a departing physician to end her or his non-compete agreement by paying a buyout[19]; and
- New Mexico bars non-compete agreements only once a health care practitioner begins working for her employer (*i.e*., a mid-employment non-compete agreement)[20]; and
- Some states have appropriately started to specifically limit the use of non-compete agreements by nurse staffing agencies[21].

This considered variation, on its own, makes clear that a one-size-fits-all rule for physicians is unwise, let alone a one-size-fits all rule across the entire United States economy. In addition, state courts have been evaluating the reasonableness of non-compete agreements on a fact-specific basis for decades, and there is no indication that they cannot continue to do so in a responsible and effective manner. There is, therefore, good reason why Congress has not given the Commission or any other federal agency the authority to regulate non-compete agreements. **Consequently, absent any federal statutory authority to impose a sweeping rule of this kind, questions regarding non-compete agreements' enforceability should continue to be left to the states**.

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[17] *E.g*., 820 Illinois Compiled Law 90/5; Rhode Island Gen. Laws § 28-59-2
[18] *E.g*., District of Columbia Law 24-175; Tennessee Code § 63-1-148.
[19] *See* Tex. Bus & Com.15.50.
[20] NM Stat § 24-1I-2 (2015)(C).
[21] *E.g*., 225 Illinois Compiled Law 510/14(g); Iowa Code § 135Q.2; *cf*. Letter from Melinda Hatton to Acting Chairwoman Rebecca Slaughter, Feb. 4, 2021, *at* https://www.aha.org/system/files/media/file/2021/02/aha-urges-ftc-examine-anticompetitive-behavior-nurse-staffing-agencies-commercial-insurers-2-4-21.pdf ("The AHA has received reports from hospitals across the nation that nurse-staffing agencies, which supply desperately needed staff to care for patients suffering from the COVID-19 virus and other conditions that require hospitalization, are engaged in anticompetitive pricing.… [W]e request the FTC use its authority to protect consumers from anticompetitive and unfair practices to investigate this activity and take appropriate action to protect hospitals and the patients whom they treat.")

B. IF THE AGENCY MOVES FORWARD DESPITE THESE LEGAL INFIRMITIES, IT MUST EXEMPT THE HOSPITAL FIELD OR, AT THE VERY LEAST, DOCTORS AND SENIOR HOSPITAL EXECUTIVES FROM ITS BAN ON NON-COMPETE CLAUSES

"Agencies do not ordinarily have to regulate a particular area all at once."[22] In fact, more often than not, that is the best approach when faced with complex economic issues. In this situation, the FTC not only lacks the legal authority to issue this far-reaching ban on non-compete agreements, it lacks the evidentiary support to do so. As explained below, the weight of the existing research indicates that non-compete agreements for certain categories of employees are beneficial – namely, doctors and senior hospital executives. This is exactly the experience of the AHA's member hospitals and health systems. Accordingly, if the FTC issues a final rule banning non-compete agreements at all, that rule should exempt hospitals and health systems or, at the very least, be limited to lower-skilled, low wage workers.

1. THE EVIDENCE CITED IN THE PROPOSED RULE (AND OTHERWISE AVAILABLE TO THE COMMISSION) DOES NOT SUPPORT APPLYING THE PROPOSED RULE TO PHYSICIANS

One of the FTC's primary justifications for the proposed rule is that it "would increase earnings for workers in all of the subgroups of the labor force for which sufficient data is available."[23] According to the Commission, "the evidentiary record indicates non-compete clauses depress wages for a wide range of subgroups of workers across the spectrum of income and job function."[24] But the evidentiary record – including the primary study cited by the Commission regarding physicians – demonstrates the opposite. The use of non-compete clauses actually *increases* the rate of earnings growth for doctors. In addition, the lead author of that study, Professor Kurt Lavetti, presented at a January 2020 FTC workshop on non-competes, where he stated that "both physician firms and workers appear to *benefit* from the use of non-compete agreements."[25] Given this evidence already in the administrative record, it would be arbitrary and capricious for the FTC to apply its proposed rule to physicians.

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[22] *Transportation Div. of the Int'l Ass'n of Sheet Metal, Air, Rail & Transp. Workers v. Federal R.R. Admin.*, 10 F.4th 869, 875 (D.C. Cir. 2021).
[23] 88 Fed. Reg. at 3501.
[24] *Id*.
[25] Kurt Lavetti, *Economic Welfare Aspects of Non-Compete Agreements*, Remarks at the Fed. Trade Comm'n Workshop on Non-Compete Clauses in the Workplace (Jan. 9, 2020) (emphasis added), *at* https://www.ftc.gov/system/files/documents/public_events/1556256/non-compete-workshop-transcript-full.pdf.

Throughout the proposed rule, the FTC cites to a study that focuses on physician earnings: Kurt Lavetti, Carol Simon, & William D. White, The Impacts of Restricting Mobility of Skilled Service Workers Evidence from Physicians, 55 J. Hum. Res. 1025, 1042 (2020). As the Commission observes, that study found that the "use of non-compete clauses among physicians is associated with greater earnings (by 14%) and greater earnings growth.[26]

Faced with findings that squarely contradict the FTC's basis for the proposed rule, the Commission attempts to downplay or evade them. Its efforts are unavailing. For example, the proposed rule contends in one breath (at 3487) that the study "does not consider how changes in non-compete clause enforceability affect physicians' earnings," but later concedes that the study concluded (at 3501 n.248) that "there is evidence that increased enforceability of non-compete clauses increases the rate of earnings growth for physicians."[27] And in an even greater indication that the evidence does not support its preferred policy result, the FTC gratuitously reinterprets data from that study (at 3524) to reach conclusions that the authors never actually studied or reached themselves.[28] Yet even then, the most the proposed rule can say (at 3501 n.248) is that the "proposed rule *may* increase physicians' earnings, although the study does not allow for a precise calculation." What is clear is that the only actual study regarding physician pay *supports* the use of non-competes. The FTC's efforts to avoid that conclusion highlights the lack of any evidentiary basis for applying its proposed rule to that class of workers and demonstrates the arbitrary and capricious nature of the proposed rule. For this reason alone, the Commission should withdraw its proposed rule as to physicians.

To make matters worse, the FTC ignores other features of the study that were presented at one of the Commission's own workshops. There, Professor Lavetti explained: "What we find is that in physician groups that use non-compete agreements, doctors are much more likely to make referrals of their patients to other doctors within the same practice, because they don't have to be as concerned about their fellow colleagues getting to know their patients and then opening a business next-door and poaching the patients."[29] According to Professor Lavetti, these increased referrals have

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[26] 88 Fed. Reg. at 3487.
[27] *See Nat. Res. Def. Council v. U.S. Nuclear Regul. Comm'n*, 879 F.3d 1202, 1214 (D.C. Cir. 2018) ("it would be arbitrary and capricious for [an] agency's decision making to be internally inconsistent." (internal quotation marks omitted)).
[28] *E.g.*, *National Gypsum Co. v. EPA*, 968 F.2d 40, 43–44 (D.C.Cir.1992) (agency cannot "infer" facts not in the record).
[29] Kurt Lavetti, *Economic Welfare Aspects of Non-Compete Agreements*, Remarks at the Fed. Trade Comm'n Workshop on Non-Compete Clauses in the Workplace (Jan. 9, 2020) (emphasis added), *at* https://www.ftc.gov/system/files/documents/public_events/1556256/non-compete-workshop-transcript-full.pdf.

three important pro-competitive and pro-health care consequences. As noted, doctors, on average, are able to bargain for higher wages over the course of their careers.[30] Employers increase their overall revenue because there is greater intra-institutional referrals.[31] And patients receive better, more integrated care through, what Lavetti called, "this patient-sharing story."[32] The experience of the AHA's member hospitals and health systems supports these conclusions.[33]

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[30] *Id*. ("For an average physician who signs a non-compete agreement, the net present value of the earnings effect at the time that they sign the contract is positive $650,000 over a single job spell, which is about 15 years, on average. They make substantially more money, and all of that difference comes from larger within-job earnings growth.").

[31] *Id*. ("That, in turn, leads these practices to generate percent more revenue per hour worked.… There's much more fluid referral of patients across doctors within groups that use these types of contracts. These gains don't seem to occur in states that have nonenforceable NCA laws.").

[32] *Id*.; *see, e.g*., Kaiser Permanent Institute for Health Policy, *An overview of our integrated care model*, *at* https://www.kpihp.org/integrated-care-stories/overview/ (discussing the benefits of integrated care); Cleveland Clinic, *Integrated Care*, *at* https://my.clevelandclinic.org/about/community/sustainability/sustainability-global-citizenship/patients/integrated-care#overview-tab (same).

[33] Lavetti, Simon and White's finding that non-compete agreements increase physician wages and intra-firm patient referrals undermines the Commission's reliance on another study by Professor Lavetti that the Commission relies on in the proposed rule. The Commission cites a study by Naomi Hausman and Professor Lavetti for the Commission's assertion (at 3490) that there "is evidence that non-compete clauses increase consumer prices and concentration in the health care sector." Whatever evidence exists, however, should be taken with a grain of salt. As an initial matter, the Hausman-Lavetti study did *not* focus on whether the use or enforceability of non-compete agreements increases concentration; instead, it focused on whether concentration leads to an increase in consumer prices, and only used variation in non-compete agreement enforcement as the natural experiment that generates 'experimental' variation in concentration. Even so, the paper never clearly shows whether increased enforcement causes an increase in *firm-level* concentration, and the proposed rule itself explains (at 3490 n.101) that "[f]or the purposes of consumer outcomes such as a price or product quality, the relevant measure of concentration is at the firm level, since firms are unlikely to compete against themselves on price or quality."

More to the point, Professor Lavetti's other research likely explains why consumer prices may slightly increase in connection with the enforcement of non-compete agreements. As noted, the Lavetti, Simon and White study indicates that the use of non-compete agreements can increase physician wage growth, which may be passed along to patients as higher prices. Thus, the increased prices associated with non-compete agreement enforcement may be the result of improvements for workers (physicians). Likewise, increased consumer prices may be the result of improved quality of care (*e.g*., increases intra-institution patient referrals and all of the other reasons, discussed below, why non-compete agreements incentivize investments that lead to improved care), which Hausman and Lavetti do not study. Again, as Professor Lavetti himself testified before the FTC, more evidence is needed, including with respect to his work on concentration and consumer prices. *See* Kurt Lavetti, *Economic Welfare Aspects of Non-Compete Agreements*, Remarks at the Fed. Trade Comm'n Workshop on Non-Compete Clauses in the Workplace (Jan. 9, 2020) (emphasis added), *at* https://www.ftc.gov/system/files/documents/public_events/1556256/non-compete-workshop-transcript-full.pdf ("Consumers may, of course, value access to convenient, integrated practices, where records and computer systems are shared across locations."); *see id*. ("Now, a lot of this, I want to caution, comes

All in all, the Commission cannot justify a ban on non-compete agreements for physicians based on the evidence it cites in the proposed rule or what was presented at FTC-sponsored workshops.[34] At a minimum, as Professor Lavetti testified, "more empirical evidence is necessary before a comprehensive ban would be scientifically justified to curtail non-competes in all contexts.…"[35]

2. ADDITIONAL EVIDENCE DEMONSTRATES THE VALUE OF NON-COMPETE AGREEMENTS FOR PHYSICIANS AND SENIOR HOSPITAL EXECUTIVES

In addition to increasing physician wage growth and promoting patient referrals (and, in turn, integrated care), there are several other benefits of reasonable non-compete agreements with physicians and senior hospital executives.

First, non-compete agreements are valuable tools for protecting investments that hospitals make to recruit doctors and senior executives. This is particularly important in rural and other medically underserved areas. According to data from HHS, in March 2020 almost 70% of areas designated as primary medical health professional shortage areas were considered rural or partially rural.[36] This shortage will only worsen in the coming years because the rural physician population is disproportionately older, with one-quarter anticipated to retire by 2030.[37] What's more, "shortages among one profession or specialty have a domino effect on others," with serve adverse consequences for rural hospitals.[38] As an expert panel explained last year in a report to Congress and the HHS Secretary:

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from the fact that we see smaller establishments. Because establishment size is shrinking, small establishments tend to have higher overhead and, therefore, higher prices.").

[34] At a minimum, as Professor Lavetti testified, "more empirical evidence is necessary before a comprehensive ban would be scientifically justified to curtail non-competes in all contexts.…" *Id*.; *see id*. ("My summary opinion overall, just to wrap up, is that my own opinion is that the scientific standard for a complete ban on non-compete agreements should be quite high. Non-competes have been used for a long time, and the literature is, in a relative sense, nascent compared to the history of the use of non-compete agreements. I think there are policies that can be used to protect vulnerable workers while still permitting non-competes in other contexts.").

[35] *Id*.; *see id*. ("My summary opinion overall, just to wrap up, is that my own opinion is that the scientific standard for a complete ban on non-compete agreements should be quite high. Non-competes have been used for a long time, and the literature is, in a relative sense, nascent compared to the history of the use of non-compete agreements. I think there are policies that can be used to protect vulnerable workers while still permitting non-competes in other contexts.").

[36] *See* Health Resources and Services Administration, Bureau of Health Workforce, *Designated Health Professional Shortage Areas Statistics*, First Quarter of Fiscal Year 2022.

[37] *See* Lucy Skinner, et al., *Implications of an Aging Rural Physician Workforce*, N Engl J Med 2019; 381:299-301.

[38] Council on Graduate Medical Education, *Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities* (Apr. 2022), *at* https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/reports/cogme-april-2022-report.pdf.

> [L]ack of access to a general surgeon as backup limits the availability of other hospital services such as trauma care, oncology treatment and colonoscopy screening. This interdependence is not limited to general surgeons. Recent reports have highlighted declining access to maternity care in rural communities, in part because hospitals face chronic shortages of maternity-care providers such as family physicians, obstetricians, certified nurse midwives, and labor and delivery nurses, as well as surgeons and anesthesiology providers. Primary care workforce shortages and difficulty accessing specialty services result in unnecessary trips to the emergency room, further straining hospitals that are already underfunded and understaffed.[39]

In addition, rural hospitals need skilled and committed executives to help them survive in challenging economic conditions. From 2010 to 2021, 136 rural hospitals closed, with a record 19 closures in 2020 alone. These closures make it pellucidly clear that rural hospitals and health systems need to be resourceful in pursuing opportunities that improve financial stability and viability. Participation in innovative payment models that provide additional investment and flexibilities can be a helpful resource too. Access to capital is important to stabilizing a vulnerable hospital or advancing an innovative one. For some rural hospitals, partnerships, collaborations, mergers or affiliations also can be a good option. But these efforts require savvy, talented leaders, both to come to rural hospitals in the first place and to stay there when they are inevitably presented with other professional opportunities.

For these reasons, it is apparent why rural and other understaffed hospitals would want to negotiate reasonable non-compete agreements. If, however, hospitals and health systems were unable to negotiate reasonable non-compete agreements as a result of the FTC's proposed rule, there would be a range of negative outcomes. For instance, nearby employers could free-ride on the initial hospital's investment in recruiting both doctors and senior executives by offering more pay to convince the employee to move a few counties away. The initial hospital's investments in searching for candidates, providing a signing bonus, relocation pay, and guaranteeing a salary for a period of time while that physician established herself in the community would be lost. This, in turn, would discourage these kinds of recruiting investments in the first place. Similarly, it would create a classic "holdup problem," whereby the recruited doctor or senior executive would have the ability to threaten to leave her initial hospital – be it for a nearby rural hospital or even a farther-away urban or suburban one – unless economically-unsupportable demands are met.[40] Here, the holdup problem would be exacerbated by existing workforce shortages, particularly in certain areas of the country.

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[39] *Id*.

[40] The previously discussed study by Professor Lavetti and others analyze whether the desire to retain employees motivated firms to negotiate non-compete agreements. The authors found that for primary

Second, non-compete agreements encourage hospitals and health systems to make investments in training their employees. While much of a physician's training occurs in medical school and residency, doctors must stay current with scientific developments and innovation. There is a constant stream of new research and technological innovations with the potential to improve patient care, and every practicing physician is always continuing his or her education. This also is the case for senior executives, who often receive management training, attend conferences and generally develop relevant leadership skills.

In standard economic terms, this kind of continued learning is considered "general human capital," *i.e*., skills or knowledge that has productive value in *other firms*, as well as her employing firm.[41] A doctor or executive who receives training in "general human capital" can quit and get a higher wage at another firm on the basis of that increased skill and knowledge. As a result, firms have weaker incentives to invest in training unless a non-compete agreement is in place. Non-compete agreements thus encourage hospitals to make sound investments in training because they know it will redound to their own patients' and communities' benefit. This is exactly the experience of AHA's members.[42]

Studies support this commonsense economic principle and real-world experience of hospitals. In fact, as FTC economist John McAdams has generally observed: "The bulk of the empirical literature finds that workers signing non-compete agreements, or workers who reside in areas with a higher incidence of NCAs, receive more training."[43] In fact, the proposed rule cites two studies but fails to acknowledge the relevant finding with respect to increased training. For example, one study found that for those who accept non-compete agreements before accepting a job, those employees are 11%

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care physicians "turnover reductions appear to be substantial, [but] they are very unlikely to be the primary motivation behind the use of NCAs among physician practices." Kurt Lavetti, Carol Simon, & William D. White, *The Impacts of Restricting Mobility of Skilled Service Workers Evidence from Physicians*, 55 J. Hum. Res. 1025, 1042 (2020). The AHA agrees with this to the extent the study recognizes that limiting turnover is a "substantial" motivation, and emphasizes that not all hospitals have the same motivations for pursuing non-compete agreements. As noted, retention may be a greater motivator for rural or other geographically isolated hospitals.

[41] *See generally* Gary S. Becker, *Human Capital* (3d ed. 1993).

[42] Although this discussion focuses mainly on training, there are additional forms of "general human capital" that would be transferrable absent non-competes, including expenditures by hospitals to market physicians in the community and expand patient relationships. As with training, hospitals will be more loath to make these purely business investments if doctors could bring those assets with them to another employer.

[43] John McAdams, *Non-Compete Agreements: A Review of the Literature*, SSRN Working Paper, SSRN-id3513639, *at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3513639; *see id*. ("The papers relying on state policy changes for identification find that non-competes lead to more firm-sponsored training among top public executives.").

more likely to have received training in the prior year.[44] Similarly, another study compared workers in states with different degrees of enforcement of non-compete agreements. It found that moving from no enforcement to the average degree of enforcement was associated with a 14% increase in employer-sponsored training of workers and no change in worker-sponsored training.[45] Although these studies did not focus specifically on physicians, the findings are significant because they again align with the experience of the AHA's members. While hospitals and health systems always strive to provide the most cutting-edge medical care and executive leadership, non-compete agreements allow them to best internalize the value of their investments.

Third, non-competes encourage the sharing of proprietary information within hospitals and health systems. For physicians, that information could include anything from patient lists to innovative research and development that can lead to improved care. For senior hospital executives, that proprietary information could include company strategy, internal business processes, names of key suppliers and customers, data with respect to payers, strengths and weaknesses vis-à-vis competitors, and more. Hospitals and health systems will want to protect the intellectual capital acquired by doctors and senior executives from falling into the hands of rivals because this information could give them an advantage. Ultimately, hospitals are by no means unique in this regard, but it is important to emphasize that this is precisely the kind of proprietary information that hospitals and health systems need to retain within their walls to stay competitive and thrive.

Crucially, non-disclosure agreements or other contractual provisions cannot fully protect employers from the outflow of proprietary information because a former employee cannot completely erase information from her own mind. And, in many instances relevant to hospital research, former employees cannot help but rely on valuable information in their subsequent employment (*e.g.*, a medical scientist will not have to re-run all of the same failed experiments she ran for her initial employer, which that initial employer paid for but her next employer will not). What's more, NDAs do not allow employers to monitor ex-employees' disclosures on a regular basis. Reasonable non-

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[44] *See* Evan P. Starr, James J. Prescott, & Norman D. Bishara, *Noncompete Agreements in the U.S. Labor Force*, 64 J.L. & Econ. 53, 53 (2021); *id*. ("Several of the facts we document are consistent with the traditional economic perspective, which views the noncompete as an efficient contracting device.… [O]ur evidence that employees with early notice of a noncompete are compensated—with higher wages, more training, information, and job satisfaction—is compatible with theories that identify noncompetes as a solution to a holdup problem.").

[45] *See* Evan Starr, *Consider This: Training, Wages, and the Enforceability of Non-Compete Clauses*, 72 I.L.R. Rev. 783, 799 (2019). To be sure, the study also found that the same increase in non-compete enforcement was associated with 4% lower hourly wages, which the author attributes to decreased worker bargaining power. This result is based on decreases in hourly wages as workers remain at the same employer. Notably, the previously-discussed study by Lavetti, Simon, and White found an increase in earnings growth for physicians.

compete clauses are thus the only way employers can negotiate protections for their proprietary information.

Non-compete agreements enable firms to encourage the sharing of proprietary information across the firm because they know that it will be protected. Again, economic studies support this. Similar to his above-quoted observation with respect to training, FTC economist John McAdams found that the "bulk of the research" concludes that non-compete agreements provide workers with "more access to information."[46] For example, the Starr, Prescott, and Bishara study, discussed above, of non-compete agreements reached before an employee starts employment found that those agreements increased the likelihood, by 7.8%, that the worker reported that her employer shares all job-related information.[47] Similarly, the Lavetti, Simon, and White study found that non-compete agreements lead to the sharing of information about what they call a firm's "most valuable" asset: client (*i.e.*, patient) relationships.[48]

Regrettably, the proposed rule fails to acknowledge these and other beneficial aspects of non-compete agreements. **Any final rule must take full account of both the existing economic literature and the real-world experience of hospitals and health systems, which has been that non-compete agreements for physicians and senior executives incentivize recruitment, retention, training, investments in career-building (*e.g.*, marketing and building individual physician practices) and the sharing of a broad range of proprietary information.**

3. ANY FINAL RULE MUST EXEMPT PHYSICIANS AND SENIOR HOSPITAL EXECUTIVES, OR SIMILARLY-SITUATED CATEGORIES OF EMPLOYEES

For all of the reasons stated in the previous two subsections, the FTC should exclude physicians and senior hospital executives from any final rule it may issue. As to physicians, the only available evidence demonstrates that the Commission was simply incorrect when it stated (at 3518) that excluding these kinds of highly-skilled workers "would deny these workers the benefits of higher earnings." As to both physicians and senior executives, the FTC failed to account for the many benefits that reasonable non-compete agreements carry, all of which are supported by both economic research and the real-world experience of AHA's member hospitals and health systems. **There is**

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[46] John McAdams, *Non-Compete Agreements: A Review of the Literature*, SSRN Working Paper, SSRN-id3513639, *at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3513639; *see id*. ("Studies relying on cross-sectional comparisons tend to find that non-competes are associated with more training and information sharing.").
[47] *See* Evan P. Starr, James J. Prescott, & Norman D. Bishara, *Noncompete Agreements in the U.S. Labor Force*, 64 J.L. & Econ. 53, 53 (2021).
[48] Kurt Lavetti, Carol Simon, & William D. White, *The Impacts of Restricting Mobility of Skilled Service Workers Evidence from Physicians*, 55 J. Hum. Res. 1025, 1042 (2020).

simply no legal, evidentiary, or policy reason to include physicians or senior hospital executives in the FTC's across-the-board ban on non-compete agreements.

Based on the language of the proposed rule and public statements by FTC officials since its publication, such exclusions would be consistent with what appears to be the Commission's primary goal. Doctors and executives are fundamentally different from other workers that have received the most attention from the FTC.[49] Critically, the FTC's core concerns of genuinely unequal bargaining power at the time of hiring or exit do not apply. As the Commission itself found (at 3503), "senior executives are likely to negotiate the terms of their employment and may often do so with the assistance of counsel." In the experience of AHA member hospitals, the same is true for physicians. These categories of employees negotiate on an even playing field with their employers, especially as compared to lower-skilled and lower-wage workers. **Accordingly, the Commission should exercise its "great discretion to treat a problem partially" and "regulat[e] in a piecemeal fashion" by exempting physicians and senior hospital executives. It should instead direct its limited resources on those who truly experience unequal bargaining power**.[50]

Relatedly, the FTC requested comment on whether, as a general matter, different standards should apply to highly-skilled and highly-paid workers, and how senior executives could be defined. To the extent the Commission does not wish to simply exclude physicians and senior hospital executives from its rule, it can look to other areas of federal law to more broadly exempt highly-skilled and highly-compensated workers.

In particular, the Fair Labor Standards Act (FLSA) and its implementing regulations provides a closely analogous model. The FLSA generally requires that employees in the United States be paid at least the federal minimum wage for all hours worked and overtime pay at not less than time and one-half the regular rate of pay for all hours worked over 40 hours in a workweek. But, as authorized by statute[51], Department of Labor regulations contain exemptions from this requirement, including for "learned professionals," "highly compensated employees," and even employees in the practice of medicine[52]. **These are finely-drawn, well-established legal categories that the**

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[49] *See* CNN, *FTC seeks to ban non-compete clauses, affecting 30M Americans*, *at* https://www.cnn.com/videos/business/2023/02/11/smr-ftc-noncompete-clauses.cnn (interview with FTC Director of the Office of Planning Elizabeth Wilkins discussing "hair stylists" and "security guards"); PBS News House, *Federal Trade Commission proposes ban on noncompete clauses* (Jan. 5, 2023), *at* https://www.pbs.org/newshour/show/federal-trade-commission-proposes-ban-on-non-compete-clauses (interview with FTC Director of the Office of Planning Elizabeth Wilkins discussing "folks who are flipping burgers" and "middle-wage workers").

[50] *Ctr. for Biological Diversity v. EPA*, 722 F.3d 401, 409–10 (D.C. Cir. 2013).

[51] 29 U.S.C. § 213(a)(7).

[52] *See* 29 C.F.R. § 541.301 (learned professionals); 29 C.F.R. § 541.304 ("practice of law or medicine"); 29 C.F.R. § 541.601 (highly compensated employees).

Commission can – and should – look to when re-evaluating its rule regarding non-compete agreements. Relying on these three categories would address the AHA's concerns about invalidating non-compete agreements for physicians and senior executives. But more important for the Commission's ostensible purposes here, several of the FLSA-exemption categories would carve out those with equal bargaining power, while allowing the Commission to exercise any regulatory authority it believes it has towards protecting lower-skilled and lower-wage employees.

C. THE COMMISSION SHOULD EXEMPT FOR-PROFIT HOSPITALS AND HEALTH SYSTEMS BECAUSE IT MUST CONDUCT FURTHER STUDY INTO THE CONSEQUENCES OF CREATING DISEQUILIBRIUM BY HAVING TO EXEMPT, AS A MATTER OF LAW, NON-PROFIT HOSPITALS FROM ITS BAN ON NON-COMPETE AGREEMENTS

A unique feature of the U.S. hospital market is that it includes non-profit, for-profit, and state and local government hospitals. In fiscal year 2020, 58% of U.S. hospitals were non-profit, 24% were for-profit, and 19% were state and local government hospitals.[53] AHA data indicates that ***78.8%*** of for-profit hospitals are located in the same Hospital Referral Region (HRR) as one non-profit hospital. Unlike other markets, then, non-profit hospitals sometimes work to attract the same employees as for-profit hospitals.

As noted above, however, the FTC lacks authority to apply its proposed rule to non-profit hospitals and health systems. This means that the proposed rule, if finalized, will apply *only* to for-profit hospitals. That disparate treatment may carry significant consequences for the health care labor markets. It is possible, for instance, that this disequilibrium could reduce the available supply of highly-trained, highly-skilled labor for for-profit hospitals in particular markets, driving up the price for such labor or at least creating serious instability in those markets. Market distortions of this kind would arise in the context of an already-challenging workforce shortage for America's hospitals (*see infra* at 1-2). The impact of this uneven playing field is counter to the stated purpose of the FTC's order.

It is unclear whether the Commission or any experts have sufficiently studied the distortions that the proposed rule would cause in this singular situation where federal law creates an uneven playing field for similarly or at least closely situated market participants.[54] It also is unclear whether the FTC could sufficiently address the significance of this problem in the anticipated timeframe for this rulemaking. **We**

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[53] American Hospital Association, Fast Facts on U.S. Hospitals, 2022, *at* https://www.aha.org/system/files/media/file/2022/02/Fast-Facts-2022-Infographics.pdf.

[54] *See generally Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.,* 463 U.S. 29, 43 (1983) ("[A]n agency [decision is] arbitrary and capricious if the agency ... entirely failed to consider an important aspect of the problem.").

therefore urge the agency to exempt for-profit hospitals from any final rule it issues until it can better study the impact that applying the rule in an uneven fashion, as the law requires, would have on labor markets that include both non-profit and for-profit hospitals.[55]

D. THE EXEMPTION FOR THE SALE OF A BUSINESS SHOULD NOT BE DEFINED BY "SUBSTANTIAL OWNERSHIP"

The FTC proposes to exempt non-compete clauses from its rule where a "seller's stake in [a] business is large enough that a non-compete clause may be necessary to protect the value of the business acquired by the buyer."[56] To that end, the proposed rule states that "the party restricted by the non-compete clause [must be] a substantial owner of, or substantial member or substantial partner in, the business entity," which the rule then proceeds to define as "as an owner, member, or partner holding at least a 25% ownership interest in a business entity."[57]

The AHA respectfully submits that the proposed 25% ownership threshold is unnecessary. Implicit in the FTC's creation of an exemption is the recognition that some non-compete agreements at the time of the sale of a business are pro-competitive. Indeed, the proposed rule states that such agreements may be "necessary to protect the value of the business acquired by the buyer."[58] While the AHA appreciates the FTC's attempt to provide clarity, states have functioned well in this area without a bright-line rule. For example, some states provide a specific statutory exemption without a particular numerical threshold[59]; other states consider the non-compete clause under the general reasonableness test. Both approaches demonstrate that it is possible to achieve the FTC's goal of eliminating non-compete agreements where ownership interests are too low, but without setting an artificial numerical ownership requirement. **Accordingly, any final rule should allow for that same case-by-case flexibility by**

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[55] *E.g.*, *Ass'n of Proprietary Colleges v. Duncan*, 107 F.Supp.3d 332, 368 (S.D.N.Y. 2015) ("DOE analyzed a number of options but ultimately decided that 'further study is necessary before we adopt [an] accountability metric that would take into account the outcomes of students who do not complete a program.' If anything, DOE would have risked violating the APA had it included one of these unproven metrics in the D/E rates calculus. That it chose not to shows restraint and careful consideration, not arbitrariness or capriciousness.").

[56] 88 Fed. Reg. at 3510.

[57] *Id*.

[58] *Id*.

[59] For example, California law contains a statutory exemption, but it does not set an artificial numerical threshold. *See* California BPC § 16601; *Strategix, Ltd. v. Infocrossing West, Inc.*, 142 Cal. App. 4th 1068, 1072-73 (Cal. Ct. App. 2006) ("Section 16601's exception serves an important commercial purpose by protecting the value of the business acquired by the buyer. In the case of the sale of the goodwill of a business it is 'unfair' for the seller to engage in competition which diminishes the value of the asset he sold. Thus, the thrust of ... section 16601 is to permit the purchaser of a business to protect himself or itself against competition from the seller which competition would have the effect of reducing the value of the property right that was acquired.").

adopting an exemption that permits all reasonable non-compete clauses upon the sale of a business.

E. CONCLUSION

For all of the reasons stated above – including its lack of authority to issue it – the FTC should withdraw the proposed rule. If it persists in issuing a final rule, the FTC would serve itself and the public best by heeding the Supreme Court's observation: "Agencies, like legislatures, do not generally resolve massive problems in one fell regulatory swoop…. They instead whittle away at them over time, refining their preferred approach as circumstances change and as they develop a more nuanced understanding of how best to proceed." *Massachusetts v. EPA*, 549 U.S. 497, 524 (2007). Here, that wise approach requires the Commission to exempt hospital and health systems altogether or, at the very least, more narrowly focus its attention on lower-skilled, lower-wage workers who have genuinely unequal bargaining power vis-à-vis their employers.

Sincerely,

/s/

Melinda Reid Hatton
General Counsel and Secretary