Advancing High Performance Health

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

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

Dear Chairwoman Khan:

On behalf of AMGA, I appreciate the opportunity to comment on the Federal Trade Commission's (FTC) proposed Non-Compete Clause Rule (RIN: 3084-AB74).

Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective, patient-centered medical care. Our members are at the forefront of population health management and the transition to value-based care. As part of those efforts, AMGA and its provider members emphasize care coordination and person-centered care.

AMGA appreciates the FTC's intent to promote healthy competition and innovation in the marketplace. However, our nation is experiencing an unprecedented healthcare workforce crisis, and the proposed rule would effectively prohibit non-compete agreements in the healthcare setting, further destabilizing local healthcare labor markets. Accordingly, AMGA disagrees with the FTC's proposal and believes it should be withdrawn.

The proposal would create a national framework for contractual provisions historically regulated effectively by individual states. Rather than fostering competition and protecting workers in the healthcare sector, the proposal will hinder the coordination of patient care and undermine competition by increasing costs for multispecialty medical groups (MSMGs) and integrated delivery systems (IDSs).

We are pleased to offer comments on the proposed Non-Compete Clause Rule. Specifically, we are providing comments on the following:

I. States are the most appropriate arbiters of non-compete agreements.

II. Non-compete agreements protect medical group investments, ensuring continued care access for patient communities.
III. The Non-Compete Clause Proposed Rule will undermine care coordination.

Our detailed comments are included below.

I. States are the Most Appropriate Arbiters of Non-Compete Agreements

Comment: States should retain their autonomy in regulating non-compete provisions in employment agreements because they are most familiar with local market conditions - a critical consideration that a national standard would negate.

The FTC seeks to impose a national standard in response to local issues. The marketplace for healthcare providers is local, and therefore, states have historically regulated issues such as non-compete provisions in employment and personal services arrangements. State statutes, case law, and the courts interpreting these issues have developed legal remedies that are better suited for local conditions than a one-size-fits-all, overarching federal approach. Indeed, we are unaware of evidence indicating that states cannot effectively evaluate the reasonableness of these contractual arrangements in the healthcare setting, thus obviating the need for a national solution. In fact, numerous states have acted to address the problems the FTC proposal purports to address. For example, Rhode Island and Illinois have regulated non-compete agreements only for low-wage workers.[1] Tennessee and the District of Columbia have excluded physicians from any restrictions on non-compete agreements.[2]

States have demonstrated their experience and expertise to effectively regulate non-compete agreements. If finalized, the FTC's proposal would undermine this work in favor of a national standard that fails to consider local market conditions.

II. Non-Compete Agreements Protect Medical Group Investments

Comment: Non-compete agreements for healthcare delivery professionals protect medical group investments to recruit and maintain physicians, and to improve quality of care and patient outcomes through substantial investments in physician professional development and training.

The time and resources invested in recruiting new physicians are significant. Searching for candidates, providing a signing bonus and relocation pay, and guaranteeing a salary constitute significant expenses to independent group practices. These expenses are necessary both to attract and retain skilled physicians to continue providing high-quality care. Data from national studies and AMGA members indicate that the estimated average cost to average cost to recruit a new primary care physician (PCP) ranges from $300,000 to $500,000.[3] This investment does not

[1] See, e.g., 820 ILCS 90/5; R.I. Gen. Laws § 28-59-2
[2] See, e.g., D.C. Law 24-175 (excluding highly compensated medical specialists); Tenn. Code Ann. § 63-1-148.
[3] Association of Staff Physician Recruiters. Executive summary. 2018 ASPR In-House Physician Benchmarking Report. Accessed October 2019.

take into account the two to three years it takes for new physicians to build their practice.

Recruiting for surgical specialists can be even more resource intensive. For example, MSMGs and IDSs must expend capital when recruiting a neurosurgeon to build, staff, and operate a neurosurgery suite. Beyond the recruitment costs of the surgeon, the MSMG must invest in nurse practitioners, physician assistants, and support staff who work together as a team to utilize cutting-edge technology to care for their patients. If the neurosurgeon were to leave, the care team and technology would remain idle until the practice recruits another surgeon. In other words, this represents both an expense to replace the physician and the cost of an unusable surgical suite, as well as potential delays in patient care delivery.

Contrary to the FTC's opinion that eliminating non-compete agreements will lower costs, AMGA asserts it will increase the cost of healthcare. If a newly recruited physician is allowed to leave for another practice with no consequences, the initial practice will have to expend an additional half-million dollars to bring a new provider on board. All the while, patient care is disrupted and sometimes delayed. Non-compete arrangements allow MSMGs and IDSs to protect their investments in recruiting physicians to help meet community healthcare needs.

Further, AMGA believes that non-compete agreements are essential to protect medical group investments in physician continuing education. Due to evolving medical standards and practices, physicians must stay current with innovations through procedure training, conferences, and sponsored collaborations. AMGA members invest in such training to promote a higher quality of patient care. However, without a reasonable non-compete agreement, physicians could benefit from the group-financed professional development and leave their practice for a higher salary based on their increased skill and knowledge.

The FTC's proposal fails to acknowledge the ongoing investments that group practices and healthcare systems make in their physicians. Without a reasonable method to protect these investments, the FTC’s proposal, perhaps ironically, would result in decreased competition through further consolidation of the healthcare market, as groups could not afford the ongoing recruitment and retention costs. AMGA is concerned that by banning non-compete clauses, providers will be subject to economically unsustainable demands that ultimately impair patient access and quality care delivery. In a worst-case scenario, this could lead to further consolidation, resulting in a local monopsony that could dictate terms to physicians.

III. The FTC Proposed Rule Will Undermine Care Coordination

Comment: Non-compete agreements ensure efficient access to patient care and safeguard the development of a continuous provider-patient relationship.

AMGA is concerned that the FTC’s Non-Compete Clause Proposed Rule would hinder MSMGs’ and IDSs’ ability to coordinate patient care. In the MSMG model, a PCP will refer patients with chronic conditions to the appropriate specialist within the medical group. By keeping the care inside the four walls of the MSGM/IDS, physicians can share medical information seamlessly and can co-develop care plans. In addition, care is typically delivered in a centralized location. This arrangement also supports the patients, including many Medicare beneficiaries, as it removes

the need for patients to search for other specialists, schedule appointments, gather medical and medication records, and coordinate transportation to new practice sites.

The MSMG model provides better, more convenient care for patients. Non-compete agreements help enable MSMGs to keep this model intact, and this carefully calibrated delivery model would suffer if the FTC proposal was implemented. For example, if a PCP from an MSMG is recruited to another practice, patients will likely follow the provider to the new practice. However, patients with chronic conditions, such as diabetes or congenital heart failure, will lose their relationship with their endocrinologist or cardiologist, as the PCP is unlikely to refer their patients to their former medical group. Making elderly patients choose between their PCP and specialist physician constitutes a significant unintended consequence of the FTC's proposal. This type of coordinated care is essential for patients and a hallmark of the MSMG model. Reasonable limitations on physician movements help to foster doctor-patient relationships and ensure the stability of patients' care teams.

Conclusion

To avoid creating instability in the healthcare industry, AMGA recommends that the FTC withdraw its proposal to ban non-compete agreements and reconsider the healthcare industry's unique challenges. States already regulate the enforcement of non-compete agreements and are uniquely positioned to consider local healthcare market needs. Enforcing a national remedy to an issue already effectively handled by states would harm MSMGs and IDSs and the patients they serve.

Thank you for your consideration of these comments. Should you have any questions, please do not hesitate to contact Darryl M. Drevna, senior director of regulatory affairs, at ddrevna@amga.org or 703.838.0033 ext. 339.

Sincerely,

Jerry Penso, MD, MBA
President and Chief Executive Officer, AMGA