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April 17, 2023

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

Re: Federal Trade Commission: Non-Compete Clause Rule, RIN 3084-AB74

Dear Chairperson Khan:

On behalf of the physician and medical student members of the American Medical Association (AMA), I thank you for the opportunity to submit comments in response to the Federal Trade Commission's (FTC) January 19, 2023, proposed rule, Non-Compete Clause Rule, RIN 3084-AB74 (Proposed Rule).[1] Physician employment arrangements frequently include non-compete agreements, and the application of non-competes to physicians can raise issues regarding physician ownership, the patient-physician relationship, and patient access to care. The AMA is deeply troubled by the fact that there are employed physicians in this country who are bound by unreasonable, coercive, and abusive non-competes. AMA ethics policy categorically opposes the use of unreasonable non-competes but does not support an outright ban on non-competes. Accordingly, the AMA appreciates the FTC raising concerns about non-competes.

Nevertheless, the AMA is not able to support the Proposed Rule in its current form. Views on non-competes differ across AMA's large and diverse membership. Physicians who are employers and owners of physician practices or leaders in integrated delivery systems may favor the use of reasonable non-competes, while physicians who are employees of practices, hospitals, health systems, or other organizations may have concerns about being subject to overly restrictive non-competes that limit employment opportunities and may impact patient access to care. The AMA thus believes that the issue of physician non-competes warrants much greater consideration of the potential disruption and unintended consequences of implementing a blanket federal approach of banning all non-competes while overlooking alternative approaches to achieve the intended objective. A one-size-fits-all ban fails to adequately address many of the factors that are unique to the physician market such as hard-won state non-compete statutes that apply specifically to physicians. Furthermore, because of limits on FTC authority, the Proposed Rule will likely not apply to some, if not many, of the 57 percent of all U.S. hospitals that operate as not for profits, significantly tilting the playing field in favor of these large employers and against physicians and physician practices.

Although the AMA cannot support the Proposed Rule at this time, the AMA strongly encourages the FTC to closely examine the unique considerations of physician non-competes in diverse markets across the

[1] The term "non-compete" here refers to a contract provision restricting for a period of time where an employee may work and what services the employee can provide post-termination.

U.S. Any such examination would need to focus on the impact that physician non-competes are having on patients, the patient-physician relationship, patient access, individual physicians, and competition in their respective markets. The AMA also encourages the FTC to consider incorporating into a future rule aspects of physician non-compete statutes that provide protections to patients and employed physicians. Such protections could include, but need not be limited to, the following: (1) prohibiting enforcement of non-competes if the physician employer terminates employment "without cause," or if the physician terminates employment "for cause;" (2) mandating that any non-compete apply only to the services that the physician was actually providing while employed, as opposed to "the practice of medicine;" (3) tying the geographic scope of any physician non-compete only to the location where the physician primarily provided the services, as opposed to any location where the employer maintains operations, offices, or facilities; and (4) a reasonable buy-out provision that, if satisfied, would free the physician from any practice restrictions.

The status of physician employment and ownership

According to the AMA's 2020 Physician Practice Benchmark Survey, almost 40 percent of physicians worked directly for a hospital or for a practice that was at least partially owned by a hospital or health system—up from 29 percent in 2012. In 2020, 50.2 percent of physicians were employed, compared to 41.8 percent in 2012, and 44 percent had an ownership stake in their practice—lower than the 53.2 percent who were owners in 2012. 2020 was the first year in which less than half (49.1 percent) of physicians worked in practices that were wholly owned by physicians (i.e., private practice). This was down from 60.1 percent in 2012.[2]

It is within this broader context, in which physician employment is increasing and practice ownership is declining, that the following discussion must be considered.

Physician positions regarding non-competes

Employed physicians

There are sound reasons why some physicians oppose non-competes. Employed physicians may have little bargaining power vis-à-vis a prospective employer and may feel compelled to accept an unreasonable non-compete on a take-it-or-leave-it basis. If enforced, that non-compete might force the physician to uproot his or her family from an area where the physician and family members have established community relationships. The concern may be particularly significant if the non-compete agreement's scope is tied to multiple sites where the employer operates.

Non-competes may have other negative effects. For example, the prospect of non-compete enforcement may significantly contribute to physician burnout—if a physician's employer does not value or empower its physicians, the physician nevertheless may be locked into that job if the physician believes that leaving is practically not an option, e.g., there are student loans to be repaid or the physician is caring for a family member. In such situations, the physician will inevitably become demoralized and suffer burnout, or worse. Also, because the employer knows that the physician cannot practically leave, it may have little motivation to improve the situation.

[2] Kane CK. Recent changes in physician practice arrangements: private practice dropped to less than 50 percent of physicians in 2020. AMA Economic and Health Policy Research. May 2021. https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf.

The patient-physician relationship, patient access, patient choice, and patient advocacy

The enforcement of physician non-competes may trigger issues regarding continuity of care and the patient-physician relationship, patient choice, and access to health care. The AMA *Code of Medical Ethics* emphasizes the importance of the patient-physician relationship, stating in part that "The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering."[3] Depending on the circumstances, enforcement of a non-compete may sever long-standing patient-physician relationships, a result that can have a negative impact on patient care in cases where the physician has been regularly involved in monitoring, managing, treating, and coordinating the care of patients with chronic mental and/or physical conditions. Even with respect to patients not having those conditions, patients place a high value on the patient-physician relationship, e.g., patients may change their health insurance plan to follow their physician if the physician is no longer a participant in the patient's previous insurance plan. However, if a non-compete requires the physician to relocate to continue practicing medicine, the patient may not be able to continue seeing that physician. And in some parts of the country, non-compete enforcement may create or exacerbate an already existing physician workforce shortage.

The previous paragraph implicates patient choice. Forcing a physician out of a community may render a patient's physician practically inaccessible. Yet, patient choice could still be negatively affected if the patient's physician moves to an area that remains geographically accessible, but that relocation forces the physician off the patient's health plan. If the physician had been out-of-network previously, continued out-of-network status may have little impact on patient choice. But if the physician had been in-network, the increase in the patient's financial obligation to stay with the physician may force the patient to select another in-network physician, contrary to the patient's wishes.

The prospect of the enforcement of non-competes may have another adverse impact on patient care, namely patient advocacy. Physicians must be able to safeguard and promote the care of individual patients and broader quality of care and workplace safety issues by freely voicing concerns and advocating on behalf of their patients. AMA policy states that "Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment."[4] However, physicians may be less likely to engage in advocacy if they know that contract termination and non-compete enforcement may be a result.

Practice owners

There are equally sound reasons supporting physician practice owners' use of reasonable non-competes. The Proposed Rule devotes roughly one page to a discussion of the legitimate business interests (LBI) courts have come to recognize that are sufficient in some cases to support a reasonable non-compete. The FTC discounts those interests, stating that "the asserted benefits from non-compete clauses do not outweigh the harms."[5] The Proposed Rule does not touch on LBI in the physician non-compete context,

[3] American Medical Association, Council on Ethical and Judicial Affairs Code of Medical Ethics, Opinion 1.1.1. https://policysearch.ama-assn.org/policyfinder/detail/%221.1.1%20Patient-Physician%20Relationships%22?uri=%2FAMADoc%2FEthics.xml-E-1.1.1.xml.
[4] American Medical Association AMA Principles for Physician Employment H-225.950.
[5] 88 Fed. Reg. 3482, page 3508.

and why protecting those interests is important to some physician practice owners. However, we appreciate the FTC's statement that its position is preliminary and welcomes comments.

State courts and some statutes recognize that physician practices and other employers have LBIs sufficient to allow a reasonable physician non-compete.[6] One of the most important protectable interests is the financial commitment that the practice makes to the physician and to his or her success. Independent physician practices may invest heavily in their physicians, spending hundreds of thousands of dollars recruiting a physician and investing in his or her continuing education. Investments can include recruitment, loans, paying off student loans, covering relocation expenses, income guarantees, specialized training, making referral sources and contacts available to the physician, providing the physician access to patients and patient lists, marketing the physician in the community, purchasing new equipment, or renting additional office space, etc.

Some independent physician practice owners strongly believe that, unless they can employ reasonable non-competes, these financial commitments will not be possible, especially in areas dominated by hospital systems and health plans. Depending on the local market, it might make little sense for a physician practice or physician organization to devote these financial resources to the physician's success, only to see the physician hired away from the practice because the practice does not have the resources to match the offer. The hospital or health plan subsequently may benefit from the information, training, patient contacts, and other resources that the practice invested in the physician.

The situation just described is highly undesirable given that, in some parts of the country, competition is needed. It is vital, then, that independent physician practices are not only sustainable, but grow and flourish so that patients have a choice of physician services and physicians have real choices regarding the practice environment in which they want to work, e.g., hospital employment, independent practice, etc. Some physician practice owners strongly believe that they need to be able to use reasonable non-competes to make this happen.

Although the Proposed Rule would permit practices and other employers to utilize contractual provisions prohibiting the solicitation of former patients, clients, or customers, as well as the disclosure of confidential information or trade secrets, etc., it is likely that some physician practice owners do not believe that these clauses will provide sufficient protection for their LBI for many of the same reasons that were voiced during FTC's January 9, 2020, workshop concerning Non-Competes in the Workplace. To provide just one example since the FTC heard much about the issue, proving that a former employee or former owner has violated a non-solicitation, confidentiality, and/or a trade secret prohibition is much more difficult, and thus much more costly to litigate, than the more "bright line" that makes reasonable non-competes easier and less expensive to utilize. The cost that an independent practice might incur in attempting to prove a violation of these other clauses might be cost prohibitive. Thus, as a practical matter, the practice may not be able to protect its LBI with anti-solicitation, confidentiality, trade secret, and other non-compete substitutes.

AMA policy regarding non-competes

The AMA's *Code of Medical Ethic*s Opinion 11.2.3.1 guides the AMA's position on non-competes. This opinion, entitled "Restrictive Covenants," states:

[6] Some state statutes codify LBI. See for example: AL Code § 8-1-191(a); AR Code § 4-75-101(b); FL Code § 542.335; GA Code § 13-8-55; ID Code § 44-2702; 26 ME Rev Stat § 599-A; MO Rev Stat § 431.202(3)(a) and (b); OR Rev Stat § 653.295(c).

> Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.
>
> Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.
>
> Physicians should not enter into covenants that:
>
> (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and
>
> (b) Do not make reasonable accommodation for patients' choice of physician.
>
> Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.[7]

Ethical Opinion 11.2.3.1 is consistent with the tradition of most states, where courts may enforce physician non-competes so long as the non-competes protect LBI, are reasonable with respect to services covered, duration, and geography, and are not otherwise against public policy, of which patient choice may be a consideration. Further, the ethics opinion is also consistent with many states that have negotiated physician or health-care-specific non-compete statutes that account for their unique health care markets and that balance competing stakeholder interests. Finally, although Ethical Opinion 11.2.3.1 opposes the use of unreasonable non-competes, it does not explicitly call on the AMA to support either the use of reasonable non-competes or an outright ban on non-competes.

The AMA's position on the Proposed Rule

The AMA does not support the Proposed Rule for several reasons. As discussed below, the application and enforcement of non-compete agreements has so far been primarily a matter of state law. The Proposed Rule would preempt over a century of thoughtful non-compete jurisprudence and supersede carefully balanced state non-compete statutes without regard to the disruption and unintended consequences that could severely and negatively impact many physician practices and their patients. Furthermore, the AMA is very concerned that the Proposed Rule may not apply to some hospitals and other organizations that have been granted 501(c)(3) status under the Internal Revenue Code.

The Proposed Rule proposes a preemptive one-size-fits-all solution to a complex issue

The AMA does not support the Proposed Rule in part because it would generally either completely or partially preempt state non-compete common law and state non-compete statutes. The FTC is entering into an area that has almost exclusively been the province of the states and in which it has little experience.

As the Proposed Rule notes, most state courts decide the enforceability of non-competes using a "reasonableness" test.[8] The test involves weighing the employer's LBI against the non-compete's geographic area, duration, and scope of services. The analysis may also involve the interpretation of a

[7] This policy may be accessed at https://www.ama-assn.org/delivering-care/ethics/restrictive-covenants. In addition to Ethical Opinion 11.2.3.1, the AMA has adopted other relevant policy: Policy H-310.929, "Principles for Graduate Medical Education;" Policy H-295.910, "Restrictive Covenants During Training;" Policy H-295.901, "Restrictive Covenants in Residency and Fellowship Training Programs;" Policy H-225.950, "AMA Principles for Physician Employment;" and Policy H-383.987, "Restrictive Covenants in Physician Contracts."

[8] See 88 Fed. Reg. 3482, pages 3494-3496.

non-compete statute (or statutes). If the restrictions are tailored to protect the LBI, then the court is likely to find that the non-compete is reasonable, and thus enforceable, although in some states a court can blue-pencil or reform the non-compete. However, even if geographic, temporal, and scope of service restrictions are reasonable, a court may nevertheless refuse to enforce a non-compete if the employer's LBI is outweighed by hardship done to the employee or public policy considerations. Over the years, each state has developed common law that reflects the unique characteristics of the state's affected market or markets, geography, employee's occupation, what constitutes an LBI, etc. Thus, application of a reasonableness test may produce precedent in one state that might be inappropriate in others. The AMA appreciates the Proposed Rule's concise description of the reasonableness test.

Unfortunately, the Rule would wholly displace this time-honored thoughtful and local approach to non-competes, since the Rule would preempt a state law "providing that an employer may enforce a non-compete clause against a worker where the non-compete clause is tailored to a legitimate business interest and reasonably limited in duration, geographic area, and scope of activity prohibited."[9]

With respect to the Proposed Rule's preemptive effect on non-compete statutes, the Proposed Rule would completely, or partially, supersede many state non-compete statutes. These statutes may be the product of difficult discussions involving many stakeholders with opposing perspectives, and it may take years of contentious debate to work out a proposal that represents different stakeholder interests sufficiently so that the proposal can be enacted. The Proposed Rule in one fell swoop would bring many of these hard-won solutions to naught. The Proposed Rule would also abruptly put a stop to any state's current and future legislative efforts to fashion its own statutory solutions to local concerns that non-competes in various contexts might raise (and such a solution could of course take the form of a universal ban). This is particularly inopportune given that "states have been particularly active in restricting non-competes," and that, by pursuing restrictions, states are moving in the direction the FTC wants to go.[10]

Aside from these general observations, the Rule's across-the-board ban does not account for unique issues that physician non-competes may implicate. The practice of medicine is unlike any other occupation, and cases may involve public policy considerations that require a fact-intensive inquiry, since those and other considerations still must be balanced against the employer's LBI. Much may depend on the physician's specialty, how long it may take to recruit a new physician to the area if one in fact can be recruited, the characteristics of the physician's patients, the health care needs of the community, local market considerations, etc. These considerations will vary greatly from state to state, and even within a state, and state courts have experience weighing these considerations.

Speaking of statutes, the FTC itself notes that, with respect to non-competes, physicians are sometimes singled out:

> *In addition, the majority of these 47 states have statutory provisions that ban or limit the enforceability of non-compete clauses for workers in certain specified occupations. In most states, those limits apply to just one or two occupations (most commonly, physicians)*.[11]

[9] 88 Fed. Reg. 3482 page 3515.
[10] 88 Fed. Reg. 3482 page 3494.
[11] 88 Fed. Reg. 3482, page 3494.

As of the writing of this correspondence, at least twenty-eight states appear to have enacted statutes that apply to physician non-competes,[12] and, in line with the previous quotation, at least fourteen states have enacted non-compete statutes applying either specifically to physicians or to health care.[13] No doubt the FTC is aware of these statutes. A close examination of these laws will show not only how diverse and unique most of them are with respect to one another, but also how, in a few cases, states have used another state's prior enactment as a model.

The AMA encourages the FTC to study issues raised specifically by physician non-competes

In January 2020, in response to comments generously solicited by the FTC as part of a series of non-compete workshops, the AMA recommended that the FTC not use its rule-making authority with respect to non-compete agreements in physician employment arrangements. The AMA expressed its concern that, given the highly fact-specific analysis that courts typically must undertake with respect to non-competes involving physicians, coupled with the diversity in how states address non-competes involving the practice of medicine, the blanket approach to physician non-competes might have limited usefulness. Furthermore, given that there appears to be an increasing interest on the part of state legislatures in considering legislation dealing with physician and health care provider non-competes, it may be prudent for the FTC to monitor evolving state legislative developments and case law rather than weighing in on what traditionally has been a state issue.

For considerations consistent with its prior FTC correspondence, the AMA believes that finalizing the Proposed Rule "as is" would be premature. If finalized, the Proposed Rule would likely have a sudden, disruptive impact on many independent physician practices in the country, with resulting unintended consequences that could significantly outweigh concerns that the Proposed Rule purports to address. To take just one example, as noted above, many physician practice owners strongly believe that their practice will not remain competitive unless they can utilize reasonable non-competes, a belief that may be particularly strong in areas where, as a result of consolidation, a dominant hospital presides. If finalized "as is," the Proposed Rule would in short order prohibit owner's use of non-competes. In response, many physician practice owners might simply decide that it does not make sense any more to try to keep the practice going and, along with the practice's physician employees, turn to hospital and other corporate employment. Is this the result that the FTC wants in present circumstances where, due to continued consolidation, hospitals and other corporate employers already dominate many parts of the country, competition is under siege, patients have fewer and fewer choices about where to get their health care, and physician practice options are increasingly narrowed? It is rather difficult to see how, in such cases, the Proposed Rule furthers the FTC's stated goals of helping workers (in this case employed physicians) increase employment opportunities, open markets to new rivals such as physician-owned ambulatory surgery centers, form new physician-owned businesses, innovate, or foster health competition. Thus, with

[12] Code of Ala. §§ 8-1-190 et seq; Cal Bus & Prof Code §§ 16600; et seq; Col. Rev. Stats. § 8-2-113; Conn. Gen. Stats § 20-14p; 6 Del. Code § 2707; Fla. Stat. §§ 542.31 et seq; Georgia Code §§ 13-8-50 et seq; HI. Rev. Stat. § 480-4; Idaho Code §§ 44-2701 et seq; LA Rev. Stat. § 23:921; 26 ME Rev. Stat. § 599A; MA GL chapter. 112, § 12X; Michigan Code § 445.774a; MO. Rev. Stat. § 431.202; Montana Code §§ 28-2-704 et seq; Nev. Rev. Stat. § 613.195 et seq; N.H. Rev. Stat. § 329:31-a; N.M. Stat. §§ 24-1I-1 et seq; North Dakota Code, §§ 9-08-03 et seq; 15 Okl. Stat. § 214 et seq; OR. Rev. Stat. § 653.295; R.I. Gen. Laws § 5-37-33; S.D. Codified Laws §§ 53-9-8 et seq; Tenn. Code § 63-1-148; Tex. Bus. & Com. Code §§ 15.50 et seq; Utah Code §§ 34-51-102 et seq; Wis. Stat. § 103.465; WV Code § 47-11E-2.

[13] Col. Rev. Stats. § 8-2-113; Conn. Gen. Stats § 20-14p; 6 Del. Code § 2707; Fla. Stat. §§ 542.31 et seq; Ind. Code § 25-22.5-5.5; MA GL chapter. 112, § 12X; Nev. Rev. Stat. § 613.195 et seq; N.H. Rev. Stat. § 329:31-a; N.M. Stat. §§ 24-1I-1 et seq; R.I. Gen. Laws § 5-37-33; S.D. Codified Laws §§ 53-9-8 et seq; Tenn. Code § 63-1-148; Tex. Bus. & Com. Code §§ 15.50 et seq; WV Code § 47-11E-2 et seq.

respect at least to physician non-competes, it is difficult to see how the Proposed Rule evinces "deep expertise,"[14] since the Proposed Rule discusses physicians in a cursory manner generally and does not make mention of the physician-specific issues identified in the AMA's previous correspondence. Finally, in the absence of a considered approach, it makes little sense to supersede well-established mechanisms that states have long established to address the complex issues raise by physician non-competes, using a reasoned case-by-case common law approach that generally disfavors non-competes and negotiated statutes, including many that are specific to physicians. For now, "deep expertise" remains with the states.

While the AMA believes that the Proposed Rule is not sufficiently informed to be finalized at this time, this opinion should not be construed to mean that the AMA believes that the FTC plays no future role with respect to physician non-competes. The AMA encourages the FTC to continue to study the issues that physician non-competes implicate, and we welcome further conversations toward that end. As the FTC builds its knowledge base and experience, it could provide valuable and impactful input and be in a much better position to advise states regarding the potential effects that banning, limiting, or leaving untouched physician non-competes in their respective markets could have, including but not limited to, providing guidance regarding the current state of competition, barriers to entry, financial impact for health care purchasers, etc.—all of which the FTC generally has great expertise.

Inapplicability to nonprofit hospitals and other nonprofit health care organizations

As the FTC knows, there are limits to its jurisdiction under the Federal Trade Commission Act (FTCA), under which the Proposed Rule has been promulgated. Section 45 of the FTCA empowers and directs the FTC to prevent persons, partnerships, or corporations with respect to "unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce." The FTCA does not, however, give the FTC jurisdiction over banks, savings and loan institutions, federal credit unions, common carriers, air carriers and foreign air carriers, and persons, etc., subject to the Packers and Stockyards Act. These exemptions are not germane to the present discussion.

What is germane is the definition of "corporation." The FTCA defines "corporation:"

> to include 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, and has shares of capital or capital stock or certificates of interest, and any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, without shares of capital or capital stock or certificates of interest, except partnerships, which is *organized to carry on business for its own profit or that of its members.*[15]

This definition implies that entities that are **not** organized to carry on business for their own profit or that of their members are not within the FTC's jurisdiction, raising the issue regarding the extent to which the Rule may apply to 501(c)(3) hospitals. (This correspondence will only discuss nonprofit 501(c)(3) charitable organizations, given that many hospitals and health care organizations are 501(c)(3) entities). To obtain 501(c)(3) charitable organization status, an organization "must be organized and operated exclusively for exempt purposes set forth in section 501(c)(3), and none of its earnings may inure to any

[14] An assertion made by the FTC during introductory remarks to its February 16, 2023, Public Forum for the Proposed Rule on Noncompetes. https://www.ftc.gov/news-events/events/2023/02/ftc-forum-examining-proposed-rule-ban-noncompete-clauses.
[15] 15 U.S.C. § 44.

private shareholder or individual."[16] The argument that some 501(c)(3) hospitals may not be subject to the FTC's authority is based on the consideration that if a 501(c)(3) is organized and operated exclusively for exempt purposes and none of its earnings inure to any private shareholder or individual, then it is also an entity that is not organized to carry on business for its own profit or that of its members. (Note that not all nonprofits lie outside the FTC's jurisdiction under the FTCA. For example, the Supreme Court has held that 501(c)(6) organizations have been organized to carry on business for their own profit or that of its members.)[17]

The FTC has stated that it lacks jurisdiction over at least some nonprofit hospitals because of the FTCA's definition of "corporation." For example, in a 2016 a Congressional statement (statement), Edith Ramirez, FTC Chairwoman, stated:

> The Commission also supports H.R. 5255, which would subject charitable, religious, educational and other nonprofit organizations to the FTC Act. Currently the FTC's jurisdiction over non-profits is limited. The FTC Act applies to "persons, partnerships, or corporations," and the Act defines "corporation" as an entity that "is organized to carry on business for its own profit or that of its members."
>
> We support extension of our jurisdiction to certain non-profit entities. In health care provider markets, where the Commission has long sought to maintain competition, the agency's inability to reach conduct by various non-profit entities has prevented the Commission from taking action against potentially anticompetitive behavior of non-profits engaged in business. These concerns also apply to our consumer protection mission. For example, despite many publicized data breaches at hospitals and universities, the FTC cannot challenge unfair or deceptive data security or privacy practices of these entities. Further, while the Commission can use Section 5 to reach "sham" nonprofits, such as shell non-profit corporations that actually operate for profit and sham charities, each such investigation requires resource-intensive factfinding to satisfy this standard.[18]

(citations omitted). A footnote in the statement adds that "the Commission generally cannot challenge anticompetitive conduct, such as collusive behavior, by non-profit hospitals," and listed three enforcement actions where the FTC "alleged that groups of physicians and hospitals had participated in unlawful price-fixing arrangements, but sued only the physicians and a for-profit hospital."[19]

Although there is considerable uncertainty and debate about the extent to which the Proposed Rule will be inapplicable to all 501(c)(3) hospitals, it is likely that the Proposed Rule will not apply to some, if not many, of the country's nonprofit hospitals. Nearly 57 percent of all hospitals are non-profit.[20] The

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[16] https://www.irs.gov/charities-non-profits/charitable-organizations/exemption-requirements-501c3-organizations#:~:text=To%20be%20tax%2Dexempt%20under,any%20private%20shareholder%20or%20individual.

[17] *See e.g., California Dental Ass'n v. FTC*, 526 U.S. 756 (1999).

[18] Prepared Statement of the Federal Trade Commission at a Legislative Hearing on Seventeen FTC Bills, Before the Subcommittee On Commerce, Manufacturing, and Trade of the Committee on Energy and Commerce, United States House of Representatives, May 24, 2016, pages 10-11. https://www.ftc.gov/about-ftc/biographies/edith-ramirez/speeches-articles-testimonies.

[19] Id. at page 10.

[20] Schwartz, K. What We Know About Provider Consolidation. Kaiser Family Foundation. September 2, 2020. Available at: https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.

prospect of disparate treatment of some nonprofit hospitals vis-a-vis independent physician practices, would give those hospitals competitive advantages that physician practices would be denied. For example, a nonprofit community hospital not subject to the Proposed Rule could use non-competes to protect its LBI, but physician practices in the community would be prohibited from doing so. By so doing, the Proposed Rule could make it difficult, if not financially infeasible, for some independent practices to grow or even just sustain themselves. Disadvantaging and weakening physician practices is the last thing that the FTC should potentially promote when competition is needed in many parts of the country and at a time when the number of physicians working in private practice has reached historic lows (49.1 percent).[21]

The FTC should continue to challenge unreasonable, coercive, or abusive non-competes and anticompetitive mergers

Although the AMA does not support the Proposed Rule, the AMA appreciates the FTC's role in preserving competition in health care. Thus, in addition to further researching the unique characteristics of physician non-competes in diverse markets and considering ways state non-compete statutes have endeavored to restrict physician non-competes,[22] the AMA encourages the FTC to challenge unreasonable, coercive, or abusive non-competes binding employed physicians. Enforcement of this nature would, as noted above, be consistent with the AMA's position expressed in Ethical Opinion 11.2.3.1, which acknowledges that non-competes may restrict competition. AMA policy in fact "urges individual physicians or physician groups that believe they are being coerced into specific employment arrangements to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel."[23] The only caveat is that the AMA urges the FTC to ensure that enforcement actions involving physician non-competes be pursued only in a manner consistent with state non-compete jurisprudence and state non-compete statutes.

At the same time, the AMA also urges the FTC to use its enforcement authority, e.g., by opposing anticompetitive mergers in health care, and any other means at its disposal to protect, and foster, the creation, growth, and sustainability of independent practice, physician-owned facilities, and physician-led organizations. Hopefully, discussions above have shown that it is likely impossible to overstate the importance of preserving and fostering independent physician and other physician-led organizations in this country, which are already under fire from dominant lay entities and gratuitous administrative burdens that divert physicians from patient care and contribute to physician burnout and workforce issues, ultimately to the detriment of patients and consumers.

Thank you for considering the AMA's comments.

Sincerely,

James L. Madara, MD

[21] See the discussion of the AMA's 2020 Physician Practice Benchmark Survey above.
[22] See, e.g., (1)-(4) discussed above on page 2.
[23] Coerced Employment of Physicians H-160.927. Reaffirmed: CMS Rep. 01, A-19.