AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Joseph J. Simons, JD
Chairman
U.S. Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: Federal Trade Commission: Non-Competes in The Workplace: Examining Antitrust and Consumer Protection Issues

Dear Chairman Simons:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to submit comments in response to the Federal Trade Commission's (FTC) January 9, 2020, workshop concerning Non-Competes in The Workplace: Examining Antitrust and Consumer Protection Issues. The AMA applauds your examination of non-competes in the workplace. 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 has a large and diverse membership, with some members having different perspectives than others on this issue. Physicians who are employers and owners in 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.

AMA Policy on Post-Employment Non-Compete Agreements

The AMA has several policies applicable to post-employment non-competition agreements. A frequently cited policy is Ethical Opinion 11.2.3.1, from the AMA's Council on Ethical and Judicial Affairs. This opinion, entitled "Restrictive Covenants" states:

> 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.[1]

Ethical Opinion 11.2.3.1 is consistent with the majority of states where courts enforce post-employment non-competition agreements in physician contracts so long as those agreements protect a legitimate business interest, are reasonable with respect to duration and geography, and are not otherwise against public policy, of which patient choice may be a consideration in some jurisdictions.

Employer's Interests in Using Non-Compete Agreements in Physician Employment Arrangements

To be enforceable, a non-compete must protect an employer's *legitimate* business interest. Courts will not honor a non-compete if it serves only to safeguard an employer from competition.

In the physician employment context, legitimate business interests may take several forms. For example, to help the physician build his or her practice, an employer may give the physician specialized training, make referral sources and contacts available to the physician, provide the physician access to patients and patient lists, market the physician in the community, and allow the physician to have access to proprietary information. The protection of proprietary information may be especially at issue if the physician is given access to sensitive information by virtue of holding a key leadership or management position.

Physician employers, like hospitals and group practices, use non-competes to prohibit a physician from leaving and then establishing a competing practice, or joining a competing practice or hospital, in the former employer's vicinity and benefitting from proprietary information, training, patient contacts, and other resources provided by the former employer. Non-competes may give the employer the peace of mind necessary to invest significant resources in the employed physician's success, without the employer having to worry that the physician will later leave the employer after the physician has developed a significant patient base, taking those patients with him or her. Because of the commitment of practice resources involved, a medical group or hospital may be particularly interested in having a non-compete in place when it is hiring a physician straight out of residency. It should be noted, however, that non-competes can benefit employed physicians, since a potential employer may be much less willing to make the time and resource commitments that are needed to help physicians succeed in medical practice without a non-compete.

Concerns Regarding Non-Competes Clauses

Challenges for the Employed Physician

Non-competes can also pose challenges to employed physicians. Enforcement of a non-compete could force a physician and his or her family to move out of the geographic area where the physician and family members may have developed significant community relationships. The concern may be particularly significant if the non-compete agreement's geographic scope is tied to multiple sites where the employer furnishes health care services or otherwise operates. Additionally, non-competes may not always

[1] This policy may be accessed at https://www.ama-assn.org/delivering-care/ethics/restrictive-covenants. In addition to the CEJA Opinion, 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."

adequately recognize the contributions that an employed physician may have made to a medical practice or hospital with regard to his or her professional skills, reputation, and patient relationships, or may overestimate the employer's investment in education and training of that physician. It should be noted, however, that in some cases, which are highly dependent on the employer and its culture, as well as market conditions, a prospective physician may be able to significantly negotiate the terms of a non-compete.

Concerns with Respect to the Patient-Physician Relationship, Patient Access, and Patient Choice

Enforcement of physician non-competes can trigger issues regarding the patient-physician relationship, access to health care, and patient choice. The enforcement of a non-compete could, for example, negatively impact patient access to care by severing a long-standing patient-physician relationship, particularly in cases where the physician has been regularly and actively involved in helping the patient manage an ongoing mental or physical condition. If a non-compete requires the physician to relocate to continue practicing medicine, the patient may not be able to continue seeing that physician.

Enforcement of a non-compete could also have negative consequences on patient care outside of a long-term patient-physician relationship. For example, depending on the geographic area, there may be just a few physicians, general practitioners or specialists, available to serve the needs of the patient population. This may be particularly true in rural parts of the country. Even if several physicians practice in the community, requiring a physician to leave the area may reduce the number of available physicians. Although a replacement physician may ultimately be brought to the area, recruitment can be a lengthy process. In the meantime, the absence of the physician subject to the non-compete could hinder patient access by increasing patient wait times—assuming the community's remaining physicians have the capacity to take on new patients. The situation could be compounded if the community has only one general practitioner or physician of a needed specialty.

Non-compete enforcement may also detrimentally impact a patient's choice of physician. Obviously, application of a non-compete can negatively affect patient choice if the non-compete obligates the patient's preferred physician to relocate to an area that is beyond the patient's practical reach. Yet patient choice could still be affected if the patient's preferred physician moves to an area that remains geographically accessible due to network considerations, e.g., if the relocation forces the physician off of the patient's health insurer or health plan network. 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 compel the patient to select another, in-network, physician.

Role of States in Non-Competition Agreement Enforcement

The application and enforcement of non-competition agreements has so far been primarily a matter of state law. Judicial analysis has been largely a matter of contract and employment law, with, at times, public policy considerations unique to the practice of medicine becoming a key consideration. Many states have a wealth of non-compete common law going back many years.

States can vary widely with respect to the enforceability of non-compete agreements, and whether a particular non-compete is enforceable can be highly fact-specific, depending on how competing concerns described above are considered and balanced. This may be particularly true regarding the application of

non-compete agreements to physicians, where temporal and geographic reasonableness, the legitimacy of business interests involved, patient demographics, physician specialty, and public policy considerations such as patient choice may vary significantly from one case to another. Thus, aside from the proposition that state courts will not enforce unreasonable physician non-competition agreements, it is difficult to draw general principles with respect to physician non-competes based on common law.

Many states have enacted statutes addressing non-competition agreements.[2] A number of states have enacted these statutes recently, and there appears to be an increase in state legislatures' interest in passing non-compete legislation.[3] As one would expect, these statutes often take significantly different, if not unique, approaches, and some of these statutes are highly detailed.

Some states prohibit non-competes generally, e.g., California, North Dakota. Oklahoma also prohibits non-competes generally as long as the former employee does not directly solicit the sale of goods, services or a combination of goods and services from the established customers of the former employer. Other states explicitly prohibit enforcement of physician non-competes, e.g., Colorado (amended 2018), Delaware, Massachusetts, New Hampshire (enacted 2016), and Rhode Island (enacted 2016). The New Mexico law (enacted 2015 and amended 2017) states, among other things, that a non-compete prohibiting a health care practitioner from providing clinical health care services is not enforceable, although an employer can enforce a provision that requires a health care practitioner who has worked for the employer for an initial period of less than three years to repay all or a portion of: (1) a loan; (2) relocation expenses; (3) a signing bonus or other remuneration to induce the health care practitioner to relocate or establish a health care practice in a specified geographic area; or (4) recruiting, education and training expenses.

Several states have enacted non-compete statutes specifically applicable to physicians or health care providers that *do not* ban non-compete agreements. Instead, these statutes represent an effort to balance the interests of employer and the employed physician or health care provider, setting out specific requirements that non-competes must satisfy or otherwise place limitations on non-competes. For example, the Connecticut statute (enacted in 2016) states, among other things, that a covenant not to compete may not restrict a physician's competitive activities for more than a period of one year and in a geographic region of more than 15 miles from the primary site where such physician practices. Non-competes also cannot be enforced against a physician if the employer terminates employment without cause. In Tennessee, a health care provider noncompete is deemed reasonable if: (1) the duration is two years or less; and (2) the maximum allowable geographic restriction is the greater of: (a) a ten-mile radius from the primary practice site of the health care provider while employed or contracted; or (b) the county in which the primary practice of the health care provider while employed or contracted is located; or (3)

[2] Code of Ala. §§ 8-1-190 et seq; Ark. Code § 4-75-101 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.

[3] Recent state enactments also include non-compete laws applicable to employees whose income does not exceed specific thresholds, e.g., Maryland SB 328 (2019), 820 Illinois Code 90/1 (enacted 2016); Rhode Island S 0698 (2019); Washington HB 1450 (2019).

there is no geographic restriction, but the health care provider is restricted from practicing the health care providers' profession at any facility at which the employing or contracting entity provided services while the health care provider was employed or contracted with the employing or contracting entity. Finally, in Texas a non-compete is enforceable against a physician if, among other things, it: (1) does not deny the physician access to a list of his or her patients whom he or she had seen or treated within one year of the end of employment; (2) provides access to medical records of the physician's patients upon authorization of the patient and any copies of medical records for a reasonable fee; (3) states that any access to a list of patients or to patients' medical records after employment termination does not require such list or records to be provided in a format different than that by which such records are maintained, except by mutual consent of the parties to the contract; (4) provides for a buy-out at a reasonable price or, at the option of either party, as determined by a mutually agreed upon arbitrator; and (5) states that the physician will not be prohibited from providing continuing care and treatment to a specific patient or patients during the course of an acute illness even after employment.

Role of the Federal Trade Commission

The AMA does not recommend that the FTC at this time use its rulemaking or other authority, such as its law enforcement authority, with respect to non-compete agreements in physician employment arrangements. 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 represented by a rule or general guidance, as well as enforcement actions, 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.

The AMA appreciates the opportunity to provide these comments. If you have questions, please contact Shannon Curtis, Assistant Director, Federal Affairs at shannon.curtis@ama-assn.org or 202-789-8510.

Sincerely,

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