Federation of American Hospitals

Charles N. Kahn III
President and CEO

November 3, 2025

The Honorable Andrew Ferguson
Chairman
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: Request for Information Regarding Employer Noncompete Agreements; Docket No. FTC-2025-0463-0001 (Sept. 4, 2025)

Dear Chairman Ferguson:

The Federation of American Hospitals (FAH or we) appreciates this opportunity to submit comments to the Federal Trade Commission (FTC) in response to the *Request for Information Regarding Employer Noncompete Agreements*, Docket No. FTC-2025-0463-0001 (Sept. 4, 2025).

The FAH is the national representative of more than 1,000 tax-paying hospitals throughout the United States. The FAH's members provide patients and communities with access to high-quality, affordable care in urban, suburban, and rural areas across 46 States, Washington, DC, and Puerto Rico. Our member hospitals include teaching, acute, rehabilitation, behavioral health, and long-term care hospitals, which together provide a wide range of critical inpatient, ambulatory, post-acute, emergency, children's, and cancer services to patients across the country.

The FAH writes to provide information about the use of noncompete agreements in the healthcare sector. In our experience, noncompete agreements are most typically applied to two categories of workers in the healthcare sector: (1) senior executives, for whom noncompetes are used to protect employers' interests in safeguarding confidential business information and strategies; and (2) physicians, for whom noncompetes are used to protect employers' investments in developing and maintaining employed physician practices, including providing the infrastructure necessary to practice and provide needed medical services, which promotes patient access to care and addresses community medical need. Looking beyond these two narrow categories, the FAH appreciates that noncompete agreements with low-wage or low-skilled workers can sometimes reflect an unfair imbalance of bargaining power between employers and their workers. But our experience is that large, sophisticated healthcare systems rarely require noncompete agreements from low-wage or low-skilled employees. And, for reasons described in more detail below, the concerns the FTC has articulated about "unfair" or "anticompetitive" noncompete agreements simply do not apply with respect to either senior executives or physicians.

As the FTC considers future investigation and enforcement actions against unfair or anticompetitive noncompete agreements, the FAH asks the FTC to remember the unique features of the healthcare industry:

1. **Noncompete agreements for senior executives and physicians in healthcare systems are neither unfair nor anticompetitive.** The **s**enior executives and physicians who work at healthcare systems are highly educated, generously compensated, and business-savvy professionals. They are precisely the types of workers for whom noncompete agreements are neither unfair nor anticompetitive, especially given the strong, consistent evidence showing that noncompetes actually ***increase*** these individuals' compensation. Therefore, absent compelling, case-specific evidence that a particular noncompete agreement is unfair or anticompetitive in effect, the FTC should affirmatively ***presume*** that senior executives and physicians are fair subjects for noncompetes.

2. **Noncompete agreements promote patient access to care and address community need.** Noncompete agreements promote greater hospital investment in developing and maintaining physician practices, including physician recruiting, relocation, and retaining top talent, including highly specialized physicians, as well as the infrastructure necessary for these physicians to practice and furnish necessary medical care to patients. Hospitals also may share proprietary information, whether training for new innovations and business operations or updating physicians on frequently changing regulatory requirements. These investments are critical for patient access to care and addessing community medical need. A hospital may not have incentives to provide these investments if physicians are free to unexpectedly and suddenly move to a competing hospital or set up their own competing physician practice.

3. **At least 19 States have already adopted laws that specifically regulate noncompete agreements for physicians.** These State laws strike reasoned balances between physicians', patients', and employers' competing interests and set clear rules of business conduct for all employers to consistently follow. The FTC should honor, not undermine, the reasoned policy judgments of sovereign States. Therefore, in making investigational and enforcement decisions, the FTC should recognize that physician noncompetes that carefully comply with applicable State law are not acting "unfairly" or "anticompetitively" as a matter of law.

4. **Singling out tax-paying hospitals for noncompete enforcement would put these businesses at an arbitrary competitive disadvantage against their tax-exempt, nonprofit and government-owned competitors.** Only 24% of U.S. community hospitals are owned by tax-paying organizations; 58% are owned by nonprofits and 18% are owned by State or local governments.[1] Selective law-enforcement of noncompete practices based on tax status would thus put the 24% of tax-paying hospitals at an unfair competitive disadvantage viz-a-viz their nonprofit and government-owned rivals.

[1] American Hosp. Ass'n, *Fast Facts on U.S. Hospitals*, 2025 (2025), *available at* https://www.aha.org/system/files/media/file/2025/01/Fast-Facts-on-US-Hospitals-2025.pdf.

We address each of these points in greater detail below.

A. Noncompete Agreements for Senior Executives and Physicians in Healthcare Systems Are Neither Unfair Nor Anticompetitive

Chairman Ferguson has written passionately about how noncompete agreements "can be, and sometime are, abused to the effect of severely inhibiting workers' ability to make a living."[2] This is, of course, a serious concern, and one that demands the attention of law enforcers. But it is not a concern that applies to those senior executives or physicians who often earn high-six-figure salaries at large, integrated healthcare organizations.

Senior executives and physicians working for large healthcare systems are typically highly educated, sophisticated business professionals. Senior executives almost always have an advanced degree such as an MBA. Medical doctors, by definition, have at least a doctorate. These individuals are well-compensated and in high demand, giving them resources and bargaining power to negotiate fair terms of employment and, if they so choose, to consult with legal counsel before signing a contract.

Why, then, do senior executives and physicians routinely sign noncompete agreements? The empirical evidence is clear. ***Senior executives and physicians sign noncompetes because, on average, these individuals make <u>considerably</u> more money when they are covered by noncompetes than when they are not.***

- **Senior Executives.** An empirical analysis of employment agreements from the Securities and Exchange Commission (SEC) EDGAR database found that "an executive with a noncompete clause is associated with a starting wage that is 13% higher than one who is free to move."[3]

- **CEOs.** A separate analysis of the SEC's EDGAR database found that CEOs with NCAs (*i.e.*, noncompete agreements) have annual total compensation that is 18.4% higher than for CEOs without NCAs.[4]

- **Physicians.** A survey of 1,967 primary care physicians spanning five States found that the average hourly earnings of physicians who have noncompetes is 14.0% higher than the earnings of physicians who lack noncompetes.[5] The study found that "physicians with NCAs have much larger initial rates of earnings growth" than physicians without them; specifically, "the predicted cumulative earnings gain over the first ten years among those with NCAs is 70 percent, compared to 35 percent for physicians without NCAs."[6] Over a physician's entire career, "there is virtually no period in the career profile in which workers without NCAs appear to recoup earnings in excess of those physicians with NCAs."[7] And importantly, there is "no significant difference in prices

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[2] Statement of Chairman Andrew N. Ferguson, Joined by Commissioner Melissa Holyoak, *Ryan, LLC v. FTC* (Sept. 5, 2025), at 2.

[3] Liyan Shi, *Optimal Regulation of Noncompete Contracts* (2022), https://www.econometricsociety.org/publications/econometrica/forthcoming-papers/2022/12/02/Optimal-Regulation-of-Noncompete-Contracts/file/18128-3.pdf, at 29.

[4] Omesh Kini et al., *CEO Noncompete Agreements, Job Risk, and Compensation*, 34 REV. FIN. STUD. 4701, at 4732 (2021).

[5] Kurt Lavetti et al., *The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians*, 55 J. OF HUM. RES. 1025, 1051 & Table 6 (2020).

[6] *Id.* at 1049.

[7] *Id.* at 1063.

charged by physicians based on the use of NCAs."[8] In other words, whether a physician has a noncompete agreement or not has no impact on the cost of patient care.

These findings are both remarkable and important. Senior executives and physicians earn between 13%-18% more money when they are subject to noncompete agreements than when they are not. Thus, for these high-earning, highly sophisticated classes of workers, noncompete agreements are a true "win-win."

Physician noncompete agreements result in increased wages by solving an "investment holdup" problem wherein healthcare providers are discouraged from making investments in physician recruitment, training, and innovations if physicians can simply take these new skills to a competitor. In short, noncompete agreements create incentives for healthcare providers to make investments that, in the long run, promote competition for the benefit of physicians and hospitals, as well as patients, as discussed further below.

For purposes of informing future investigation and enforcement decisions, these forgoing research suggests two takeaways. First, absent clear evidence to the contrary, the FTC should openly presume that noncompete agreements with senior executives and physicians are not "unfair." Noncompetes allow these workers to take home 13-18% more compensation than they otherwise would. Simply put, it is not coercive or unfair for employers to strike "win-win" agreements with their most sophisticated, well-compensated workers. To leave any uncertainty in this area will only serve to chill legitimate, procompetitive business activities, harming the very workers the FTC wishes to protect.

The second takeaway is that less-restrictive alternatives to noncompete agreements, such as nondisclosure agreements, are insufficient because they do not prevent physicians from erasing the knowledge, training, and skills they have learned and can then use with a competitor. Further, with respect to non-disclosure agreements, hospitals are not privy to physician disclosures to a new competitor and as a practical matter, cannot monitor these disclosures.

B. Noncompete Agreements Promote Patient Access to Care and Address Community Need

Noncompete agreements promote greater hospital investment in developing and maintaining physician practices, especially in rural areas where there is a shortage of physicians which is projected to significantly increase by 2030.[9] These are multi-pronged investments that include physician recruiting, relocation, and retaining top talent, including highly specialized physicians for many different types of medical specialty services. For many specialties, if a physician can leave suddenly and without warning, it can take a hospital system months or even a year or more, to replace that physician, and during that time, the types of services furnished by that physician may be delayed or not available at all for patients.

In addition, hospitals provide all of the infrastructure necessary for physicians to practice and furnish needed medical care to patients, including practice space, furniture, fixtures, and equipment, medical supplies, staffing, a electronic medical record (EMR) system, and marketing. Hospitals also may share proprietary information with physicians, such as training for new innovations as well as business operations, and updating physicians on frequently changing regulatory requirements. All of these factors are critical for

[8] *Id.* at 1061.
[9] See Lucy Skinner, et al., *Implications of an Aging Rural Physician Workforce*, N Engl J Med 2019; 381:299301.

keeping up with current and future trends, patient access to and continuity of care, and addressing specific community medical need.[10]

Without noncompete agreements, hospitals would have less incentive to provide these investments if physicians could take advantage of these investments and suddenly and unexpectedly leave for employment at a competitor hospital or to set up their own competing physician practice. Additionally, where a physician suddenly and unexpectedly leaves to be employed by or provide services at a competitor hospital or other facility, if the competitor is not in a patient's network or the patient's immediate geographic community, it can cause network disruptions that adversely impact the physician-patient relationship and continuity of patient care. Further, when physicians leave without warning, this can cause the availability of on-call physicians in certain medical specialties to be in short supply, thus resulting in a lack of these services for patients, and even more alarming, can risk the ability of hospitals to meet certain certifications for that specialty. The loss of even one physician in a particular specialty may mean shuttering an entire program and depriving patients of access to multiple types of services across that entire program, such as a trauma or other type of program.

Accordingly, the foregoing hospital investments are critical for establishing and maintaining patient access to care, including support for programs that offer services across of broad range of medical specialty services, while also addressing specific community medical need, especially in rural and underserved areas. And, noncompete agreements are important tools for creating appropriate investment incentives that promote these patient access results.

C. Physician Noncompetes that Comply with Applicable State Law Are Neither Unfair Nor Anticompetitive

As of this writing, at least 19 States have statutes that specifically regulate noncompete agreements for physicians or other healthcare providers. These statutes take many different forms, reflecting the fact that every State has its own unique legislative priorities and supply-and-demand circumstances. Eight States currently prohibit physician noncompetes by statute.[11] But other States take a more nuanced approach, drawing clear lines for when physician noncompetes are impermissible. For instance:

- **Connecticut** prohibits physician noncompetes that (i) last for longer than one year; (ii) reach more than 15 miles from the physician's primary site of practice; and (iii) are not supported by a material increase in compensation (with certain exceptions and additional limitations).[12]

- **Louisiana** prohibits physician noncompetes that (i) last for longer than two years after the end of the physician's employment, or five years from the contract's initial effective date (or, in the case of primary care physicians, general pediatricians, and general obstetricians, three years), whichever time period is shorter; or (ii) apply to the parish of the physician's principal site of practice and "no more than two contiguous parishes in which the employer carries on a like business."[13]

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[10] These same principles apply to senior executives in which hospitals invest to improve leadership and management skills.

[11] *See* Ark. Code Ann. § 4-75-101(k)(1); Colo. Rev. Stat. § 8-2-113; Del. Code Ann. Tit. 6, § 2707; Mass. Gen. Laws. 112 § 12X; N.H. Rev. Stat. Ann. § 329:31-a; N.M. Stat. Ann. § 24-1I-1 *et al.*; R.I. Gen. Laws § 5-37-33(a); S.D. Cod. Law § 53-9-11.1. This does not count the five States—California, Minnesota, North Dakota, Oklahoma, and Wyoming—that prohibit noncompetes for all workers.

[12] Ct. Gen. Stat. § 20-14p.

[13] La. Rev. Stat. § 23:921(M)&(N).

- **Maryland** prohibits physician noncompetes that (i) last for longer than one year; (ii) reach more than 10 miles from the physician's primary place of employment; or (iii) apply to physicians who make less than $350,000 per year.[14]

Other States take an even stronger approach, explicitly ***allowing*** physician noncompetes that satisfy certain criteria. For instance:

- **Florida** affirmatively presumes certain employee noncompetes to be enforceable so long as the employer proves the existence of a legitimate business interest; Florida does not, however, recognize a legitimate business interest for restricting a physician if the employer employs all of the physicians who practice a given specialty within a given county.[15]

- **Texas** declares physician noncompetes to be "enforceable," so long as the noncompete (i) is clearly stated in writing; (ii) does not last longer than one year; (iii) does not reach more than a five-mile radius from the physician's primary site of practice; (iv) allows for a "buyout" for no more than the physician's annual wages; (v) allows the physician to access a list of patients and, upon consent, those patients' medical records; and (vi) allows the physician to continue treating patients during the course of an acute illness.[16]

When a State clearly expresses its legislative policy by drawing bright legal lines to define the permissibility of physician noncompetes, the FTC should not seek to blur these bright lines by injecting a subjective notion of "unfairness" into the analysis. As a matter of law, employers are not acting "unfairly" or "anticompetitively" when they carefully comply with applicable State law. Complying with State noncompete law means playing by the same rules as every other employer who operates in the same territory—the very essence of fair competition.

D. The FTC Must Be Careful Not to Subject Tax-Paying Healthcare Providers to Fundamentally Different Rules of Competition Than the Rules that Apply to Tax-Exempt Non-Profit and Government Entities

As the FAH has argued previously, one of the most serious defects with the FTC's ill-conceived Noncompete Rule[17] was the fact that the FTC does not have equal jurisdiction to prevent "unfair methods of competition" by tax-exempt, nonprofit and government entities versus for-profit, tax-paying entities. The FTC can regulate unfair methods of competition by tax-paying hospitals, but it cannot regulate unfair methods of competition by nonprofit or government-owned hospitals. As a result, the Noncompete Rule

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[14] Md. Labor & Emp. Art. § 3-716(b). Other States with similar approaches include Pennsylvania, Tennessee, and West Virginia. *See* 35 Pa. Stat. § 10324 (physician noncompetes may not exceed one year and do not apply if physician was dismissed by the employer); Tenn. Code Ann. § 63-1-148 (physician noncompetes may not exceed 2 years in duration and either a 10-mile radius or the physician's primary county of practice, and may not apply to physicians specializing in emergency medicine); W.V. Code § 47-11E-2 (physician noncompetes may not exceed 1 year in duration and 30 miles in radius, and are void if the employer terminates the physician). Other states with their own approaches include Idaho, Indiana, and Nevada. *See, e.g.*, Idaho Code § 39-6109 (prohibiting noncompetes for physicians with a J-1 visa or in certain visa waiver programs); Ind. Code §§ 25-22.5-5.5-1 *et seq.* (prohibiting noncompetes for primary care physicians and in various other enumerated circumstances); Nevada Rev. Stat. § 439A.170 (prohibiting noncompetes for physicians with a J-1 visa).

[15] Fla. Stat. §§ 542.335-542.336.

[16] Tex. Bus. & Com. Code § 15.50(b).

[17] *See* Comments of Federation of American Hospitals, RIN: 3084-AB74 (Apr. 19, 2023), at 6-7, *available at* https://downloads.regulations.gov/FTC-2023-0007-21034/attachment_2.pdf; Comments of Federation of American Hospitals, Dkt. Nos. FTC-2025-0088-0001 and ATR-2025-0001 (May 21, 2025), at 4-5, *available at* https://downloads.regulations.gov/FTC-2025-0028-0074/attachment_2.pdf. The FAH incorporates these earlier comments into this letter by reference.

would have created fundamentally different rules of competition for different companies in the same industry based solely on their tax status—a result that finds no support in empirical evidence, common sense, or any reasonable definition of "fairness." (It is telling that not a single State considers the tax status of an employer as a relevant factor in evaluating the legality of a noncompete.) Thus, far from preventing an "unfair method of competition" as between workers and employers, the Noncompete Rule would have instead ***created*** an unfair method of competition as between nonprofit and government health systems versus their tax-paying competitors.[18]

While the FAH applauds the FTC's decision to accede to the vacatur of the Noncompete Rule in favor of case-by-case enforcement, the problem of the FTC's inconsistent jurisdiction still remains. As it currently stands, the FTC can challenge the noncompete practices of the 24% of U.S. community hospitals that are "organized to carry on business for [their] own profit or that of [their] members," but the FTC cannot challenge the noncompete practices of the 58% of U.S. community hospitals that are owned by nonprofits, nor the 18% that are owned by State or local governments[19]—even when a tax-paying hospital competes head-to-head with a nonprofit or government hospital for workers.

The FAH appreciates that the FTC can only act within the bounds of its statutory jurisdiction and that the FTC is duty-bound to try to stop a company within its jurisdiction from engaging in an unfair method of competition. However, given the Request for Information's specific focus on the effects of noncompete agreements in the healthcare industry, the FAH would urge the FTC to remain conscientious of the consequences of selective enforcement before taking overly aggressive action to challenge noncompetes in the healthcare sector.

For example, before taking action against a tax-paying healthcare provider for its use of noncompetes, the FTC should at a minimum pause to consider whether doing so might put such a tax-paying healthcare provider at a competitive disadvantage viz-a-viz its tax-exempt, nonprofit or government rivals. In this respect, the FTC should place significant weight on whether the tax-paying healthcare provider follows the noncompete laws of its particular jurisdiction, given that those State laws apply with equal force to tax-paying, nonprofit, and government employers.

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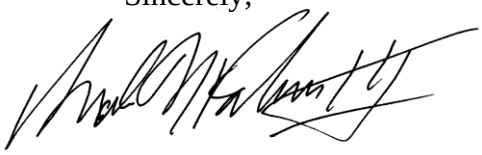
The FAH appreciates this opportunity to submit these comments. If you have any questions, or if there is any other way that we can assist the Agencies as they consider the Requests, please contact me or any member of my staff at (202) 624-1500.

Sincerely,



[18] The FTC made no secret of these jurisdictional limitations when it adopted the Noncompete Rule. Non-Compete Clause Rule, 89 Fed. Reg. 38,342, at 38,448 (May 7, 2024) ("the Commission recognizes that not all entities in the healthcare industry fall under its jurisdiction"). However, the FTC dismissed the FAH's concerns out of hand, concluding that "even if true, arguments that for-profit and other covered entities could suffer competitive harm … would not change the Commission's finding." *Id.* at 38,450.

[19] American Hosp. Ass'n, *Fast Facts on U.S. Hospitals*, 2025 (2025), *available at* https://www.aha.org/system/files/media/file/2025/01/Fast-Facts-on-US-Hospitals-2025.pdf.