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SUBJECT: Non-Compete Clause Rulemaking, Matter No. P201200

SUBMITTED BY: The Society for Cardiovascular Angiography & Interventions, April 17, 2023

The Society for Cardiovascular Angiography & Interventions (SCAI) is pleased to provide the following comments regarding the Federal Trade Commission (FTC) proposed rule that would ban non-compete clauses in employment contracts in most instances (the "Proposed Rule").

SCAI is a nonprofit professional association with over 4,500 members representing the majority of practicing interventional cardiologists and cardiac catheterization teams in the United States, including those providing percutaneous coronary interventions (PCI) to adults and children. SCAI promotes excellence in invasive and interventional cardiovascular medicine through education, representation, and the advancement of quality standards to enhance patient care and access.

The Effect of Non-Competes on Interventional Cardiologists

As SCAI noted in its statement provided for the FTC Workshop on Making Competition Work: Promoting Competition in Labor Markets, held on December 6-7, 2021 (the "Workshop"), SCAI is specifically concerned about the unfair use by hospitals, health systems, and others requiring interventional cardiologists to sign restrictive covenants not-to compete in physician contracts.[1] These provisions are contained in what amounts, in many cases, to contracts of adhesion because a physician's only choice is to accept the terms of the contract without revision or else forgo employment. In addition, these "take it or leave it" contracts also often contain terms that require that the interventional cardiologist live within 20 minutes of the hospital at which they work to ensure their ability to perform timely, life-saving procedures related to patient heart attack. Durational stipulations also mandate that the interventional cardiologist not practice within a

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[1] *See* The Society for Cardiovascular Angiography & Interventions Statement for the Federal Trade Commissions Work
Shop on Making Competition Work,
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjGmY3y68r9AhXrKlkFHYuyBD0QFnoECAoQAQ&url=https%3A%2F%2Fdownloads.regulations.gov%2FFTC-2021-0057-0008%2Fattachment_1.pdf&usg=AOvVaw3YspOpY82tt2BT5Ww6go9U.

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specified area surrounding either a specific hospital, or often any facility owned by a health system. These geographic restrictions typically last for a period of time ranging from 6 months to 2 years after separation from employment with the health care system. As a result, these geographic and durational limitations contained in typical non-compete clauses, governed by state law, all but force interventional cardiologists to either remain in their current hospital or move far away from the area in order to find a new position. Given that physicians are licensed on a state-by-state basis, and given the rapid conglomeration of health care systems, the non-compete clauses that cover all of a health system's facilities can effectively restrict physicians from finding gainful employment in the same state or region as their licensure. In addition, the control of credentialing of hospital-based physicians, such as interventional cardiologists, by these large hospital systems subjects interventional cardiologists to further restriction on their job mobility.

The Effect of Non-Competes in Consolidated Hospital/Health System Markets

As we also noted in our Workshop comments, there is ample evidence that the markets related to the U.S. hospital sector are broken. Over the last 30 years, a wave of hospital mergers in the U.S. have substantially increased market concentration. In fact, some calculations indicate that, at present, more than 80% of hospital markets in the U.S. are "highly concentrated," based on criteria set out in the Department of Justice/FTC horizontal merger guidelines.[2] In addition, there has been a marked increase in the consolidation of health systems.[3] Hospitals and health systems are also increasingly buying physician practices—a concerning trend with the potential to further shield hospitals from competition from and among physician practices. According to a recent report by Avalere, nearly 70% of U.S. physicians are now employed by a hospital or a corporate entity.[4] There is also growing concern that hospital credentialing policies are being used to promote corporate economic interests and to stifle competition instead of promoting professional standards and quality care as originally intended. Many SCAI members have been at the receiving end of these anticompetitive trends. For example, in 2010, approximately 80-85 percent of our members practiced medicine in an office- based or group practice. Now, more than a decade later, approximately 85 percent of SCAI members are employed by hospitals and health systems.

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[2] Federal Trade Commission and Department of Justice Horizontal Merger Guidelines, https://www.justice.gov/atr/horizontal-merger-guidelines-08192010 (Aug. 19, 2010).
[3] Michael Furukawa et al., *Consolidation Of Providers Into Health Systems Increased Substantially, 2016–18*, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00017 (Aug. 2020).
[4] COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020, http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3d%3d (June 2021).

These restrictions on competition in the hospital and health system market have had a corresponding adverse effect on competition in the market for physician services. These anticompetitive trends are compounded by the prevalence of restrictive non-compete agreements to which a significant portion of physicians are subject. Already limited by their state licensure and hospital credentialing policies, "take it or leave it" covenants not to compete with ever-growing hospital systems have substantially limited the ability of interventional cardiologists to take positions that will allow them to provide the best quality care to their patients.

The consolidation of health systems has resulted in reduced access to care for patients in rural, underserved, and lower socio-economic status areas, a problem that is aggravated by restrictive physician non-competes, resulting in inequitable outcomes for diverse and underserved patient populations across the United States.

Regulation of Non-Competes is Long Overdue and Supported by Substantial Evidence

We also noted in our Workshop comments that the FTC conducted an examination of non-compete clauses in January 2020, bringing the number of Administrations that have examined health care competition to three, including the Biden Administration. In March 2016, the U.S. Treasury Department issued a report entitled, "Non-Compete Contracts: Economic Effects and Policy Implications," based mostly on non-public studies, asserting pervasive misuse of non-competition agreements. In October 2016, President Barack Obama issued a "State Call to Action on Non-Compete Agreements" to "address wage collusion, unnecessary non-compete agreements, and other anticompetitive practices." In Congress, a bill titled the Workforce Mobility Act (the "Act") was recently reintroduced in February, seeking to prohibit the use and enforcement of post-employment non-competition agreements. The Act empowers the FTC, the U.S. Department of Labor, and states to investigate and enforce a ban on non-compete agreements. Unfortunately, this legislative effort has thus far failed, but the FTC clearly has the power to restrict the use of non-competes, without additional legislative authority. The Proposed Rule is clearly supported by Section 5(a) of the Federal Trade Commission Act as well as President Biden's wide ranging Executive Order issued on July 15, 2021, Promoting Competition in the American Economy, which encourages the FTC to "curtail the unfair use of non-compete clauses and other clauses or agreements that may unfairly limit worker mobility."

We applaud the FTC for its very thorough scholarship regarding non-complete clauses, including the close to 200 pages of extensive and thoughtful research into the harmful impact of non-compete clauses in its Proposed Rule. This research showed, among other things, that 45% of all physicians are under some type of non-compete clause, that about one in five of all American workers are bound by a non-compete clause that restricts them from pursuing

better employment opportunities, and that non-compete clauses clearly harm the economy, harm workers, and harm patient access to the healthcare they desperately need.

Non-compete agreements prevent physicians from practicing medicine in their communities when they want or have to change jobs—de facto limiting patients' access to their physicians, and ultimately impacting public health as a whole. In a recent study conducted on the impact of non-compete clauses on surgeons in the State of Louisiana, physicians surveyed strongly believed non-compete clauses negatively impacted patients, including forcing patients to drive long distances to maintain continuity of care (64.4%) and forcing surgeons to abandon their patients if they seek new employment (76.7%).[5] Continuity of care was the issue cited in *Statesville Medical Group v. Dickey*, where a physician defendant was the only practicing endocrinologist in the area. A non-compete agreement would have prevented him from providing endocrinology services in his community, which would force existing patients to travel an additional 40 miles to see the nearest provider.[6] The court ruled against enforcing the non-compete agreement because that distance would have impacted "the availability of a doctor at all times for an emergency." In addition, it would have ended existing doctor-patient relationships, severing continuity of care.

Unsurprisingly, non-compete agreements can also have a detrimental impact on public health, as was the case in *Iredell Digestive Disease Clinic v. Petrozza*.[7] In that litigation, enforcing a gastroenterologist's non-compete would have left only one remaining gastroenterologist in the community. Without another gastroenterologist, patients would not only lose their continuity of care, but it would have also created a monopoly for the remaining gastroenterologist, taking the choice away from patients to decide which provider to see based on their needs and preferences. The court viewed these possible outcomes as a danger to public health and refused to enforce the non-compete stating, "if ordering [the physician] to honor his contractual obligation would create a substantial question of potential harm to the public health, then the public interests outweighs the contract interests…"

Some commenters have argued that the FTC must make an exception for non-compete agreements with physicians. There is certainly no legal basis for this claim, and the idea that non-compete clauses somehow benefit physicians or patients is defied by the facts. As shown above, non-compete clauses restrict physician job mobility and incomes and limit their ability to provide high quality treatment to their patients. An economic argument could be made in cases where an employer is seeking recoupment for reasonable resources expended in

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[5] William F. Sherman et al., *The Impact of a Non-Compete Clause on Patient Care and Orthopaedic Surgeons in the State of Louisiana: Afraid of a Little Competition?,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9569414/ (Oct. 2022).

[6] *Statesville Med. Grp., P.A. v. Dickey*, 106 N.C. App. 669, 671, 418 S.E.2d 256, 258 (1992).

[7] *Iredell Digestive Disease Clinic, P.A. v. Petrozza*, 92 N.C.App. 21, 30, 373 S.E.2d 449, 454 (1988).

connection with their time and training of an employee. Should the FTC contemplate any exceptions in the future we want to be clear, however, that they should reasonable, limited, and not limited to physicians and nurses only. For example, "small employers" are often provided special considerations and defined to include businesses with variable numbers of full-time employees (e.g., 10-50 employees).

In addition, we note that the same commentators referenced above have strongly suggested that the FTC investigate reports of anticompetitive pricing by nurse-staffing agencies. We have no doubt that hospitals and health systems have been forced to pay a premium for the cost of traveling nurses. We would, however, not be surprised to discover that one of the major economic drivers underlying these complaints is the very same non-compete clauses -- only this time in the contracts between nurses and their agents.

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In summary, non-compete clauses, combined with ever-growing hospital and health system consolidations, prevent the interventional cardiology community from providing care and, importantly, restrict patients' access to care. The FTC's Proposed Rule is a critical step in reducing this problem and will offer an important lifeline to the millions of patients we serve.

We stand prepared to provide the FTC with our enthusiastic assistance as it pursues this critical matter. Please contact Curtis Rooney, Vice President, Government Relations at crooney@scai.org, should you have questions.