AMERICAN COLLEGE of CARDIOLOGY

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April 3, 2023

The Honorable Lina M. Khan
Chair
Federal Trade Commission
600 Pennsylvania Ave, 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 Chair Khan:

As the voice of cardiovascular clinicians who treat cardiology patients in hospitals, private practices, and all manner of healthcare settings across the nation and the world, the American College of Cardiology (ACC) appreciates the opportunity to comment to the Federal Trade Commission on their proposed rule regarding the use, maintenance, and representation of non-compete clauses as an unfair method of competition. The College's comments focus on the history of the ACC and cardiologists in general as it relates to the proposed rule, comments in support of many of the Commission's proposals and commentary on what the ACC believes would be reasonable exceptions to the proposed curtailment of non-compete clauses. Ultimately, the key takeaway must be that clinicians should be free from unnecessary constraints that interfere with patient care and diminish well-being. The College appreciates the FTC's interest in removing unreasonable restrictions.

The ACC is the global leader in transforming cardiovascular care and improving heart health for all. As the preeminent source of professional medical education for the entire cardiovascular care team since 1949, and now with more than 56,000 members from over 140 countries, the ACC credentials cardiovascular professionals who meet stringent qualifications and leads in the formation of health policy, standards, and guidelines.

Introduction/Background

As the proposed rule makes clear, non-compete clauses in employment contracts affect a significant portion of the national workforce, including many physicians. In these comments we will address the topic generally, but also focus on how it impacts physicians and, more specifically, cardiologists. The ACC's Board of Governors previously convened a workgroup to research this issue as concern over the negative effects of non-compete clauses and other restrictive covenants had been brought forth by many of our members. The study yielded interesting and relevant insights on this topic for cardiologists.

Industry survey data shows that in 2008, 90% of cardiologists operated in a private practice setting while 10% were in an employed/integrated model. In the same survey ten years later, the results were nearly the inverse, with 84% of cardiologists employed and just 16% remaining in private practice settings.[i] This

dramatic shift in the employment structure of cardiologists, coupled with the common and often non-negotiable presence of stringent non-compete clauses and other restrictive covenants in cardiologist employment contracts, is the driver of our membership's interest in this topic. Surveys also showed that 68% of respondent cardiologists were subject to restrictive covenants in their employment contracts. Meanwhile, only 10% of respondents noted having the ability to negotiate any changes in said restrictive covenants.

Restrictive covenants have become often non-negotiable elements of contracts, especially in markets controlled by comparatively few employers. Physicians cannot often negotiate the geographic limits (especially important in large health systems with wide geographic range) or time duration of the non-compete clause. In addition, practices are often reluctant to enter into unique customized agreements with members, preferring uniformity related to contractual terms. Generally, younger physicians lack the fiscal and legal resources to challenge restrictive covenants. The cost and time requirements to renegotiate restrictive covenants are likely prohibitive, especially when an individual physician is opposed by a fully resourced corporate legal department.

A chief concern regarding non-compete clauses among ACC members is the geographic restrictions often attached to them when imposed by ever-sprawling health systems. As an anecdotal example, a member advised that the health system he works for has so many satellite locations and the radius restricted from each by his non-compete clause was such that he would have to actually leave the state to seek new employment. This creates obvious burdens of relocating themselves and their families, obtaining new licensure and credentialing, and purchasing new liability insurance for both the new state and tail coverage in the prior state. Above all, such changes alter countless long-established doctor/patient relationships that are lost under these circumstances. Loss of continuity of specialty care, especially in cardiology, can negatively impact patient outcomes.

Beyond geographic restrictions and reduced compensation there is evidence that non-compete clauses and other restrictive covenants have adverse effects on other aspects of physician work life. These include practice autonomy, workplace culture, patient access and satisfaction, burnout and more, which we will discuss next.

Support for the FTC Proposal to Consider Non-Competes an Unfair Method of Competition

There are myriad reasons that it would be beneficial to employees and the public to consider non-complete clauses an unfair method of competition across all economic ecosystems throughout the country. Considering physicians specifically, these include promoting rather than stifling innovation, promoting healthier workplace culture that would reduce physician burnout and improve patient experience, reducing costs of care to both the system and the patients, and promoting greater patient access to care.

Restrictive covenants may negatively impact efforts to build better working conditions by promoting an immobile or captive workforce culture. It is much easier to enforce clinically unattractive utilization policies and fail to fund or develop clinical programs when physicians have strong non-compete clauses as opposed to physicians who can freely leave and seek employment in systems with more favorable policies or work environments. Health systems individually have little incentive to renegotiate any portion of the non-compete clause, especially in large multispecialty employed physician groups. Physicians can try to

negotiate for compensation, more support, programmatic investment, or other important considerations, but have limited recourse if a non-compete is in place.

Restrictive covenants may compel physicians who are disengaged to stay in their current practice, leading to a toxic/negative and less productive culture.[ii] Rather than rely on these coercive means to retain their physician workforces, practices and hospitals could foster retention through innovation, positive and progressive culture, and trust.

Access to affordable care is an important foundation for population health. Improved affordability and enhanced patient experience can come from innovative care models. For example, ambulatory surgical centers (ASCs) that lower costs and can offer a more convenient pathway for patients may not be successful in communities with captive and immobile physician workforces. Physicians disadvantaged by highly limiting non-competes may be restricted from ASCs due to competing financial interests of healthcare systems and independent ASCs. If physicians are not permitted to participate, due to their non-competes, then the value proposition of ASCs to the community is diminished.

Reduced access to diverse caregivers can occur when patients cannot find the type of physician (race, gender, ethnicity, expertise or skill set, experience) that they need or desire. If physicians from underrepresented minority groups leave their practice and are subject to non-competes, then patients are forced to choose from the remaining physicians who might not be their first choice for caregivers. Accountability and outcomes, especially in complex or chronic patient care, are improved with strong longitudinal provider/patient relationships. Physicians who exit health systems with restrictive covenants may leave patients unable to access an established and trusted physician, resulting in loss of care continuity, fragmented care, and costly re-establishment with other clinicians. As a recent example, the closure of a large medical center in Atlanta led Georgia Senator Raphael Warnock to call on the center's health system to release its employed physicians from non-competes so as to not "prevent them from continuing to serve the Atlanta community."[iii]

Patients may also suffer harm due to system resistance to innovation fostered by captive work culture that may stifle the healthy competition required to spark change in health care. Top-rated care systems (for patient and doctor) with better services and offerings should serve as "magnets" and patients should be given the choice of following their physician for the same reason. In this way, a physician helps advocate for their patients indirectly and generates the competition that drives innovation.

Reasonable Exceptions Under Which to Allow Certain Non-Compete Clauses

While the ACC generally supports the Commission's proposal to eliminate non-compete clauses as an unfair method of competition, the College believes narrow, reasonable exceptions to the rule may be considered. These reasonable approaches would be available to any employer but could be successful in the remaining privately-owned medical practices which can play an important role in community-based care and due to their structure must make proportionately larger investments in newly hired physicians. As noted earlier in these comments, ever-expanding health systems with massive footprints in any given state or region that impose non-compete clauses with radii from *any* of their locations is clearly unreasonable and disruptive to clinicians and the patients they serve. However, if some geographic

restrictions are allowed, it could be considered reasonable if an employer with multiple locations were to impose a non-compete clause with a limited distance radius from only the location where the former employee worked the majority of their time for that employer. This kind of narrow restriction could mostly alleviate the issue described earlier of a large employer barring a former employee from seeking work anywhere in their state, region, or even a reasonable distance from where they reside, and would potentially preserve established physician-patient relationships.

The Commission discusses various forms of non-compete clauses that require the former employee to pay a monetary penalty or fee to be able to work for a competing employer. The College does not find a specific, static dollar amount cap on such a fee to be appropriate. However, it would seem reasonable for an employer to be able to recoup an amount of money that could be directly and demonstrably correlated to expenses actually incurred by said employer. For instance, if an employer offers to pay off $10,000 of a prospective employee's student loans if they agree to work for the employer for 5 years. It would not be unreasonable for the employment contract to require a pro-rated amount of that $10,000 to be paid back if the employee should leave prior to 5 years. If the employee left after 3 years, they would have to re-pay a pro-rated amount of $4,000 which correlates to the percentage of agreed-upon time of employment that was not served. This would be a direct and demonstrable expense incurred by the employer on behalf of the employee in exchange for a term of the contract which the employee did not entirely fulfill. A similar formula could be derived for other various forms of employer-incurred expenses including incentives, salary overhead, training, relocation, sales commission drawbacks, etc. What the College does not find reasonable is an employer imposing an onerous exit fee that is not directly related to the expenses incurred by the employer and is simply used as a prohibitive barrier to the employee finding other employment.

Non-Compete Restrictions Based on Salary Threshold

The proposed rule discusses the possibility of imposing different standards regarding non-compete clauses based on the workers' earnings. One of several noted possibilities was allowing non-compete clauses to be used if the worker's earnings were over $100,000 for an employee or $250,000 for an independent contractor. The ACC does not believe a threshold of any kind should be set for several reasons. First, the freedom of economic movement being restricted for anyone of any occupation or salary level is antithetical to the free market system on which this nation's economy is founded. To do so would unduly penalize the economic advancement of workers at or near the stated thresholds. This threshold type also infers that workers only change jobs for higher salaries. Workers change jobs for many reasons. To allow non-compete clauses for workers above a certain threshold would bar these workers from seeking new employment not only for a higher salary but also for better working conditions, schedule flexibility, better ancillary benefits, or a culture more aligned to the workers' values. We see no rational argument to deny workers these options simply because they earn $100,000 vs. $99,999 or any other fixed threshold. Further, a static amount set as a threshold for what a "relatively high" salary is, absent some mechanism to adjust this amount for inflation and geography, could over time become obsolete and restrictive as such a

salary eventually would not be considered high as inflation and other market forces inevitably progress at various rates over the years.

Conclusion

The ACC appreciates the opportunity to provide input to the FTC as it considers acting to eliminate the use of non-compete clauses. We generally support the Commission's stated intent to consider non-compete clauses an unfair method of competition while acknowledging some extremely limited forms and usage of the practice may be reasonable. From our perspective, any implemented reforms must be considered through the lens of improving patient care and should promote the continued effectiveness of our clinical workforce. For any questions or follow-up please contact Matthew Minnella, Associate Director of Medicare Payment Policy at mminnella@acc.org or 202-375-6232.

Sincerely,

Dr. B. Hadley Wilson, MD, FACC
President, American College of Cardiology

[i] Sobal, L. (2019, November 6). *Has employment of cardiologist been a successful strategy – Part 1.* American College of Cardiology, Cardiovascular Management Section. (https://www.acc.org/membership/sections-and-councils/cardiovascular-management-section/section-updates/2019/11/06/09/49/has-employment-of-cardiologists-been-a-successful-strategy-part-1).
[ii] Douglas P, et al. ACC Statement on Workplace Culture 2022
[iii] Senator Warnock press release October 14, 2022 and AJC article.