

October 20, 2025

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

***Re: September 4, 2025, FTC Request for Information Regarding Employer
Noncompete Agreements***

Dear Chairman Ferguson:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinical partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks the Federal Trade Commission (FTC) for dismissing its appeals in *Ryan, LLC v. FTC*, No. 24-10951 (5th Cir.), and *Properties of the Villages v. FTC*, No. 24-13102 (11th Cir.), and acceding to the vacatur of the Non-Compete Clause Rule. We also write to respond to the Request for Information (RFI) Regarding Employer Noncompete Agreements issued on September 4, and in particular to offer our insights in response to questions 12 and 13 of the RFI.

The AHA appreciates the FTC's recognition that "narrowly tailored noncompetes can serve valid purposes in certain circumstances," and that non-compete agreements may be more appropriate for "certain roles" than others.¹ This is particularly true for hospitals and health systems. As we outlined in our February 2023 comment and subsequent amicus brief in *Ryan v. FTC*, exempting physicians and senior hospital executives from non-compete enforcement is necessary because of the unique features of the health care labor market.

For this reason, we have concerns about the letters the FTC issued on September 10 to certain health care employers and staffing firms, informing them to review their

¹ Template FTC letter Re Noncompete Agreements (Sept. 10, 2025), at https://www.ftc.gov/system/files/ftc_gov/pdf/noncompete-warning-letter-template.pdf.



employment agreements for unreasonable non-compete agreements. We agree that *certain* non-compete agreements can “have particularly harmful effects in health care markets.” But it is important to be clear about *which kind of* non-compete agreements can have these adverse effects so that the FTC can appropriately tailor its enforcement efforts. After all, “[n]oncompete agreements are not new. They are much older than the Republic There is no tradition of federal regulation of noncompete agreements.”²

Hospitals and health systems employ a wide variety of personnel, from food service employees in their cafeterias, to nurses, translators and social workers in their patient rooms, to surgeons in their operating rooms. Some hospital employees are highly trained; some are lower skilled. Some are highly compensated; some are lower wage.

Many of these more-highly compensated hospital employees, especially physicians and senior executives, *do not* present the same considerations with respect to noncompete agreements as other types of employees.³

Accordingly, the AHA urges the FTC to target any enforcement efforts against practices that unduly constrain lower-skilled, lower-wage employees who lack bargaining power. It should *not* challenge non-compete agreements that are negotiated and agreed upon by highly skilled or highly compensated employees, such as physicians and hospital executives. As explained below, the research is either inconclusive or shows that non-compete agreements with physicians and senior executives are neither unfair nor anticompetitive within the meaning of the FTC Act and, more importantly, advance patient access to care, particularly in rural and other underserved areas.⁴ The Commission therefore should be cautious about

² Dissenting Statement of Commissioner Andrew Ferguson, *In the Matter of the Non-Compete Clause Rule*, Matter No. P201200 (June 28, 2024), at https://www.ftc.gov/system/files/ftc_gov/pdf/ferguson-noncompete-dissent.pdf.

³ See Statement of Commissioner Mark R. Meador, *In the Matter of Non-Compete Clauses*, Matter No. P201200 (Sept. 5, 2025) at https://www.ftc.gov/system/files/ftc_gov/pdf/meador-statement-noncompete-agreements-9.5.25.pdf (“Noncompetes tend to be less justified when applied to low-wage workers, as such individuals are less likely to receive employee-specific training and typically have limited access to confidential information. Noncompete provisions in this context are more likely to operate in a manner that restricts worker mobility without protecting legitimate business interests. By contrast, noncompetes for highly-skilled or specialized employees may be more readily justified where employers make substantial investments in training, provide access to proprietary methods, or share confidential business information.”); see also Statement of Chairman Andrew N. Ferguson Joined by Commissioner Melissa Holyoak, *In the Matter of Gateway Pet Memorial Services*, Matter No. 2210170 (Sept. 4, 2025) at https://www.ftc.gov/system/files/ftc_gov/pdf/gateway-ferguson-holyoak-statement-2025.09.04.pdf (“These workers are critical to providing cremation services, and they make up the vast majority of Gateway’s employees, but their job duties do not require extensive training that might justify some noncompete restrictions.”)

⁴ See Dissenting Statement of Commissioner Andrew Ferguson, *infra* n. 2 (“The lack of evidence on noncompete agreements’ effects on innovation, wages, productivity, and on the effects of potential

any anecdotal information it receives in response to this RFI. The actions it takes against one hospital will ripple across the entire field. The Commission must be certain that it is targeting the most egregious forms of noncompete agreements — namely, those that impact employees who cannot effectively bargain for different terms.

The AHA agrees with the Commission's decision to adopt a "case-by-case" enforcement approach to non-compete agreements. For the following five reasons, however, the FTC should be extremely judicious when pursuing enforcement actions against hospitals and health systems. Put another way, even within a "case-by-case approach," some cases are more deserving of the Commission's attention and resources than others. We therefore respectfully request that you take the following information into consideration as the Commission develops its enforcement priorities.

First, non-compete agreements are valuable tools for protecting investments that hospitals make to recruit doctors and senior executives. This is especially important in rural and other medically underserved areas.

According to Department of Health and Human Services (HHS) data published in March 2025, over 70% of areas designated as primary medical health professional shortage areas were considered rural or partially rural.⁵ This shortage will only worsen in the coming years because the rural physician population is disproportionately older, with one-quarter anticipated to retire by 2030.⁶ What's more, "shortages among one profession or specialty have a domino effect on others," with severe adverse consequences for rural hospitals.⁷ As an expert panel explained in a report to Congress and the HHS Secretary:

[L]ack of access to a general surgeon as backup limits the availability of other hospital services such as trauma care, oncology treatment and colonoscopy screening. This interdependence is not limited to general surgeons. Recent reports have highlighted declining access to maternity care in rural communities, in part because hospitals face chronic shortages of maternity-care providers such as family physicians, obstetricians, certified nurse midwives, and labor and delivery nurses,

alternatives to those agreements, points to a broader problem that infects the Commission's analysis: the economic literature on noncompete agreements is new and still being developed. Indeed, one of our own economists pointed this out just a few years ago, writing that "[f]urther research is needed in several areas" because "the existing empirical literature on non-compete agreements suffers from several important limitations that raise questions as to whether it has successfully estimated the causal effect of such agreements on mobility, wages, entrepreneurship, and innovation.")

⁵ See Health Resources and Services Administration, Bureau of Health Workforce, *Designated Health Professional Shortage Areas Statistics*, Second Quarter of Fiscal Year 2025.

⁶ See Lucy Skinner, et al., *Implications of an Aging Rural Physician Workforce*, *N Engl J Med* 2019; 381:299-301.

⁷ Council on Graduate Medical Education, *Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities* (Apr. 2022), at <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/reports/cogme-april-2022-report.pdf>.

*as well as surgeons and anesthesiology providers. Primary care workforce shortages and difficulty accessing specialty services result in unnecessary trips to the emergency room, further straining hospitals that are already underfunded and understaffed.*⁸

In addition, rural hospitals need skilled and committed executives to help them survive in challenging economic conditions. From 2016 to 2025, 92 rural hospitals either closed their doors or ceased being able to provide inpatient services.⁹ Hospitals and health systems, especially those located in rural areas, need to be resourceful in pursuing opportunities that improve their financial viability. But these efforts require savvy, talented leaders, both to come to rural hospitals in the first place and to stay there when they are inevitably presented with other professional opportunities.

For these reasons, it is apparent why rural and other understaffed hospitals would want to negotiate reasonable non-compete agreements. If, however, hospitals and health systems are disincentivized by FTC enforcement efforts, there would be a range of negative outcomes. For instance, nearby employers could “free ride” on the initial hospital’s investment in recruiting both doctors and senior executives by offering more pay to convince the employee to move a few counties away. The initial hospital’s investments in searching for candidates, providing a signing bonus, relocation pay, and guaranteeing a salary for a period while that physician became established in the community would be lost. This, in turn, would discourage recruiting investments in the first place. Similarly, it would create a classic “holdup problem,” whereby the recruited doctor or senior executive would have the ability to threaten to leave the initial recruiting hospital — be it for a nearby rural hospital or even a farther-away urban or suburban one — unless economically-unsupportable demands are met.¹⁰ Here, the holdup problem would be exacerbated by existing workforce shortages, particularly in certain areas of the country.

Second, non-compete agreements encourage hospitals and health systems to make investments in training their employees. While much of a physician’s training occurs in medical school and residency, doctors must stay current with scientific developments and innovation. There is a constant stream of new research and technological innovations with the potential to improve patient care, and every practicing physician is always continuing

⁸ *Id.*

⁹ American Hospital Association, *Rural Hospitals at Risk: Cuts to Medicaid Would Further Threaten Access* (June 2025) at https://www.aha.org/fact-sheets/2025-06-13-rural-hospitals-risk-cuts-medicaid-would-further-threaten-access?utm_source=chatgpt.com.

¹⁰ See Kurt Lavetti, Carol Simon, & William D. White, The Impacts of Restricting Mobility of Skilled Service Workers Evidence from Physicians, 55 J. Hum. Res. 1025, 1042 (2020). Analyzing whether the desire to retain employees motivated firms to negotiate non-compete agreements, the authors found that for primary care physicians “turnover reductions appear to be substantial, [but] they are very unlikely to be the primary motivation behind the use of NCAs among physician practices.” The AHA agrees with this to the extent the study recognizes that limiting turnover is a “substantial” motivation and emphasizes that not all hospitals have the same motivations for pursuing non-compete agreements. As noted, retention may be a greater motivator for rural or other geographically isolated hospitals.

his or her education. This also is the case for senior executives, who often receive management training, attend conferences and generally develop relevant leadership skills.

In standard economic terms, this kind of continued learning is considered “general human capital,” i.e., skills or knowledge that has productive value in *other firms*, as well as one’s employing firm.¹¹ A doctor or executive who receives training in “general human capital” can quit and get a higher wage at another firm on the basis of that increased skill and knowledge. As a result, firms have weaker incentives to invest in training unless a non-compete agreement is in place. Non-compete agreements thus encourage hospitals to make sound investments in training because they know it will redound to their own patients’ and communities’ benefit. This is exactly the experience of AHA’s members.¹²

Studies support this commonsense economic principle and real-world experience of hospitals. In fact, as FTC economist John McAdams has generally observed: “The bulk of the empirical literature finds that workers signing non-compete agreements, or workers who reside in areas with a higher incidence of NCAs, receive more training.”¹³ Additional studies demonstrate the relationship between noncompetes and this increased training. For example, one study found that for those who accept non-compete agreements before accepting a job, those employees are 11% more likely to have received training in the prior year.¹⁴ Similarly, another study compared workers in states with different degrees of enforcement of non-compete agreements. It found that moving from no enforcement to the average degree of enforcement was associated with a 14% increase in employer-sponsored training of workers and no change in worker-sponsored training.¹⁵ Although these studies did not focus specifically on physicians, the findings are significant because they again align with the experience of the AHA’s members. While hospitals and health systems always strive to provide the most cutting-edge medical care and executive

¹¹ See generally Gary S. Becker, *Human Capital* (3d ed. 1993).

¹² Although this discussion focuses mainly on training, there are additional forms of “general human capital” that would be transferrable absent non-competes, including expenditures by hospitals to market physicians in the community and expand patient relationships. As with training, hospitals will be more loath to make these purely business investments if doctors could bring those assets with them to another employer.

¹³ John McAdams, *Non-Compete Agreements: A Review of the Literature*, SSRN Working Paper, SSRN-id3513639, at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3513639; see *id.* (“The papers relying on state policy changes for identification find that non-competes lead to more firm-sponsored training among top public executives.”).

¹⁴ See Evan P. Starr, James J. Prescott, & Norman D. Bishara, *Noncompete Agreements in the U.S. Labor Force*, 64 J.L. & Econ. 53, 53 (2021); *id.* (“Several of the facts we document are consistent with the traditional economic perspective, which views the noncompete as an efficient contracting device.... [O]ur evidence that employees with early notice of a noncompete are compensated—with higher wages, more training, information, and job satisfaction—is compatible with theories that identify noncompetes as a solution to a holdup problem.”).

¹⁵ See Evan Starr, *Consider This: Training, Wages, and the Enforceability of Non-Compete Clauses*, 72 I.L.R. Rev. 783, 799 (2019). To be sure, the study also found that the same increase in non-compete enforcement was associated with 4% lower hourly wages, which the author attributes to decreased worker bargaining power. This result is based on decreases in hourly wages as workers remain at the same employer. Notably, the previously-discussed study by Lavetti, Simon, and White found an increase in earnings growth for physicians.

leadership, non-compete agreements allow them to best internalize the value of their investments.

Third, the FTC's own cited evidence indicates that the use of non-compete clauses increases the rate of earnings growth for physicians. The evidentiary record submitted by the FTC in connection with its now-vacated rule makes this clear. Throughout the proposed rule, the FTC cited to the Lavetti, Simon, and White study focusing on physician earnings, *infra* n. 10. As the Commission observed at that time, that study found that the “use of non-compete clauses among physicians is associated with greater earnings (by 14%) and greater earnings growth.”¹⁶

Additional compelling features of the study were presented at one of the Commission's own workshops. There, Professor Lavetti explained: “What we find is that in physician groups that use non-compete agreements, doctors are much more likely to make referrals of their patients to other doctors within the same practice, because they don't have to be as concerned about their fellow colleagues getting to know their patients and then opening a business next-door and poaching the patients.”¹⁷ According to Professor Lavetti, these increased referrals have three important pro-competitive and pro-health care consequences. As noted, doctors, on average, are able to bargain for higher wages over the course of their careers.¹⁸ Employers increase their overall revenue because there are greater intra-institutional referrals.¹⁹ And patients receive better, more integrated care through what Professor Lavetti called “this patient-sharing story.”²⁰ The experience of AHA's member hospitals and health systems supports these conclusions and underscores the value of non-compete agreements for physicians.

Fourth, non-compete agreements encourage the sharing of proprietary information within hospitals and health systems. For physicians, that information could include anything from patient lists to innovative research and development that can lead to improved care. For senior hospital executives, that proprietary information could include

¹⁶ 88 Fed. Reg. at 3487.

¹⁷ Kurt Lavetti, *Economic Welfare Aspects of Non-Compete Agreements*, Remarks at the Fed. Trade Comm'n Workshop on Non-Compete Clauses in the Workplace (Jan. 9, 2020) (emphasis added), at https://www.ftc.gov/system/files/documents/public_events/1556256/non-compete-workshop-transcript-full.pdf.

¹⁸ *Id.* (“For an average physician who signs a non-compete agreement, the net present value of the earnings effect at the time that they sign the contract is positive \$650,000 over a single job spell, which is about 15 years, on average. They make substantially more money, and all of that difference comes from larger within-job earnings growth.”).

¹⁹ *Id.* (“That, in turn, leads these practices to generate percent more revenue per hour worked.... There's much more fluid referral of patients across doctors within groups that use these types of contracts. These gains don't seem to occur in states that have nonenforceable NCA laws.”).

²⁰ *Id.*; see, e.g., Kaiser Permanent Institute for Health Policy, *An overview of our integrated care model*, at <https://www.kpihp.org/integrated-care-stories/overview/> (discussing the benefits of integrated care); Cleveland Clinic, *Integrated Care*, at <https://my.clevelandclinic.org/about/community/sustainability/sustainability-global-citizenship/patients/integrated-care#overview-tab> (same).

company strategy, internal business processes, names of key suppliers and customers, data with respect to payers, strengths and weaknesses vis-à-vis competitors, and more. Hospitals and health systems will want to protect the intellectual capital acquired by doctors and senior executives from falling into the hands of rivals because this information could give them an advantage. Ultimately, hospitals are by no means unique in this regard, but it is important to emphasize that this is precisely the kind of proprietary information that hospitals and health systems need to retain within their walls to stay competitive and thrive.

Crucially, non-disclosure agreements or other contractual provisions cannot fully protect employers from the outflow of proprietary information because a former employee cannot completely erase information from her own mind. And, in many instances relevant to hospital research, former employees cannot help but rely on valuable information in their subsequent employment (e.g., a medical scientist will not have to re-run all of the same failed experiments she ran for her initial employer, which that initial employer paid for but her next employer will not). What's more, non-disclosure agreements do not enable employers to monitor ex-employees' disclosures on a regular basis. Reasonable non-compete clauses are thus the only way employers can negotiate protections for their proprietary information.

Non-compete agreements enable firms to encourage the sharing of proprietary information across the firm because they know that it will be protected. Again, economic studies support this. Similar to his above-quoted observation with respect to training, FTC economist John McAdams found that the "bulk of the research" concludes that non-compete agreements provide workers with "more access to information."²¹ For example, the Starr, Prescott, and Bishara study of non-compete agreements reached before an employee starts employment found that those agreements increased the likelihood, by 7.8%, that the worker reported that her employer shares all job-related information.²² Similarly, the Lavetti, Simon, and White study found that non-compete agreements lead to the sharing of information about what they call a firm's "most valuable" asset: client (i.e., patient) relationships.²³

Fifth, focusing enforcement efforts on noncompete agreements with lower-skilled, lower-wage employees, while permitting noncompete agreements to remain in place for higher-skilled, highly compensated employees, is entirely consistent with related referral law. Doctors and executives are fundamentally different from other workers who have received the most attention from the FTC. Other areas of federal law recognize this and broadly exempt highly-skilled and highly-compensated workers from requirements that

²¹ John McAdams, *Non-Compete Agreements: A Review of the Literature*, SSRN Working Paper, SSRN-id3513639, at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3513639; see *id.* ("Studies relying on cross-sectional comparisons tend to find that non-competes are associated with more training and information sharing.").

²² See *Noncompete Agreements in the U.S. Labor Force*, *infra* n. 14.

²³ *The Impacts of Restricting Mobility of Skilled Service Workers Evidence from Physicians*, *infra* n. 10.

apply broadly to employees. In particular, the Fair Labor Standards Act (FLSA) and its implementing regulations provides a closely analogous model. The FLSA generally requires that employees in the United States be paid at least the federal minimum wage for all hours worked and overtime pay at not less than time and one-half the regular rate of pay for all hours worked over 40 hours in a workweek. But, as authorized by statute, Department of Labor regulations contain exemptions from this requirement, including for “learned professionals,” “highly compensated employees,” and even employees in the practice of medicine.^{24,25}

These are finely-drawn, well-established legal categories that the Commission can — and should — look to when considering its enforcement priorities. Focusing enforcement efforts outside of these three categories would address the AHA’s concerns about undermining non-compete agreements for physicians and senior executives. But more important for the Commission’s ostensible purposes here, several of the FLSA-exemption categories would carve out those with equal bargaining power, while allowing the Commission to exercise any regulatory efforts towards protecting lower-skilled and lower-wage employees. **Accordingly, the Commission should exercise its “great discretion to treat a problem partially” and “regulat[e] in a piecemeal fashion” by exempting physicians and senior hospital executives from its enforcement campaign.**²⁶ It should instead direct its limited resources toward those who truly experience unequal bargaining power.

For all the reasons outlined above, the AHA respectfully submits that the FTC consider the importance of noncompete agreements for highly skilled and highly compensated employees — and the costs to the health care sector of disincentivizing or penalizing them — in its evaluation of this critical issue and any subsequent enforcement efforts.

We appreciate your careful consideration of these issues. Please contact me at jschenker@aha.org or Chad Golder, AHA’s general counsel and secretary, at cgolder@aha.org, if you have any questions.

Sincerely,

/s/

Julie Schenker
Deputy General Counsel

²⁴ 29 U.S.C. § 213(a)(7).

²⁵ See 29 C.F.R. § 541.301 (learned professionals); 29 C.F.R. § 541.304 (“practice of law or medicine”); 29 C.F.R. § 541.601 (highly compensated employees).

²⁶ *Ctr. for Biological Diversity v. EPA*, 722 F.3d 401, 409–10 (D.C. Cir. 2013).