



November 3, 2025

Chairman Andrew N. Ferguson
Federal Trade Commission
Office of the Secretary
600 Pennsylvania Avenue NW
Suite CC-5610 (Annex B)
Washington, DC 20580

Re: Request for Information — Employer Noncompete Agreements; Docket No. FTC-2025-0463

Dear Chairman Ferguson,

Thank you for the opportunity to comment on the Federal Trade Commission's Request for Information (Docket No. FTC-2025-0463) regarding employer noncompete agreements. We appreciate the FTC's leadership in examining how these agreements affect competition, innovation, and worker mobility across sectors—particularly in healthcare, where restrictive employment contracts directly affect patient access and system-wide efficiency. The Brown University Center for Advancing Health Policy through Research (CAHPR) is a nonpartisan research and policy center that advances the understanding and development of policies that will lower spending growth, improve patient outcomes, and enhance efficiency in the US healthcare delivery system.¹ This public comment is informed by relevant research from a team of health economists, health services researchers, and lawyers on competition and labor market dynamics from the lens of quantitative policy analysis and legal evaluation.

As noncompete agreements (NCAs) expand across multiple sectors, our research has shown that there may be several significant benefits to addressing this practice in health care. In line with the FTC's request for information to better understand the scope, prevalence, and effects of employer noncompete agreements, these comments summarize empirical evidence on how such agreements uniquely affect the healthcare labor market, competition, and patient outcomes. The comments below respond to questions 5, 8, 10, 12, and 13 of the request for public comment.

The research elucidates how noncompete agreements influence access to care, reduce market competition, and increasingly restrict healthcare workers due to the rapid consolidation of healthcare. Reducing unreasonable restrictions on provider mobility will not only promote competition and innovation, but may also yield substantial reductions in healthcare costs over the next decade.²

¹ *The opinions and conclusions expressed in this public comment are the authors' alone and do not reflect those of Brown University, the Brown University School of Public Health or any of the research sponsors.*

² "Noncompete Rule," Federal Trade Commission, April 16, 2024, <https://www.ftc.gov/legal-library/browse/rules/noncompete-rule>.

The Growth of Noncompete Agreements for Physicians

Noncompete agreements (NCAs) are terms in physician employment contracts that prohibit a physician from practicing medicine within a certain geographic area for a period of time after the end of employment. They are designed to enable firms to engage in specialized training and investments in workers without the fear of firms taking specialized knowledge to competitors. The use of NCAs in physician employment is pervasive and growing. According to one estimate, by 2007 nearly half of US primary care physicians were bound by noncompete agreements;³ some specialties, such as cardiology, may have restrictive noncompete agreements as high as 68%.⁴ These figures are almost certain to have risen over time as physicians are increasingly employed by health systems and other corporate entities, such as insurers and private equity (PE) firms,⁵ which now employ more than three quarters of US physicians.⁶

Physician noncompete agreements are currently regulated by state law, which varies considerably. Research is also limited given a lack of data and transparency on the scope and enforceability of NCAs in health care.⁷ In states where NCAs are allowed, they typically restrict physicians from practicing within a specific geographic area of the entity and its affiliated offices—whether an entire county or a 100-mile range from a practice location, for example⁸—and for an average duration of two to three years. To break a noncompete agreement, physicians must pay severe penalties. In Kansas, for example, a family physician would have needed to pay the group 25% of her earnings over a three-year period to leave her medical group.³ These restrictive covenants have consequences for both worker mobility and patient continuity of care: practitioners must relocate or face unemployment if they leave their former employer, and patients are often given no information about what happened to their previous physician.^{9,10}

³ Kurt Lavetti et al., “The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians,” *Journal of Human Resources* 55, no. 3 (2020): 1025–67, <https://doi.org/10.3368/jhr.55.3.0617-8840R5>.

⁴ “Re: Notice of Proposed Rulemaking, Federal Trade Commission; Non-Compete Clause Rule; 88 Fed. Reg. 3482 (RIN: 3084-AB74),” April 3, 2023, accessed October 23, 2025, https://www.acc.org/-/media/Non-Clinical/Files-PDFs-Excel-MS-Word-etc/2023/04/FTC-Non-Compete-ACC-Letterhead_Signed-HW.

⁵ Elizabeth Dailey, “Physician Employment Is Changing. What Does That Mean for the Industry?,” Advisory Board, August 26, 2025, <https://www.advisory.com/daily-briefing/2022/04/27/physician-employment>.

⁶ “PAI-Avalere Physician Employment Trends Study 2019-2023 Final.Pdf,” n.d., accessed October 31, 2025, <https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d>.

⁷ J. Jeffrey Marshall et al., “Restrictive Covenants and Noncompete Clauses for Physicians,” *JACC: Advances* 2, no. 7 (2023): 100547, <https://doi.org/10.1016/j.jacadv.2023.100547>.

⁸ Jason E. Liebowitz, “Private Equity in Healthcare—Safeguarding Patient Care,” *JAMA Internal Medicine* 184, no. 8 (2024): 989, <https://doi.org/10.1001/jamainternmed.2024.1887>.

⁹ “AMA Backs Effort to Ban Many Physician Noncompete Provisions,” American Medical Association, accessed October 23, 2025, <https://www.ama-assn.org/medical-residents/transition-resident-attending/ama-backs-effort-ban-many-physician-non-compete>.

¹⁰ Michelle Andrews, “Did Your Doctor Disappear Without a Word? A Noncompete Clause Could Be the Reason,” *Business, The New York Times*, March 15, 2019, <https://www.nytimes.com/2019/03/15/business/physician-non-compete-clause.html>.

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Potential Benefits of Banning Noncompete Agreements in Health Care

Noncompete agreements are often justified as necessary to protect business interests and investments in employee training and to maintain a consistent workforce. The healthcare sector may present an exception to this rationale, however, as the practice of medicine is standardized across practices and is less prone to trade secrets and firm-specific knowledge.¹¹ Additionally, a large portion of health care training, most notably residency programs, is heavily subsidized by taxpayers and the federal government. In most cases, public programs, rather than individual firms, are responsible for training US physicians and the health care workforce.

Market Competition and Healthcare Consolidation

As healthcare practices consolidate, the consequences of noncompete agreements amplify. Health systems and other corporate entities, including insurers and private equity firms, now employ nearly 75 percent of US physicians.¹² These clauses can stifle competition in healthcare markets, including the ability of physicians to start new healthcare practices, thereby constraining market entry that can encourage competition in the healthcare system. A 2009 natural experiment in Michigan, for example, found that allowing NCAs reduced the job mobility of inventors by about 8%.³ Increasing healthcare consolidation means that health systems and practice chains occupy greater geographic territory, which in turn could increase the scope of NCAs for employed physicians. The broader the geographic scope, the greater the burden on the physician.¹³

Not only do noncompete agreements impact competition in healthcare, but research has demonstrated the correlation between NCAs, physician market concentration, and elevated prices. Firstly, large, consolidated health systems can negotiate higher reimbursement rates from insurers, which increase prices for consumers.^{14,15} Secondly, consolidated markets with low physician mobility can prevent the growth of cost-saving initiatives or innovative care models that can improve affordability. For instance, ambulatory surgical centers (ASCs) can reduce costs and offer patients a better alternative to hospital-based care for many procedures.¹⁶ However, the success of ASCs relies on physician participation. In communities where physicians are bound by restrictive noncompete agreements, there may be an insufficient workforce to support their establishment.⁴ Along with reduced entrepreneurship,

¹¹ “The FTC’s Noncompete Rule: Legal Challenges And Potential Solutions For Physician Markets,” August 30, 2024, <https://doi.org/10.1377/forefront.20240828.827737>.

¹² “The Impact of Noncompetes on Healthcare: 7 Expert Takeaways | HBHI,” Johns Hopkins University, Hopkins Business of Health Initiative, December 13, 2023, <https://hbhi.jhu.edu/news/impact-noncompetes-healthcare-7-expert-takeaways?utm>.

¹³ *Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs: S. Hrg. 118-661 before the Committee on Finance*, United States Senate (2023).

¹⁴ Richard M Scheffler et al., “Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk,” *SSRN Electronic Journal*, ahead of print, 2023, <https://doi.org/10.2139/ssrn.3860353>.

¹⁵ Yashaswini Singh et al., “Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications,” *JAMA Health Forum* 6, no. 1 (2025): e244935, <https://doi.org/10.1001/jamahealthforum.2024.4935>.

¹⁶ Matthew P. Maughan et al., “Commercial Insurers Paid More For Procedures At Hospital Outpatient Departments Than At Ambulatory Surgical Centers: Article Examines Differences in Commercial Insurer Payments for Procedures at Hospital Outpatient Departments versus Ambulatory Surgical Centers,” *Health Affairs* 44, no. 10 (2025): 1291–97, <https://doi.org/10.1377/hlthaff.2025.00297>.

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studies have found that noncompete agreements are associated with 3-5% lower wages across affected occupations.^{17,18} Lastly, practices that use NCAs choose to retain high-reimbursement patients with private insurance or Medicare, and treat fewer uninsured or Medicaid patients. This results in 17% more physician revenue per hour of patient care than those without NCAs.³

Continuity and Quality of Care

Noncompete agreements are designed to, and are largely effective at, increasing workforce retention. However, workforce continuity comes at the expense of patient-provider continuity if the provider must fully relocate to change employers. Some specialists are part of health systems with satellite locations so sprawling that in order to seek new employment, they are forced to leave the state. Beyond the clear burden to the physician, including relocating, new licensure and credentialing, and insurance, this clearly ends the established doctor-patient relationship that plays a critical role in patient outcomes.⁴ Even in circumstances of more proximal relocation, gag clauses often prevent practices or physicians from disclosing the physician's new practice location to patients, which can lead to gaps in care.¹⁹

Noncompete agreements can also prevent significant shifts from over-served healthcare markets to under-served healthcare markets. By restricting the local supply of clinicians, particularly in rural or underserved areas, NCAs can consequently lead to longer wait times and reduced patient access. Practices in need of healthcare workers are often unable to recruit their preferred hire due to a noncompete restriction, which prevents necessary mobility to improve healthcare access.⁷ Indeed, in areas where noncompete agreements are prohibited, physicians may be more evenly distributed across regions, improving the availability of limited specialty care.²⁰ NCAs can also impede innovation that increases access and quality of care – including the ability for physicians to work for multiple hospitals to enhance the availability of specialist coverage. Provider mobility is a key factor in expanding patient access to care, and noncompete agreements significantly hinder that mobility.²¹

¹⁷ U. S. Government Accountability Office, “Noncompete Agreements: Use Is Widespread to Protect Business’ Stated Interests, Restricts Job Mobility, and May Affect Wages | U.S. GAO,” May 16, 2023, <https://www.gao.gov/products/gao-23-103785>.

¹⁸ Evan Starr et al., “Noncompetes in the U.S. Labor Force,” *SSRN Electronic Journal*, ahead of print, 2017, <https://doi.org/10.2139/ssrn.2625714>.

¹⁹ Emily Sohn, “Your Longtime Doctor Moves. Will You Lose That Physician Because of a Noncompete Clause?,” *The Washington Post*, June 7, 2019, https://www.washingtonpost.com/health/your-longtime-doctor-moves-will-you-lose-that-physician-because-of-a-noncompete-clause/2019/06/07/08c62840-7680-11e9-bd25-c989555e7766_story.html.

²⁰ Rebecca Leibowitz and Travis W. Blalock, “The Noncompete Agreement: A Detriment to Patients and Dermatologists Alike,” *The Journal of Clinical and Aesthetic Dermatology* 17, no. 3 (2024): 9–10.

²¹ American Medical Association. 2023. “AMA Backs Effort to Ban Many Physician Noncompete Provisions.” *American Medical Association*, June 13, 2023. <https://www.ama-assn.org/medical-residents/transition-resident-attending/ama-backs-effort-ban-many-physician-noncompete>.

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Considerations for Rural and Critical Access Hospitals and Independent Physician Practices

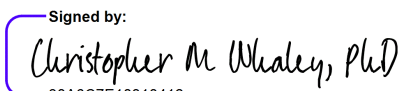
Notably, important considerations are needed for rural and critical access hospitals, where attracting healthcare providers can be challenging and physician turnover can be particularly disruptive. These practices may rely on noncompete agreements to ensure continuity of care and to protect their investment in healthcare workers with specific specialties or experience.³ In many cases, however, these recruitment agreements contain financial incentives outside of non-competes (e.g., loan forgiveness terms or other benefits that vest over time) to retain the physician's service for a period of years. Special considerations may be warranted for rural or underserved areas that face distinct challenges in workforce recruitment and retention.

Conclusion

Noncompete agreements are frequently justified as tools to safeguard business interests, protect investments in employee training, and promote workforce stability. However, this rationale may be less applicable in health care, where clinical practice is largely standardized and provider mobility is essential to improve healthcare access. Importantly, limited transparency surrounding NCAs—often reinforced by nondisclosure and related contractual provisions—has hindered efforts to assess their prevalence, scope, and effects. The FTC may therefore wish to use its Section 6(b) authority to examine the role of NCAs within an increasingly consolidated health care market. Although additional research is needed, existing evidence indicates that NCAs restrict health care workforce mobility, stifle competition, and disrupt continuity of care. Taken together, these factors suggest that NCAs may not be an effective or appropriate means of promoting workforce stability in the health care sector.

Should you have any questions or would like to discuss our comments further, please contact Jared Perkins, Assistant Director of Health Policy Strategy, at jared_perkins@brown.edu.

Sincerely,

Signed by:

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