Welcome to the Hotel California: Physicians and Noncompetition Agreements

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Noncompetition agreements between employers and employees have long been a subject of antitrust litigation, state regulation, and public policy debate.[2] At present, almost every state in the Union regulates noncompetion agreements to a greater or lesser (sometimes much lesser) degree. Physician noncompetes are one subset of NCAs that raise both competitive issues and strong public policy concerns, and hence have been in the spotlight as the federal government looks at entering the field as a regulator of NCAs.

This article reviews the state of NCA regulation as of this writing, with a focus on regulation of physician NCAs, and discusses the case for and against their use.[3] The article then turns to the broad-spectrum ban on NCAs proposed by the Federal Trade Commission (FTC) in 2023, which remains pending as of this writing.

The Use and Prevalence of Noncompetition Agreements

A noncompetition agreement is a covenant within an employment contract (or a freestanding agreement) between an employer and an employee that restricts the employee's ability to work for another employer (or to start a business) competitive with the original company for a specified period of time after termination of the relationship with the original employer.[4] The restriction may or may not be (but usually is) delimited by a geographic area.[5] The NCA may or may not define what

[1] "You can check out any time you like, but you can never leave," Felder, D., G. Frey, & D. Henley, *Hotel California* (1976).

[2] In the article, noncompetition agreements may also be referred to as "noncompetes" or "NCAs"

[3] This article will not address laws and policies concerning the often-related topics of non-solicitation agreements, nondisclosure agreements, or confidentiality agreements. Nor will this article discuss NCAs in the context of the sale of a business, which are often treated differently under the law than employee noncompetes.

[4] For ease of reference, this article will use the terms "employer" and "employee" to refer to the two parties to an NCA. Notably, some state statutes concerning NCAs may distinguish between employees and independent contractors.

[5] The usefulness of defining geographic territories covered by an NCA is increasingly questionable in at least some industries because (1) more employees are able to work remotely and (2) particularly as industries consolidate, more businesses operate on a regional or national (or global) basis.

constitutes a "competitive" position beyond simply employment by a firm engaged in the same business as the original employer.

The U.S. Government Accountability Office (GAO) recently examined the general prevalence of NCAs using both historical published studies and its own, non-generalizable survey results.[6] The GAO's findings indicate:

- About half of all private sector employers (in states permitting NCAs) require NCAs of at least some employees, and about a third require NCAs of all employees.
- NCAs are less prevalent among small businesses than larger enterprises.
- NCAs are more prevalent in executive and management employment, but nonetheless are used by some employers with respect to all worker types – salaried non-management workers, hourly workers, and part-time workers as well as executives and management.
- The prevalence of NCAs in the health care and social services sector is somewhat greater than the average, and the prevalence of NCAs among professional and technical employees (in all industries) is the among the highest of any employment category.
- The great majority of employers using NCAs require them as a condition of employment. Workers typically cannot (or simply do not) negotiate the terms of NCAs.[7]
- Only a small percentage of employers offer incentives for employees to sign NCAs, and the use of incentives by those employers is mostly limited to executives and salaried management.[8]

Information on the prevalence of NCAs in employment of health care workers, and specifically their use in physician contracts, is sparse and somewhat dated. A paper published in 2018 reported that 45 percent of all physicians are bound by noncompetes.[9] An earlier (2007) survey

[6] U.S. Government Accountability Office, NONCOMPETE AGREEMENTS – USE IS WIDESPREAD TO PROTECT BUSINESS' STATED INTERESTS, RESTRICTS JOB MOBILITY, AND MAY AFFECT WAGES, GAO-23-103785 (May 2023) ("GAO Report").

[7] One study concluded that NCAs are negotiated in only about 10% of cases. Starr, E., J. Prescott, and N. Bishara, *Noncompete Agreements in the U.S. Labor Force*, 64 J. L. & ECON. 53 (2021).

[8] Typical incentives include specialized training, signing bonuses, stock options or other long-term incentives, or post-separation financial compensation (so-called "garden leave").

[9] Nunn, R., and M. Marx, "The Chilling Effect of Non-Compete Agreements," *EconoFact* (May 20, 2018), https://econofact.org/the-chilling-effect-of-non-compete-agreements.

found that 45 percent of primary care physicians in group practices had signed NCAs.[10] A more recent survey by the Private Practice Study Group of the American Academy of Otolaryngology found that 50.6 percent of the surveyed members had NCAs and that NCAs were more prevalent (58%) among respondents under 45 year of age.[11]

State Law Governing Noncompetes

Traditionally, the regulation and enforceability of NCAs has been a matter of state law. State laws governing NCAs vary widely.[12] In the majority of states, physician noncompetes are permissible and generally treated the same as noncompetes affecting other workers. However, in 22 states, physician noncompetes are either illegal or subject to specific limitations established by statute.

States having blanket prohibitions of NCAs. Four states – California[13], Minnesota,[14] North Dakota,[15] and Oklahoma[16] ban most or all employee noncompetes, including physician noncompetes. The California, North Dakota, and Oklahoma statutes contain narrow exceptions applicable in the context of the sale of a business or the dissolution of a partnership or limited liability company.

States specifically prohibiting or limiting physician noncompetes (or NCAs with health care workers more broadly defined). The laws of 18 states specifically prohibit or impose specific conditions on NCAs to which a physician is a party, or to which a practitioner in a broader category of health care professionals that may include physicians (or some physicians), is a party.[17] Although

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[10] Lavetti K, Simon C, White WD. *The impacts of restricting mobility of skilled service workers evidence from physicians,* 55 J. HUM. RESOUR. 1025 (2020).

[11] Dubin, M, D. Melon, D. Gold, A. Pham, and M. Seybt**, "**Survey: Employee Contract Non-Compete Clauses," *bulletin* (Feb. 20, 2023), https://bulletin.entnet.org/business-of-medicine-practice-management/article/22710972/ppsg-corner-employee-contract-noncompete-clauses-survey.

[12] The 50-state survey maintained and recently updated by Epstein Becker Green is a good entry point into the jungle of state laws. Epstein Becker Green, 50-State Noncompete Survey (updated Dec. 22, 2023), https://20754472.fs1.hubspotusercontent-na1.net/hubfs/20754472/50-STATE-NON-COMPETE-SURVEY.pdf?.

[13] Cal. Bus. & Prof. Code § 18600 *et seq*.

[14] Minn. Stat. 181.988.

[15] N.D. Cent. Code § 9-08-06.

[16] OK Stat. § 15-219A.

[17] Prohibitions and conditions specific to "physicians" are found in the laws of Colorado (C.R.S. § 8-2-113(3)); Connecticut (Conn. Gen. Stat. Ann. § 31-50b); Delaware (6 Del. Code Ann. § 2707); Florida (Fla. Stat. Ann. § 542.336); Indiana (Ind. Code § 25-22.5-5.5); Massachusetts (M.G.L. c. 112 § 12X); New Hampshire (N.H.

some of these statutes void (or purport to void) physician NCAs outright, others impose conditions short of prohibition.[18]

For example, Florida law declares all agreements that prevent a physician from practicing medicine to be void and against public policy. The laws of Colorado and Delaware expressly declare any physician NCA to be void; however, covenants providing for payment of liquidated damages upon termination (which in some situations may have the effect of a noncompete) are permitted. Similar laws in Massachusetts, New Hampshire, and Rhode Island leave the door open for liquidated damages and similar requirements to pay the employer upon termination of employment (*e.g.*, repayment of loans, relocation expenses, training expenses, signing bonuses, etc.) by declaring that all provisions of an agreement other than one specifically restricting the right of a physician to practice medicine in any geographic area for any period of time after termination are not within the scope of the noncompete ban.

Connecticut is among the states that do not ban physician NCAs but place special conditions on their use. In Connecticut, a physician NCA can only restrict a physician from practicing inside of a 15-mile radius of the physician's primary practice site, and for a period of no more than one year. Further, a physician NCA can be enforced only in the event that the physician resigns or is discharged for cause, not in the event of a termination without cause or the expiration or non-renewal of the agreement. West Virgina law likewise sets time and scope limitations and provides that a physician NCA cannot be enforced if the employer is the party terminating the agreement.

Texas law permits physicians NCAs but requires that such covenants contain specific provisions (*e.g.*, ensuring the terminating physician access to patient lists and patient records) designed to facilitate continuity in the relationship of the physician with existing patients who may

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Rev. Stat. § 329-31-a); Rhode Island (R.I. Gen. Laws § 5-37-33); Texas (Tex. Bus. Com. Code § 15.50(b)); and West Virginia (W. Va. Code § 47-11E-1-5). States regulating NCAs for categories of health professionals that in some cases may include physicians are: Arkansas (17 AR Code Subtitle 3) ("licensed medical professionals"); District of Columbia (D.C. Official Code § 32-581.03) ("medical specialists"); Iowa (Ia. Code ch. 147.164) ("mental health professionals"); New Jersey (N.J.A.C. § 13.42-10.16) ("psychologists"); New Mexico (N.M.S.A. 1978 § 24-11-1 *et seq*.) ("health care practitioners"); North Carolina (common law precedent) ("health care workers"); South Dakota (S.D. Codified Laws § 53-9-11.1) ("health care providers"); and Tennessee (Tenn. Code Ann. § 63-1-148) ("health care providers").

[18] In these states physician noncompetes (if permitted) also would be subject to any laws of general applicability to noncompetes, *e.g.*, limitations on the duration of an NCA.

elect to follow the physician, and also requires the contract to permit the physician to buy out of the NCA at a reasonable price.

Indiana law is something of a hybrid – completely prohibiting NCAs in primary care physician contracts, while requiring the inclusion of certain terms in all other physician NCAs, including a buy-out right for the physician. Like many of these states, Indiana does not permit an NCA to be enforced against a physician unless the physician terminates employment without cause before the expiration of the agreement.

Status of noncompetes in the remaining states. The status of noncompete laws in the remaining states can be divided into two categories:

- *States that have no law applicable to employee noncompetes (except lawyers)*. In nine states,[19] no statute or regulation exists to restrict or regulate noncompetes, save the prohibition of NCAs in attorney employment, partnership, and shareholder agreements.[20]

- *States that have a statute of general applicability to employee noncompetes*. In the remaining 19 states, noncompetes are lawful, but are subject (to a greater or lesser degree) to regulations established by statute. These rules apply to all employee noncompetes, including physician noncompetes. These laws typically regulate such matters as the permitted duration or geographic scope of a noncompete restriction, sufficiency of consideration, validity of choice of law provisions for NCAs,[21] transparency to the employee, and sufficiency of notice. Importantly, the laws may define the types of business interests that permissibly may be protected by an NCA.[22] These laws also may

[19] Alaska, Kansas, Michigan, Mississippi, Nebraska, Ohio, Pennsylvania, Wisconsin, and Wyoming.

[20] The prohibition on NCAs for lawyers (which in fact exists in the statutes or state bar rules of every state) is rooted in the fact that state codes of attorney conduct are largely based on the ABA Model Rules of Professional Conduct, which bar an attorney's "participation" in any agreement that restricts her right to practice after termination of the relationship. ABA Model Rule 5.6. The ABA adopted this Rule to ensure that attorneys do not limit their professional autonomy, and clients have the freedom to select counsel of their choice. ABA Model Rule 5.6 (Comment). In this regard, it has been argued that the concerns of the legal profession in barring NCAs are analogous to the concerns of the medical profession and provide support for banning physician noncompetes. *See, e.g.*, Starr, E., NONCOMPETE CLAUSES: A POLICYMAKER'S GUIDE THROUGH THE KEY QUESTIONS AND EVIDENCE (Economic Innovation Group Oct. 2023) at 17.

[21] This topic is discussed under the heading "Forum Selection and Choice of Law Terms," *infra*.

[22] The significance of this topic is discussed under the heading "Legitimate Business Interests," *infra*. As an example, Idaho Code § 44-2702(2) defines "legitimate business interests" as "includ[ing], but not ... limited to, an employer's goodwill, technologies, intellectual property, business plans, business processes

define some categories of employees, either by industry (e.g., broadcasting is somewhat common) or categorically (e.g., non-exempt, lower-wage, or hourly workers) for whom NCAs are not permitted. Generally, physicians do not fall into any such employee groupings, although there are exceptions. In Georgia, for example, an NCA is not enforceable except against employees who are engaged in sales or soliciting customers, manage a department, or otherwise are "key" employees.[23] Similarly NCAs are not enforceable in Idaho except against "key" employees or independent contractors.[24] Whether physicians are "key" employees and therefore shielded from NCAs would be a circumstantial question, but would probably require that the physician have a relatively prominent role and significant involvement in management, research, population health, or clinical quality improvement processes.

In Illinois, NCAs are prohibited with respect to employees covered by collective bargaining agreements.[25] Physician membership in unions is still relatively small but has been growing steadily. The American Medical Association reports that in 2019, nearly 68,000 physicians (or about 7.2 percent of actively practicing physicians) belonged to unions. This represented an approximate 26 percent growth in physician union membership since 2014.[26]

Absent specific prohibitions or the imposition of contract terms by the legislature, traditional common law principles as interpreted by the courts determine the enforceability of any NCA.

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and methods of operation, customers, customer lists, customer contacts and referral sources, vendors and vendor contacts, financial and marketing information, and trade secrets …".

[23] Ga. Code Ann. § 13-8-53.

[24] Idaho Code § 44-2701. The statute defines a "key" employee as "those employees or independent contractors who, by reason of the employer's investment of time, money, trust, exposure to the public, or exposure to technologies, intellectual property, business plans, business processes and methods of operation, customers, vendors or other business relationships during the course of employment, have gained a high level of inside knowledge, influence, credibility, notoriety, fame, reputation or public persona as a representative or spokesperson of the employer and, as a result, have the ability to harm or threaten an employer's legitimate business interests." *Id*. § 44-2702(1).

[25] 820 ILCS 90/10(d).

[26] American Medical Ass'n, ARC ISSUE BRIEF: COLLECTIVE BARGAINING FOR PHYSICIANS AND PHYSICIANS-IN-TRAINING (2023), https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf.

Judicial Analysis of Noncompetes

Like all restrictive covenants, NCAs are disfavored by courts.[27] Employment noncompetes are restraints of trade. Fundamentally, they are market allocation agreements, securing the contracting party's promise not to compete in a defined market area for a defined period of time. But they are not illegal *per se*; rather NCAs are judged under the Rule of Reason.[28] They are thus subject to a facts-and-circumstances analysis.[29]

Traditionally, the reasonableness of a restraint created by a noncompete agreement is determined with reference to two overarching questions: (1) does the NCA serve to protect a legitimate business interest of the employer? and (2) are the limitations imposed by the NCA reasonable as to time, geography, and the scope of restricted activity? [30]

Legitimate business interests

Employers typically cite one or more of the following reasons for requiring NCAs of their employees.[31] First, a noncompete agreement may be used to protect trade secrets, intellectual property, or proprietary information of the employer from being publicly disclosed or used to compete against the employer. Protectable information might include business plans, product

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[27] *Morgan Lumber Sales Co. v. Toth*, 41 Ohio Misc. 17, 19 (1974) ("Covenants not to compete should in general be strictly construed, since such covenants are normally written by the employer and are in restraint of trade and the right to a livelihood.")

[28] *Lektro-Vend Corp. v. The Vendo Co.*, 660 F.2d 255, 265 (7th Cir. 1982) ("Legitimate reasons exist to uphold noncompete covenants even though by nature they necessarily restrain trade to some degree."); *Consultants Designers, Inc. v. Butler Serv. Group*, 720 F.2d 1553, 1560 (11th Cir. 1983) (characterizing argument that non-compete agreements should constitute a *per se* antitrust violation "bizarre and frivolous").

[29] The Rule of Reason requires the fact finder to "weigh[] all of the circumstances of a case," to determine whether the challenged restraint of trade is unreasonable. Relevant factors include information about the relevant business, the nature and history of the restraint, the justification offered by the defendant, and the existence of any anticompetitive effects flowing from the restraint. *Leegin Creative Leather Products, Inc. v. PSKS, Inc.*, 551 U.S. 877, 885-86 (2007). *See also Minnesota Ass'n of Nurse Anesthetists v. Unity Hosp.*, 208 F.3d 655, 659 (8th Cir. 2000) ("Most agreements are evaluated under the `rule of reason,' a standard that asks whether the contract unreasonably restrains trade in a relevant product or geographic market.").

[30] *See General Medicine v. Manolache*, No. 88809 (Ohio Ct. App. Aug. 16, 2007) (holding that if there is no legitimate interest of the employer to protect, then a noncompete agreement is unreasonable regardless of scope or duration); *Wigton v. Univ. of Cincinnati Physicians*, 179 N.E.3d 241 (Ohio Ct. App. 2021) ("Ohio courts have refused to enforce covenants not to compete against physicians where there is no legitimate business interest to protect.").

[31] GAO Report, n. 6, *suppra*, at 13-17.

designs, marketing strategies, business methods, cost and profit margins, and financial projections. A related, second, explanation is that an NCA is necessary to protect the employer's proprietary client and customer lists and customer relations (goodwill). Employees who are customer-facing often are seen as the face of the company itself, particularly in service industries, and the argument is that it would be unfair for the employee to use those relationships – cultivated on the employer's behalf and at the employer's expense – to compete against the employer.

Another commonly expressed interest is to protect the employer's investments in worker recruitment, training, and other worker resource expenditures. That is, an employer would not wish to train employees (particularly technical and technology employees) in specialized business processes only to see those employees parlay that knowledge and training into a job with a competitor.

Other typical justifications for use of noncompete agreements are to protect research and development investments; to prevent the recruiting of staff; and to minimize worker turnover. These concerns arise less frequently in physician noncompete litigation.

Notably, one common reason for using noncompetes typically remains (and should remain) unspoken. Noncompete agreements can create effective impediments to a rival firm's ability to compete in the marketplace – e.g., by restricting the available pool of labor, particularly skilled labor – depending of course on market supply and market demand for the type of employee(s) in question. (Hence the judicial focus on the reasonableness of the restraint.) However, to state the obvious, a desire to inhibit competition, even just a little, is not a rationale that courts will countenance.

With respect to physician noncompetes, a typical expressed interest of the employer, be it a hospital or a medical practice, is protecting patient information and goodwill. In this respect, noncompetes are often coupled with nonsolicitation covenants that prohibit a departing physician from contacting former patients during the noncompete period.[32]

In this context, however, patient information (as in patient care information) is distinct from patient lists. Patient information belongs to the patient and, in most cases, is portable in the patient's

[32] In addition, employers of physicians typically will not provide patients with information that would allow them to contact the former physician employee.

discretion.[33] It thus is improbable that a court would enforce an NCA solely to protect a former employer's interest in patient care information.[34] However, courts have recognized that patient lists can constitute confidential business information and a protectable business interest.[35] Nonetheless, an employer's ability to assert the need to protect such information may be conditional on the employer's demonstration of its efforts to maintain the confidentiality of that information in the course of its business.[36]

A physician may acquire knowledge of other forms of proprietary information in the course of employment, and protection of that information can be a legitimate and protectable business interest. For example, a physician may work in an administrative capacity instead of or in addition to clinical practice. Similarly, a physician may direct clinical activities, such as utilization management and quality improvement. In these situations, the physician may have gained knowledge of the employer's business methods that courts would find to be justification for enforcing a noncompete agreement.[37]

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[33] This concept is codified in the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 1320d–2, 1320d–4, and 1320d–9.

[34] *See, e.g.*, *Field v. Lamar*, 822 So. 2d 893, 900-02 (Miss. 2002) (McRae, J., dissenting) (criticizing majority's failure to consider the public policy considerations of patient choice and concluding, "Noncompetition agreements must be reasonable on the restrictions *and economic justifications*. … Any exclusive right to impinge on a physician's autonomy and the patient's right of choice would undoubtedly undermine the public policy interests.") (emphasis added; citation omitted)).

[35] *Helping Hands Home Care, Inc. v. Home Health of Tarrant Cnty, Inc.,* 393 S.W.3d 492 (Tex. Ct. App. 2013) (affirming jury verdict premised on confidentiality of patient lists); *Community Hosp Group, Inc. v. More*, 183 N.J. 36, 58; 869 A 2d 884 (2005) ("legitimate interests may include … protecting confidential business information, including patient lists); Saliterman v. Finney, 361 N.W.2d 175 (Minn. Ct. App. 1985) (affirming trial court finding that patient lists were protectable confidential information); *Alan Dampf, P.C. v. Bloom*, 127 A.D. 2d 719, 512 N.Y.S.2d 116 (N.Y. App. Div. 1987) ("Patient lists are often treated as confidential information."); *Dickinson Medical Group, P.A. v. Foote*, Del. Ch., C.A. No. 834-K (May 10, 1984) (holding patient lists to be trade secrets); *but see Prohealth Care Assoc., LLP v. April*, 2004 N.Y. Slip Op. 50919 (N.Y. Sup. Ct. 2004) (holding that patient list would only be confidential and proprietary to the extent it was used by the former physician employee to solicit patients other than those treated by the physician at the former employer).

[36] *Allan M. Dworkin, D.D.S., P.A. v. Blumenthal*, 77 Md. Ct. App. 774, 782 (1989) (affirming trial court's determination that patient list was not confidential where "there were no rules, regulations, or known procedures which restricted the availability of the patient information only to select persons" and the former employer "took no measures to guard the [list's] secrecy").

[37] *Blue Ridge Anesthesia & Critical Care v. Gidick*, 389 S.E.2d 467, 469 (Va. 1990) (identifying a physician's knowledge about the employer's methods of operation as a protectable interest). As discussed *infra*, however, the scope of the noncompete in such a case must be commensurate with the physician-employee's responsibilities to the former employer.

Protecting patient goodwill is a facet of an employer's business interests separate from protecting the identity of patients from competitors. Where a physician-employee is the embodiment of a practice to the patients that physician regularly serves, the physician's relocation to a competing practice will threaten to deprive the employer of an asset (goodwill) created at the employer's expense and for the employer's benefit. Preserving that asset has been recognized by courts as sufficient business justification for a post-employment noncompete agreement, including with respect to physician employment agreements.[38]

A final justification often cited for physician NCAs is protecting the employer's investment in the physician's training or professional development. The employer relying on this rationale must demonstrate that the nature of the training or education furnished to the physician is of a unique character that enhanced the physician's economic value and would provide an unfair advantage if used by the physician to compete with the former employer or transferred to a competitor.[39] Courts considering this issue have referred to the "specialized" nature of the training and have affirmed the legitimacy of the employer's interest.[40] However, mere accumulation of experience and expertise over the course of employment will not suffice.[41]

Reasonableness in time, geography, and scope of restricted activities

As discussed above, in some states, the permitted duration and geographical scope of an NCA are defined in statute. Where courts have examined the questions, they do so in reference to

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[38] *Mercy Health Servs. v. Efstratiadis*, 579 F. Supp. 3d 1096, 1116 (N.D. Iowa 2022) (noncompete prevents defendant from "trading on the reputation and goodwill that the Mercy Clinic helped him establish as part of his employment with the Mercy Clinic to … directly compete with the Mercy Clinic in its territory."); *St. Clair Med., P.C. v. Borgiel*, 270 Mich. App. 260, 266-67 (Mich. Ct. App. 2006) ("A physician who establishes patient contacts and relationships as the result of the goodwill of his employer's medical practice is in a position to unfairly appropriate that goodwill and thus unfairly compete with a former employer upon departure.") The court reached this conclusion notwithstanding that it found the lower court record to be contradictory as to whether the defendant had access to confidential information, including patient lists. *Id.* at 267.

[39] *Fields Found., Ltd. v. Christensen*, 309 N.W.2d 125 (Wis. Ct. App. 1981) (experience and skill gained by employee during employment cannot, by itself, justify a noncompete provision in a physician's contract — there must be something about that employment that gives the employee an unfair advantage.)

[40] St. Clair Med., 270 Mich. App. at 266 ("a restrictive covenant can protect against unfair competition by … protecting an employer's investment in *specialized* training of a physician …")(emphasis added); More, 183 N.J. at 58 (legitimate interests may include "protecting investment in the training of a physician.")

[41] Blake, H., *Employment Agreements Not to Compete*, 73 HARV L. R. 625, 652 (1960) ("general knowledge, skill, or facility acquired through training or experience . . . acquired or developed during the employment does not, by itself, give the employer a sufficient interest to support a restraining covenant. …'").

the nature of the business, competition in the marketplace, and the purported rationale for the noncompete covenant. Case law is replete with formulations similar to that of an Ohio court: "Generally, a noncompete is enforceable only if the restraint is no greater than is required for the protection of the employer, does not impose undue hardship on the employee, and is not injurious to the public."[42] Noncompetes in health care can raise additional questions of reasonableness.[43] Indeed, some courts, taking into account public policy considerations, have concluded that physician noncompetes can *never* be reasonable, although legislative action has pre-empted many of those decisions.[44]

Duration. **"**The temporal term must be considered in the context of the entire covenant."[45] Thus, where the purpose of an NCA is to protect confidential information, a court might consider the amount of time after which the information would be "stale" and of little or no competitive value. Where the purpose of the NCA is to protect the employer's goodwill, the court might seek to determine what a reasonable amount of time would be to rebuild or recover that asset.[46]

Most noncompetes are of short duration – typically not more than two years post-employment, and courts generally find such lengths of time to be reasonable.[47] There is, however, (absent a statutory requirement or presumption) no particular rule-of-thumb to define a reasonable

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[42] *Raimonde v. Van Vlerah*, 42 Ohio St. 2d 21, 325 N.E.2d 544 (Ohio 1975).

[43] *See, e.g.*, *Williams v. Hobbs*, 9 Ohio App.3d 331, 333 (1983), in which the court held that a covenant restraining a physician employee from competing with his former employer is unreasonable when it imposes undue hardship on the physician and is injurious to the public, the physician's services are vital to the health, care and treatment of the public, and the demand for the physician's medical expertise is critical to the people in the community.

[44] *See Murfreesboro Medical Clinic, P.A. v. Udom*, 166 S.W.3d 674 (Tenn. 2005), *superseded by statute*, Tenn. Code Ann. § 63-1-148 (as noted in *Central v. Krueger*, 882 N.E.2d 723, 728 (Ind. 2008)).

[45] *Emerick v. Cardiac Study Ctr., Inc*., 357 P.3d 696, 727 (Wash. Ct. App. 2015).

[46] *St. Clair Med.*, 270 Mich. App. at 268 (one-year noncompete provided employer with time to regain the goodwill of its patients).

[47] *Radio One, Inc. v. Wooten*, 270 Mich. App. at 266 (six-month duration of radio personality's noncompete held to be reasonable); *Zellner v Conrad*, 183 A.D. 2d 250 (N.Y. App. Div. 1992) (upholding covenant prohibiting an ophthalmologist from practicing within a two mile radius of the employer's office in Brooklyn for a period of two years); *Rifkinson-Mann v Kasoff*, 226 A.D.2d 517 (N.Y. App. Div. 1996) (covenant prohibiting neurosurgeon from practicing at a particular hospital for a period of one year held enforceable); *Gazzola-Kraenzlin v Medical Group*, 10 A.D. 3d 700 (N.Y. App. Div. 2004) (restriction prohibiting pediatrician from practicing within a ten mile radius of the employer's White Plains office for a period of two years held not unreasonable).

length of time for a noncompete. Courts consider the circumstances of the particular case (including the geographic scope of the restraint) in making such determinations.

For example, although post-employment terms of five years are often considered unreasonable, a New York court upheld a covenant prohibiting an obstetrician/gynecologist from practicing within 30 miles of Albany for a period of five years.[48] In a lawsuit to enforce the covenant, the physician challenged the reasonableness of the restraint in part by arguing that he was the only fellowship-trained physician who provided treatment for all of the medical conditions peculiar to his subspecialty. The court found, however, that the physician's arguments failed to overcome the testimony of a division chief of the medical staff that all of the conditions identified by the physician could be (and were) treated by other members of hospital's staff. Accordingly, the court concluded that the five-year restriction was not unreasonable. The court did not inquire into whether the hospital's business interests required a restriction as long as five years.

A Washington appellate court upheld the reasonableness of a four-year noncompete (that had been reformed from five years by the trial court).[49] In doing so, the court noted that, under the terms of the reformed covenant, the physician was only restrained from establishing a competitive cardiology practice within a two-mile radius of any existing office of his former employer for four years and was not otherwise prevented from practicing cardiology at any hospital or emergent care clinic, making house calls, prescribing medicine, ordering tests, or otherwise caring for patients. The court concluded that the physician "[had] not established, on balance, that the reformed noncompete covenant as a whole unreasonably infringed on his ability to earn a living in cardiology or that it provides unreasonable protection to [his former employer]."[50]

Geographic Scope. The geographic area in which a noncompete is to be observed may be expressed in terms of a radius around the former employer's place or places of business, or by political boundaries (*i.e.*, a metropolitan area, county, or state), or even as limited as a specific place of business.[51] As with questions of duration, the reasonableness of the geographic scope is determined within the facts and circumstances of the particular NCA, such as the urban or rural

[48] *Medical College v Lobel*, 296 A.D. 2d 701 (N.Y. App. Div. 2002).

[49] *Emerick v. Cardiac Study Ctr., Inc.*, 357 P.3d 696 (2015).

[50] *Id.* at 728.

[51] *See, e.g.*, *Rifkinson-Mann*, *supra* (noncompete limited to practicing at a specific named medical center).

nature of the restricted area, the size of and nature of competition in the area in which the former employer conducts business, and (particularly in health care) the availability of the same or similar services within he restricted area.

It is a requirement in virtually all states – whether by statute or as a matter of case law – that the NCA have a defined geographic scope.[52] That may seem self-evident when one thinks of traditional employment models, but as more commerce is conducted online (e.g., telemedicine), it is no longer clear that a geographic limitation is meaningful in all cases.[53]

But in the usual case, in an action to enforce an NCA, the reasonableness of the geographic limitation will be decided by the court. As with questions of duration, there is no "safe harbor" or rule-of-thumb, other than to avoid obviously excessive restrictions. Limited, simple restrictions are generally found to be enforceable (unless otherwise regulated by statute).[54]

A medical practice (employer) in a rural area would typically draw patients from a wide geographic area. Thus, a restriction prohibiting a cardiovascular and thoracic surgeon from practicing within a 20-mile radius of the employer's office in a rural county was held to be enforceable.[55] The court also observed in that case that the employer had spent 29 years developing the practice and cultivating referrals. To compare, another New York court, while observing that a 10-mile restriction in a physician noncompete would be reasonable in an upstate county, or other rural locale, ruled that, given the physician's narrow field of specialization, a 10-mile radius in a densely populated area of Nassau County, containing several major hospitals, was unreasonable.[56]

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[52] *E.g.*, *Zep Mfg. Co. v. Harthcock*, 824 S.W.2d 654 (Tex. Ct. App. 1992) ("The noncompete covenant in this case contained *no* limitation as to geographical area. ... The noncompete covenant, if enforced as written, would prohibit Harthcock from working as an industrial chemist anywhere, regardless of whether he sought employment in an area not serviced by Zep or not serviced by him during his employment with Zep.")

[53] *See, e.g.*., *Victaulic v. Tieman*, 499 F.3d 227, 237 (3d Cir. 2007) ("In this Information Age, a *per se* rule against broad geographic restrictions would seem hopelessly antiquated, and, indeed, Pennsylvania courts (and federal district courts applying Pennsylvania law) have found broad geographic restrictions reasonable so long as they are roughly consonant with the scope of the employee's duties.")

[54] *Delli-Gatti v. Mansfield*, 223 Ga. App. 76, 477 S.E.2d 134 (Ga. Ct. App. 1996) (upholding covenant barring a physician from providing medical care within a single county for one year following the termination of a medical services agreement).

[55] *Bollengier v Gulati*, 233 A.D. 2d 721 (N.Y. App. Div.1996).

[56] Yoon-Schwartz v. Keller, 2010 N.Y. Slip Op. 32680 (N.Y. Sup. Ct. 2010).

Courts have found it unreasonable if the restricted geographic area of an NCA is broader than the area from which the employer obtains business (*i.e.*, patients in the case of an NCA for a practicing physician). For example, an Arkansas court declined to enforce a noncompete that barred an electrophysiologist from practicing within a 75-mile radius of his former employer's location for a period of two years. The court found that the restriction extended into the City of Memphis, a location in which the specialist physician could find new employment, but from which the former employer drew no patients.[57] Similarly a noncompete prohibiting a physician who had practiced exclusively in Manhattan from practicing in any of the five boroughs of New York City was held to be unenforceable.[58] The court found it unreasonable that, "the non-compete and non-solicit agreements here bar Defendant from practicing in a city with millions of potential patients and thousands of doctors and clinics" noting that the plaintiff practice was far less likely to be damaged if the defendant opened an office in another borough where patients would have no knowledge of the plaintiff practice.

Further, most courts would hold that an NCA can only restrict competition from the former employee in the specific area where the employee actually conducted business for the employer. Thus, agreements that define a restricted area as a particular radius around all of a hospital's inpatient and outpatient locations may not pass muster. The same is true of a physician practice with multiple locations.[59]

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[57] *Jaraki v. Cardiology Associates*, 55 S.W.3d 799 (Ark. Ct. App. 2001) ("Where a geographic restriction is greater than the trade area, the restriction is too broad and the covenant not to compete is void. ... The trade area included in the non-compete enforced against appellant covers (at least some of) the city of Memphis, Tennessee, and many of the E.P. cardiology facilities in Memphis. ... It is simply not reasonable to restrict Dr. Jaraki (regardless of his current intent) from practicing in a large market like Memphis, especially when Memphis is not part of [Cardiology Associates'] referral base.")

[58] *Patients Med., P.C. v. Kellman,* 601722/2009 (N.Y. Sup. Ct. 2011) (unpublished), casetext 2011 N.Y. Slip Op. 31626). This decision concerned a noncompete entered into in regard to the sale of the defendant-physician's solo practice, but the concerns expressed by the court align with those applicable to an employed physician's NCA. *Compare Zellner v Conrad*, n. 47, *supra* (upholding a covenant prohibiting an ophthalmologist from practicing within a two-mile radius of the former employer's office in Brooklyn).

[59] *Osta v. Moran*, 430 S.E.2d 837 (Ga. Ct. App. 1993) (Covenant forbidding physician from engaging in the practice of medicine for two years within a fifty-mile radius of any office operated by a clinic deemed unenforceable and overbroad because it encompassed future locations of the clinic where physician, by definition, never practiced as a clinic employee.)

Scope of restricted activities

Courts will not enforce post-employment NCAs that prohibit a former employee from performing services or holding positions other than those services performed for the former employer, or positions held with, the former employer.[60] This tenet is the common-sense flipside of premise that the purpose of employment noncompetes is to prevent an employee from competing *unfairly* with her former employer. However, interpreting the scope of a restriction is not always a matter of plain meaning or narrow interpretation, and courts exercise much discretion in this regard.

Administrative responsibilities. It might seem intuitive that a physician who agrees not to provide clinical services for a period of time nonetheless might not be barred from providing administrative services within the restricted geographic area. But it is sometimes the case that the physician has served in both clinical and administrative roles with the former employer.

In that regard, the Ohio Court of Appeals addressed the case of a physician – a burn specialist – who upon first employment by a hospital agreed to a covenant restricting his provision of "consulting, medical expert or professional services similar to those [he provided] as an employee of [employer] MetroHealth" within a radius of 35 miles for a period of two years post-employment (a radius that encompassed the only other hospital burn center in Akron, Ohio).[61] Between the time of that agreement and his departure from MetroHealth to become the director of the other Akron burn center, the physician was given increasing responsibility, ultimately becoming director of the MetroHealth burn center. In affirming the trial court's decision to bar the physician from serving as the director of the cross-town burn center for one year, the appeals court observed: "the business of running a burn center can be considered proprietary. The court heard testimony ... that through Dr. Khandelwal's leadership roles at MetroHealth's Burn Center, Dr. Khandelwal was exposed to pricing structures, profit and loss statements, audits, and other proprietary information related to running

[60] *See, e.g.*, *Wallace Butts Ins. Agency v. Runge*, 68 N.C. App. 196, 199 (N.C. Ct. App. 1984) ("A careful reading of the restrictive covenant leads us to the conclusion that the limitations imposed on the defendant are overly broad and unnecessary to protect the employer. The defendant is barred from employment in any capacity by a company which sells credit life and/or health insurance. Nor can the defendant participate in or be in any manner connected with the ownership, management, operation or control of a credit or health insurance company. Such limitations could, if enforced, compel the defendant to seek employment completely alien to his life's work or to move outside the area not only where plaintiff was operating at the time of employment but any other areas added thereafter.")

[61] *MetroHealth v. Khandelwal*, 2022 Ohio 77, 183 N.E.3d 590 (Ohio Ct. App. 2022).

MetroHealth's verified burn center. To protect against any potential unfair competition, the [trial] court enjoined Dr. Khandelwal from serving as director for one year ..."[62]

This decision was a bit ironic, though, because the trial court found the noncompete to be overbroad insofar as it restricted the physician's *clinical* practice at the other Akron burn center, based in part on a finding that the two burn centers were *not* competitors.[63] It does appear, however, that the trial and appellate courts were also concerned with the public health implications of enjoining the practice of a highly specialized physician and adopted a view more favorable to the physician's ability to continue in practice.[64]

Courts can be very fluid in their interpretations of restricted activities, particularly when they perceive the geographic and temporal terms to be reasonable. A Georgia Court of Appeals considered an arrangement in which the former employee-physician agreed not to provide "pediatric *or other medical care* as a physician within Upson County ... for twelve (12) months immediately following ... termination."[65] The court acknowledged that the evidence in the case established that the employer's interest to be protected was the practice of pediatrics. Yet, conceding that the covenant was "very restrictive" as to the physician's ability to provide any "medical care" in Upson County, the court found the restriction on to be reasonable, in part (and perhaps principally) because it found the geographic and temporal restrictions reasonable and in part because the record showed that the plaintiff occasionally treated adult patients and that other doctors in the County occasionally treated pediatric patients (which, in the latter case, would seem to be a *post-hoc* rationalization that the court could have treated as a *de minimis* fact).[66]

Another example of how the courts examine the scope of a physician's post-employment restraint situationally arises from a case involving two cardiologists who, separately, signed NCAs prohibiting them from "practicing medicine" within a defined radius of their employer's clinic or any of four named hospitals[67]. In an action to enforce the NCA, the trial court ruled that the the restriction

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[62] 2022 Ohio 77 at 11.

[63] *Id*. at 12.

[64] *Id*. at 17.

[65] *Delli-Gatti*, n. 54, *supra*.

[66] *Delli-Gatti*, 223 Ga. App. At 79.

[67] *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill. 2d 52, 866 N.E.2d 85 (Ill. 2006).

on "the practice of medicine" was overbroad – greater than necessary to protect the interests of defendants, who specialized in the practice of cardiology.

The appellate court (affirmed by the state supreme court) rejected this ruling, however, holding that the physicians' specialization in cardiology would not preclude or prevent them from seeing patients in other areas of medicine, if they so chose, placing them in competition with their former employer.[68] This could perhaps be seen as disingenuous, but the court identified other facts that appeared to limit the court's concerns about the effects of the noncompetes. These included the appellate court's findings that the five-mile limit of the NCA would impose no undue hardship on the physicians, given their location in the heavily populated Chicago metropolitan area.[69]

Perhaps one might argue that cardiology is a subspecialty of the broader practice of internal medicine and therefore the risk that the cardiologists might compete against their former employer in other specialties was not zero. But it is also true that courts have interpreted even well-defined and arguably narrow prohibitions on the practice of a specialty more broadly than one might expect. Consider the case of a physician whose employment contract with a cardiovascular practice contained his agreement, subsequent to termination, "not to carry on or engage in the business of the practice of medicine in the sub-specialty of cardiology."[70] After leaving the employ of the practice, the physician opened a preventive medicine practice within the restricted area. Considering the record in the case, the court concluded that the physician *was* actually practicing cardiology because his preventive health services had a primary focus on cardiac and circulatory health. The appeals court affirmed a trial court injunction prohibiting the physician from practicing not only cardiology, but also in the fields of internal medicine, prevention, and wellness.

Additional Legal Considerations in Noncompetition Agreements

Forum Selection and Choice-of-Law Terms

Unfavorable law, be it statutory or common law, can be avoided through forum selection and choice-of-law provisions that would apply the law of (and require the matter to be heard in) a different, presumably more favorable, jurisdiction. Such provisions generally are enforceable

[68] 225 Ill. 2d at 76.

[69] 225 Ill. 2d at 77.

[70] *Cardiovascular Inst. of the S., Corp. v. Abel*, No. 2014 CA 1268 (La. Ct. App. Mar. 9, 2015).

provided that there is a substantial relationship between the chosen state and the agreement.[71] Thus, forum selection and choice-of-law provisions are typical in physician contracts when the employer operates in multiple jurisdictions and the physician's practice is located in one of those jurisdictions that is not the location of the employer's primary place of business.

Courts in some states may decline to enforce choice-of-law provisions in noncompete agreements, however, on the basis that they contravene the law or public policy of the state.[72] A few states have banned or limited the applicability of forum selection and choice-of-law provisions in employment contracts by statute in order to avoid subversion of state employment law.[73]

Liquidated Damages and Buy-Out Provisions

Liquidated damage clauses and buy-out provisions are not uncommon in noncompete agreements. There is really no difference denoted by the two labels.[74] Both refer to an agreement to pay a predetermined amount to the employer in the event the employee engages in activity prohibited by the NCA. Both can function as a deterrent to taking a job with a competing employer.

Liquidated damage clauses in physician employment agreements are subject to the same rules of state contract law as liquidated damages in other types of contracts. In particular, the

[71] *TGG Ultimate Holdings, Inc. v. Hollett*, 224 F. Supp. 3d 275, 281-82 (S.D.N.Y. 2016) ("In deciding whether the parties' choice-of-law provision is enforceable, New York follows the 'substantial relationship' approach provided in the Restatement (Second) of Conflict of Laws.")

[72] *Osborne v. Brown & Saenger, Inc.*, 904 N.W.2d 34, 38 (N.D. 2017) ("[T]he forum-selection clause is unenforceable because the non-compete clause is unenforceable: another state's forum applying that state's law to the non-compete clause would violate North Dakota's public policy against non-compete agreements.") In situations such as this, an employee seeking to avoid a noncompete will seek to file a declaratory judgment action in the "home" state to void the NCA before the employer can file an enforcement action in the selected forum state (a so-called "race to the courthouse").

[73] Under Minnesota law, out-of-state choice-of-law and venue provisions are unenforceable. Minn. Stat. 181.988. In Massachusetts, NCAs cannot apply another state's law if the employee lived in Massachusetts for the last 30 days before cessation of employment, and actions to enforce an NCA must be brought in the employee's home county or Suffolk County (Boston). M.C.L. ch. 149 § 24L.

[74] *See* Horton, R., RESTRICTIVE COVENANTS IN PHYSICIAN EMPLOYMENT RELATIONSHIPS (AHLA Apr. 2013) at 20, suggesting that the exercise of a buy-out clause is voluntary whereas liquidated damage clauses anticipate a breach of the NCA. This nonetheless would seem to be a distinction without a difference.

payment amount must bear a reasonable relationship to actual damages.[75] There must be a reasonable basis for the selection of the liquidated damage amount.[76]

Courts have recognized that an NCA containing a liquidated damages clause is, in that sense, less restrictive than one without.[77] This may enhance an argument that the restrictions of an NCA are reasonable. Indeed, as previously noted, some state laws that prohibit physician noncompetes nonetheless permit liquidated damage provisions in physician employment agreements to the extent otherwise lawful.[78]

NCAs as Restraints on Competition

Regardless of state law setting the parameters of reasonableness for NCAs, those agreements are still subject to compliance with the antitrust laws. A state court's consideration of the reasonableness of a restraint on a single physician's ability to practice certainly aligns in some respects with the concerns of the antitrust laws under the Rule of Reason. But it may not capture the bigger picture – the effects of many NCAs in the marketplace.

The use of NCAs can create an antitrust issue for employers having market power. In this regard, NCAs can be analogized to exclusive dealing contracts. If a firm has enough market power to demand an exclusive dealing arrangement, it probably has little need for it other than the foreclosure it creates for potential competitors. That is, a dominant firm – because it has market power – arguably can get the pricing and other benefits of an exclusive dealing arrangement with a vendor whether or

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[75] *Intermountain Eye v. Miller*, 142 Idaho 218, 224, 127 P.3d 121 (Ida. 2005).

[76] *Physician Specialists in Anesthesia v. MacNeill* , 246 Ga. App. 398, 401-402, 539 S.E.2d 216 (Ga. Ct. App. 2000) (liquidated damages provision was unenforceable when the amount of damages was chosen because it "would be practical, and easy to implement" and no evidence was presented that the potential amount of loss was actually estimated in advance, even though the amount was reasonable in hindsight); *Grayhawk Homes, Inc. v. Addison*, 355 Ga. App. 612, 845 S.E.2d 356 (Ga. Ct. App. 2020) (same $100,000 liquidated damage provision used in nearly every employee held unenforceable where employer admitted the damages would not be the same for each employee).

[77] *Intermountain Eye,* 142 Idaho at 224 ("The non-compete provision in this case is a hybrid of sorts. The provision does not place an absolute prohibition on Dr. Miller's ability to practice. Rather, it allows him to practice, provided that he pays a practice fee.")

[78] *See supra,* n. 18 and subsequent text. For example, Delaware law voiding physician noncompetes goes on to state, "… all other provisions of such an agreement shall be enforceable at law, including provisions which require the payment of damages in an amount that is reasonably related to the injury suffered by reason of termination of the principal agreement." 6 Del Code § 2707.

not the arrangement is actually exclusive. The only additional "benefit" of exclusivity is foreclosing the ability of potential rivals to deal with the same vendor.

One could argue that a health system or other health care employer that is dominant in the market probably does not need NCAs with each and every employed physician in order to retain the physicians it needs or to protect its goodwill. But a prevalence of NCAs in the marketplace could well impede the ability of potential rivals to recruit physicians. And this concern is one of several motivating the Biden administration to regulate employment noncompetes.

Noncompetes, the Biden Administration, Public Policy, and the FTC

Early on in the Biden Administration, the President issued an Executive Order calling for a whole-of-government initiative to address competition problems in American markets, with the announced objective of remedying high prices for consumers, suppressed wages for workers, and the stifling of innovation.[79] The Order strongly reflects a policy concern with the increasing consolidation of American markets and the resulting effects on labor within those markets. "Consolidation has increased the power of corporate employers, making it harder for workers to bargain for higher wages and better work conditions. Powerful companies require workers to sign non-compete agreements that restrict their ability to change jobs."[80]

The Order directed and encouraged a broad array of federal agencies (not just the antitrust agencies) to adopt rules to remedy perceived deficiencies in competition within an array of economic sectors. This position represented a significant shift away from the economic/political philosophy that for a half-century maintained that regulatory intervention in markets is disfavored and, if undertaken, should be limited in scope. Among its specific directives, the Executive Order stated, "To address agreements that may unduly limit workers' ability to change jobs, the Chair of the FTC is encouraged to consider working with the rest of the Commission to exercise the FTC's statutory rulemaking authority under the Federal Trade Commission Act to curtail the unfair use of non-compete clauses and other clauses or agreements that may unfairly limit worker mobility."[81]

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[79] Executive Order 14036 of July 9, 2021, Promoting Competition in the American Economy, 86 Fed. Reg. 36987 (July 14, 2021) ("Exec. Order").

[80] *Id*. § 1.

[81] *Id*. § 5(g).

In compliance with the Executive Order, the Federal Trade Commission embarked on a massive reconsideration and revision of many of its former policies and procedures.[82] Among those actions, the FTC withdrew and then replaced its policy concerning enforcement of Section 5 of the Federal Trade Commission Act (the principal statutory authority of the Federal Trade Commission with respect to matters of competition").[83] The new Section 5 enforcement policy[84] is significant in two ways.

First, the Commission adopted an interpretation of Section 5 permitting it to challenge "unfair methods of competition" that would not otherwise violate federal antitrust law as interpreted under the Sherman Act and the Clayton Act.[85] Whether the FTC has authority to challenged so-called "freestanding" violations of Section 5 has been a matter of debate for decades.[86] In the 2002 Statement, the Commission adopted a significantly expanded interpretation of its statutory authority. This is significant insofar as it opened the door to examination of employee noncompetes even in situations where no obvious lessening of competition (as defined for purposes of the Sherman Act) existed.

Second, the Commissioners adopted the position that Section 5 grants the Commission authority to promulgate regulations to prevent unfair methods of competition.[87] Historically, the

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[82] For an overview of the FTC's actions at that time, *see* McCann, R., *Turnabout and Fair Play: The Changing Antitrust Enforcement Landscape*, HEALTH LAW HANDBOOK 2022 EDITION (A. Gosfield, ed. 2022).

[83] Section 5 of the FTC Act, 15 U.S.C. § 45, *inter alia*, empowers the Commission "to prevent persons, partnerships, or corporations … from using unfair methods of competition in or affecting commerce and unfair or deceptive acts or practices in or affecting commerce."

[84] Fed. Trade Comm'n, Policy Statement Regarding the Scope of Unfair Methods of Competition Under Section 5 of the Federal Trade Commission Act (Nov. 10, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/p221202sec5enforcementpolicystatement_002.pdf ("Section 5 Policy").

[85] Section 5 Policy at 8, stating that courts have recognized that "Section 5 reaches 'conduct which, although not a violation of the letter of the antitrust laws, is close to a violation or is contrary to their spirit,' and *further recognized the importance of deference to the Commission where it acts against conduct that is unfair."* (emphasis added)

[86] For a more fulsome discussion of the history and implications of the debate over the scope of Section 5, *see* McCann, R., *A Little More Surreal: Once More Unto the Breach With the FTC*, HEALTH LAW HANDBOOK 2023 EDITION (A. Gosfield, ed. 2023).

[87] *See* Fed. Trade Comm'n, Statement of Chair Lina M. Kahn Joined by Commissioner Rebecca Kelly Slaughter and Commissioner Alvaro M. Bedoya On the Adoption of the Statement of Enforcement Policy Regarding Unfair Methods of Competition Under Section 5 of the FTC Act (Nov. 10, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/Section5PolicyStmtKhanSlaughterBedoyaStmt.pdf at 5. *See also* President Biden's statement on the FTC's authority, n. 81, *supra,* and accompanying text.

Commission had never expressed or attempted to exercise this authority. But this newly recognized authority was first exercised to propose federal regulation of employee noncompetes.

The Noncompete Rule

In January, 2023, the FTC proposed a new regulation under Section 5 that would prohibit virtually all forms of employment-related non-competes, which followed on the heels of the FTC's announcement of settlements of Section 5 complaints against three companies and multiple executives for imposing non-compete restrictions on their workers.[88] Both sets of actions were quite unprecedented.

The settlements involved brief (three-page) complaints that, consistent with the tenor of the Section 5 Policy, contain only conclusory allegations that the use of the non-competes "is unfair and has the tendency or likely effect of harming competition, consumers, and workers, including by: (i) impeding the entry and expansion of rivals …, (ii) reducing employee mobility, and (iii) causing lower wages and salaries, reduced benefits, less favorable working conditions, and personal hardship to employees."[89] In the Complaints and accompanying documents, the Commission provided no assessment of actual anticompetitive effects resulting from the non-competes or of the reasonableness of the non-competes in the context of the specific markets and employees at issue. The complaints took no note of prior court opinions limiting the application of Section 5 to employee non-compete agreements.[90]

Similar to the FTC's approach to those cases, the proposed regulation would treat all employee non-compete agreements (express or *de facto*) as *per se* violations of Section 5.[91] It would

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[88] *In re Prudential Security, et al.,* FTC File No. 2110026 (Complaint and Proposed Decision and Order posted Jan. 4, 2023); In *re O-I Glass, Inc.*, FTC File No. 2110182 (Complaint and Proposed Decision and Order posted Jan. 4, 2023), https://www.ftc.gov/legal-library/browse/cases-proceedings/2110182-o-i-glass-inc-matter; *In re Ardagh Group, S.A.*, FTC File No. 2110182 (Complaint and Proposed Decision and Order posted Jan. 4, 2023), https://www.ftc.gov/legal-library/browse/cases-proceedings/2110182-ardagh-group-et-al-matter.

[89] O-I Glass Complaint, ¶ 8.

[90] *Snap-On Tools Corp. v. Fed. Trade Comm'n*, 321 F.2d 825 (7th Cir. 1963) (holding that non-compete clauses are legal under Section 5 unless unreasonable in duration and scope and holding, further, that even if such a clause were unreasonable in geographic scope, the court would not treat it as a *per se* violation of the antitrust laws).

[91] 88 Fed. Reg. 3482 (Jan. 19, 2023) (the "Noncompete Rule"). The Noncompete Rule, if adopted in final form, is likely to face a variety of legal challenges based on arguments: that the FTC lacks authority under Section 5 to regulate in the area of competition (as opposed to consumer protection); that the Noncompete

prohibit any "contractual term between an employer and a worker that prevents the worker from seeking or accepting employment with a person, or operating a business, after the conclusion of the worker's employment with the employer."[92] It also would prohibit any contractual term that has the effect of prohibiting a worker from doing the foregoing, giving as non-exhaustive examples (1) broadly-written non-disclosure agreements and (2) contractual obligations requiring a worker, upon termination, to repay training costs in excess of an amount reasonably related to the costs incurred by the employer.[93]

The Noncompete Rule, further, would require employers to rescind existing NCAs and give notice to workers that those clauses are no longer in effect and may not be enforced. The Noncompete Rule would apply retroactively and accordingly notice also would be required to affected former employees to the extent possible.[94] The only proposed exception to the prohibition on NCAs would be those entered into in connection with the sale of a business or disposal of an ownership interest in a business by a person who is a substantial owner of the business being sold.[95]

Given the Commission's lack of enforcement experience in this area (save for the three cases settled the day before announcement of the Noncompete Rule) and the fact that employee non-competes are lawful to some degree in the vast majority of states, the Proposed Rule represents a "radical departure" from legal precedent.[96]

The publication of the Noncompete Rule touched off a blizzard of formal comments, articles, and informal commentary with regard to the validity (or not) of the Commission's rationale for a nationwide ban. This included a significant amount of debate over physician noncompetes, with the American Medical Association and a host of medical specialty societies and individual physicians

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Rule exceeds the Commission's authority under the "major questions" doctrine (*see West Virginia et al. v. Environmental Protection Agency et al.*, 142 S. Ct. 2587 (2022)); that the Noncompete Rule constitutes an improper delegation of legislative power to the Commission; and that, in general, the Commission's statements of basis and purpose are conclusory and substantively anemic, thereby rendering the Noncompete Rule arbitrary and capricious.

[92] 88 Fed. Reg. at 3535.

[93] *Id.*

[94] *Id.*

[95] *Id.* at 3536.

[96] Fed. Trade Comm'n, Dissenting Statement of Commissioner Christine S. Wilson Regarding the Notice of Noncompete Rulemaking for the Non-Compete Clause Rule, File No. P201200-1 (Jan. 5, 2023) at 1.

and health care workers on one side, and the American Hospital Association, the Federation of American Hospitals, and the U.S. Chamber of Commerce on the other.

In the Preamble to the Noncompete Rule, the FTC reviewed a wide range of studies and economic analyses concerning the effects of noncompetes on competitive conditions in labor markets, including effects on earnings, job creation, worker mobility. The FTC also reviewed studies analyzing the effects of noncompetes on product and service markets, including effects on consumer prices, market concentration, innovation, new business formation, and investment in job training. Although not all studies cited by the FTC reached the same conclusions or reached definitive conclusions at all, the FTC found the studies on balance to support the position that NCAs adversely affect labor and consumer markets.

Accordingly, the FTC concluded, in the context of its authority to interdict "unfair methods of competition," that NCAs constitute restrictive conduct that negatively affects competitive conditions and, with respect to workers other than senior executives, NCAs are exploitative and coercive both at the time of contracting and at the time of a worker's potential departure from employment.

With respect to the effects of NCAs on competitive conditions in labor markets, the FTC concluded that noncompetes restrict workers' ability to change jobs, resulting in suboptimal matching of workers with employment opportunities, in turn resulting in less competition among employers for workers – leading to reduced wages, and affecting all workers in the market including those *not* subject to NCAs. The FTC noted that the adverse outcomes are the effects of NCAs in the aggregate – when NCAs are prevalent among many employers in the market.

With respect to the effects of NCAs on competitive conditions in consumer markets, the FTC concluded that NCAs reduce labor mobility, which in turn reduces innovation and new business formation. NCAs also, according to the FTC, increase market concentration and, in turn, lead to higher consumer prices. Interestingly, for this conclusion, the FTC relied principally on a study examining physician markets which concluded that, although noncompetes have a positive effect on practice efficiency, a significant presence of noncompetes in a market leads to greater concentration (fewer entities employing physicians) and higher consumer prices.[97]

[97] Hausman, N. and K. Lavetti, *Physician Practice Organization and Negotiated Prices: Evidence From State Law Changes*, 13 AM. ECON. J. APPLIED ECON, 258 (2021). The posited relationship between the prevalence of NCAs in a market and market concentration is theorized to be the result of some firms thereby becoming

The comment period for the FTC's Proposed Rule concluded in 2023. As of this writing, no final rule has been promulgated.

Opponents of the NCA Rule have presented their own economic evidence concerning the effects of NCAs which, of course, supports a different set of conclusions. The American Hospital Association's comments on the NCA Rule, which are fairly representative of opposition from employers of physicians, challenged the FTC's reading of the economic literature, but also offered arguments regarding the positive effects of NCAs in the context of physician employment by hospitals.[98]

First, the AHA has argued that NCAs have positive effects on physician compensation – physicians with NCAs earn more than their counterparts not subject to NCAs.[99] This argument relies mainly on a study positing that in physician groups that use NCAs, doctors are much more likely to make referrals within the same practice because they need not worry about their colleagues poaching their patients.[100] This, according to the study, has a positive productivity effect leading to increased revenue, giving the doctors more ability to bargain for higher wages over the course of their careers.[101]

Primarily, however, AHA advanced the same arguments typically advanced to defend NCAs in contracts with highly compensated professional employees, such as physicians: that NCAs protect investments that hospitals make to recruit doctors and senior executives and eliminate freeriding on those investments by competitors, that NCAs encourage hospitals and health systems to make investments in training their employees and creating "general human capital," which is a

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disadvantaged in recruiting and competing for necessary talent and, as a consequence, exiting the market or merging with another market participant.

[98] Letter to Lina Kahn, Chair, Federal Trade Commission from Melinda Reid Hatton, General Counsel and Secretary, American Hospital Association (February 22, 2023) , https://www.aha.org/lettercomment/2023-02-22-aha-comments-ftc-proposed-non-compete-clause-rule ("AHA Letter"). The AHA, like other opponents of the Noncompete Rule, also argued extensively that the FTC lacks authority under Section 5 to promulgate the Noncompete Rule. See n. 91, *supra*.

[99] *Id*. at 7-9.

[100] Lavetti, *et al.*, n. 10, *supra* at 1042.

[101] The AHA's arguments were oddly dismissive of evidence connecting NCAs and higher physician compensation to higher consumer prices, stating that higher prices (to the extent they occur) probably do reflect higher compensation for physicians (which the AHA characterized as "improvements for workers") but also may reflect the benefits consumers receive from greater quality created by the investment incentives in markets where NCAs are prevalent (*i.e.*, consumers pay more for better quality). AHA Letter at 9, n. 33.

similar anti-freeriding argument, and that NCAs encourage the sharing of proprietary information within hospitals and health systems (which is said to be a benefit to research and patient care) by making it difficult for physicians to take that information to a job with a competitor.[102]

There is a debate as to whether there are less restrictive means (than a noncompete agreement) to protect or promote those interests, which is a relevant question in considering whether NCAs are an unfair method of competition. The FTC, in the Preamble to the proposed Noncompete Rule, acknowledged that the available alternatives "may not be as protective as employers would like," but concluded that the alternatives are preferable to NCAs because "they reasonably accomplish the same purposes as non-compete clauses while burdening competition to a less significant degree. … Rather than restraining a broad scope of beneficial competitive activity—by barring workers altogether from leaving work with the employer for a competitor [or] starting a business that would compete with the employer—employers have alternatives for protecting valuable investments that are much more narrowly tailored to limit impacts on competitive conditions."[103]

Those alternatives, according to the FTC, include state and federal trade secrets laws,[104] which authorize civil remedies for misappropriation of trade secrets and even, in the case of federal law, authorizes, in extraordinary circumstances, *ex parte* orders to prevent dissemination of a trade secret.[105] The FTC argued that the viability of statutory protection is demonstrated by the fact that approximately 2,000 lawsuits are filed annually under these laws in state and federal court.

The FTC also cited the use of non-disclosure agreements (NDAs), long-term employment contracts, and retention incentives as additional ways to protect employers' investments in their employees. The Commission noted that many large businesses, notably in the technology and energy sectors, are located in and have been highly successful in states where NCAs are prohibited,

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[102] AHA Letter at 10-14.

[103] 88 Fed. Reg.at 3505.

[104] Forty-eight states have adopted a version of the Uniform Trade Secrets Act, (https://www.uniformlaws.org/viewdocument/final-act-128?CommunityKey=3a2538fb-e030-4e2d-a9e2-90373dc05792&tab=librarydocuments). The federal Defend Trade Secrets Act ("DTSA"), 18 USC §§ 1836 *et seq*. creates a federal, private cause of action for trade-secret protection and provides a uniform statutory scheme to be applied in federal court. The DTSA does not pre-empt state law. The Economic Espionage Act, 18 U.S.C. § 1831 *et seq*. criminalizes the theft of trade secrets for the economic benefit of anyone other than the owner.

[105] 88 Fed. Reg. at 3506.

"suggesting that alternative methods are fundamentally viable for protecting valuable firm investments."[106]

The most common objection to the FTC's position in favor of alternative means of protection is that NDAs and similar contract-based options provide insufficient protection against the loss of proprietary information because, if an employee is free to leave the employer, valuable information concerning the employer's business will be within the knowledge of that employee and can't be erased. In addition, employers argue that NDAs do not provide a way to monitor ex-employees' disclosures.

There are holes in these arguments on each side. Lawsuits are not simple ways to redress the loss of proprietary information and some proprietary information will not rise to the level of a "trade secret" under applicable statutes. On the other hand, a motivated employer can pursue a buy-out of a recruited employee's NCA. Also, much of the general knowledge and training that an employee gains does not constitute a sufficient protectable business interest to support enforcement of an NCA.

To the extent the FTC's use of its Section 5 authority is directed toward health care providers, that authority will be circumscribed in certain cases by the FTC Act itself. The FTC's jurisdiction over corporations and associations extends only to such entities "organized to carry on business for [their] own profit or that of [their] members."[107] To be outside of the FTC's jurisdiction, there must be a sufficient nexus between the conduct in question and the nonprofit organization's public purpose, and the profits earned must be devoted to public, rather than private, interests.[108] Nonprofit hospitals and other tax-exempt providers may not meet this requirement when they pursue diversified business relationships or participate in for-profit ventures.[109] Although there is little question that the FTC's jurisdiction under Section 5 does not extend to the conduct of *e.g.*, nonprofit charitable hospitals acting solely as such, joint ventures, partnerships, and associations between nonprofit

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[106] *Id.* at 3507.

[107] 15 U.S.C.A. § 44. This limitation does not extend to the FTC's ability to enforce Section 7 of the Clayton Act against nonprofit organizations. *See Fed. Trade Comm'n v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991).

[108] *In re College Football Ass'n*, 117 F.T.C. 971, 1994 WL 16011007 (1994).

[109] *See California Dental Ass'n v. Fed. Trade Comm'n*, 526 U.S. 756, 766–68, (1999) (application of the jurisdictional requirement is not formulaic nor is there a substantiality requirement).

hospitals and private individuals (e.g., physicians) or for-profit organizations, and for-profit subsidiaries, are another matter, and the FTC has exerted jurisdiction over, *e.g.*, PHOs on many occasions.

Whether or how the FTC might enforce its Noncompete Rule against nonprofit health care organizations is a puzzling question. It would seem that, in general, the Noncompete Rule could not be enforced with respect to employees of nonprofit providers engaged in the delivery of health care services or otherwise in furtherance of a provider's charitable purposes but might be enforceable against employees engaged in unrelated business activities or joint ventures. This would require definitional line-drawing by the Commission, particularly as it may concern employees who act in multiple capacities.

Also, if the Noncompete Rule cannot be enforced against nonprofit hospitals, it will put for-profit hospitals at a unique competitive disadvantage. That is, to the extent NCAs restrict physician mobility, for-profit hospitals may face difficulties in finding qualified physicians in local markets in which they compete with nonprofit hospitals, raising recruitment costs, or will incur additional costs to buy out the contracts of physicians at their nonprofit competitors.

The fate of the Noncompete Rule is undetermined as of this writing. There has been speculation that the Commission may modify the Noncompete Rule to encompass a more limited universe of employees (e.g., non-exempt employees, employees under a certain compensation threshold, etc.) in the manner of some state laws.[110] The AHA has argued for the categorical exclusion of physicians from any regulation of noncompetes, and it is conceivable that the FTC would consider some categorical inclusions or exclusions. Fundamentally, however, a close reading of the Preamble suggests that the FTC will prefer the broadest possible scope for the final Noncompete Rule. Any form of final Rule will have to surmount the inevitable legal challenges.[111]

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[110] This approach continues to be discussed in the states. In late 2023, the Governor of New York vetoed a bill that would have banned employee noncompetes. The Governor had sought a compromise under which NCAs would be permitted for employees whose compensation exceeded $250,000. The compromise failed and so did the bill. Vielkind, J. "New York Gov. Kathy Hochul Rejects Ban on Noncompete Agreements," *Wall Street Journal* (Dec. 23, 2023), https://www.wsj.com/us-news/law/new-york-gov-kathy-hochul-to-reject-ban-on-noncompete-agreements-3f0eb7d4.

[111] Even if the FTC were to significantly revise or even withdraw the Noncompete Rule, the debate over its purposes and effects will have highlighted the inconsistencies of state laws and the incomplete state of economic evidence – particularly in the health care field. In the absence of a federal rule applicable to physicians, opponents of physician noncompetes could well gain momentum to seek changes in state law.

Noncompetes and Patient Care

Although some of the studies debated in the context of the proposed Noncompete Rule examined physician noncompetes, they did so with respect to effects on physician compensation, market concentration, and consumer prices. None addressed effects on patient care. And no one seems to be arguing that physician noncompetes benefit patient care. The closest arguments seem to emerge from one study, cited by the FTC and more prominently by the AHA, that posited that NCAs, by fostering intra-practice referrals, lead to more integrated care delivery.[112] And the AHA's comments also suggest (in a left-handed way) that higher consumer prices identified in one study as an effect of NCAs may be evidence of improvements in the quality of the care delivered.

However, numerous medical associations and literally hundreds of physicians provided comments to the FTC arguing that NCAs are harmful to patient care.[113] The comments submitted by the American Academy of Family Physicians are representative. The AAFP argues, "[N]oncompete agreements in health care threaten to disrupt patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, stifle competition, and contribute to an increasingly concentrated healthcare market. … These concerns are exacerbated for family physicians who provide continuous, comprehensive care for patients over their lifespan. Continuity of care is known to improve outcomes, particularly for patients with complex chronic conditions. …"[114]

Apart from formal comments, many articles and commentaries have been published since the issuance of the proposed Noncompete Rule about the adverse effects of noncompetes on the health and well-being of patients. Commentary also has raised the question of whether NCAs contribute to physician burn-out, as physicians are forced to remain in jobs that they no longer wish

[112] *See* Lavetti, *et al.*, n. 10, *supra*.

[113] The House of Delegates of the American Medical Association, traditionally noncommittal on the subject, adopted a resolution in 2023 opposing noncompete contracts for physicians in clinical practice who are employed by hospitals, health care systems or staffing companies. Amer. Med. Ass'n Press Release, *AMA to urge end of noncompete covenants in many physician contracts* (June 12, 2023)(" Allowing physicians to work for multiple hospitals can enhance the availability of specialist coverage in a community, improving patient access to care and reducing health care disparities."), https://www.ama-assn.org/press-center/press-releases/ama-urge-end-noncompete-covenants-many-physician-contracts.

[114] Letter from Sterling N. Ransone, Jr., MD, FAAFP, Board Chair, Ame. Acad. Family Phys. to Lina M. Khan Chair, Fed, Trade Comm. and April Tabor Office of the Secretary, Fed. Trade Comm. (Apr. 6, 2023) at 1-2.

to pursue by an NCA's economic disincentives or the prospect of relocating, and whether that effect also adversely affects patient care.[115]

These stories of course are not scientific evidence but their concerns would seem to be fundamental to policy decisions concerning physician noncompetes.

Conclusion

The default position in this debate is to continue to leave the regulation of noncompetition covenants to the state legislatures and state courts. It is one argument advanced by the AHA, and it is not wholly illogical given the differing conclusions of economic studies to date as to whether NCAs have adverse market effects. On the other hand, the delivery of physician services in every state has moved beyond domination by the small practices and clinics of independent physicians – a time in which the effects of NCAs on the delivery of care and the market consolidation were undoubtedly small. But that is no longer the case. Currently, three of every four practicing physicians are employed. More than 40 percent are employed by hospitals and hospital-based systems, and an increasing proportion are employed by other corporate entities such as insurers and private equity firms. It would seem to be time to reach a broader consensus on the questions of the benefits and costs of physician noncompetes. The FTC's Noncompete Rule may not be the answer. But it would be logical to think that more information would be useful on the effects of noncompetes on patient care, health equity, and physician job satisfaction. It would be logical to think that whether or not NCAs raise costs is not the relevant question if patient care is being affected adversely.

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[115] The Century Foundation, *Noncompete Agreements for the Health Care Workforce Put Profits over Patients* (Aug. 14, 2023) at 4, ("NCAs help to drive burnout and moral injury among physicians as doctors are forced to prioritize corporate profit models above patient care and wellbeing (even doctors at private, nonprofit hospitals). … These factors are contributing to distressing trends in the health care workforce, including increasing physician stress and frustration, mounting job dissatisfaction, and rising exit rates."), https://tcf.org/content/commentary/noncompete-agreements-for-the-health-care-workforce-put-profits-over-patients/; Hellman, J, "Noncompete rule puts doctors, hospitals at odds," *Roll Call* (Mar. 9, 2023) ("'It actually traps an unhappy workforce, and it negatively impacts patients,' said Erik Smith, a clinical assistant professor of anesthesiology at the University of Southern California's Keck School of Medicine. 'There's an extraordinary amount of burnout, fear and dissatisfaction with the way that health care workers are being treated. Part of that is because of noncompete agreements,' said Smith, who was under a noncompete agreement while working in Maryland."), https://rollcall.com/2023/03/09/noncompete-rule-puts-doctors-hospitals-at-odds/; *see also* Filchak, D., "Doctor files lawsuit against Lutheran over noncompete clause," *The [Fort Wayne, IN] Journal-Gazette* (July 6, 2023) (Pediatric intensivist filed suit to void noncompete clause, alleging he was forced to see four or five times more patients after hospital laid off all the pediatricians who primarily worked in the hospital).

Postscript

The FTC issued the Noncompete Rule in final form, largely unchanged from the proposed rule, on April 23, 2024 (published at 89 Fed. Reg. 38342 (May 7, 2024)). The final Noncompete Rule became the immediate subject of multiple court challenges, of which the lead case is *Ryan LLC v. FTC*, No. 3:24-cv-00986-E (N.D. Tex. Apr. 23, 2024). The lawsuit maintains that the Rule is an arbitrary and capricious exercise of the Commission's power and violates the Major Questions Doctrine which circumscribes federal agencies' authority to interpret their statutory authority. The lawsuit remains pending as of June, 2024.