Advancing High Performance Health

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The Honorable Andrew N. Ferguson
Chair
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: Request for Information Regarding Employee Noncompete Agreements, Federal Trade Commission (September 4, 2025)
Docket (FTC-2025-0463)

Dear Chairman Ferguson:

On behalf of the American Medical Group Association (AMGA), I appreciate the opportunity to respond to the Federal Trade Commission's (FTC's) Request for Information Regarding Employer Noncompete Agreements.

Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 177,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective, patient-centered medical care. Our members are at the forefront of population health management and the transition to high-value care. As part of those efforts, AMGA and its provider members emphasize care coordination and person-centered care.

AMGA appreciates the FTC's interest in examining the effects of employer noncompete agreements, particularly in the healthcare sector. We share the Commission's commitment to ensuring healthy competition, fostering innovation in the marketplace, and addressing harmful labor market practices. At the same time, we believe it is critical that policy interventions acknowledge the unique structure and economics of healthcare delivery and avoid undermining models that have demonstrated success in improving care quality and reducing costs.

Key Recommendation:

- The FTC should defer to state legislatures and courts as the primary regulators of noncompete agreements in healthcare, recognizing their superior ability to assess local market dynamics, workforce availability, and patient access challenges

The regulation of noncompete agreements has historically been—and should remain—primarily under the purview of states. A national avenue of regulating noncompete agreements should recognize state primacy, allowing for state flexibility in developing and enforcing tailored state-specific approaches. States are best equipped to assess local market dynamics, workforce availability, and patient access challenges. This is especially true for healthcare, where markets are inherently local. State legislatures and courts have decades of experience evaluating the reasonableness of noncompete provisions, including balancing worker mobility with the need for stability in healthcare delivery. Numerous states have already acted to address concerns about overly restrictive covenants: Rhode Island and Illinois limit agreements for low-wage workers,[1] while Tennessee and the District of Columbia prohibit their use for physicians altogether.[2] With states actively tailoring solutions to their unique labor markets, a one-size-fits-all national standard would disrupt local solutions.

With our nation facing an unprecedented healthcare workforce crisis, AMGA welcomes the opportunity to provide input on how noncompete agreements affect recruitment, retention, and the continuity of patient care. Our members consistently report that reasonable, narrowly tailored noncompete agreements strengthen local healthcare labor markets and decrease costs by enabling coordinated care through multispecialty medical groups and integrated delivery systems.

Our comments address the following question:

12. Have any noncompete agreements covering workers in the healthcare sector affected wages, labor mobility, or the availability, quality, or cost of healthcare services in particular? If so, how?

Our detailed comments are included below.

I. **Comment:** Noncompete agreements protect healthcare organizations' investments in workforce development and sustain access to care.

Noncompete agreements can protect the significant time and resources invested in recruiting, retaining, and training skilled physicians. The process of searching for candidates, providing a signing bonus and relocation pay, guaranteeing a salary, and providing extensive onboarding and continuing education, constitutes a significant expense for medical groups and health systems. According to data from national studies and AMGA members, the average cost to recruit a new primary care physician (PCP) ranges from $300,000 to $500,000, excluding the two to three years often required for a new physician to build a patient panel.[3] Without a reasonable noncompete agreement, newly hired physicians could take advantage of the group-financed professional development and leave their practice for a higher salary, equipped with increased skills and knowledge.

[1] See, e.g., 820 ILCS 90/5; R.I. Gen. Laws § 28-59-2

[2] See, e.g., D.C. Law 24-175 (excluding highly compensated medical specialists); Tenn. Code Ann. § 63-1-148.

[3] Association of Staff Physician Recruiters. Executive summary. 2018 ASPR In-House Physician Benchmarking Report. Accessed October 2019.

Specialty recruitment is even more resource intensive. For example, bringing a neurosurgeon or interventional cardiologist on board often entails facility upgrades, hiring advanced practice clinicians, and building multidisciplinary teams. If such a physician departs unexpectedly, the practice or system incurs the cost of replacement and the operational disruption associated with unused clinical infrastructure.

Without a reasonable method to protect these investments, these investments become difficult to sustain, particularly in competitive labor markets already strained by shortages. In this environment, noncompete agreements serve not as barriers to opportunity, but as tools that promote workforce stability, continuity of care, and the long-term viability of healthcare delivery organizations.

II. **Comment:** Noncompete agreements ensure access to care and safeguard the development of a continuous provider-patient relationship.

AMGA's members operate under integrated, team-based models that depend on continuity among physicians, advanced practice clinicians, and support staff. Within these models, primary care physicians and specialists collaborate closely (often within the same system), sharing data through unified electronic health records and jointly managing chronic conditions.

Reasonable noncompete provisions help sustain these coordinated systems by reducing turnover and ensuring that patient care plans remain intact. When a key clinician leaves and patients follow, the transition can fragment care, disrupt established treatment relationships, and increase costs through duplicated tests or delayed interventions. Maintaining stable clinical teams supports care integration and advances the goals of high-value care: improving outcomes, enhancing patient experience, and reducing overall system costs.

III. **Comment:** Noncompete agreements can help preserve healthcare access in rural and underserved areas.

AMGA recognizes the FTC's concern that noncompete agreements may have distinct implications in rural or underserved areas where access to care is already limited. Our members share this concern, but experience shows that appropriately structured, state-regulated noncompete agreements can help *preserve* rural access.

Recruiting physicians to rural communities requires significant investment in relocation, community integration, and infrastructure development. Without reasonable noncompete provisions, a clinician could leave for a nearby urban center soon after arrival, undermining local continuity of care and forcing patients to travel long distances for essential services. Carefully tailored agreements, limited in scope and duration, can help maintain local workforce stability and ensure that patients in rural and frontier areas retain consistent access to trusted providers.

Because rural market conditions vary widely across states, state-level regulation remains the most effective and responsive framework for ensuring that noncompete agreements balance the interests of healthcare organizations, clinicians, and patients. States are uniquely positioned to

evaluate workforce dynamics, community needs, and economic conditions, making them far better suited than a federal agency to determine when and how such agreements should apply.

Conclusion
AMGA supports the thoughtful use of appropriate and tailored noncompete agreements to support stability, lower healthcare costs, and increase care quality in the healthcare industry.

Thank you for your consideration of these comments. Should you have any questions, please do not hesitate to contact Darryl M. Drevna, senior director of regulatory affairs, at ddrevna@amga.org or 703.838.0033 ext. 339.

Sincerely,

Jerry Penso, MD, MBA
President and Chief Executive Officer, AMGA