AMERICAN COLLEGE of CARDIOLOGY

Heart House
2400 N St. NW, Washington, DC 20037
1-202-375-6000 | 1-800-253-4636 | Fax: 1-202-375-6842
ACC.org

October 28, 2025

Andrew N. Ferguson
Chair
Federal Trade Commission
600 Pennsylvania Ave, NW
Washington, DC 20580

RE: Request for Information Regarding Employee Noncompete Agreements

Dear Chair Ferguson:

As the voice of cardiovascular clinicians who treat cardiology patients in hospitals, private practices, and all manner of healthcare settings across the nation and the world, the American College of Cardiology (ACC) appreciates the opportunity to comment to the Federal Trade Commission on request for information (RFI) regarding the use of noncompete clauses. The College's response focuses on cardiologists in general as it relates to the RFI. Ultimately, the key takeaway must be that clinicians should be free from unnecessary constraints that interfere with patient care and diminish well-being. The College appreciates the FTC's interest in removing unreasonable restrictions.

The ACC is a global leader dedicated to transforming cardiovascular care and improving heart health for all. For more than 75 years, the ACC has empowered a community of over 60,000 cardiovascular professionals across more than 140 countries with cutting-edge education and advocacy, rigorous professional credentials, and trusted clinical guidance. From its world-class JACC Journals and NCDR registries to its Accreditation Services, global network of Chapters and Sections, and CardioSmart patient initiatives, the College is committed to creating a world where science, knowledge and innovation optimize patient care and outcomes. Learn more at www.ACC.org or connect on social media at @ACCinTouch.

Background

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

Industry survey data shows that in 2008, 90% of cardiologists operated in a private practice setting while 10% were in an employed/integrated model. In the same survey ten years later, the results were nearly the inverse, with 84% of cardiologists employed and just 16% remaining in private practice settings.[ii] This dramatic shift in the employment structure of cardiologists, coupled with the common and often non-negotiable presence of stringent noncompete clauses and other restrictive covenants in cardiologist employment contracts, is the driver of our membership's interest in this topic. Surveys also showed that 68% of respondent cardiologists were subject to restrictive covenants in their employment contracts. Meanwhile, only 10% of respondents noted having the ability to negotiate any changes in said restrictive covenants.

Cardiologists' Experience

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

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

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

For physicians specifically, limitations on noncompete clauses could promote rather than stifle innovation. ACC members generally believe changes would create a healthier workplace culture that would reduce physician burnout, promote greater patient access to care, improve patient experience, and reduce costs of care to both the system and the patients.

Restrictive covenants may negatively impact efforts to build better working conditions by promoting an immobile or captive workforce culture. It is easier to enforce clinically unattractive utilization policies and fail to fund or develop clinical programs when physicians have strong noncompete

clauses as opposed to physicians who can freely leave and seek employment in systems with more favorable policies or work environments. Health systems individually have little incentive to renegotiate any portion of the noncompete clause, especially in large multispecialty employed physician groups. Physicians can try to negotiate for compensation, more support, programmatic investment, or other important considerations, but have limited recourse if a noncompete is in place.

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

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

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

Reasonable Exceptions Under Which to Allow Certain Noncompete Clauses

While the ACC generally supports elimination of noncompete clauses, the College believes narrow, reasonable exceptions may be considered. These reasonable approaches would be available to any employer but could be successful in the remaining privately-owned medical practices which can play an important role in community-based care which, due to their structure, must make proportionately larger investments in newly hired physicians.

As noted earlier in these comments, noncompete clauses imposed by ever-expanding health systems with massive footprints in any given state or region with radii from *any* of their locations are clearly unreasonable and disruptive to clinicians and the patients they serve. However, if some geographic restrictions are allowed, it could be considered reasonable if an employer with multiple locations were to impose a noncompete clause with a limited distance radius from only the location where the former employee worked the majority of their time for that employer. This kind of narrow restriction could mostly alleviate the issue described earlier of a large employer barring a former

employee from seeking work anywhere in their state, region, or even a reasonable distance from where they reside, and would potentially preserve established physician-patient relationships.

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

Noncompete Restrictions Based on Salary Threshold

Salary thresholds have been considered as a proxy to demonstrate that an employee has special characteristics that ought allow restriction through a noncompete agreement. As cardiologists' experience demonstrates, simply earning a high salary does not mean that one is better positioned to refuse a noncompete agreement or negotiated more favorable terms. The ACC does not believe a threshold of any kind should be set. The freedom of economic movement being restricted for anyone of any occupation or salary level is antithetical to the free market system on which this nation's economy is founded. Doing so would unduly penalize the economic advancement of workers at or near the stated thresholds. This threshold type also infers that workers only change jobs for higher salaries. Workers change jobs for many reasons. To allow noncompete clauses for workers above a certain threshold would bar these workers from seeking new employment not only for a higher salary but also for better working conditions, schedule flexibility, better ancillary benefits, or a culture more aligned to the workers' values. We see no rational argument to deny workers these options simply because they earn, for example, $100,000 vs. $99,999 or any other fixed threshold. Further, a static amount set as a threshold for what is considered a "relatively high" salary, absent some mechanism to adjust this amount for inflation and geography, would over time become obsolete and restrictive as such a salary eventually would not be considered high as inflation

and other market forces inevitably progress at various rates over the years.

Conclusion

The ACC appreciates the opportunity to provide input to the FTC as it considers action regarding the use of noncompete clauses. From our perspective, any implemented reforms must be considered through the lens of improving patient care and should promote the continued effectiveness of our clinical workforce. For any questions or follow-up please contact James Vavricek, Director of Regulatory Affairs, at jvavricek@acc.org.

Sincerely,

Christopher M. Kramer, MD
President, American College of Cardiology

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[i] Marshall, J, Ashwath, M, Jefferies, J. et al. Restrictive Covenants and Noncompete Clauses for Physicians. *JACC Adv.* 2023 Sep, 2 (7) .https://doi.org/10.1016/j.jacadv.2023.100547

[ii] Sobal, L. (2019, November 6). *Has employment of cardiologist been a successful strategy – Part 1.* American College of Cardiology, Cardiovascular Management Section. (https://www.acc.org/membership/sections-and-councils/cardiovascular-management-section/section-updates/2019/11/06/09/49/has-employment-of-cardiologists-been-a-successful-strategy-part-1).

[iii] Douglas, P, Mack, M. et al. 2022 ACC Health Policy Statement on Building Respect, Civility, and Inclusion in the Cardiovascular Workplace: A Report of the American College of Cardiology Solution Set Oversight Committee. JACC. 2022 May, 79 (21) 2153–2184. https://doi.org/10.1016/j.jacc.2022.03.006