A proposed noncompete ban could upend business for health providers

Dr. Desiree Pineda employs three clinical employees, two of whom hold noncompete agreements, at her D.C. primary care and endocrinology practice.

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IN THIS ARTICLE

Hospitals
Topic

FTI Consulting Inc.
Company

George Washington University
Company

George Washington University Hospital
Company

MedChi, The Maryland State Medical Society
Company

Universal Health Services Inc.
Company

Desiree Pineda
Person

More

By Sara Gilgore
Staff Reporter, Washington Business Journal
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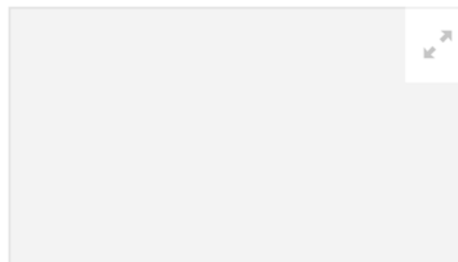
Dr. Desiree Pineda makes no secret of why she opened her own D.C. private medical practice 30 years ago. The primary care physician and endocrinologist wanted to help ease people's pain.

But now, she may be the one in need of serious financial relief,

short, it could open the door for two of her key clinical employees to leave, set up their own shops down the street or in a nearby hospital — and take her practice's patients with them.

"The value of your practice is your patients," said Pineda, a former president of the Medical Society of the District of Columbia. "If that patient leaves and goes to another practice, ... then there is a loss itself for a practice — an economical loss."

At issue is a seemingly bureaucratic change that could upend parts of the health care industry. It stems from a Federal Trade Commission proposal, announced in early January, to get rid of noncompete agreements across sectors, essentially no longer preventing exiting employees from enacting similar work within a short geographic distance or period of time for a competitor. The agency argues such agreements are too restrictive, blocking new players from entering the market and driving up prices for consumers. Its proposed rule, it estimates, would save patients up to $148 billion on health care costs each year.



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It's in response to years of criticism from free-market advocacy groups and others that noncompete agreements are unreasonably anticompetitive, resulting in lawsuits, including by the FTC itself, and moves by several jurisdictions, including D.C., Maryland and Virginia, to outlaw them up to a certain salary cap.

But for countless small private practices and massive health systems alike, the clauses have served a crucial purpose in recruiting and retaining high-paying, highly experienced professionals. A January 2021 survey found 48% of physician respondents had noncompete clauses in their contracts and 64% reported leaving a job that included such a clause, according to clinical information website Medscape.

Experts say noncompetes are especially prevalent in saturated, competitive markets like Greater Washington, which claims one of the nation's highest concentrations of doctors at 2.78 physicians per thousand jobs, according to Bureau of Labor Statistics data. A federal ban on the agreements, they say, would force dramatic changes in how health care providers structure employment, as well as incentives to hold onto highly specialized, revenue-generating employees to remain sustainable — a daunting task in an era already beset by ever-tightening budgets and chronic labor challenges.

"It's going to cause organizations and health care entities to be more cautious and careful in how they write the arrangements between the health care systems and their affiliated physicians," said Robert Bonar, a former health system executive and professor of health care administration in George Washington University's Milken Institute School of Public Health. "They're going to have to come up with other

ways to try to cement, if you will, those physicians to the health system."

A world without noncompetes

The FTC rule change is as controversial as it is broad, applying to high-level executives and hourly workers across industries.

In medicine, it could affect everyone from everyday clinical staff up to health system CEOs. That may include respiratory nurse anesthetists who contract with hospitals, for example, or nurse practitioners and physician assistants employed by independent practice owners. But it would have the most significant effect on doctors "because of their powerful role in

being licensed to oversee the patients' care," said Bonar, also director of GWU's Master of Health Administration Program.

The contracts are largely driven by state laws, with various degrees of enforceability. As it stands now, an oncologist under a noncompete agreement at one provider, for one, wouldn't be precluded from generally treating cancer patients upon leaving. But that doctor likely couldn't do it within a certain radius of that provider's locations to avoid encroaching on its market or revenue base.

"It's within the employer or the buyer's market, and they deem it to be potentially negatively impacting their business or their interests — then they're going to enforce that," said Todd Mello, a senior managing director in the health solutions practice of D.C.'s FTI Consulting Inc.

But in a world without noncompetes, things would quickly change in both stark and nuanced ways. An academic medical center that recruits a high-profile neurosurgeon may not want to invest in multimillion-dollar equipment and real estate if that doctor could just depart for another across the street. A large health care company might fear training its CEO to then be poached by a direct competitor in the same market. A private practice could think twice before hiring a rare specialist who could just as easily set up their own shop in the same building months later.

That's where nonsolicitation agreements typically come in. Under those, medical staffers who leave agree not to explicitly ask patients to follow them to their new offices. The FTC's proposal may toss out such nonsolicitation agreements deemed overly restrictive or broad, causing plenty of contention as well. But most know the reality is, even with a

nonsolicitation agreement in place, a health system can't restrict where a consumer decides to seek care.

The change also carries implications — and potential exceptions — for consolidation deals within the industry. In the case of a physician practice selling itself to a hospital, for instance, the practice's doctors may become employees of that hospital post-transaction. In that case, "a noncompete for an employed position may not be valid under the proposed rule," said Sarah Swank, a D.C. health care attorney with Nixon Peabody LLP.

But in that same scenario, the practice might be able to maintain its noncompete agreements for the physicians who hold equity interests in the business for a period of time following the transaction. That would ensure the practice's owner couldn't just start an identical practice to compete with its buyer the next day.

Without that exception, it would be "a deal-breaker to people buying businesses if the sellers don't have noncompetes," Mello said. "Otherwise, how do they protect the value of that interest?"

Series of far-reaching effects

To add to the confusion, the FTC's proposed rule change offers an unsettling exception for many industry leaders: Nonprofits do not fall within the agency's authority and, therefore, would not need to eliminate their noncompete agreements.

Most of the D.C. region's biggest providers are nonprofit health systems, many of which do use noncompete agreements. So being exempt from the ban would give them "a big competitive advantage," said Gene Ransom, CEO of MedChi, the Maryland State Medical Society. "You would

create a complete economic market that was unfair and unbalanced."

An organization's employment structure would also inform how the FTC rule gets applied, potentially then affecting nonprofit networks. In some cases, nonprofit hospitals set up for-profit subsidiaries within their umbrellas to employ their physicians. "You could see a situation where they would simply start switching the way they employ people," Ransom said.

Additionally, the proposed rule could threaten competition for talent between geographic markets, which have varying concentrations of nonprofit health systems. "If that were to hold, that would create mayhem in the Maryland market," where every health system is a nonprofit, Ransom said. That's in contrast, for instance, to one of the leading players in the District's market in George Washington University Hospital, owned by for-profit, publicly traded Universal Health Services, based in King of Prussia, Pennsylvania.

Many major health care players are opting to take a wait-and-see approach to the potential changes, spurning a public stance on the issue. A dozen D.C.-area health systems and hospitals either declined to comment for this story or did not return requests for comment.

Another facet of the proposed rule could affect more clinical workers by wiping away other agreements that elicit the same effect as a noncompete pact, including a type of contract common among nurses. Health systems often require nurses to enter Training Repayment Agreement Provisions, colloquially known as debt TRAPs, which require nurses to pay "sometimes tens of thousands of dollars" if they leave

before their contracts run out, said Carmen Comsti, lead regulatory policy specialist with National Nurses United.

“So it doesn’t necessarily say you cannot work with the hospital across the street,” Comsti said. “But it has the same effect, which is that the nurses are so scared of leaving because they’ll be charged with a lot of money if they end up working for another employer.”

Carrots-over-sticks approach

While employers have long been wary of overcompensating doctors due to regulations around pay, the FTC rule change

could also spark price wars for specialty areas of medicine already facing acute shortages.

“So it makes it somewhat complex and risky for all parties involved,” Bonar said. “But in theory, it would make the market more competitive.”

For nurses, an FTC ban on noncompetes could drive up salaries, as debt contracts can “lock nurses into low wages,” Comsti said. It could also improve patient outcomes, she said, pointing to cases when recent nursing school graduates might be assigned to too many patients on shifts without adequate support, which can lead to errors. To that end, the FTC rule “would enable our nurses to be able to actually demand for better working conditions,” Comsti said. “If anything, nurses will stay at the bedside longer.”

For providers, it would likely induce innovative methods to hold onto staff members, such as perhaps offering additional payments for successful and less costly health care outcomes, retention bonuses or forgivable loans — “other financial vehicles to lock people in that look more like a carrot and less like a stick,” Mello said.

Take private equity. Doctors who sell their practices to private equity firms may take upward of 75% of the price in upfront cash and roll the rest into equity in the new organization — meaning they’d have to stay a handful of years to exit with their full investment. And if the business does well and their stock increases in value, “they get a second bite at the apple,” Mello said. “So private equity, frankly, has more tools in their toolbox to lock doctors in than hospitals.” Baked into that structure is a financial incentive for the doctors to stick around, even apart from noncompetes — and may provide a model for other employers.

For others, perks can go beyond the industry norm. When leading a health system in Texas, Bonar spearheaded an effort to retain a large physician group that brought important referrals to its hospital. His system sold land to that group, then created a joint venture to build and own an ambulatory surgery center on that property, in which the physician group was the majority partner, he said. "And my philosophy in doing that was, 'Let's give them a reason why they want to work with us.'"

That type of creativity, Pineda said, will be critical to her own practice's future, even if she doesn't know what form it will take just yet. She's hardly unique in not knowing what comes next for her business, or what she can do to hold onto her staff should noncompete agreements get eliminated. But she'll be watching the next several months quite closely.

"It's becoming more and more expensive to go to medical school, to train and, like in any other businesses, to keep the doctors in one area for long periods of time," she said. "For medical practices — for a lot of businesses — it's a big problem."