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Centers for Medicare and Medicaid Services, Department of Health and Human Services Proposed Action Memorandum

November 2, 2023

Issuing Medicare and Medicaid Condition of Participation regulating health care employers' use of traditional and de facto non-compete clauses

I. Introduction

Today, many of the country's largest healthcare systems and staffing agencies engage in widespread, exploitative, and unfair practices that threaten patient care and conditions, diminish competition, and hamper our economy and economic growth. President Biden himself recognizes the danger that concentration and anti-competitive behavior pose, including in the healthcare sector, and issued an executive order on Promoting Competition in the American Economy that called for a whole of government approach to “ensure patients are not harmed” by such behavior.¹

As healthcare systems look to concentrate their power within hospital markets, they've increasingly relied on their power within labor markets. Systems routinely use traditional non-compete clauses; these prohibit staff from working elsewhere in the healthcare industry for a pre-set period of time and within a certain geographic area after leaving their current job. Now, as the Biden Administration² and state lawmakers,³ have cracked down on traditional non-compete clauses, healthcare systems are increasingly relying on new, nefarious contractual provisions: stay-or-pay contracts. They operate as de facto non-compete clauses,⁴ intentionally designed to evade bans on traditional non-compete clauses while achieving the same outcome through different means. These contracts, often presented as a precondition for employment, require departing employees to pay their employer tens of thousands of dollars if they leave their job before an arbitrarily set date, and can include a host of other financial penalties. Throughout this memo, the term “non-compete clause” refers to both traditional and de facto non-compete clauses.

A number of federal agencies have clear statutory authority to regulate the use of non-compete clauses, including the Department of Health and Human Services.⁵ As needed to protect patient health and safety, the

¹ The White House, Fact Sheet: Executive Order on Promoting Competition in the American Economy, (Jul. 9, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/07/09/fact-sheet-executive-order-on-promoting-competition-in-the-american-economy/>.

² See, e.g., Federal Trade Commission, FTC Proposes Rule to Ban Noncompete Clauses, Which Hurt Workers and Harm Competition, (Jan. 5, 2023), <https://www.ftc.gov/news-events/news/press-releases/2023/01/ftc-proposes-rule-ban-noncompete-clauses-which-hurt-workers-harm-competition>; National Labor Relations Board, NLRB General Counsel Issues Memo on Non-compete Violating the National Labor Relations Act, (May 30, 2023), <https://www.nlr.gov/news-outreach/news-story/nlr-general-counsel-issues-memo-on-non-competes-violating-the-national>.

³ SHRM, More States Block Noncompete Agreements, (Sept. 15, 2022), <https://www.shrm.org/resourcesandtools/legal-and-compliance/state-and-local-updates/pages/states-restrict-noncompete-agreements-colorado.aspx>.

⁴ Zoe Salzman, Liquidated Damages Clauses in Employment Agreements, https://www.americanbar.org/content/dam/aba/publications/aba_journal_of_labor_employment_law/v34/number-2/liquidated-damages-clauses.pdf (comparing liquidated damages clauses to non-compete agreements in their effects of preventing worker mobility).

⁵ For example, stay-or-pay contracts may be subject to the Consumer Financial Protection Act's prohibitions on unfair, deceptive, or abusive acts and practices in consumer financial products or services because of the debt obligations they create. 12 U.S.C. § 5531(a). Additionally, the Federal Trade Commission and the Department of Transportation may have jurisdiction to regulate such agreements under their unfair methods of competition or unfair or deceptive acts and practices authorities under their respective organic statutes. 49 U.S.C. § 41712(a); 15 U.S.C. § 45(a); see generally American Economic Liberties Project letter to White House Competition Council, (May 30, 2023),

Social Security Act empowers the Secretary of Health and Human Services to impose Conditions of Participation (“CoPs”) on facilities that serve Medicare and Medicaid patients. Traditional and de facto non-competes, which are particularly prevalent in the healthcare industry, have been shown to negatively affect patient health and safety – through interrupted patient care, reduced worker morale, and reduced ability of staff to advocate for safe patient conditions.⁶

This memorandum proposes that the Centers for Medicare and Medicaid Services (“CMS”) promulgate, through notice-and-comment rulemaking, a regulation banning the use of traditional and de facto noncompetes in healthcare worker employment arrangements.

II. Justification

A. *Non-compete clauses in the healthcare sector*

Non-compete clauses are ubiquitous throughout the healthcare industry. For example, up to 80 percent of certified registered nurse anesthetists are currently subject to traditional non-compete clauses.⁷ In part due to the recent federal and state regulatory attention paid to traditional non-compete clauses, de facto non-compete clauses, which include stay-or-pay arrangements like training repayment agreement provisions (“TRAPs”) and liquidated damages provisions,⁸ have also become commonplace within the healthcare sector, particularly among healthcare professionals at the onset of their careers. A TRAP requires a worker who is fired or quits before a set period of time to pay the employer for the cost of on-the-job training. A liquidated damages provision is similar, but the financial penalty accounts for broader claimed expenses like recruitment and onboarding costs. In 2022, the National Nurses United (“NNU”) conducted a survey of registered nurses and found that about half of respondents were required to participate in a training or residency program during their career, and 55 percent of the registered nurses working in hospitals who participated in such programs reported being required to repay their employer for the cost of their training if they departed the hospital before their employment contract expired.⁹ TRAPs are often instituted at less desirable hospitals with unsafe working or patient care conditions, including at the largest for-profit healthcare system in the country, HCA Healthcare.¹⁰ Indeed, TRAPs have become so ubiquitous in the healthcare sector that nurses who

<http://www.economicliberties.us/wp-content/uploads/2023/05/2022-05-30-Competition-Council-Noncompetes-Letter.pdf> (outlining various authorities that agencies may have to regulation non-compete agreements).

⁶ The Impact of a Non-Compete Clause on Patient Care and Orthopaedic Surgeons in the State of Louisiana: Afraid of a Little Competition?, *Orthopedic Reviews* Vol 13, Issue 4 at 10, (2022),

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9569414/pdf/orthopedicreviews_2022_14_4_38404.pdf (hereinafter “Orthopedic Survey”); National Nurses United comment on Consumer Financial Protection Bureau Request for Information, (Sept. 23, 2022), <https://www.regulations.gov/comment/CFPB-2022-0038-0048> (hereinafter “NNU Comment”); see also Shannon Pettypiece, *‘Indentured servitude’: Nurses hit with hefty debt when trying to leave hospitals*, NBC News, (Mar. 12, 2023),

<https://www.nbcnews.com/politics/economics/indentured-servitude-nurses-hit-hefty-debt-trying-leave-hospitals-rcna74204> (quoting a regulatory policy specialist at National Nurses United who stated, “[h]aving that debt hanging over them means that nurses have a harder time advocating for safe conditions for themselves and their patients”).

⁷ AANA, *The Compete Clause and the Nurse Anesthetist: An Assessment of Knowledge, Perception, and Experience*, (Accessed: May 31, 2023),

https://www.aana.com/docs/default-source/aana-journal-web-documents-1/noncompete-clause-1015-pp329-335.pdf?sfvrsn=a4cd48b1_6.

⁸ Bloomberg, *Giving Four Months’ Notice or Paying to Quit Has These Workers Feeling Trapped*, (Jan. 26, 2023), <https://www.bloomberg.com/news/articles/2023-01-26/concentra-health-employees-feel-trapped-at-work>.

⁹ NNU Comment at 8.

¹⁰ Student Borrower Protection Center, *Trapped at Work* 15, (July 2022),

https://protectborrowers.org/wp-content/uploads/2022/07/Trapped-at-Work_Final.pdf (hereinafter “Trapped at Work report”).

purposefully search for jobs that do not require TRAPs can struggle to find them.¹¹ Consider one example of how HCA uses TRAPs to immobilize workers and reduce their bargaining power:¹²

Newly hired new graduate RNs seeking employment at HCA Healthcare’s Mission Hospital in Asheville, NC and a number of other HCA Healthcare hospitals are required to sign a [Training Repayment Agreement] with HCA Healthcare subsidiary HealthTrust, a health care industry supply chain management company Under the contract, HealthTrust requires newly graduated nurses—who are fully licensed and working as RNs in HCA Healthcare hospitals — to complete the company-run StarRN program to receive so-called nursing coursework. Under the contract, these newly graduated nurses are required to take out a \$10,000 promissory note for program costs and must for years accept suppressed wages that are frequently lower than other RNs working in the same job but outside the StarRN program. Additionally, as temporary employees these nurses do not receive benefits. After completing the program, nurses are required to work full-time for HCA Healthcare for two years or else they must repay the promissory note. RNs working at Mission Hospital who are in the StarRN program make a set rate of \$24 an hour, potentially depressing wage growth, while the hourly median wage for RNs in the state is \$32.13.¹³

HCA is not alone, of course: UCHealth, MedStar Health, and other health systems also use TRAPs, for which the payback amounts range from \$5,000 to \$50,000.¹⁴

Cognizant of the increased regulatory and media scrutiny on the use of TRAPs in employment, some employers instead use restrictive debt clauses tied to sign-on and relocation bonuses. These arrangements function much the same way as other stay-or-pay contracts, by constraining the employment choices that workers have. If setting debt traps was not their purpose, employers could instead offer relocation bonuses that are not subject to repayment or improve retention and protect training investments by offering longevity bonuses.¹⁵

As the Consumer Financial Protection Bureau (“CFPB”) explained in a recent report on employer-driven debt, workers are often rushed into signing up for de facto non-compete contracts and debt loads because they are presented as conditions of employment.¹⁶ Additionally, employers misrepresent the value and nature of the contracts that workers are required to sign: whereas workers are made to believe that the contracts and debt are necessary to achieve career mobility and higher earnings,¹⁷ employers instead use the contracts as tools to reduce outside employment options.

¹¹ Consumer Financial Protection Bureau, Issue Spotlight: Consumer risks posed by employer-driven debt, (Jul. 20, 2023), <https://www.consumerfinance.gov/data-research/research-reports/issue-spotlight-consumer-risks-posed-by-employer-driven-debt/full-report> (hereinafter “CFPB Report”).

¹² HCA recently announced that it would stop using TRAPs after intense media and regulatory scrutiny. Student Borrower Protection Center, First Major Healthcare Company Commits to Stop Using TRAPs to Keep Nurses From Leaving Jobs, (May 10, 2023), <https://protectborrowers.org/first-major-healthcare-company-commits-to-stop-using-traps-to-keep-nurses-from-leaving-jobs/>.

¹³ Trapped at Work report quoting National Nurses United, Comment Submitted on Federal Trade Commission and Department of Justice Merger Enforcement No. FTC-2022-0003 (Apr. 21, 2022), <https://www.regulations.gov/comment/FTC-2022-0003-1831>.

¹⁴ CFPB Report.

¹⁵ NLRB General Counsel Memo 23-08 5, (May 30, 2023), <https://www.nlr.gov/news-outreach/news-story/nlr-general-counsel-issues-memo-on-non-competes-violating-the-national>.

¹⁶ CFPB Report..

¹⁷ *Id.*

In a recent regulatory comment, the Student Borrower Protection Center identified other examples of stay-or-pay contracts in the healthcare sector.¹⁸ When a doctor at Concentra, Inc. concluded that the job was a bad fit, he was unable to leave because his boss told him, "[w]e will make you pay" and "[t]he contract will be enforced."¹⁹ The stay-or-pay provision of the contract required that he give four months notice to quit or pay a fee that was equivalent to his salary for the remainder of that time period, which amounted to tens of thousands of dollars. During the four month period, the doctor turned down multiple job offers. The contract also included non-compete, non-solicitation, and non-disclosure clauses.

One nurse from the Philippines at Health Carousel, LLC, an international healthcare recruiting and staffing agency, learned upon starting her placement in Pennsylvania that she was paid much less than other nurses, earning only \$25.50 per hour compared to more than \$35 per hour. The nurse was troubled by the work, which she found to be brutal and often dangerous due to understaffing, and the healthcare staffing agency exerted intense control over her life: not allowing her to discuss working conditions with other staff or leave town without the agency's permission. When the nurse decided she needed to leave her job, the staffing agency, invoking the contract she had signed in the Philippines, demanded \$20,000, which she paid with money her boyfriend had been saving for years to buy a house.²⁰ Similar stories of exploitation by nurse staffing agencies are all-too-common.²¹

Restrictive employment contracts like traditional and de facto non-competes tend to produce relatively more negative impacts on women, workers of color, and workers with disabilities. These workers are generally more likely to be low-wage workers,²² who are most negatively impacted by stay-or-pay practices. In healthcare specifically, Black women are disproportionately represented in the sector and are heavily concentrated in some of its lowest-wage and most hazardous jobs²³ – precisely the types of positions for which employers use restrictive employment contracts to constrain workers. Additionally, TRAPs in healthcare are most common among new nurses and foreign-born nurses, both of which are more likely to be workers of color and women.²⁴

B. Patient safety and health

Non-compete clauses like these threaten patient health and safety in several ways. Perhaps most obviously, as the American Medical Association's Code of Medical Ethics explains, traditional non-compete clauses that restrict the ability of departing staff to work in the healthcare industry within a certain geographic area can

¹⁸ Comment from Student Borrower Protection Center to the Federal Trade Commission 4, (Apr. 19, 2023), <https://protectborrowers.org/wp-content/uploads/2023/04/FINAL-SBPC-FTC-Non-Compete-NPRM-Comment.pdf>

¹⁹ *Id.*

²⁰ Comment from Student Borrower Protection Center to the Federal Trade Commission 4, (Apr. 19, 2023), <https://protectborrowers.org/wp-content/uploads/2023/04/FINAL-SBPC-FTC-Non-Compete-NPRM-Comment.pdf>

²¹ *See generally*, Shannon Pettypiece, *Trapped at work: Immigrant health care workers can face harsh working conditions and \$100,000 lawsuits for quitting*, NBC News, (Jun. 4, 2023), <https://www.nbcnews.com/politics/economics/trapped-work-immigrant-health-care-workers-can-face-harsh-working-conditions-rcna83979>.

²² Economic Policy Institute, *Workers of color are far more likely to be paid poverty-level wages than white workers*, (Jun. 21, 2018), <https://www.epi.org/blog/workers-of-color-are-far-more-likely-to-be-paid-poverty-level-wages-than-white-workers/>; Pew Research Center, *More women than men earn the federal minimum wage*, (May 5, 2014), <https://www.pewresearch.org/short-reads/2014/05/05/more-women-than-men-earn-the-federal-minimum-wage/>; Maria Manansala, *Disabled Workers Can Be Paid Less Than \$7.25 an Hour. It's Time to Change That.*, National Partnership, (Aug. 7, 2023), <https://nationalpartnership.org/disabled-workers-paid-less-than-725-time-to-change-that/>.

²³ Janette Dill & Mignon Duffy, *Structural Racism And Black Women's Employment In The US Health Care Sector*, (Feb. 2022), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01400>.

²⁴ *Trapped at Work* report at 14.

“disrupt continuity of care[] and may limit access to care.”²⁵ A 2022 survey about the impacts of traditional non-compete clauses on patient care revealed that overwhelming majorities of the orthopedic surgeon respondents agreed that such clauses negatively affect patients.²⁶ Eighty percent of respondents agreed with this statement about traditional non-compete clauses: “I would have to abandon patients I had cared for over many years leaving their care to someone who did not know them or their surgical history as well,” and 72.6 percent of respondents agreed with this statement: “My patients would have to drive a long distance to see me at my new practice after I left due to my non-compete clause.” Congressional leaders have also taken note that “thoughtless enforcement” of non-compete clauses can interrupt patient care.²⁷

The immobilizing effects that the clauses have on healthcare workers also lead to worse conditions for patients. These clauses limit employees’ ability to exit a job, raising the stakes of termination or quitting, and depriving them of leverage to raise concerns about workplace conditions.²⁸ In many cases, the monetary sum that workers would have to pay out to their employer in the event of resignation or termination is prohibitively large. For example, the Department of Labor recently filed a complaint under the Fair Labor Standards Act, alleging that the liquidated damages provision utilized by a healthcare staffing agency would have required its FEN employee to repay all income that he grossed during the entirety of his employment, thus depriving him of the statutorily mandated minimum wage.²⁹ Even where such contractual provisions are not enforced, or are not legally enforceable, they have an *in terrorem* effect, and their mere existence may pressure workers into staying in an otherwise unacceptable job.³⁰ For example, one nurse decided to return to their job after the hospital sent a post-resignation letter demanding that the nurse either pay the hospital \$18,000 or return to work and complete the two-year/4,000 hour requirement.³¹

As the National Nurses Union (“NNU”) explained in a comment to the Consumer Financial Protection Bureau, “when employers hold nurses hostage as debtors, it makes it difficult for nurses to speak out about unsafe working conditions and to advocate for their patients to ensure they receive safe and effective nursing care.”³² In survey comments and interviews with National Nurses United, registered nurses frequently reported “being required to work in units that had dangerously low nurse-to-patient ratios.”³³ The employee in the DOL complaint referenced above, for example, wanted to quit largely because of concerns about patient safety, which he raised with his employer to no avail. He eventually “grew deeply concerned that he

²⁵ American Medical Association Code of Medical Ethics, Opinion 11.2.3.1 Restrictive Covenants, (Accessed: May 31, 2023), <https://code-medical-ethics.ama-assn.org/ethics-opinions/restrictive-covenants>.

²⁶ Orthopedic Survey at 10.

²⁷ Letter from Senators Warren and Murphy to the Federal Trade Commission 3, (Jul. 22, 2020), [https://www.warren.senate.gov/imo/media/doc/2020.07.22%20Letter%20to%20FTC%20on%20Non-Competes%20\(1\).pdf](https://www.warren.senate.gov/imo/media/doc/2020.07.22%20Letter%20to%20FTC%20on%20Non-Competes%20(1).pdf).

²⁸ National Labor Relations Board, NLRB General Counsel Issues Memo on Non-compete Violating the National Labor Relations Act, (May 30, 2023), <https://www.nlr.gov/news-outreach/news-story/nlr-general-counsel-issues-memo-on-non-competes-violating-the-national> (explaining that non-competes chill employees’ ability to leave their jobs).

²⁹ Complaint, *Department of Labor v. Advanced Care Staffing, LLC*, et. al at 8, (Mar. 20, 2023), <https://www.dol.gov/sites/dolgov/files/OPA/newsreleases/2023/03/23-481-NAT.Su%20v.%20Advanced%20Care%20Staffing%20%26%20Sam%20Klein%20complaint.pdf> (hereinafter “DOL complaint”).

³⁰ CFPB Report; see also *Stein v. HHGREGG, Inc.*, 873 F.3d 523 (6th Cir. 2017) quoting *Mich. Ass’n of Governmental Emps. v. Mich. Dep’t of Corr.*, 992 F.2d 82, 86 (6th Cir. 1993) (in the context of an unenforced commission policy, explaining that unenforced policies or unenforceable debts can have significant practical effects on how people live: “[s]imply because a [policy] has never been applied does not mean that the employee has not been affected by the policy”).

³¹ CFPB Report.

³² NNU Comment at 2; see also Shannon Pettypiece, *‘Indentured servitude’: Nurses hit with hefty debt when trying to leave hospitals*, NBC News, (Mar. 12, 2023), <https://www.nbcnews.com/politics/economics/indentured-servitude-nurses-hit-hefty-debt-trying-leave-hospitals-rcna74204> (quoting a regulatory policy specialist at National Nurses United who stated, “[h]aving that debt hanging over them means that nurses have a harder time advocating for safe conditions for themselves and their patients.”)

³³ *Id.* at 14.

could not meet his ethical and professional responsibilities under [his employer's] working conditions, including a heavy patient load that he believed in good faith did not permit him to provide adequate patient care” and began suffering physical and mental health harms from his employment.³⁴ An SEIU regulatory comment identified the University of Pittsburgh Medical Center as a healthcare employer that has a “well-documented history of retaliating against workers” who speak up about workplace issues, but explained that workers would be less able to speak up about working conditions because of the stay-or-pay provisions in their employment contracts.³⁵

Trapping workers in toxic working conditions can also contribute to burnout. Burnout and toxic work environments for medical workers have been found to increase rates of medical error.³⁶ As one surgeon respondent put it in a survey about non-compete clauses in their field: “[s]urgeons who remain in unhealthy orthopaedic groups/practices cannot emotionally or psychologically be their best versions.”³⁷ One nurse interviewed by NBC News, who ended up quitting despite her \$2,000 TRAP, reported that she “didn’t even have time to take a lunch break, [her] hair was falling out, the level of stress just wasn’t sustainable.”³⁸ Another explained that she quit because she was afraid her working conditions would cause her to accidentally harm a patient, but most of her colleagues remained in their jobs because of the debt scheme.

Finally, non-compete clauses can negatively impact patient safety and health through their effects on prices for healthcare services. A 2021 study examined the relationship between the enforceability of non-compete clauses in the healthcare industry, as modulated by state legislation, and healthcare prices. The authors found that increased enforceability of non-compete clauses is associated with increased final good prices.³⁹ Higher prices for healthcare leads to higher out-of-pocket costs for patients. This can exacerbate financial insecurity, which is linked to worse health outcomes.⁴⁰ While Medicare and Medicaid enrollees may be protected from such prices through their insurance programs, most privately insured and all uninsured patients are not, leaving millions unprotected when receiving care. Moreover, Medicare and Medicaid patients could nonetheless be affected if a privately insured or uninsured family member encounters higher healthcare prices, or because of “churning” between private health insurance, uninsured status, and the Medicare and Medicaid programs, based on income and other eligibility criteria.⁴¹

III. Current State

³⁴ DOL Complaint at 8.

³⁵ Comment from Service Employees International Union to the Consumer Financial Protection Bureau 2, (Sept. 23, 2022), <https://www.regulations.gov/comment/CFPB-2022-0038-0051>.

³⁶ John Commins, *Workplace Culture Could Drive Physician Burnout, Medical Errors*, HealthLeaders, (Jul. 12, 2018), <https://www.healthleadersmedia.com/clinical-care/workplace-culture-could-drive-physician-burnout-medical-errors>; American Association of Critical-Care Nurses, *Well-Being, Work Environment Affect Medical Errors*, (May 4, 2021), <https://www.aacn.org/newsroom/well-being-work-environment-affect-medical-errors>; Alison Motluk, *Do doctors experiencing burnout make more errors?*, (Accessed: May 31, 2023), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6175626/>.

³⁷ Orthopedic Survey at 9.

³⁸ Shannon Pettypiece, *'Indentured servitude': Nurses hit with hefty debt when trying to leave hospitals*, NBC News, (Mar. 12, 2023), <https://www.nbcnews.com/politics/economics/indentured-servitude-nurses-hit-hefty-debt-trying-leave-hospitals-rcna74204>.

³⁹ Federal Trade Commission, Non-Compete Clause Proposed Rule, 88 Fed. Reg. 3482, 3490 (Jan. 19, 2023) citing Naomi Hausman & Kurt Lavetti, *Physician Practice Organization and Negotiated Prices: Evidence from State Law Changes*, 13 a.m. Econ. J. Applied Econ. 258, 284 (2021).

⁴⁰ Emily Brown Weida, et. al., *Financial health as a measurable social determinant of health*, PLoS One. 2020; 15(5): e0233359, (May 18, 2020), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0233359>.

⁴¹ Anna L. Goldman & Benjamin D. Sommers, “Among Low-Income Adults Enrolled in Medicaid, Churning Decreased After the Affordable Care Act,” *Health Affairs* 39(1) (summarizing the current literature on the impact of churning and noting that those who experience churn and other coverage disruptions are more likely to delay care, receive less preventive care, refill prescriptions less often, and increase the number of emergency department visits).

Advocacy efforts around ending non-compete clauses in healthcare have accelerated in recent years in response to the increased use of such anticompetitive practices in the industry. Additionally, the decline of physician-owned practices means that more physicians practice as employees who are increasingly subject to restrictive covenants on their employment.

NNU has led regulatory advocacy against stay-or-pay contracts in the healthcare sector. As noted above, in a comment in response to the CFPB's request for information on employer-driven debt practices, the union detailed the results of its survey of registered nurses on the subject.⁴² The comment explained how employer-driven debt arrangements like TRAPs create unsafe and unfair conditions for nurses and their patients, and identified other troublesome employer practices in the industry. NNU also submitted a comment on a FTC and DOJ merger enforcement request for information asking the agencies to consider the “emergence of coercive employment contracts, including nurse training repayment agreements.”⁴³

Congressional leaders, too, have made calls for federal agencies to consider how anti-competitive employment contracts may run afoul of existing laws. For example, Senators Warren, Brown, and Murray sent a letter to the CFPB asking the Bureau to investigate and regulate TRAPs which, they explained, “raise significant concerns about consumer and worker protection.”⁴⁴

There has been some enforcement and potential regulation of non-compete clauses at other federal agencies, but no such regulation from CMS. For example, the FTC has proposed to ban traditional and some forms of de facto non-compete contracts in a forthcoming rule.⁴⁵ However, the FTC does not traditionally enforce antitrust laws against anticompetitive practices of most nonprofit entities. Almost half of all hospitals are technically not-for-profit.⁴⁶ Additionally, the DOL's recently filed lawsuit reference above was based on minimum wage and overtime laws.⁴⁷ However, even if the DOL had the resources to vigorously go after each instance in which anti-competitive contracts caused employers to violate the FLSA, many healthcare workers may earn too much to fall within the law's bare-minimum protections.

IV. Proposed Action

A. Legal authority

An HHS CoP regulation banning non-compete clauses for any worker in facilities that receive Medicare or Medicaid funds would be on firm legal footing, based on the applicable statute, regulatory history, and case law.

1. Statutory authority

HHS has the authority to make this change under Section 1861(e) of the Social Security Act. Section 1861(e) authorizes the Department to update its Medicare CoPs for hospitals as needed, granting broad authority to the Secretary to adopt “such other requirements” that they “find[] necessary in the interest of the health and

⁴² NNU Comment.

⁴³ National Nurses United comment on Federal Trade Commission and Department of Justice Request for Information 14, (Apr. 21, 2022), <https://www.regulations.gov/comment/FTC-2022-0003-1831>.

⁴⁴ U.S. Senate Committee on Banking, Housing, and Urban Affairs, *Brown, Murray, Colleagues Urge Investigation of Training Repayment Agreements Saddling Workers With Debt*, (Apr. 21, 2022), <https://www.banking.senate.gov/newsroom/majority/brown-murray-colleagues-investigation-training-repayment-agreements-workers-debt>.

⁴⁵ Federal Trade Commission, Non-Compete Clause Proposed Rule, 88 Fed. Reg. 3482 (Jan. 19, 2023).

⁴⁶ See American Hosp. Ass'n, Fast Facts on U.S Hospitals, (2019), <https://www.aha.org/statistics/fast-facts-ushospitals>.

⁴⁷ Department of Labor, *Department Of Labor Seeks Court Order To Stop Brooklyn Staffing Agency From Demanding Employees Stay 3 Years Or Repay Wages*, (Mar. 20, 2023), <https://www.dol.gov/newsroom/releases/sol/sol20230320>.

safety of individuals who are furnished services in the institution.”⁴⁸ Hospitals that receive Medicaid payments must also meet Medicare CoPs.⁴⁹

Additionally, 42 U.S.C. § 1302(a) authorizes CMS to “publish such rules and regulations ... as may be necessary to the efficient administration of the [agency's] functions.” And 42 U.S.C. § 1395hh(a)(1) authorizes CMS to “prescribe such regulations as may be necessary to carry out the administration of the insurance programs” under the health insurance sections of the Social Security Act, as amended.

While the CoPs proposed in this memorandum do tend to benefit Medicare and Medicaid beneficiaries, the fact that they also protect the “interest of the health and safety of” non-Medicare or Medicaid patients provides yet another reason that CMS possesses the statutory authority to issue these regulations. CoP regulations are valid even if they tend to benefit patients that are not enrolled in Medicare or Medicaid more than those that are. There is no statutory limitation that requires a CoP to explicitly benefit Medicare or Medicaid patients. As stated above, HHS’s authority to set facility-level policy stems from Section 1861(e)(9), which allows new CoPs that are “in the interest of the health and safety of *individuals who are furnished services in the institution*” (emphasis added). This gives the Department the authority to adopt CoPs that improve the health, safety, and well-being of hospital patients in general, without requiring a CoP to benefit Medicare patients explicitly. Further, Medicare CoPs apply on a facility-wide basis and thus extend to all patients, regardless of insurance status or payment source. Implementing regulations for prior CoPs on visitation rights, for instance, confirmed that these protections apply to all patients, regardless of payor.⁵⁰

2. Scope of authority and regulatory history

Issuing CoPs for facilities that participate in the Medicare and Medicaid programs is a long-standing practice for HHS.⁵¹ In fact, the first CoPs were developed and issued in 1966, mere months following the passage of the statute that authorized creation of the Medicare and Medicaid programs.⁵² Since the 1960s, HHS has issued CoPs for participating facilities that define myriad requirements relating to governing bodies, medical staff, nursing services, and many other aspects of administration and care.⁵³

Regulations implementing Medicare CoPs for hospitals have been in place since at least 1966 and updated regularly over time. CoPs have been revised in response to, for instance, new technological advances like telehealth,⁵⁴ a broader recognition of patient rights,⁵⁵ the need to modernize definitions of family,⁵⁶ and new organizational models like multi-hospital systems.⁵⁷ HHS has also routinely used its authority to issue CoPs that relate to staffing issues and employee management generally.⁵⁸

⁴⁸ 42 U.S.C. § 1395x(e)(9); *see also* 42 C.F.R. § 482.1(a)(1)(ii) (“The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals.”).

⁴⁹ 42 U.S.C. § 1396d; 42 C.F.R. § 440.10(a)(3)(iii).

⁵⁰ *See, e.g.*, 75 Fed. Reg. at 70835 (“This applies to all patients, regardless of their payment source.”)

⁵¹ *Biden v. Missouri*, 142 S. Ct. 647, 652 (2022) (noting “the longstanding practice of Health and Human Services in implementing” the statute that authorizes CoPs).

⁵² Lohr KN, editor, Institute of Medicine (US) Committee to Design a Strategy for Quality Review and Assurance in Medicare, Medicare: A Strategy for Quality Assurance: Volume 1 Ch. 5 (1990), <https://www.ncbi.nlm.nih.gov/books/NBK235451/>.

⁵³ *See, e.g., id.* at Table 5.1; *see generally* 42 C.F.R. Subchapter G “Standards and Certification.”

⁵⁴ *See, e.g.*, 76 Fed. Reg. 25550-65 (May 5, 2011) (adopting a new credentialing and privileging process for physicians and practitioners providing telemedicine services).

⁵⁵ *See, e.g.*, 71 Fed. Reg. 71378-428 (Dec. 8, 2006) (setting forth requirements for patients’ rights in hospitals related to issues such as restraints, seclusion, and monitoring).

⁵⁶ *See* 75 Fed. Reg. 70831-44 (Nov. 19, 2010) (requiring hospitals to ensure visitation rights for all patients, including same-sex spouses and chosen family members).

⁵⁷ *See, e.g.*, 79 Fed. Reg. 27106, 27112-17 (May 12, 2014) (updating CoPs regarding governing body consultation and membership requirements for multi-hospital systems).

⁵⁸ *See, e.g.*, 42 C.F.R. § 482.12(a)(6), 482.23.

The Supreme Court recently considered the scope of the Secretary’s authority to set Medicare CoPs in *Biden v. Missouri*.⁵⁹ In that case, several states challenged HHS’s interim final rule imposing a CoP that required many healthcare workers in Medicare-participating facilities to receive the COVID-19 vaccine.⁶⁰ The states argued, and the dissenting justices agreed, that the scope of the Secretary’s CoP authority was limited to “bureaucratic rules regarding the technical administration of Medicare and Medicaid.”⁶¹ Under that “narrower view,” the vaccine mandate would fail.

The Court disagreed in a 5-4 decision, explaining that CoPs have always been more than technical rules. Instead, the Court pointed to a “host of conditions that address the safe and effective provision of healthcare, not simply sound accounting.”⁶² The Court found that the vaccine mandate “fit[] neatly within the language of the statute” in part because ensuring that medical providers avoid passing dangerous viruses to their patients “is consistent with the fundamental principle of the medical profession: first, do no harm.”⁶³

In a key passage, the Court addressed HHS’s authority to impose conditions related to healthcare workers:

Moreover, the Secretary routinely imposes conditions of participation that relate to the qualifications and duties of healthcare workers themselves. *See, e.g.*, §§ 482.42(c) (2)(iv) (requiring training of “hospital personnel and staff” on “infection prevention and control guidelines”), 483.60(a)(1)(ii) (qualified dietitians must have completed at least 900 hours of supervised practice), 482.26(b)–(c) (specifying personnel authorized to use radiologic equipment). And the Secretary has always justified these sorts of requirements by citing his authorities to protect patient health and safety. *See, e.g.*, §§ 482.1(a)(1)(ii), 483.1(a)(1)(ii), 416.1(a)(1). As these examples illustrate, the Secretary’s role in administering Medicare and Medicaid goes far beyond that of a mere bookkeeper.⁶⁴

Acknowledging that the vaccine mandate was unprecedented, the Court explained that the Department never had to grapple with a “problem of this scale and scope before.”⁶⁵

Additional existing CoPs that the Supreme Court did not mention but also relate to either the qualifications and duties of healthcare workers or what hospitals can or must do as employers include:⁶⁶ 42 C.F.R. § 482.12(a)(6), which requires the hospital’s governing body to “[e]nsure the criteria for selection [of medical staff] are individual character, competence, training, experience, and judgment;” and 42 C.F.R. § 482.23, which requires hospitals to have “adequate numbers of” nurses and enough staff to ensure “the immediate availability of a registered nurse for the care of any patient.”⁶⁷

3. Legal policy justification

A CoP rule that disallows or otherwise regulates non-compete clauses for healthcare workers would be well in line with the “conditions of participation that relate to the qualifications and duties of healthcare workers”

⁵⁹ 142 S. Ct. 647 (2022)

⁶⁰ *Id.* at 651.

⁶¹ *Id.* at 652.

⁶² *Id.* at 652.

⁶³ *Id.* at 652.

⁶⁴ *Id.* at 653.

⁶⁵ *Id.* at 652.

⁶⁶ But are not limited to—there are many others.

⁶⁷ It is also important to note, given the changing nature of the healthcare labor landscape, that these rules extend not just to employees, but to workers that work in the facilities due to other arrangements like contracting or volunteering. For example, the hospital CoPs that require adequate nursing services explicitly require that a director of nursing services of a Medicare hospital “must provide for the adequate supervision and evaluation of the clinical activities of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).”

that the Supreme Court identified as within the scope of the Secretary’s CoP-setting authority “in the interest of the health and safety” of patients. There are several justifications that the Secretary could use in setting a CoP regulating these contracts. Generally, hospitals use these contracts to prevent workers from leaving instead of improving deteriorated working and patient conditions that threaten patient safety and health. Specifically:

- Non-compete clauses can threaten the health and safety of patients by disrupting continuity of care and limiting patient access to familiar care. As described in the Justification section, non-compete clauses that restrict workers from working in the healthcare industry in a particular geographic area and/or timeframe can cause patients to lose contact with the personnel that best knows their medical histories.
- Non-compete clauses can threaten the health and safety of patients by preventing workers from speaking up about dangerous conditions that harm patient well-being. Because of the heightened stakes of quitting or being fired,⁶⁸ healthcare workers may be more hesitant to advocate to ensure safe conditions for patients.⁶⁹ For example, a survey of nurses conducted by NNU identified “nurses [who] reported being required to work in units that had dangerously low nurse-to-patient ratios” but felt “constrained in their ability to complain or leave” because of their employer-created debts.⁷⁰ Research about unionization among nurses identifies worker voice as a factor that benefits patient safety.⁷¹ Surveys of physicians reveal that traditional non-compete clauses also have this effect. 60 percent of surgeon respondents in one survey agreed with this statement: “I would have to give substandard patient care because my non-compete prevents me from leaving my job and remaining in the area my family wishes to live.”⁷²
- Non-compete clauses can threaten the health and safety of patients by creating toxic work environments and increasing medical error. A hospital staffed with personnel who would prefer to

⁶⁸ Many TRAPs, for example, require repayment upon early separation regardless of whether the employee quits or is fired. *See, e.g.*, Student Borrower Protection Center, Trapped at Work 23, (July 2022), https://protectborrowers.org/wp-content/uploads/2022/07/Trapped-at-Work_Final.pdf (explaining Chipotle’s TRAP, which applied in cases of voluntary *and* involuntary termination).

⁶⁹ *See* NNU Comment at 2 (explaining that “when employers hold nurses hostage as debtors, it makes it difficult for nurses to speak out about unsafe working conditions and to advocate for their patients to ensure they receive safe and effective nursing care”); *see also* Shannon Pettypiece, *‘Indentured servitude’: Nurses hit with hefty debt when trying to leave hospitals*, NBC News, (Mar. 12, 2023), <https://www.nbcnews.com/politics/economics/indentured-servitude-nurses-hit-hefty-debt-trying-leave-hospitals-rcna74204> (quoting a regulatory policy specialist at National Nurses United who stated, “[h]aving that debt hanging over them means that nurses have a harder time advocating for safe conditions for themselves and their patients.”)

⁷⁰ *Id.*

⁷¹ Arindrajit Dube, et. al, Nurse Unions and Patient Outcomes, ILR Review 69(4) 828, (Aug. 2016), <https://www.nationalnursesunited.org/sites/default/files/nnu/files/pdf/Nurse%20Unions%20and%20Patient%20Outcomes.pdf>.

⁷² Orthopedic Survey at 10; *see also* Shannon Pettypiece, *Biden’s push to ban noncompete agreements could have big implications for health care*, (Feb. 13, 2023), <https://www.nbcnews.com/politics/economics/biden-ban-non-compete-agreements-health-care-industry-rcna70099> (Quoting an emergency medicine doctor that explained, “When you tie in a noncompete that says if I’m fired I can’t work within a 100-mile radius, that means I’m going to have to take my kids out of school, move my entire family or I’m going to have to live in a hotel and not see my family when I’m working . . . [i]t has a real chilling effect on physicians’ willingness to speak out about unethical or unfair practices.”); *see also* <https://www.regulations.gov/comment/FTC-2023-0007-14443> (“the combination of noncompete clauses with a lack of due process, is a powerful malignant force serving to intimidate physicians against speaking out for patient rights. The recent COVID pandemic has provided multiple examples of physicians being fired, removed from the schedule, or otherwise relegated for speaking out about patient safety issues. The goal of noncompete clauses is to intimidate the emergency physician into unquestioning servitude to business interests. Given physicians’ ethical obligation to patients, many continue to speak out for patient safety; however, knowing that they can be fired at will and then forced to relocate their family to another city or state can have a chilling effect on physicians advocacy for patients”).

not work for their employer - but are doing so under financial duress - may be less conducive to safe and healthy conditions for patients. As one surgeon respondent put it in a survey about non-compete clauses in their field: “[s]urgeons who remain in unhealthy orthopaedic groups/practices cannot emotionally or psychologically be their best versions.”⁷³ Burnout and toxic work environments for medical workers has been found to increase rates of medical error.⁷⁴

- De facto non-compete clauses like TRAPs are not necessary to maintain staffing levels. Employers might argue that doing away with stay-or-pay contracts like TRAPs will make them unable to retain adequate staffing levels to satisfy other CoPs that they must fulfill. However, coercive contractual arrangements are not the way to ensure retention. Health care professionals compelled to stay in unsafe working conditions through debt traps often leave as soon as the contract is over, if not sooner. Employers can retain workers by creating good jobs where they can care for their patients safely. Indeed, the largest for-profit healthcare system in the world announced recently that it would stop using TRAPs to retain its staff.⁷⁵
- Non-compete clauses harm all patients through poorer health outcomes caused by financial insecurity. Non-compete clauses have been shown to increase healthcare prices. Increased healthcare prices causes financial insecurity linked to poorer health outcomes. This threatens the health and safety of uninsured patients and those whose insurance plans include cost-sharing. Further, increased healthcare prices affect the health and safety of Medicare and Medicaid beneficiaries because of financial instability within mixed-insurance status households and the significant rate of churn between Medicare, Medicaid, private insurance, and self-pay statuses.

The relationship between restrictive employment contracts and patient safety and health, explained above, could support a finding by the Secretary that banning traditional and de facto non-compete clauses is “necessary in the interest of the health and safety of individuals who are furnished services” in facilities that accept Medicare and Medicaid funding.⁷⁶ Such a regulation would be a natural addition to the “host of conditions that address the safe and effective provision of healthcare.”⁷⁷

In order to survive arbitrary and capricious review, such justifications would need to be based on empirical evidence from research and comments in the rulemaking record. For example, in proposing a CoP that required open visitation rights in Medicare facilities, HHS cited a study published in the *Journal of the American Medical Association*, which contained a literature review and anecdotal evidence about how open visitation “may help [patients] by providing a support system and shaping a more familiar environment as they engender trust in families, creating a better working relationship between hospital staff and family members.”⁷⁸

B. Issue a new CoP via notice-and-comment rulemaking

⁷³ Orthopedic Survey at 9.

⁷⁴ John Commins, *Workplace Culture Could Drive Physician Burnout, Medical Errors*, HealthLeaders, (Jul. 12, 2018), <https://www.healthleadersmedia.com/clinical-care/workplace-culture-could-drive-physician-burnout-medical-errors>; American Association of Critical-Care Nurses, *Well-Being, Work Environment Affect Medical Errors*, (May 4, 2021), <https://www.aacn.org/newsroom/well-being-work-environment-affect-medical-errors>; Alison Motluk, *Do doctors experiencing burnout make more errors?*, (Accessed: May 31, 2023), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6175626/>.

⁷⁵ Although that does not necessarily mean that the healthcare giant is giving up on employer-driven debt altogether – they could shift to prepaid signing bonuses with restrictive repayment terms. Sarah Falcone, *HCA Ends TRAPs Forcing Nurses To Repay Training Costs*, (May 19, 2023), <https://nurse.org/articles/HCA-ends-nurse-training-repayment-contracts/>.

⁷⁶ 42 U.S.C. § 1395x(e)(9); see also 42 C.F.R. § 482.1(a)(1)(ii) (“The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals.”).

⁷⁷ *Biden*, 142 S. Ct. at 652.

⁷⁸ 75 Fed. Reg. 36612 (internal quotation omitted).

We recommend that the Department use standard notice-and-comment rulemaking procedures by issuing a notice of proposed rulemaking, accepting public comment for 60 days, and then issuing a final rule. A 60-day comment period is appropriate given the stakeholder interest that this proposal will generate, and is in line with past practice: the Obama administration provided a 60-day comment period on a 2010 proposal to update Medicare CoPs to provide equal visitation rights for LGBT families.⁷⁹ Because this rule will affect market dynamics and contract negotiations between physicians, hospitals, nurses, and other workers, we recommend an effective date that balances the need to quickly protect patients while providing time for stakeholders to operationalize adjustments as needed.⁸⁰

The new CoP should prohibit a participating health care organization, or any parent, subsidiary, or third-party agent or company (including staffing agencies), from use of any contract or contract term that includes a non-compete clause or requires a health care worker to pay for a debt if the health care worker's employment or work relationship with a specific health care employer is terminated.

V. Conclusion

Healthcare employers are deploying noncompetes and stay-or-pay contracts to trap workers in poor working conditions that create risks to patient health and safety. CMS should use its COP authority to issue regulations banning these practices among healthcare facility employers that accept Medicare and Medicaid funds.

⁷⁹ The proposed visitation rule was published on June 28, 2010 (with a 60-day comment period), and the final rule was published on November 19, 2010. *See* 75 Fed. Reg. at 70831; 75 Fed. Reg. 36610-15 (Jun. 28, 2010).

⁸⁰ As a point of comparison, the Trump administration finalized a rule to require hospitals to publicly disclose negotiated rates. The proposed rule, issued in late July 2019, included an effective date of January 1, 2020, which was ultimately delayed in the final rule to January 1, 2021. *See* 84 Fed. Reg. 65524, 65585-86 (Nov. 27, 2019).