tribal businesses' ability to retain skilled workers is impacted. The Commission declines to categorically exclude tribes or tribal businesses from coverage under the final rule. The FTC Act is a law of general applicability that applies to Indians, Indian Tribes, and tribal businesses.[933] The Commission recognizes, however, that in some instances these entities may be organized in such a way that they are outside the Commission's jurisdiction.[934] Whether a given Tribe or tribal business is a corporation within the FTC Act will be a fact-dependent inquiry. The Commission is aware of no evidence suggesting that the final rule would disproportionately impact tribes or tribal businesses.[935]

5. Coverage of Healthcare Industry

Many commenters representing healthcare organizations and industry trade associations stated that the Commission should exclude some or all of the healthcare industry from the rule because they believe it is uniquely situated in various ways. The Commission declines to adopt an exception specifically for the healthcare industry. The Commission is not persuaded that the healthcare industry is uniquely situated in a way that justifies an exemption from the final rule. The Commission finds use of non-competes to be an unfair method of competition that tends to negatively affect labor and product and services markets, including in this vital industry; the

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[933] *See Fed. Power Comm'n v. Tuscarora Indian Nation,* 362 U.S. 99, 116-17 (1960) (examining case law supporting the conclusion that "a general statute in terms applying to all persons includes Indians and their property interests"); *FTC v. AMG Servs., Inc.*, No. 2:12-CV-00536-GMN, 2013 WL 7870795, at *16-*21 (D. Nev. July 16, 2013), *report and recommendation adopted,* No. 2:12-CV-00536-GMN, 2014 WL 910302 (D. Nev. Mar. 7, 2014) (discussing the FTC Act's applicability to Indian Tribes and tribal businesses).

[934] *See, e.g.*, *AMG Servs.*, 2013 WL 7870795, at *22 (finding genuine dispute of material fact barring summary judgment on question of whether tribal chartered corporations were corporations under the FTC Act).

[935] The commenter also asked the Commission to engage Indian tribes about the proposed rule, citing Executive Order 13175. However, the Commission notes that Executive Order 13175, which requires consultation with Indian Tribes before promulgating certain rules, does not apply to independent regulatory agencies such as the Commission. E.O. No. 13175, 65 FR 67249 (Nov. 6, 2000) (stating that the term "agency," which governs the applicability of the executive order, excludes agencies "considered to be independent regulatory agencies, as defined in 44 U.S.C. 3502(5)"); 44 U.S.C. 3502(5) (listing the Commission as an "independent regulatory agency"). The Commission did, however, provide extensive opportunities for public input from any and all stakeholders, including a 120-day comment period (extended from 90 days) and a public forum held on February 16, 2023, that provided an opportunity to directly share experiences with non-competes.

Commission also specifically finds that non-competes increase healthcare costs. Moreover, the Commission is unconvinced that prohibiting the use of non-competes in the healthcare industry will have the claimed negative effects.

a. Comments Received

Many business and trade industry commenters from the healthcare industry seeking an exception, including, for example, hospitals, physician practices, and surgery centers, focused on whether the Commission has jurisdiction to regulate nonprofit entities registered under section 501(c) of the Internal Revenue Code. The Commission addresses its jurisdiction in Part II.E and considers comments related to requests for an industry-based exclusion for all or part of the healthcare industry in this section. As stated in Part II.E, entities claiming tax exempt status are not categorically beyond the Commission's jurisdiction, but the Commission recognizes that not all entities in the healthcare industry fall under its jurisdiction.

Based on the assumption that entities claiming tax-exempt status as nonprofits and publicly owned healthcare organizations would be exempt, many industry commenters contended that for-profit healthcare organizations must be also exempted from the rule as a matter of equal treatment. Commenters cited data from the American Hospital Association (AHA) indicating that as many as 58% of all U.S. hospital systems claim tax-exempt status as nonprofits, 24% are for-profit hospitals, and 19% are State and local government hospitals. One commenter cited AHA data indicating that 78.8% of for-profit hospitals are located in the same Hospital Referral Region (HRR) as at least one entity that claims tax-exempt status as a nonprofit. Many commenters argued that for-profit entities and entities that claim nonprofit status compete for patients, physician and non-physician staff, and market share. These commenters contended that a rule covering only for-profit healthcare entities will distort the

market in favor of entities claiming tax-exempt status as nonprofits, which would continue using non-competes. One commenter identifying as an entity claiming nonprofit tax-exempt status argued that such entities need to rely on non-competes to compete with for-profit competitors because, unlike for-profit health systems, they invest significantly in specialized training and mentorship, and offer a guaranteed minimum salary to recent graduates.

Some commenters contended that favoring entities claiming tax-exempt status as nonprofits would have negative effects. Some commenters argued that disparate coverage under the rule may exacerbate consolidation in the healthcare industry by advantaging entities that claim tax-exempt status as nonprofits. They stated that increased consolidation would reduce the available supply of skilled labor for for-profit hospitals, increasing labor costs and contributing to higher prices paid by patients. Commenters noted a trend in physicians increasingly leaving private practice to work at large hospital groups claiming tax-exempt status as nonprofits, which, they contended, may continue to lock those physicians up using non-competes. Industry commenters also argued that insurance premiums will rise more than they would absent the rule because of the greater market power and resulting leverage of entities that claim tax-exempt status as nonprofits in provider network negotiations. One manufacturing industry association commenter argued that the burden of rising premiums will be passed on to manufacturers who provide health insurance to their employees.

Commenters also argued that a rule covering for-profit healthcare providers would cause independent, physician-owned practices, and small community practices to suffer a competitive disadvantage compared to larger entities that claim tax-exempt status as nonprofits and public hospital groups, reducing the number of these practices and interrupting continuity of care for their patients. Commenters stated that such practices will suffer these consequences acutely in

States or localities that are particularly saturated with entities that claim tax-exempt status as nonprofits or exempt State or local hospitals, and cited New York and Mississippi as examples. A commenter claimed that public hospitals regulated by the Commission will incur losses because of their reduced ability to hire and retain physicians that perform profitable procedures. One commenter cited a 1996 Commission study to contend that, all else equal, hospitals that claim tax-exempt status as nonprofits set higher prices when they have more market power. A business commenter contended that, given what they considered a large-scale exemption of certain physician employers from the Commission's jurisdiction, the States are more appropriate regulators of non-competes between physicians and employers. Other commenters claimed that the Commission must further study the consequences of differential treatment.

Conversely, many commenters vociferously opposed exempting entities that claim tax-exempt status as nonprofits from coverage under the final rule. Several commenters contended that, in practice, many entities that claim tax-exempt status as nonprofits are in fact "organized to carry on business for [their] own profit or that of [their] members" such that they are "corporations" under the FTC Act. These commenters cited reports by investigative journalists to contend that some hospitals claiming tax-exempt status as nonprofits have excess revenue and operate like for-profit entities. A few commenters stated that consolidation in the healthcare industry is largely driven by entities that claim tax-exempt status as nonprofits as opposed to their for-profit competitors, which are sometimes forced to consolidate to compete with the larger hospital groups that claim tax-exempt status as nonprofits. Commenters also contended that many hospitals claiming tax-exempt status as nonprofits use self-serving interpretations of the IRS's "community benefit" standard to fulfill requirements for tax exemption, suggesting that the best way to address unfairness and consolidation in the healthcare industry is to strictly

enforce the IRS's standards and to remove the tax-exempt status of organizations that do not comply. An academic commenter argued that the distinction between for-profit hospitals and nonprofit hospitals has become less clear over time, and that the Commission should presumptively treat hospitals claiming nonprofit tax-exempt status as operating for profit unless they can establish that they fall outside of the Commission's jurisdiction.

The Commission also received many comments about coverage of the health care sector generally under the rule. Some commenters urged the Commission to ensure that health care workers, including doctors and physicians, were covered by the final rule. Several commenters stated that eliminating non-competes would allow doctors wishing to change jobs to stay in the same geographic area, fostering patient choice and improving continuity of care. Other commenters urged the Commission to create an exception for health care workers. Some argued that the evidence does not support the Commission's conclusion that non-competes depress earnings in health care. Other reasons commenters cited in support of an exception included concerns about continuity and quality of care for patients, the increased costs for employers of health care workers, physicians' negotiating power with their employers, and the effect on incentives for employers to train their health care workers.[936]

Thousands of healthcare workers submitted comments supporting a ban on non-competes. Worker commenters did not always identify whether they were working at for-profit organizations, entities that claim tax-exempt status as nonprofits, or State or local healthcare organizations, but each category was represented in the comments. These commenters detailed the negative effects of non-competes on their families, their mental health, their financial health,

[936] Some commenters also contended that the health care industry should be exempt from the rule because many health care providers fall outside of the Commission's jurisdiction. The Commission summarizes and responds to those commenters in Part II.E.2.

and their career advancement, as elaborated in Part IV.B.2.b.ii. Specifically, healthcare workers commented that because non-competes prohibited them from switching jobs or starting their own businesses, they had to stay at jobs with unsafe and hostile working conditions, to take jobs with long commutes, to relocate their families, to give up training opportunities, and to abandon patients who wanted to continue seeing them. Illustrative comments are highlighted in Parts I and IV.

Additionally, commenters stated the hardship patients have suffered because of non-competes when, for example, their physician was required to move out of their area to work for a different employer. The Commission highlights some of these comments in Part IV.B.2.b.ii and includes two further illustrative comments here:

- As a patient, non compete clauses are affecting mine and my [family's] ability to receive medical care. Our pediatrician left a practice and we aren't able to be informed where they are going. When we find out, it is an hour away [because] of the non compete. And when we look for other [doctors] closer they aren't accepting new patients. So for an entire year we are driving 2 [hours] round trip to see our pediatrician until they can move back to a local medical group. The non compete clause is not just affecting the life of the [doctor], but is also impacting many of us who rely on their services.[937]
- As a family physician this has caused much grief and obstructs my desire to work and provide care for underserved populations. I am a NHSC scholarship recipient and due to non compete clauses was unable to continue working in the town I served due to its rurality. This created a maternity desert in the region I served. Now in a more metropolitan area, there has been an exodus of physicians in the area due to non compete clauses that has caused worsening access to primary care, specialty services, including behavioral health and substance use disorder treatment.[938]

A number of physician group commenters stated that nonprofit healthcare organizations regularly impose non-competes on physicians, and that the impact of the rule would be limited if nonprofits are not required to comply. Some physician group commenters urged the Commission to work with other agencies to fill in gaps in applying the rule based on the Commission's

[937] Individual commenter, FTC-2023-0007-10085.
[938] Individual commenter, FTC-2023-0007-0924.

jurisdiction, citing the importance of banning non-competes as widely as possible because of the harms they impose on physicians and patients irrespective of employer status. Specifically, commenters suggested that the Commission use its antitrust and referral authority to aggressively monitor nonprofit organizations for antitrust violations, to collaborate with other Federal agencies, including the IRS, and to provide incentives and guidance to States, which can enact measures to ensure that a prohibition on non-competes is implemented comprehensively. One commenter also noted that a ban would bring scrutiny to non-competes and would likely intensify pressure to eliminate them. A few commenters also contended that entities claiming tax-exempt status as nonprofits are subject to the Commission's jurisdiction as "persons" under the FTC Act.

b. The Final Rule

After carefully considering commenters' arguments, the Commission declines to exempt for-profit healthcare employers or to exempt the healthcare industry altogether.

First, as described in Part IV, the Commission finds that certain uses of non-competes are an unfair method of competition. The use of unfair methods of competition cannot be justified on the basis that it provides a firm with pecuniary benefits to help them compete with other firms that use similar tactics.[939] In this case, for-profit and other covered entities have urged the Commission to allow them to continue to employ an unfair method of competition (*i.e.*, use non-competes) because some competitors are not prohibited from doing so as they are beyond the Commission's jurisdiction. The Commission is committed to stopping unlawful conduct to the full extent of its jurisdiction. For example, the Commission would not refrain from seeking to

[939] *See Atl. Refin. Co. v. FTC*, 381 U.S. 357, 371 (1965) ("Upon considering the destructive effect on commerce that would result from the widespread use of these contracts by major oil companies and suppliers, we conclude that the Commission was clearly justified in refusing the participants an opportunity to offset these evils by a showing of economic benefit to themselves.").

enjoin unlawful price fixing by a for-profit within its jurisdiction because entities outside its jurisdiction under the FTC Act would not be subject to the same FTC action.

Second, the Commission disagrees with commenters' contention that all hospitals and healthcare entities claiming tax-exempt status as nonprofits necessarily fall outside the Commission's jurisdiction and, thus, the final rule's purview. As explained in Part II.E.2, a corporation's "tax-exempt status is certainly one factor to be considered," but that status is not coterminous with the FTC's jurisdiction and therefore "does not obviate the relevance of further inquiry into a [corporation's] operations and goals."[940] Accordingly, as noted by commenters, entities that claim tax-exempt nonprofit status may in fact fall under the Commission's jurisdiction. Similarly, whether the final rule would apply to quasi-public entities or certain private entities that partner with States or localities, such as hospitals affiliated with or run in collaboration with States or localities, depends on whether the particular entity or action is an act of the State itself under the State action doctrine, which is a well-established, fact-specific inquiry.[941] Thus, some portion of the 58% of hospitals that claim tax-exempt status as nonprofits and the 19% of hospitals that are identified as State or local government hospitals in the data cited by AHA likely fall under the Commission's jurisdiction and the final rule's purview. Further, many States have banned non-competes for a variety of healthcare professionals in both for-profit and nonprofits entities by statute.[942] Even if the final rule's coverage extends only to

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[940] *In the Matter of the Am. Med. Assoc.*, 94 F.T.C. 701, 1979 WL 199033 (FTC Oct. 12, 1979).

[941] *In the Matter of Ky. Household Goods Carriers Ass'n, Inc.*, 139 F.T.C. 404, 405 (2005) ("The Supreme Court has made clear that the state action doctrine only applies when (1) the challenged restraint is clearly articulated and affirmatively expressed as state policy, and (2) the policy is actively supervised by the State itself.") (citation and alterations omitted)*; see also id.* at 410-13 (applying test); *Elec. Inspectors, Inc. v. Vill. of East Hills*, 320 F.3d 110, 117-19 (2d Cir. 2003).

[942] Colo. Rev. Stat. sec. 8-2-113(5)(a) (Colorado statute banning non-competes for physicians); D.C. Code sec. 32-581.01 (D.C. statute banning non-competes for medical specialists earning less than $250,000, compared to $150,000 for other workers); Fla. Stat. sec. 542.336 (Florida statute banning non-competes for physician specialists in certain circumstances); Ind. Code Ann. secs. 25-22.5-5.5-2 and 2.5(b) (Indiana statute banning non-competes for

hospitals that do not identify as tax-exempt non-profits based on AHA data, as explained in Part IV.A.1, the Commission finds every use of covered non-competes to be an unfair method of competition and concludes that the evidence supports the Commission's decision to promulgate this final rule, which covers the healthcare industry to the full extent of the Commission's authority.

Relatedly, in response to commenters' concern that large numbers of healthcare workers will not benefit from the final rule because they work for entities that the final rule does not cover, the Commission notes many workers at hospitals, including those that claims tax-exempt status as a nonprofit or government-owned hospital, contract with or otherwise work for a for-profit entity, such as a staffing agency or physician group. Although some of these individuals may work at an excluded hospital, the final rule applies to their employer—the staffing agency or for-profit physician group—because it is covered by the final rule.

The Commission disagrees with commenters stating the ability to use non-competes will provide a material competitive advantage to entities claiming tax-exempt status as nonprofit or publicly owned entities that are beyond the Commission's jurisdiction. To the contrary, those entities outside FTC jurisdiction that continue to deploy non-competes may be at a self-inflicted disadvantage in their ability to recruit workers, even if they derive some short-term benefit from trapping current workers in their employment. Furthermore, commenters' concern that for-profit healthcare entities will be at a competitive disadvantage is based on the false premise that entities outside the jurisdiction of the FTC will not be otherwise regulated or scrutinized with respect to

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primary care physicians and restricting non-competes for other physicians); Iowa Code sec. 135Q.2(3)(a) (banning non-competes for health care employment agency workers who provide nursing services); Ky. Rev. Stat. sec. 216.724(1)(a) (Kentucky statute banning non-competes for temporary direct care staff of health care services agencies); N.M. Stat. Ann. secs. 24-1I-1 and 2 (New Mexico statute banning non-competes for several types of health care practitioners); S.D. Codified Laws secs. 53-9-11.1-11.2 (South Dakota statute banning non-competes for several types of healthcare practitioners); Tex. Bus. & Com. Code secs. 15.50-.52 (Texas statute restricting the use of non-competes for physicians).

the use of non-competes. States currently regulate non-competes by statute, regulation, and common law. According to the AHA data cited by commenters, over 12% (398/3,113) of nonprofit hospitals and 13% of government hospitals (187/1,409) are in States that ban non-competes for all employers. In any event, even if true, arguments that for-profit and other covered entities could suffer competitive harm by not being able to employ an unfair method of competition would not change the Commission's finding that use of certain non-competes is an unfair method of competition, as further discussed in Part IV.

While the Commission shares commenters' concerns about consolidation in healthcare, it disagrees with commenters' contention that the purported competitive disadvantage to for-profit entities stemming from the final rule would exacerbate this problem. As some commenters stated, the Commission notes that hospitals claiming tax-exempt status as nonprofits are under increasing public scrutiny. Public and private studies and reports reveal that some such hospitals are operating to maximize profits, paying multi-million-dollar salaries to executives, deploying aggressive collection tactics with low-income patients, and spending less on community benefits than they receive in tax exemptions.[943] Economic studies by FTC staff demonstrate that these

[943] *See, e.g.*, Press Release, Office of U.S. Sen. Chuck Grassley, *Bipartisan Senators Probe Potential Abuse Of Tax-Exempt Status By Nonprofit Hospitals* (Aug. 9, 2023), https://www.grassley.senate.gov/news/news-releases/bipartisan-senators-probe-potential-abuse-of-tax-exempt-status-by-nonprofit-hospitals; Request for Information Regarding Medical Payment Products, 88 FR 44281 (July 12, 2023); U.S. Gov't Accountability Off., Testimony Before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives, *Tax Administration: IRS Oversight of Hospital's Tax-Exempt Status*, GAO-23-106777 (Apr. 26, 2023), https://www.gao.gov/assets/gao-23-106777.pdf; *Pottstown Sch. Dist. v. Montgomery Cnty. Bd. of Assessment Appeals*, 289 A.3d 1142 (Pa. Commw. Ct. 2023) (holding that for-profit hospitals purchased by nonprofit claiming tax exempt status under Federal law do not qualify under State law for nonprofit tax exemption); *Phoenixville Hosp., LLC v. Cnty. of Chester Bd. of Assessment Appeals*, 293 A.3d 1248 (Pa. Commw. Ct. 2023); *Brandywine Hosp., LLC v. Cnty. of Chester Bd. of Assessment Appeals*, 291 A.3d 467 (Pa. Commw. Ct. 2023); *Jennersville Hosp., LLC v. Cnty of Chester Bd. of Assessment Appeals*, 293 A.3d 1248 (Pa. Commw. Ct. 2023); The Daily, *How Nonprofit Hospitals Put Profits Over Patients* (Jan. 5, 2023), https://www.nytimes.com/2023/01/25/podcasts/the-daily/nonprofit-hospitals-investigation.html; Gov't Accountability Off., *Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status*, GAO-20-679 (Sept. 17, 2020), https://www.gao.gov/products/gao-20-679; Danielle Ofri, *Why Are Nonprofit Hospitals So Highly Profitable?*, N.Y. Times, Feb. 20, 2020, https://www.nytimes.com/2020/02/20/opinion/nonprofit-hospitals.html; Maya Miller & Beena

hospitals can and do exercise market power and raise prices similar to for-profit hospitals.[944] Thus, as courts have recognized, the tax-exempt status as nonprofits of merging hospitals does not mitigate the potential for harm to competitive conditions.[945]

Commenters provide no empirical evidence, and the Commission is unaware of any such evidence, to support the theory that prohibiting non-competes would increase consolidation or raise prices. To the contrary, as elaborated in Parts IV.B.3.a and IV.B.3.b, the empirical literature suggests, and the Commission finds, that the final rule will increase competition and efficiency in healthcare markets, as workers at for-profit healthcare entities will be able to spin off new practices or work for different employers where their productivity is greater. This is true even if the Commission does not reach some portion of healthcare entities. While the Commission's prior research may indicate, as one commenter suggested, that nonprofit hospitals set higher

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Raghavendran, *Thousands of Poor Patients Face Lawsuits From Nonprofit Hospitals That Trap Them in Debt,* ProPublica (Sept. 13, 2019), https://www.propublica.org/article/thousands-of-poor-patients-face-lawsuits-from-nonprofit-hospitals-that-trap-them-in-debt.

[944] *See, e.g.*, Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. Indus. Econ. 63 (2001), http://onlinelibrary.wiley.com/doi/10.1111/1467-6451.00138/epdf (finding substantial price increases resulting from a merger of nonprofit, community-based hospitals, and determining that mergers involving nonprofit hospitals are a legitimate focus of antitrust concern); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, 18 Int'l J. Econ. Bus. 65, 79 (2011), http://www.tandfonline.com/doi/full/10.1080/13571516.2011.542956 (finding evidence of post-merger price increases ranging from 28%-44%, and concluding that "[o]ur results demonstrate that nonprofit hospitals may still raise price quite substantially after they merge. This suggests that mergers involving nonprofit hospitals should perhaps attract as much antitrust scrutiny as other hospital mergers.").

[945] *See, e.g.*, *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1081 (N.D. Ill. 2012) ("[T]he evidence in this case reflects that nonprofit hospitals do seek to maximize the reimbursement rates they receive."); *FTC v. ProMedica*, No. 3:11 CV 47, 2011 WL 1219281 at *22 (N.D. Ohio Mar. 29, 2011) (finding that a nonprofit hospital entity "exercises its bargaining leverage to obtain the most favorable reimbursement rates possible from commercial health plans."); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284-87 (7th Cir. 1990) (rejecting the contention that nonprofit hospitals would not seek to maximize profits by exercising their market power); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1213-14 (11th Cir. 1991) ("[T]he district court's assumption that University Health, as a nonprofit entity, would not act anticompetitively was improper."); *Hospital Corp. of America v. FTC*, 807 F.2d 1381, 1390-91 (7th Cir. 1986) (rejecting the contention that nonprofit hospitals would not engage in anticompetitive behavior). *See also* FTC & Dep't of Jusitce, *Improving Health Care: A Dose of Competition* 29-33 (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf (discussing the significance of nonprofit status in hospital merger cases, and concluding that the best available empirical evidence indicates that nonprofit hospitals exploit market power when given the opportunity and that "the profit/nonprofit status of the merging hospitals should not be considered a factor in predicting whether a hospital merger is likely to be anticompetitive").

prices when they have more market power, the Commission finds that the final rule is not likely to increase healthcare prices through this same mechanism because it is unlikely to lead to significant increases in healthcare nonprofits' market share, if at all.

Moreover, the Commission has other tools to address consolidation in healthcare markets and is committed to using them. The Clayton Act grants the Commission authority to enforce compliance with, *inter alia*, section 7 of the Clayton Act. The Clayton Act does not include any carveout for entities that are nonprofit or otherwise do not operate for profit—and the FTC's jurisdictional limit based on the definition of "corporation" in the FTC Act does not apply in this context.[946] Accordingly, the Commission has authority under the Clayton Act to review and challenge mergers and acquisitions involving healthcare entities or hospitals regardless of nonprofit status.[947] Thus, even if the jurisdictional limitations of the final rule were to somehow incentivize some hospitals and other healthcare entities claiming non-profit status to consolidate, the Commission will continue to scrutinize those mergers and work with State partners to vigorously defend competition.[948] For the same reason, the Commission disagrees with commenters who contended that the effects of consolidation and staffing shortages will be worse in areas highly saturated with nonprofits claiming tax-exempt status.

Finally, the Commission disagrees with commenters that stated the Commission must further study the final rule's effect on healthcare workers and entities. The Commission has specific, long-time expertise in the healthcare market as anticompetitive mergers and conduct in

[946] 15 U.S.C. 18; 15 U.S.C. 45; *Univ. Health, Inc.*, 938 F.2d at 1214-16.
[947] *Id.*
[948] *See, e.g.*, *In the Matter of RWJ Barnabas Health and Saint Peters Healthcare Sys.*, Docket No. 9409 (Jun. 2, 2022) (complaint); *FTC v. Advoc. Health Care*, No. 15 C 11473, 2017 WL 1022015, at *1 (N.D. Ill. Mar. 16, 2017); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 332 (3d Cir. 2016).

healthcare markets have long been a focus of FTC law enforcement, research, and advocacy.[949] This work includes economic analyses of the effects of mergers involving nonprofit hospitals and studies of the impacts of hospital mergers.[950] Accordingly, given this expertise and the extensive record in the rulemaking, the Commission finds it has sufficient understanding of healthcare markets and that the evidence supports the final rule's application to the healthcare industry.

6. Coverage of Franchisors vis-à-vis Franchisees

a. The Proposed Rule

The Commission proposed to exclude franchisees from the definition of "worker" and requested comment on whether and to what extent the rule should cover non-competes between franchisors and franchisees ("franchisor/franchisee non-competes").[951] The Commission explained that it proposed to exclude franchisees from the definition of "worker" because, in some cases, the relationship between a franchisor and franchisee may be more analogous to the relationship between two businesses than the relationship between an employer and a worker.[952]

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[949] *See, e.g.*, FTC, *Competition in the Health Care Marketplace*, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care; FTC, *Overview of FTC Actions in Health Care Services and Products* (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2022.04.08%20Overview%20Healthcare%20%28final%29.pdf; Joseph Farrell et al., *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals*, 35 Rev. Indus. Org. 369 (2009), http://link.springer.com/content/pdf/10.1007%2Fs11151-009-9231-2.pdf; FTC, *Examining Health Care Competition* (Mar. 20-21, 2014), https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition; FTC & Dep't of Justice, *Examining Health Care Competition* (Feb. 24-25, 2015), https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition; *Improving Health Care: A Dose of Competition*, *supra* note 945.

[950] *See*, *e.g.*, FTC, *FTC Policy Perspectives on Certificates of Public Advantage* (Aug. 15, 2022), www.ftc.gov/copa; FTC, *Physician Group and Healthcare Facility Merger Study* (ongoing, initiated Jan. 2020), https://www.ftc.gov/enforcement/competition-matters/2021/04/physician-group-healthcare-facility-merger-study; Christopher Garmon, *The Accuracy of Hospital Merger Screening Methods*, 48 RAND J. of Econ. 1068 (2017), https://www.ftc.gov/system/files/documents/reports/accuracy-hospital-merger-screening-methods/rwp_326.pdf; Joseph Farrell, et al., *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets*, 39 Rev. Indus. Org. 271 (2011), http://link.springer.com/content/pdf/10.1007%2Fs11151-011-9320-x.pdf; Devesh Raval, Ted Rosenbaum, & Steve Tenn, *A Semiparametric Discrete Choice Model: An Application to Hospital Mergers*, 55 Econ. Inquiry 1919 (2017).

[951] NPRM at 3511, 3520.

[952] *Id.* at 3511.