American Nurses Association

8403 Colesville Road, Suite 500
Silver Spring, MD 20910
+1 (301) 628.5000
ana.org

May 22, 2025

The Honorable Pam Bondi, Attorney General
Department of Justice
950 Pennsylvania Ave., NW
Washington, DC 20530

RE: Docket No. ATR-2025-0001as

Dear Attorney General Bondi,

The American Nurses Association (ANA) appreciates the Department of Justice (DOJ) for convening the Anticompetitive Regulations Task Force, which was created to advocate for the elimination of regulations that undermine free market competition. Nurses are frequently impacted by anticompetitive behavior in the healthcare marketplace but are rarely included in discussions when new regulations are promulgated. Many of these regulations result in perverse incentives or unintended consequences that have implications for nurse practice. As the Task Force examines which regulations should be eliminated, ANA has identified specific recommendations within healthcare and nursing around:

- non-compete agreements;
- mergers;
- collaboration agreements; and
- allowing advanced practice registered nurses (APRNs) to practice at the top of their license.

ANA is the premier organization representing the interests of the nation's over 5 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA members also include the four APRN roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members.

Nurses are critical to a robust health care system. Nurses meet the needs of patients and provide quality care that leads to better health outcomes for all patients. Moreover, nurses are

critical to coordinated care approaches for Medicare beneficiaries in all settings, including hospital outpatient settings. Patient-centered care coordination is a core professional standard for all RNs and is central to nurses' longtime practice of providing holistic care to patients.

We appreciate the agency's thoughtful consideration of our comments.

Non-Compete Agreements Are Detrimental to Nurse Practice

Non-compete agreements are the antithesis of a free market and competitive behavior. The whole reason that these agreements exist is to restrain trade and reduce employee salaries. Employees bound by non-compete agreements might stay in jobs just to remain employed, as the employee may be frozen out of the job market if they leave their current position. Even if the non-compete agreement does not entirely restrict the employee, they may be forced to undergo expensive and lengthy retraining in a different specialty so that they are not in violation of their non-compete agreement.

ANA understands that the original purpose of non-compete agreements was to protect trade secrets and does not oppose their use by corporations to protect their proprietary information**. However, ANA does strongly oppose the use of non-compete agreements for all nurses but especially for bedside nurses.** We are seeing an alarming trend where in nursing and other healthcare areas non-compete agreements are becoming increasingly common. We are confounded by this trend as bedside nurses do not have access to "trade secrets" and, while they do have access to some potentially confidential information, there are other ways that health systems can protect sensitive information. Nurses are bound by the Health Insurance Portability and Accountability Act (HIPAA) and combining that with non-disclosure agreements (NDAs) would have the same effect as a non-compete agreement without restraining the employee's ability to seek new employment.

Currently, four states have banned non-compete agreements[1] and others have limited their use. The states that have banned non-compete agreements are not politically similar and have banned the agreements for various reasons. Examples of these include highly paid and skilled oil rig employees and minimum wage fast food employees. For states that have limited or eliminated non-compete agreements for nurses, the result is typically a freer employment market.

This change could help eliminate one of the reasons that nurses leave the profession, as nurses frequently feel that the non-compete agreement they are forced to sign as a condition of employment drastically limits their choice of employment if they want to stay in nursing. One extreme example was a nurse whose non-compete agreement forbade them from working within 3,500 miles of their current employer which would have banned them from working anywhere in the contiguous 48 states. Non-compete agreements can also forbid nurses from working in their field for up to five years. This only serves to further restrict a workforce that faces shortages and other challenges. **As such, we encourage the Task Force to examine**

[1] California, Minnesota, North Dakota, Oklahoma

noncompete agreements for healthcare personnel, and eliminate these barriers to nurse practice.

Mergers Must be Reviewed to Ensure that Competition Remains in the Marketplace
Over the last few years, many smaller medical practices have either merged or been bought out by either larger practices, healthcare systems, or private equity. These consolidations leave very few standalone practices in communities, restricting or eliminating competition and patient choice. This also results in fewer opportunities for nurses, since the market share of the larger practices does not allow these nurses to look for jobs in other practices if they are unhappy with their current employment.[2] Furthermore, nurses often lack meaningful choice in selecting their employers, which contributes to lower salaries due to the absence of a truly competitive labor market. Additionally, these large practices often place additional restrictions on nurse employment that leads to dissatisfaction. For example, requiring noncompete agreements, as discussed above, places even greater limitations to nurse employment choice if the large healthcare system has consolidated all or most practices in a community.

These consolidations, mergers, and acquisitions only serve to limit employer choice for nurses, remove competition in the marketplace needed to restrain costs, and remove patients' ability to have choice of trusted provider. The Task Force must examine what current regulations either encourage or fail to meaningfully oversee this ever-growing trend of consolidation in the healthcare system. **ANA urges the Task Force to recommend DOJ action that leads to real protection for employment and patient choice in our nation's healthcare delivery system.**

Collaboration and Supervision Agreements Must Be Limited to Ensure APRNs can Practice Medicine Nationwide
Collaborative agreements fulfill a regulatory requirement placed by many states on APRN practice, which require an agreement between a physician and an APRN for either a limited period (transition to practice) or granting permission to practice. Many of these requirements were relaxed by President Trump during the COVID-19 public health emergency (PHE) with no effect on patient care. **ANA firmly believes that the flexibilities provided during the pandemic should be made permanent.**

These flexibilities do not relate to the APRNs' scope of practice (SOP), and there is no evidence to suggest that these collaborative agreements protect patients. Additionally, these transition-to-practice requirements are becoming increasingly difficult to initiate and maintain as the number of primary care physicians and psychiatrists continues to decrease, especially in rural areas. Additionally, requirements in some mergers and acquisitions prevent physicians from signing agreements with APRNs who are not employed by their parent organization, creating additional barriers to practice. This all only serves to limit the number of APRN practices and, thus, patient access to care. **Removing collaboration requirements would greatly increase the number of APRN practices, increasing competition for both employees and patients.**

[2] These nurses are also frequently bound by non-compete agreements

Additionally, supervision requirements are very similar to collaborative agreements and generally require that a physician sign off on the services APRNs provide to their patients. Currently, many states allow APRN practice without these unnecessary supervision requirements.[3] Part of the reasoning behind supervision requirements is to prevent APRNs from exceeding their scope of practice. However, APRNs only wish to practice at the top of their license, while allowing physicians to provide services that the APRN is not licensed to do. During the COVID-19 PHE, the Trump Administration rightfully relaxed these supervision requirements without any discernible difference in patient care. **ANA maintains that these relaxed supervision requirements should become permanent.**

Physicians and APRNs can and do collaborate and work together to meet patient and community needs without the need for burdensome collaborative and/or supervision agreements. **ANA urges the Task Force to examine these requirements and eliminate them to remove outdated and unnecessary barriers to nurse practice.**

Scope of Practice Laws Must be Made Consistent with APRN Licensing
In a similar vein to collaboration agreements, burdensome rules about scope of practice continue to limit APRNs. Highly trained APRNs across the country are constrained by outdated regulations that bar them from using their education, expertise, and training to practice at the top of their license.

There is a nationwide shortage of physicians which is expected to worsen over the next decade. APRNs are ready and willing to fill in this gap and have started to do so. There are other practice areas where there are physician shortages and APRNs have been ready and willing to do this work, which they are trained to do.

Not allowing APRNs to practice at the top of their license ultimately harms patient access to care and reinforces old paradigms that APRNs are secondary providers to physicians. That only discounts the education and training of these clinicians and their critical role in the nation's health care delivery system. Additionally, by not having the ability to practice at the top of their license, it is nearly impossible for APRNs to start their own practices, as they are beholden to antiquated requirements for physicians to oversee their work. **ANA would encourage DOJ to look at scope of practice laws and ensure that APRNs can practice at the top of their license.**

APRNs are not looking to practice outside of their scope, rather they are only looking to do the work that they have spent years learning how to do. There is a national shortage of trained medical practitioners and APRNs are both qualified and able to do much of the work nationwide, all that remains are outdated barriers to practicing nursing at the top of their license.

[3] NPs can practice in 39 states, CNS' and CNMs can practice in 28 states, and CRNAs can practice in 27 states

ANA appreciates the opportunity to have this discussion and looks forward to continued engagement with the Trump Administration. Please contact Tim Nanof, ANA's Executive Vice President, Policy & Government Affairs at (301) 628-5166 or tim.nanof@ana.org with any questions.

Sincerely,

Bradley Goettl, DNP, DHA, RN, FAAN, FACHE
Chief Nursing Officer

cc: Jennifer Mensik Kennedy, PhD, MBA, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, ANA Chief Executive Officer