

NONCOMPETE AGREEMENTS FOR PHYSICIANS: CLEAR AND CONSISTENT POLICY IS NEEDED



by John O'Shea, M.D., and David Balat

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Foundation**

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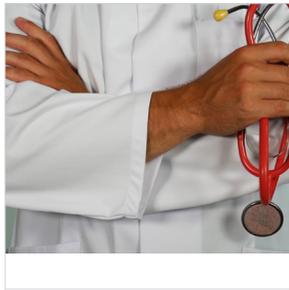


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Noncompete Agreements for Physicians: Clear and Consistent Policy Is Needed

John O’Shea, M.D., and David Balat

Introduction

A restrictive covenant is a clause in an employment contract that places post-employment limits on an employee. The most common type of restrictive covenant is a noncompete agreement (NCA) that prohibits the employee from offering their services within the agreement’s geographic extent for a period after leaving the employer. Other restrictions may include limits on an employee’s ability to solicit the employer’s customers or employees for a period of time.

The existence of (and resistance to) NCAs dates to at least the 1400s, when master craftsmen prohibited their apprentices from competing in the local market after receiving years of valuable training ([Starr, 2018](#)). Even though there has been longstanding legal, economic, and even ethical opposition to NCAs ([Lee, 2019, pp. 8–12](#)), they are currently enforceable to varying degrees in most U.S. states, as long as they are “reasonable” and protect “legitimate” employer interests.

Although NCAs may have merit in certain circumstances, they are increasingly regarded as being potentially harmful when applied to medical practice. When the medical profession was predominately made up of small independent practices, run as privately owned small businesses, noncompete agreements were used to protect an established practice from a partner or co-worker leaving and opening a competing practice nearby. However, in the current era of healthcare consolidation, small, independent medical practices are disappearing. Substantial market influence by large, even multi-state hospital systems can limit employment options for physicians, who may face the prospect of signing an NCA or not practicing in the area. In addition, the employment restrictions in these agreements can make it essentially impossible for a physician to change employment without completely disrupting their life ([Garcia, 2021](#)).

NCAs are currently regulated at the state level, and the considerable variability from state to state, as well as the ambiguity in terms of the criteria used to evaluate NCAs, has resulted in an inconsistent regulatory framework whereby most states are left to decide the enforceability of these agreements on an inefficient and unpredictable case-by-case basis. This has prompted increasing interest in coherent policy by states to establish clear guidelines for the appropriate use of NCAs. This is especially important in medicine, where the argument for the need to protect the interests of the employer is less compelling and where the restrictions can negatively affect access to care, patient choice, continuity of care, and the patient–doctor relationship.

Because of its unique position in the public interest, the medical profession differs in important ways from the general labor market, and NCA reform will require a separate policy approach that protects patient access to care, reduces the

Key Points

- Although noncompete agreements may have merit in certain circumstances, they are increasingly regarded as being potentially harmful when applied to medical practice.
- In the current era of healthcare consolidation, noncompete agreements can limit employment options and make it difficult for physicians to change employment without major disruptions to their livelihood.
- Noncompete agreements can negatively impact access to care, limit a patient’s choice of provider and interrupt the patient–doctor relationship.
- Through the effects they exert on physician organizational structures, noncompetes may also contribute to increased healthcare prices.

legal ambiguity and burdens of litigation, safeguards the integrity and mobility of the healthcare workforce, and promotes competition. States should take the lead in these reform efforts.

NCA in the General Labor Market

Historically, noncompete agreements have been used throughout the economy to protect the legitimate interests of purchasers of businesses or to prevent an employee from using specialized training and confidential information gained from the employment to directly compete with the employer.

Because of a deficiency of empirical studies, the extent to which NCAs are used in the general labor market is not completely known. In a 2019 survey by the Economic Policy Institute ([Colvin & Shierholz, 2019](#)), 49.4% of responding establishments reported that at least some of their employees were required to sign an NCA, and 31.8% indicated that all employees were required to sign an NCA, regardless of pay or job duties. Another study ([Starr et al., 2020](#)) examined the use and implementation of NCAs, as well as the employee outcomes associated with these provisions, using nationally representative survey data on 11,505 labor force participants.¹ Approximately 18% of labor force participants surveyed reported working under an NCA at the time of the study, and 38% entered into at least one NCA in their careers. Although NCAs were more likely to be found in high-skill, high-paying jobs, they were also found in low-skill, low-paying jobs. Interestingly, the study found that employers use NCAs virtually as often in states where they are clearly unenforceable as in states where they are vigorously enforced. Only 10% of employees negotiated over their NCA, and about one third of employees were presented with their noncompete after having already accepted their job offer. The study also found that wages are relatively lower where NCAs are easier to enforce.

Stringently enforced NCAs have also been found to have negative social welfare spillover effects on entrepreneurship, innovation, and worker mobility that go beyond the employer–employee relationship ([Starr et al., 2018](#)). It has also been argued that, in addition to the inhibitory effects on worker mobility and economic growth in general, NCAs may prevent laid-off workers from taking advantage of new job opportunities because many noncompete agreements remain valid even in cases of layoffs ([O'Donnell, 2021](#)). Several agreements even resulted in disputes that ended up in court ([Giombetti, 2020](#)).

NCAs in Healthcare

The most common form of NCA in healthcare is used when an entity (e.g., hospital or group practice) employs a physician. Other arrangements where an NCA might be used include a solo practitioner who wishes to bring on a partner or an entity that purchases a physician's practice. Data on NCAs in healthcare are incomplete. A 2018 survey of 1,967 primary care physicians in 5 states² found that about 45% were bound by NCAs ([Lavetti et al., 2020](#)). Whether these findings can be generalized beyond primary care or beyond the states that were included in the survey is unknown.

As in other industries, the justification often given for NCAs in the medical profession is that the employer has a right to protect their legitimate business interests, including investment in specialized training, confidential or “proprietary information,” and client relationships or “good will.” However, the argument is not as compelling in healthcare as in other parts of the labor market. For example, hospitals and practices that employ physicians generally do not provide them with unique training beyond what they have already acquired in medical school and residency. Also, in healthcare, an employer will only rarely have protectable proprietary information that can be used by a previously employed physician. The most “valuable” information that a physician can use is the information relevant to patient care. Although the ownership of this information varies from state to state, patients have legal control over access to this information ([Health Insurance Portability and Accountability Act, 1996](#)).

The issue of good will is also not straightforward. In general, the personal relationships and good will cultivated between an employee and the employer's customers are considered by the courts to be the “protectable” property of the employer ([Horton, 2013, p. 7](#)). However, in the healthcare context, the ownership of the patient–doctor relationship also raises public policy issues beyond the need for the employer to protect their patient base ([pp. 13–14](#)). The bond developed in the patient–doctor relationship is often stronger than that found in the general labor market. If a physician wishes to leave their current employment, patients may want to follow in order to continue care with the physician. However, the patient may find this impossible if the geographic boundary of the NCA is prohibitive. In that case, patients may be denied the benefits of continuing to receive care from a provider with whom they have developed a trusting relationship ([Chipidza et al., 2015](#)). Patients

1 The survey sample population included labor force participants aged 18 to 75 who were employed in the private sector or in a public healthcare system or who were unemployed.

2 The states included California, Georgia, Illinois, Pennsylvania, and Texas.

may also face a disruption in their care as they transition to a new physician ([Andrews, 2019](#)).

An additional public policy concern is the impact of NCAs on the healthcare workforce. Recent findings from the Association of American Medical Colleges predict a shortage of 37,800 to 124,000 physicians by 2034 ([IHS Markit Ltd, 2021, pp. 5–6](#)). NCAs that restrict a physician's choice of where they practice and limit patient preference can contribute to workforce insufficiencies. It has also been argued that employee retention and workforce stability are better achieved through a working environment that incentivizes physicians to stay, rather than contractual restrictions that make it difficult for them to leave ([Garcia, 2021](#)).

NCAs, through the effects they exert on physician organizational structures, may also contribute to increased healthcare prices. By quantifying the variation in state-level NCA laws systematically over time, Hausman and Lavetti estimate that a state-level legislative judicial change that results in a decrease in NCA enforceability of 10% of the observed policy spectrum results in a 4.3% decrease in average physician prices. They suggest that a comparable policy change at the national level could reduce aggregate medical spending by over \$25 billion annually ([Hausman & Lavetti, 2019](#)).

AMA Position

The Code of Medical Ethics of the American Medical Association ([AMA, n.d.](#)) states:

Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms. Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

The AMA advises physicians not to enter into covenants that:

Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and that do not make reasonable accommodation for patients' choice of physician.

Furthermore, physicians in training are advised not to sign "covenants not to compete as a condition of entry into any residency or fellowship program" ([AMA, n.d.](#)).

In February 2020, the AMA sent a letter ([Letter from James Madara, 2020](#)) to the Federal Trade Commission calling for the agency to consider the complexity of NCAs and stressing the evolving nature of this issue in different

states. Nevertheless, the letter did not recommend federal involvement and instead suggested that each state should enact its own rules and regulations regarding NCAs, citing the "limited usefulness" ([p. 5](#)) that broad federal legislation is likely to have, given the complexity of case law related to these agreements.

Enforceability

NCAs are generally regulated at the state level, where limits are increasingly being placed on these agreements, especially when they are seen to restrict trade or interfere with an individual's ability to work. Estimates of enforceability vary according to the data source and the varying state-by-state criteria used to evaluate these agreements. Because of the regulatory variability from state to state and the often-ambiguous statutory language, enforceability of NCAs in the medical profession is mostly left to an inefficient system of case-by-case litigation of individual agreements. When evaluating NCAs, courts generally ask questions such as the following: Does the employer have a legitimate business interest? Are the restrictions (e.g., distance, time, and scope of practice) reasonable? Do the restrictions unduly limit the physician's ability to make a living? Are there public policy interests to be considered? ([Horton, 2013, pp. 4–11](#)). Not surprisingly, what courts find to be acceptable responses to these queries is subjective and inconsistent ([Davis et al., 2021](#)).

Healthcare Consolidation

According to the American Medical Association Physician Practice Benchmark Survey, 2020 represented the first year that less than half (49.1%) of U.S. doctors worked in a private practice setting, and among employed physicians, 70% were under age 40, suggesting that this trend toward employment will continue ([Kane, 2021](#)). As of 2020, hospitals and health systems represented the largest private sector employer in at least 17 states ([Gooch, 2020](#)). Another recent study by Avalere Health ([2021](#)) reported that as many as 70% of U.S. physicians were employed by hospital systems or other corporate entities such as private equity firms and health insurers at the beginning of 2021. There was a significant increase in this trend in 2019 and 2020, which the authors attribute, at least in part, to the COVID-19 pandemic. Healthcare consolidation can limit options for a physician, thereby reducing their bargaining power in employment negotiations. Furthermore, if a physician enters into an NCA with a multi-state entity that prohibits the physician from working in any area where the employer has interest in a practice, the physician could conceivably be excluded from practicing in a large section of the country. Dealing with contradictory regulations in more than one state could also complicate any litigation of the agreement.

Additional Policy Considerations

In attempting to address the policy issues surrounding NCAs, it is important to consider the proper role of government in mutually agreed-upon contractual relations between employer and employee. However, there is evidence to suggest that many NCAs are entered into without ample opportunity to negotiate. As noted above, more than 30% of employees who enter into NCAs first learn of the agreement only after they have already accepted the offer, and 26% of them report that if they had known about the NCA earlier, they would have reconsidered taking the job. In addition, only 10% of employees report negotiating over the terms of the NCA. Among the remaining 90% who enter into an NCA without negotiating, 20% report not negotiating the agreement out of fear of creating tension with the employer or losing the job. ([Starr et al., 2020, p. 8](#)). In a 2011 survey of engineers, Marx found that 24.5% of respondents who signed an NCA were asked to do so on the first day of work, 22.8% were asked to sign after the first day and some of them reported that they felt pressured to sign or were told the noncompete was nonnegotiable ([Marx, 2011, p. 706](#)). These findings are from surveys of labor force participants from a broad array of industries, occupations, and other demographic categories and not specific to the medical profession. However, although a direct correlation between these findings and NCAs in medicine cannot be made, it is reasonable to assume that similar forces that limit negotiation opportunities operate to some extent in the medical profession, especially given the increase in healthcare consolidation. For example, if a healthcare market is dominated by one or two large employers, a physician may face the choice of signing an NCA or not practicing in their preferred location. The physician technically has a choice, but this is not suggestive of a freely competitive labor market.

Although many NCAs are ultimately resolved through litigation, there are also externalities that operate through an inhibitory effect that not only restricts employment mobility but can also deter litigation on the part of a physician, even when the agreement is unenforceable, especially if the physician anticipates incurring substantial legal fees in the process. Interestingly, although employment-based NCAs are essentially unenforceable in California, as many as 31% of physicians in group practices have signed them ([Lavetti et al., 2018, p. 20](#)). Some have argued that NCA reform should go beyond enforceability in a court of law to address

whether firms should be allowed to require employees to enter into these agreements ([Marx, 2018](#)).

Legislative and Regulatory Efforts

State Level

According to a *Forbes* article ([Kurter, 2021](#)), three states (North Dakota, California, Oklahoma) and the District of Columbia consider NCAs broadly unenforceable.³ The D.C. ban on NCAs excludes medical specialists making more than \$250,000 per year ([Ban on Non-Compete Agreements Amendment Act, 2021](#)). Massachusetts, Maine, Illinois, New Hampshire, Rhode Island, and Washington prohibit NCAs for low-wage employees ([Kurter, 2021](#)). In other states, statutes restrict enforcement of NCAs and establish factors that will be considered in determining whether those agreements are reasonable. In states where there is no statute governing enforceability, court decisions have established the relevant factors to be considered.

Several states do not prohibit NCAs generally but will decline to enforce them against physicians. In 1977, Massachusetts passed a law that contains a clear prohibition on NCAs in the medical profession. [Mass. Gen. Law Ch. 112 § 12X](#) renders void and unenforceable a contract that includes “any restriction of the right of such physician to practice medicine in any geographic area for any period of time after the termination of such partnership, employment or professional relationship.”⁴

In 2017, Rhode Island enacted legislation ([R.I. Gen. Laws §5-37-33](#)) that also prohibits NCAs in medicine and defines the specifics of the ban, rendering void and unenforceable any restrictions on:

- (1) The right to practice medicine in any geographic area for any period of time after the termination of such partnership, employment, or professional relationship; and
- (2) The right of such physician to provide treatment, advise, consult with, or establish a physician/patient relationship with any current patient of the employer; and
- (3) The right of such physician to solicit or seek to establish a physician/patient relationship with any current patient of the employer.

The Rhode Island statute also specifies that the prohibition “shall not apply in connection with the purchase and sale of

³ The date D.C. employers must comply with the legislation was postponed to October 1, 2022.

⁴ In addition to physicians, the Massachusetts statute also applies to other medical professionals, such as nurses, psychologists, and social workers, among others.

a physician practice, provided the restrictive covenant and/or non-compete covenant is for a period of a time of no more than five (5) years.”

Similar statutes enacted in Delaware ([6 Del. Code Ann. § 2707](#)) and Colorado ([CO Rev Stat § 8-2-113](#)) also void NCAs that restrict the right of a physician to practice medicine. However, they both contain language that allows other provisions of the agreement to be enforceable, including the payment of damages related to injury suffered by termination of the agreement or related to competition.

Texas is among a minority of states that do not ban physician NCAs outright but apply more exacting standards to physician NCAs than they do to NCAs in general ([Tex. Bus. & Com. Code Ann. § 15.50](#)). Texas addresses the issue of NCAs in the medical profession in the context of broader legislation dealing with restraints on competition and trade practices in general. [Section 15.50](#) of the Texas Business and Commerce Code establishes requirements that an agreement must meet in order to be considered enforceable. Several of these requirements are aimed at reducing the impact of NCAs on continuity of care, including providing the physician⁵ access to a list of patients seen or treated in the past year, providing access to medical records with consent of the patient, and allowing the physician to continue to treat patients during the course of an acute illness even after the contract or employment has been terminated. Enforceable agreements must also provide for a buyout of the agreement at a “reasonable” price, although deciding what is a reasonable price may involve an arbitration process. Although these enforceability requirements are an improvement over the regulatory situation in most states, the legislation lacks language that specifically invalidates an NCA that restricts the right of a physician to practice medicine in any geographic area for any period.

Federal Level

The inefficient and inconsistent regulation of NCAs at the state level has prompted interest in finding a national solution. In response to an executive order issued by President Donald Trump on October 12, 2017, entitled “Promoting Healthcare Choice and Competition Across the United States” ([Exec. Order No. 13813, 2017](#)), the U.S. departments of Health and Human Services, Treasury, and Labor issued a report titled *Reforming America’s Healthcare System Through Choice and Competition*. The report suggested that NCAs may be overly burdensome and restrictive on providers and recommended that states scrutinize these

agreements, especially the impact they have on patient access to care and the supply of healthcare providers ([U.S. Department of Health and Human Services et al., 2018, pp. 61–63](#)).

Biden Executive Order

In July 2021, President Joe Biden issued Executive Order 14036 with the broad goal of promoting competition in “the interests of American workers, businesses, and consumers” ([para. 1](#)). Regarding NCAs, the order contains the following language:

To address agreements that may unduly limit workers’ ability to change jobs, the Chair of the FTC is encouraged to consider working with the rest of the Commission to exercise the FTC’s statutory rulemaking authority under the Federal Trade Commission Act to curtail the unfair use of non-compete clauses and other clauses or agreements that may unfairly limit worker mobility. ([Sec. 5\(g\)](#))

However, the order does not mandate the prohibition of NCAs or even suggest that in all circumstances a noncompete clause will unduly limit worker mobility. Although its authority is limited, the FTC, it has been suggested, could provide clarity that may help reduce the inefficient and often ambiguous state-by-state and case-by-case evaluations of the enforceability of NCAs ([Chopra & Khan, 2020, pp. 373–374](#)). However, it is unclear what impact this would have on agreements entered into by physicians.

Congressional Activity

A number of bills have been introduced in Congress to prohibit or restrict NCAs, none of which have proceeded beyond the committee stage.

In 2015, the Mobility and Opportunity for Vulnerable Employees or MOVE Act was introduced in the U.S. Senate. The legislation would have prohibited employers from entering into NCAs with low-wage employees, defined as an employee earning less than \$15 per hour or \$31,200 per year ([MOVE Act, 2015](#)). In July 2021, the Freedom to Compete Act was re-introduced⁶ by Sen. Marco Rubio (R-FL). This legislation ([Freedom to Compete Act, 2021](#)) would ban NCAs for any employee who does not qualify for the minimum wage and overtime exemption for bona fide executive, administrative, professional, and outside sales employees under the Fair Labor Standards Act of 1938 ([29 U.S.C.A. § 201 et seq.](#)). In February 2021, Sens. Chris Murphy (D-CT), Todd Young (R-IN), Kevin Cramer

5 The Texas legislation refers to persons licensed as physicians by the Texas Medical Board.

6 The bill was previously introduced in the 116th Congress in January 2019.

(R-ND), and Tim Kaine (D-VA), and Reps. Scott Peters (D-CA), Mike Gallagher (R-WI), Anna Eshoo (D-CA), and Peter Meijer (R-MI-03) reintroduced⁷ the Workforce Mobility Act, which would prohibit the use of NCAs, except in situations involving the sale of a business or dissolution of a partnership ([Workforce Mobility Act, 2021](#)).

Policy Options and Recommendations

A number of strategies have been considered to address NCA reform in the medical profession. Ideally, reform of NCAs should happen at the state level. However, although interest in NCA reform at the state level has increased in recent years, only a few states have gone so far as to prohibit or render unenforceable NCAs in general or specifically for medical professionals. In those states that do address NCAs in medicine, the legislative language is often vague or inadequate. For example, recent legislation in the District of Columbia ([Ban on Non-Compete Agreements Amendment Act, 2021](#)) banning the general use of NCAs excludes medical specialists with an annual income of \$250,000. By focusing on income level, the ban appears to follow legislation meant to protect low-wage workers but fails to address broader issues, such as workforce mobility and patient access, that are unique to the medical profession.

President Biden's recent executive order is a recommendation that the FTC consider rulemaking to clarify the appropriateness of NCAs in general. Although the FTC could provide guidelines, as noted above, any impact this would have on NCA policy in medicine is uncertain.

Proposed congressional legislation would place broad prohibitions on NCAs and could impact NCAs in medicine, but there is no indication that the bills currently introduced will see committee action in the near future, and similar bills previously introduced failed to pass.⁸ Federal legislation is also likely to encounter opposition based on Tenth Amendment grounds if the legislation is seen as appropriating regulation that has traditionally been the purview of the individual states.

Due in large part to the public interest involved, the medical profession differs in important ways from the general labor market and, as such, NCA reform in healthcare requires a separate policy approach in the form of distinct legislation or explicit language incorporated into general NCA reform legislation that addresses NCAs in medicine. The individual states should follow the recommendation of the 2018 report from the departments of Health and Human Services, Treasury and Labor ([p. 63](#)) and evaluate their policies

regarding NCAs in the medical profession, including the impact that these agreements have on patient access to care and the supply of healthcare providers. Specifically, state policies should allow for a competitive labor market that does not restrict the entry and exit of healthcare providers.

As noted, Texas is among the small number of states that have specifically addressed NCAs in medicine. By establishing statutory requirements meant to mitigate the negative effect these agreements can have on continuity of patient care, the legislation goes well beyond the current regulatory status in most other states and places Texas in a leadership position. However, in order to maintain patient access to care, maximize the opportunity of patients to choose their provider, and promote a freely competitive and open healthcare labor market, the Texas statute should incorporate language that specifically renders void and unenforceable any agreement or portion of agreement that places geographic and/or time-defined restrictions on a physician's ability to practice medicine.

Conclusion

Noncompete agreements or NCAs have been used for centuries as a means of placing post-employment restrictions to prevent an employee from using specialized training and confidential information to compete with the employer. Even though there has been longstanding opposition to NCAs, they are currently enforceable to varying degrees in most U.S. states. However, when applied to the medical profession, especially in the face of increasing healthcare consolidation, they are increasingly regarded as potentially harmful. The argument that NCAs are necessary to protect the legitimate business interests of the employer is less compelling when applied to physicians than it is in the general labor market. Post-employment restrictions on physicians can also create additional problems in terms of access to and continuity of care and can exacerbate healthcare workforce shortages.

NCAs have traditionally been regulated by the individual states. However, this has resulted in a patchwork of inconsistent and inadequate policies that have stimulated interest at the federal level. The executive order issued by President Biden in July 2021 suggests that the FTC should assess the applicability of NCAs in general but does not address the issue of NCAs in medicine. Various bills have also been introduced in Congress to address NCAs, but without success.

7 The bill was originally introduced in the Senate in 2019 and the House in 2020.

8 For example, the Freedom to Compete Act was previously introduced in January 2019 and died in committee.

The medical profession occupies a unique position in the public interest. Therefore, NCA reform for physicians requires a policy approach that is separate from NCA reform in general. States should evaluate their policy toward NCAs in medicine to ensure that they maximize access to care and promote an open and competitive healthcare labor

market. Texas should strengthen its leadership role by specifically rendering void and unenforceable any agreement that places geographic and/or time-defined restrictions on a physician's ability to practice medicine. ★

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ABOUT THE AUTHORS



John O'Shea, M.D., is senior fellow for Right on Healthcare at the Texas Public Policy Foundation. He is also a surgeon and independent researcher. From 2014-2019 O'Shea was a senior fellow in the Center for Health Policy Studies at the Heritage Foundation in Washington, D.C., where he worked on a number of health policy issues, including implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), healthcare payment and delivery reform, Medicare Advantage, VA healthcare, emergency medical care, and graduate medical education.

From 2013-2015, O'Shea was a visiting scholar in the Engelberg Center for Health Care Reform at the Brookings Institution, where he was clinical lead on a project with MITRE and CMMI to develop alternative payment models for specialty care. From 2011 to 2013, he served as senior health policy advisor to the U.S. House Committee on Energy and Commerce, where he helped draft the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that replaced the Sustainable Growth Rate formula for reimbursing physician services in the Medicare program.

Before moving to D.C. in 2011, O'Shea was an assistant professor of surgery at the Albert Einstein College of Medicine in Bronx, NY. He completed his surgical training at New York Medical College in New York City and holds a master of public administration from the Harvard Kennedy School and master's degrees in history and sociology of science from the University of Pennsylvania.

O'Shea has published widely on health policy, clinical surgery, the history of surgery, and the history of health policy.



David Balat is the director of the Right on Healthcare initiative at the Foundation. He has broad experience across the healthcare spectrum with special expertise in healthcare finance. He is a former congressional candidate in Texas' 2nd Congressional District and a seasoned hospital executive with more than 20 years of healthcare industry leadership and executive management experience.

Balat has earned the privilege of being invited to testify before the U.S. House Committee on Oversight and Reform in Washington, D.C., and before various House committees in the Texas state Legislature. He is a published author and op-ed columnist in Newsweek, U.S. News & World Report, Real Clear Politics, and other news outlets. He is also an active speaker and commentator on matters of health policy.

Balat often volunteers to help families navigate their bills and how to understand their benefits. He serves as a board member for a nonprofit focused on educating legislators and the community about important matters pertaining to healthcare freedom.

Balat is a first generation American and the first in his family to graduate from college. He received his B.S. from the University of Houston and joint master's degrees in business administration and hospital administration from the University of Houston – Clear Lake.

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