Federal Bill Seeks to Outlaw the Friendly PC/MSO Model Nationwide, but State Enforcement Is the Real Near-Term Risk

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Executive Summary

- **Sweeping federal proposal**. On September 16, 2026, Democratic lawmakers led by Sens. Warren, Wyden, and Merkley introduced the Stop Corporate Takeovers of Physicians Act of 2026 (the "Act"), which would create a federal corporate practice of medicine ("CPOM") ban modeled on Oregon's SB 951 and would effectively end the friendly professional corporation ("PC") / management services organization ("MSO") model as it is commonly structured today. A companion bill (H.R. 10444) was introduced the same day in the House.
- **Core provisions restrict non-physician involvement**. The Act would bar entities not majority-owned by licensed clinicians from owning or controlling medical practices (with exemptions for nonprofit and public providers and hospitals), prohibit MSO equity ownership, share-transfer restrictions, continuity arrangements, and de facto MSO control over key operations, and void most non-compete, non-disclosure, and non-disparagement provisions.
- **Significant enforcement risk from multiple parties**. Violations would be enforceable by the Federal Trade Commission ("FTC"), state attorneys general, and private plaintiffs seeking treble damages, with mandatory divestiture and disgorgement and potential exclusion from federal health care programs.
- **Near-term enactment unlikely, but influential**. With no Republican cosponsors and only months left in the 119th Congress, the Act is unlikely to advance soon, but it offers a preview of proposals likely to surface in state legislatures in 2027 – and potentially in the next Congress, depending on the outcomes of the midterm elections. Because it sets a federal floor rather than replacing state law, it would also create uncertainty even in states with robust CPOM regimes.
- **Increased state enforcement remains immediate risk**. California and other states are already acting under existing law (e.g., the California Attorney General's Carbon Health and Aspen Dental settlements, SB 351, and AB 1415's transaction notice requirements), and the Federation of State Medical Boards' ("FSMB") May 2026 guidance gives medical boards a roadmap. Friendly PC/MSO structures should be reviewed now for control, share-transfer, termination, financing, and restrictive covenant provisions.

Background

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On September 16, 2026, the Stop Corporate Takeovers of Physicians Act of 2026 (the "Act") was introduced in the Senate by Sens. Elizabeth Warren (D-MA), Ron Wyden (D-OR), and Jeff Merkley (D-OR), alongside a parallel bill in the House (H.R. 10444), introduced by Reps. Val Hoyle (D-OR), Suhas Subramanyam (D-VA), and Alexandria Ocasio-Cortez (D-NY). The Act would establish a federal CPOM prohibition and would sharply curtail the "friendly PC" model, under which a physician-owned PC contracts with an MSO for financial and administrative support.

The proposed legislation reflects a broader national conversation regarding corporate influence in health care and frustration with a regulatory landscape that remains highly fragmented. Even among states with well-developed CPOM doctrines, significant differences exist in statutory requirements, enforcement priorities, and the degree to which regulators scrutinize management arrangements, ownership structures, and operational controls. The legislation seeks to create a more uniform national framework, driven by concerns that existing state approaches produce inconsistent results and leave perceived gaps in oversight.

The Act faces substantial political and practical hurdles. Its sponsors and cosponsors are all Democrats, and it was introduced in the final months of the 119th Congress, which ends in January 2027, making enactment unlikely in the near term; the Act would need to be reintroduced in the next Congress to advance. Moreover, the arrangements the Act targets are already receiving scrutiny from state attorneys general, state regulators, and private litigants under existing state CPOM, fee-splitting, and professional practice laws. Nevertheless, the Act offers an important window into the concerns of policymakers and regulators that are likely to surface in state legislatures during the 2027 session.

What the Act Proposes

The Act is modeled in part on Oregon's SB 951, which, when enacted in 2025, imposed some of the nation's strictest restrictions on the friendly PC model. The Act would extend comparable restrictions to physician practices nationwide and, in some respects, go further than Oregon. In effect, the Act would import the most restrictive elements of state corporate practice laws and elevate them into a nationwide framework.

As proposed, the Act would:

- Prohibit entities that are not majority-owned and controlled by licensees (defined to include physicians and advanced practice providers such as physician assistants and nurse practitioners) from owning or controlling medical practices or employing licensees, with exemptions for nonprofit and public health care providers, hospitals and hospital-affiliated clinics, critical access hospitals, and rural emergency hospitals;
- Prohibit MSOs, their owners, and affiliated personnel from holding equity interests in, governing, financing the acquisition of, or receiving dividends from managed physician practices;
- Prohibit MSOs from controlling or restricting the sale or transfer of a practice's shares, interests, or assets, effectively banning the continuity agreements, stock transfer restriction agreements, nominee arrangements, and similar structures that underpin most friendly PC models;
- Restrict management agreements by requiring that the practice negotiate them at arm's length through legal counsel, negotiators, and financial advisors it selects, and that compensation be consistent with fair market value;
- Require licensee owners to be licensed and present in a state where the practice furnishes services to patients and to be "substantially engaged" in delivering medical care;
- Prohibit MSOs from advertising the services of a medical practice under the name of an entity that is not the medical practice;
- Prohibit MSOs from exercising de facto control over key operational functions, including hiring, clinician compensation, staffing, scheduling, revenue disbursement and targets, coding and billing, pricing, payer contracting, and clinical standards;
- Void non-disclosure and non-disparagement agreements with licensees and prohibit non-compete agreements except with licensees who hold 25 percent or more of the practice's equity (a far narrower exception than Oregon's, which, as amended by HB 3410, permits non-competes with licensees holding as little as 1.5% of the practice's equity

and in certain recruitment and non-clinical arrangements, so the Act would void a substantially broader set of physician non-competes than Oregon law);
- Prohibit health care providers from interfering with or controlling licensees' clinical judgment, including decisions regarding time spent with patients, admission status, diagnoses, referrals, and clinical orders;
- Authorize substantial enforcement mechanisms, including FTC enforcement as an unfair or deceptive practice, state attorney general actions, private lawsuits with treble damages and attorney's fees, mandatory divestiture and disgorgement remedies, and potential exclusion from federal health care programs.

Federal Legislation Creates Tension with Existing State Frameworks

The proposed legislation is premised on the view that private equity firms, insurers, and corporate actors have exploited gaps in state CPOM laws through the use of friendly PC/MSO structures and that states have failed to protect patients and providers from corporate influence.

That framing overlooks an important reality: the friendly PC/MSO model is not unlawful per se. States have spent decades refining regulatory and enforcement frameworks that preserve physician control while allowing practices to access capital, operational expertise, and administrative infrastructure. States have intentionally crafted different approaches to address the distinct realities of their healthcare markets and regulatory environments.

Existing CPOM frameworks already provide meaningful safeguards against inappropriate corporate influence. States such as California, New York, Texas, and North Carolina historically have been among the most active in using existing state law and regulations to ensure that physicians maintain independence over clinical decision-making. The California Attorney General's June 2026 settlement with Carbon Health (which imposes $4.5 million in penalties and requires Carbon Health to restructure its friendly PC arrangement) and its settlement with Aspen Dental in May 2026 (under the parallel prohibition on the corporate practice of dentistry), together with AB 1415, which as of January 1, 2026 requires private equity groups, hedge funds, and MSOs to give the Office of Health Care Affordability ("OHCA") at least 90 days' advance notice of certain material change transactions (with OHCA's implementing emergency regulations still pending), demonstrate that state authorities have, and are using, the tools to investigate and address arrangements that improperly cede clinical control to unlicensed persons and corporate entities. California also enacted SB 351 (signed October 2025; effective January 1, 2026), codifying limits on private equity and hedge fund interference with the professional judgment of physicians and dentists and restricting certain non-compete and non-disparagement provisions.

Even in states where CPOM regimes may be less robust, attorneys general and regulators are positioned to limit improper arrangements, a reality recognized in guidance released by the Federation of State Medical Boards in May 2026 (the "Guidance"). The Guidance provides a practical framework for medical boards and other regulators, acting under existing state law, to evaluate whether physician-owned practices maintain meaningful clinical control. The Guidance also demonstrates that states already possess substantial authority to address the concerns driving the federal legislation, often through regulatory frameworks that are better tailored to the realities of their local healthcare markets. It calls for greater enforcement against "straw ownership" arrangements, emphasizing that physician owners should retain ultimate authority over clinical policies, staffing, financial distributions, and payer relationships, and encourages regulators to define and investigate impermissible third-party interference in clinical decision-making. Collectively, the Guidance provides a compliance roadmap for providers and management organizations that aligns with many existing state law requirements.

Notably, the Guidance recognizes that private investment and third-party participation can play a constructive role in healthcare delivery by supporting practice growth, improving operational efficiency, and enhancing access to care. These considerations are often absent from broader critiques of PC-MSO models and may be difficult to reconcile with certain restrictions the proposed federal legislation contemplates.

Compliance Complexity as a Hidden Cost of the Federal Framework

Oversight of the practice of medicine and the ownership of healthcare entities has long been a matter of state law. A federal statute regulating physician practice ownership, clinical control, and MSO involvement would therefore introduce a significant new layer of federal oversight into an area traditionally governed by the states. The proposed legislation attempts to address that tension by establishing a federal floor: its savings clause preserves state laws that impose equal or more stringent requirements, while federal requirements would apply wherever state law falls short. As a result, the Act would not displace more restrictive state regimes, but it would effectively override state laws that permit ownership structures, management arrangements, or contractual practices prohibited under the federal framework.

This distinction is significant because many state corporate practice of medicine laws advance similar policy objectives without imposing the same specific restrictions the Act contemplates. Consequently, even states with historically robust CPOM regimes could fall short of the federal standard if they allow arrangements the Act would prohibit, even though they share its goal of limiting corporate influence. For example, state laws that permit non-licensee ownership interests, grant MSOs operational authority the Act restricts, or allow certain non-compete, non-disclosure, or non-disparagement provisions applicable to licensed professionals would be effectively superseded to the extent they conflict with federal requirements. Even the law enacted in Vermont earlier this year (Act 133), which expressly prohibits private equity firms and hedge funds from interfering with clinical judgment or exercising control over clinical matters, likely would not be viewed as providing equivalent protection in all respects, because it does not prohibit private equity ownership and expressly permits MSO arrangements.

As a practical matter, the lack of clarity surrounding what qualifies as an equivalent level of protection likely would generate substantial uncertainty. Introducing additional uncertainty in the health care market underscores the challenge of imposing a federal framework on an area of health care regulation that has long been governed by state laws that are capable of addressing the underlying concerns.

Reinforce Your Compliance Framework as Enforcement Pressures Rise

The immediate compliance focus for healthcare organizations should remain on the existing CPOM guardrails enforced by state medical boards, attorneys general, and other state regulators. Although the proposed federal legislation may drive a shift in some states towards more active regulatory oversight of the governance and operational structures surrounding clinical care, most states are likely to continue to operate under CPOM enforcement regimes that preserve room for investment and management models that respect physician autonomy, preserve or provide access to care, and support patient-centered care.

As the debate over MSO oversight and physician practice ownership continues in state legislatures and the halls of Congress, providers and MSOs operating under a friendly PC structure should proactively review key agreement provisions to ensure continued compliance and reduce enforcement risk regardless of the state of operation:

- **Delineate Control**: Ensure that PC-MSO agreements clearly separate administrative support from clinical control. Confirm that physicians, not the MSO, retain ultimate authority over clinical staffing, clinician compensation, payer contracting, coding and billing, and equipment decisions that could influence patient care.
- **Physician Owner Engagement**: Document that PC owners are appropriately licensed in the state and actively engaged in clinical and governance decisions, consistent with the Guidance's focus on "straw ownership" and the Act's requirement that owners be substantially engaged in delivering medical care.
- **Ownership Transfer Provisions**: Review succession and continuity mechanisms to ensure share transfers are tied to defined events, such as death, disability, loss of license, or material breach, rather than broad MSO discretion.
- **Termination Rights**: Confirm that the PC retains meaningful rights to terminate the agreement for cause without effectively forfeiting the practice.
- **Financing Arrangements**: Distinguish permissible market-rate secured lending from financing structures that create excessive dependence on or control by the MSO.
- **Restrictive Covenants**: Inventory non-compete, non-disclosure, and non-disparagement provisions in physician and advanced practice provider agreements, which are a focus of recent state laws (including Oregon SB 951 and

California SB 351) as well as the Act.

- **Branding and Advertising**: Confirm that patient-facing names, websites, and advertising accurately identify the PC as the provider of professional services, an issue in both recent California Attorney General settlements and a specific target of the Act.

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