

Congress Proposes Bill Taking Aim at Corporate Control and Investment in Medical Practices

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On September 16, 2026, Senators Ron Wyden, Jeff Merkley, and Elizabeth Warren, together with Representatives Val Hoyle, Alexandria Ocasio-Cortez, and Suhas Subramanyam, introduced the Stop Corporate Takeovers of Physicians Act of 2026 (the “Act”) in the House and Senate. The introduced House bill, H.R. 10444, draws from Oregon’s [SB 951](#) and seeks to establish federal prohibitions on the Corporate Practice of Medicine (“CPOM”). These restrictions reflect a broader [state-level trend](#) toward increased [scrutiny](#) of non-physician investment in medical practices and “friendly physician” arrangements.

This blog post provides a general overview of the Act’s key provisions and prohibitions, enforcement mechanisms, and potential impacts.

Key Provisions and Prohibitions

CPOM Prohibition

The Act would make it unlawful for any partnership or corporate entity that is not majority-owned and controlled by one or more licensed physicians (“licensees”) to: (1) own or control, in whole or in part, a medical practice; (2) employ or contract for the professional services of a licensee; or (3) engage in the practice of medicine.

To satisfy the majority-ownership requirement under the Act, licensees must both hold a majority of the ownership or membership interests in the medical practice and constitute a majority of the practice’s governing body.

The Act provides an exception from this ownership and employment prohibition for nonprofit and public health care providers, hospitals, hospital-affiliated clinics, critical access hospitals, and rural emergency hospitals. Note, these entities would not be exempt from the Act generally and could remain subject to other provisions, including the licensee-autonomy protections and restrictions on certain restrictive covenants.

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Restrictions on Management Services Organizations

The Act also imposes extensive restrictions on management services organizations (“MSOs”). Such restrictions target “friendly physician” arrangements between MSOs and medical practices.

Among other restrictions, MSOs would be prohibited from owning or controlling an interest in a medical practice; paying dividends from shares or an ownership interest in a medical practice; financing the acquisition of an interest in a medical practice; controlling the transfer of practice interests or assets; participating in the management of the medical practice; or advertising services of a medical practice under the name of an entity that is not the medical practice. The Act further provides that MSOs would be prohibited from exercising “ultimate decision-making authority” over specified matters, including but not limited to, clinician hiring and termination, compensation, billing and coding, and payer contracting.

Any agreement between an MSO and a medical practice must be negotiated at arm’s length, using advisors selected by the medical practice and providing for compensation consistent with fair market value. An agreement that violates these prohibitions would be considered void and unenforceable.

Licensee Owner Requirements

The Act would also impose two requirements for licensee owners of a medical practice. Licensee owners must be: (1) “licensed and present” in a state where the medical practice furnishes services to patients and (2) “substantially engaged” in delivering medical care. The engagement requirement appears aimed at preventing passive licensee ownership under a “friendly physician” arrangement. The phrase “licensed and present,” however, may raise interpretive questions for multistate and telehealth practice models, including whether and under what circumstances services furnished through telehealth would satisfy the presence requirement.

Licensee-Autonomy Protections

To protect licensee autonomy, health care providers, including medical practices, would be prohibited from using discipline, punishment, threats, adverse employment actions, coercion, retaliation, or excessive pressure to interfere with, direct, or control a licensee’s clinical decisions. The Act identifies specific prohibited conduct and includes a catch-all covering other conduct that interferes with licensee decision-making.

Restrictions on Non-Competition, Non-Disclosure and Non-Disparagement Agreements

Under the Act, agreements involving a licensee would be void and unenforceable to the extent they impose a noncompete clause or prohibit the licensee from disclosing or disparaging certain matters. The Act provides a limited exception for a noncompete clause between a medical practice and a licensee who holds an ownership interest of at least 25 percent in the practice; that ownership exception does not extend to the

separate nondisclosure and nondisparagement restrictions.

Enforcement Mechanisms

The Act contemplates multiple avenues for enforcement:

- The Federal Trade Commission (“FTC”) would have authority to enforce the Act. Violations would be treated as unfair or deceptive acts or practices under the Federal Trade Commission Act and would be subject to the penalties available under that statute.
- The Act also creates a private right of action for individuals injured by a violation. Relief may include treble damages, attorneys’ fees and litigation costs, and other equitable or declaratory relief deemed appropriate by the court.
- State attorneys general may bring civil actions on behalf of state residents.

In any of the actions described above, a court may grant equitable and injunctive relief, including cease-and-desist relief, divestiture, and disgorgement of revenues attributable to the violation period. Additionally, the Act proposes to amend the Social Security Act to permit exclusion from federal health care programs for entities found to have violated the Act.

Preemption

Finally, the Act expressly provides that any state law which imposes equal or more stringent requirements on medical practices, licensees, and MSOs would *not* be preempted or displaced. In effect, the Act would create a new floor for regulating the CPOM.

Takeaways & Potential Impacts

CPOM regulation historically has been a state-law matter. The Act would depart from that approach by establishing a nationwide federal floor for medical practice ownership and control. Because the legislation has only been introduced and must proceed through the committee and legislative process, enactment is not imminent or assured. Even if the Act does not advance, however, it may influence federal and state policy discussions regarding medical-practice ownership, MSO arrangements, restrictive covenants, and licensee autonomy.

Although the Act would not prohibit every form of non-physician investment in health care, it would substantially restrict non-licensee ownership and control of medical practices and could require significant changes to common MSO structures and existing “friendly physician” arrangements. Entities operating in states without existing CPOM restrictions could face particularly significant restructuring. Entities in states that already regulate CPOM would need to assess whether their existing ownership structures and contractual arrangements comply with the new federal statutory requirements.

Because the Act would preserve state laws imposing equal or more stringent requirements, CPOM regulation would remain a patchwork of requirements that vary

across states. If enacted, entities operating across multiple states would need to evaluate compliance with both the federal requirements and any stricter state-law prohibitions.