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Healthcare Alert

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Federal bill proposes banning the corporate practice of medicine nationwide

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The Stop Corporate Takeovers of Physicians Act of 2026 would statutorily ban the corporate practice of medicine nationwide, void core PC-MSO contract terms, and require licensee owners to practice in a state where their practice delivers care.

What's the impact?

- The bill proposes to ban PC-MSO structures in which a non-licensee is the majority owner, or otherwise controls, or exercises de facto control over a medical practice.
- If enacted, a nationwide minimum standard will be imposed. States could implement stricter ownership and control requirements, but states that currently permit corporate ownership of medical practices could no longer do so.

On September 16, 2026, Senator Elizabeth Warren, together with Senators Ron Wyden and Jeff Merkley and Representatives Val Hoyle, Alexandria Ocasio-Cortez, and Suhas Subramanyam, introduced the Stop Corporate Takeovers of Physicians Act of 2026 (the Act).

The bill draws substantially from Oregon's Senate Bill 951 (SB 951) and proposes to establish a federal corporate practice of medicine prohibition, enforced by the Federal Trade Commission (FTC), private plaintiffs, and state attorneys general. For any entity operating a physician platform, a management services organization (MSO), or an investor-backed provider business, the proposed law seeks to impose restrictions covering the following four key areas (which are described in more detail herein):

- Non-licensee ownership or control of a medical practice;
- Licensee-owner qualifications (including license and active practice requirements);
- MSO ownership, governance, and control; and
- Protections for licensees (including limits on using restrictive covenants and interfering with clinical judgment).

The discussion below addresses each prohibition, the enforcement scheme, the jurisdictional and preemption questions raised by the bill, and the potential impact of the bill on stakeholders.

The core prohibition

The proposed law targets for-profit physician groups, including MSO-supported practices,[1] and would make it unlawful for any partnership or corporate entity that is not majority-owned and controlled by one or more licensees to (a) own or control, in whole or in part, such a medical practice; (b) employ, or enter into a contract for the professional services of, a licensee; or (c) engage in the practice of medicine. "Majority-owned and controlled" is a two-part test: the licensees must hold not less than a majority of the ownership or membership interest, and they must constitute a majority of the governing body.

The bill applies only to the practice of medicine. Dentistry, optometry, podiatry, and chiropractic practices appear to fall outside the bill's reach, as do behavioral health practices to the extent that they are not owned by physicians, physician assistants, or nurse practitioners.

A new federal test for ownership of a practice

If the bill is enacted, licensee owners of a medical practice would be required to be (i) licensed and present in a State where the practice furnishes services to patients, and (ii) substantially engaged in delivering medical care. Two consequences follow:

- **Passive licensee owners would not qualify**. A licensee owner who holds equity but does not

[1] The proposed law would not apply to nonprofit or public healthcare providers, hospitals, hospital-affiliated clinics, critical access hospitals, or rural emergency hospitals, as those terms are defined in section 1861 of the Social Security Act.

practice would not satisfy the "substantially engaged in delivering medical care" requirement. The bill does not elaborate on what this requirement means in practice, creating uncertainty for stakeholders without additional guidance or rulemaking from the FTC.

- **The presence requirement is unresolved for multistate practices**. Licensee owners must be "present" in a "[s]tate where services to patients are furnished by the medical practice." A single professional entity delivering care across multiple states, such as a telehealth platform, a national specialty group, or a practice operating in a metropolitan area that spans across a state line, would require licensee owners to be licensed and present in those states. Notably, the bill does not define what it means to be "present," creating ambiguity about whether a licensee owner must be physically present or whether presence via telehealth would satisfy this requirement.

Restrictions on MSOs

The bill proposes restrictions applicable to MSOs. Among other restrictions, an MSO (or any shareholder, director, member, manager, officer, employee, or contractor of an MSO) would not be permitted to:

- Own or control an interest in a medical practice;
- Issue, or cause a medical practice to issue, shares or other ownership interests in the practice, a subsidiary, or an affiliate;
- Pay dividends from shares or an ownership interest in a medical practice;
- Finance the acquisition of shares or other ownership interest in a medical practice;
- Advertise the services of a medical practice under the name of an entity that is not the medical practice;
- Control or exercise de facto control over the administrative, business, or clinical operations of a medical practice in a manner that affects the nature or quality of care; or
- Exercise "ultimate decision-making authority" over certain enumerated financial, clinical, and operational matters, including, but not limited to, hiring and termination of practice employees, staffing levels, appointment lengths, clinical standards and policies, billing policies, and third-party payor contracting.

Protections for licensees

NON-COMPETES, NDAS, AND NON-DISPARAGEMENT AGREEMENTS

The bill proposes to make it unlawful for any licensee, healthcare provider, or MSO to enter into a non-compete, non-disclosure, or non-disparagement agreement and renders any such agreements void and unenforceable, although an exception would apply to non-competes between a medical practice and a licensee who owns or controls 25% or more of the practice.

INTERFERENCE WITH CLINICAL JUDGMENT

The proposed law would prohibit a healthcare provider from interfering with, controlling, or directing a licensee's professional judgment or clinical decisions through discipline, punishment, threats, adverse employment actions, coercion, retaliation, or excessive pressure. Enumerated examples of interfering with professional or clinical decisions include, for example: specifying the time a licensee may spend with a patient and how quickly treatment should be initiated, controlling discharge referrals, and controlling or limiting the range of clinical orders available. The bill proposes authorizing the FTC to designate additional interfering actions by rules.

Enforcement, remedies, and exclusion

If enacted, three enforcement channels will be created: (i) FTC enforcement under section 18(a)(1)(B) of the FTC Act, which would treat a violation as an unfair or deceptive act subject to steep civil penalties; (ii)) a private right of action with treble damages, which would allow an injured person to recover three times the actual damages proven; and (iii) a state attorney general may sue on behalf of the state for equitable relief and monetary damages. The bill separately proposes to add violations as a basis for permissive exclusion from federal healthcare programs, which can have devastating impacts on a provider. Excluded providers will not only lose the ability to be paid by Medicare or Medicaid, but may also lose their professional licenses and hospital privileges and have their agreements with private payors terminated.

Jurisdictional and preemption questions

This bill raises structural questions that extend beyond compliance planning. These include:

STATE REGULATION

Regulating the practice of medicine and professional entities are matters typically reserved for the states and, regarding the practice of medicine, state medical boards. Notably, the bill makes no mention of state licensing boards, and the FTC's consultation obligation runs to the Secretary of Health and Human Services rather than to state regulators.

While the bill relies heavily on state licensure considerations, including whether a licensee owner is "licensed and present in a [s]tate" (an issue typically reliant on state law and reserved for a state medical board), the state licensing authorities are given no role in administering the proposed law. State medical boards would not possess any authority to enforce the federal requirement, even though this requirement is dependent upon state licensure.

As written, the bill creates ambiguity as to how federal and state enforcement mechanisms would interact.

PREEMPTION OF STATE LAW

While the bill provides that nothing in the Act would preempt, displace, or supersede any state law that imposes equal or more stringent restrictions, the Act does not address state law that is *more permissive.* Therefore, the proposed law would operate as a national minimum standard, and the proposed federal requirements would reach states that do not otherwise restrict corporate ownership of medical practices.

For organizations operating in those states, the impact could be significant. A practice that has been structured on the assumption that a non-professional person or entity may own a medical practice and employ physicians directly would need to undertake a comprehensive restructuring; transfer majority ownership and governance control to licensees who are themselves licensed and present in the state and substantially engaged in delivering care (which could be particularly challenging for multi-state physician platforms); unwind non-licensee and MSO equity (including MSO-financed acquisitions of practice interests); renegotiate agreements between the PC and MSO to remove transfer restrictions, governance rights, and fee terms prohibited by the terms of the proposed law; and abandon platform-level branding and payor contracting.

Looking ahead

The bill would take effect one year after enactment, with no grandfathering provision, transition mechanism, or cure period. Even practices in states that already restrict corporate ownership—and that may already comply with some of these requirements—would need to evaluate whether their existing arrangements satisfy each of the bill's specific mandates and make any necessary adjustments within that window.

While the corporate practice of medicine doctrine is not new and the doctrine has operated for decades across a majority of states, its source and enforceability vary widely from state to state. The federal bill proposes in a single text to consolidate and codify existing corporate practice of medicine principles, as well as statutory protections recently advancing in states such as Oregon and California, into a uniform and enforceable national standard. Independent of its prospects for enactment, the bill is worth watching and may serve as a reference point for state legislatures crafting similar legislation.

Stakeholders with physician platform exposure should continue to monitor these developments and proactively assess their ownership structures, MSO arrangements, and licensee protections in light of both this proposal and the broader regulatory trend.

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