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Congressional Cage Match 2026: Private Equity Squares Off Against Patient Care

By Douglas Nadjari and Chaya Rosenbaum
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A coalition of congressional Democrats has introduced legislation that could fundamentally reshape physician practice management throughout the United States. The proposed "Stop Corporate Takeovers of Physicians Act of 2026" (S. 5419) would establish a nationwide prohibition on many arrangements commonly associated with the "corporate practice of medicine."

According to Senator John Markey (D-Mass) "corporate greed is running rampant in every industry, but it is especially dangerous in healthcare. When private equity firms put profit over patients, our loved ones are harmed, health workers suffer, and communities are left to clean up the mess.

To his point, the new bill restricts both actual and de facto ownership of many healthcare entities through the auspices of management services organizations (MSOs). Aimed largely at private equity (PE), it contains sweeping restrictions, confers broad public and private enforcement authority and reflects this growing national debate: whether healthcare delivery should continue to rely upon PE or whether its influence has exalted the business of medicine over the art of medicine, all to the detriment of patient care and well-being.



Photographer: Nadine Hutton/Bloomberg

Patients wearing hospital-branded pyjamas sleep in the general ward of Natalspruit hospital in Katlehong, South Africa, on Monday, Sept. 19, 2011. "There is a base of 28.5 million people in the African market where there will be demand for the healthcare," Andre Meyer, Medscheme Ltd.'s chief executive officer said.

The cornerstone of the legislation prohibits any entity that is not majority-owned and controlled by licensed healthcare professionals from either owning or controlling a medical practice or employing physicians, nurse practitioners, physician assistants, or other covered licensed clinicians.

In so doing, it threatens the most common MSO structures and would diminish the influence of PE by prohibiting MSOs owned by them

from: (i) controlling ownership transfers of physician practices; (ii) financing acquisitions of physician practices; (iii) owning interests in physician practices; (iv) controlling physician compensation; (v) determining staffing levels; (vi) establishing productivity or revenue targets; (vii) controlling billing practices; (viii) directing payer contracting; (ix) influencing diagnostic coding; and (x) controlling clinical policies or exercising de facto operational control over medical practices.

The bill also: (a) prohibits non-clinicians from controlling patient admission decisions, clinical documentation, referrals, coding, discharge planning, or referrals to other professionals or services, (b) makes it unlawful for healthcare providers or MSOs to enter into non-compete agreements with physicians and certain other clinicians, and any prohibited non-compete provision would be deemed void and unenforceable and (c) prohibits MSOs from advertising for, hiring, or staffing medical practices.

The bill will cripple the MSO model prevalent in New York and elsewhere and its enforcement provisions are as sweeping as its prohibitions:

· Violations would constitute unfair or deceptive practices under consumer protection law, and the FTC would gain investigative authority over for-profit and certain nonprofit healthcare entities.

· State attorneys general could seek monetary and equitable relief and the bill creates private rights of action permitting any person injured by a violation to bring suit.

· Courts could order divestiture and disgorgement of revenues earned during noncompliance, and award treble damages, attorneys' fees, and costs.

· Violators would be subject to exclusion from federal healthcare programs.

· Agreements that offend the statute would be deemed void.

New York's regulatory scheme lies within a constellation of statutes and regulations that prohibit the corporate practice of medicine. At its foundation, both the Business Corporation Law and the Limited Liability Company Law permit only those who hold medical licenses to be shareholders or members of a professional corporation or professional limited liability company. These basic restrictions are supported by prohibitions upon fee splitting, (punishable as professional misconduct).

In addition, litigators have long argued that once private equity insinuates itself through aggressive MSOs, objective medical decision-making is compromised. Such conduct, they contend, may constitute de facto ownership, the actual practice of medicine and, some argue, a felony offense proscribed by Ed. Law 6512(1).

Despite this, New York lacks strong enforcement power and de facto corporate ownership is becoming the rule rather than the exception. To be sure, physician practices across the state (and country) have been acquired at an alarming rate, in one form or another, largely by PE firms.

For better or worse, the seductive power of PE is undeniable; practices have a dire need for capital necessary to counter dwindling reimbursement, keep up with staffing needs and acquire new equipment necessary to remain competent and competitive.

A PE firm may acquire an established practice and then acquire smaller practices, thus building better economies of scale, larger referral networks and the bargaining power that enables them to negotiate higher reimbursements from health insurers. In general, PE firms aim for annual returns exceeding twenty percent in a short investment period with an eye toward profitable resale.

While PE provides a necessary cash infusion, the fear is that healthcare decisions are being made by PE firms (or the MSOs they control) and when the art of medicine is subservient to its business, physicians, who are compensated

based upon the volume of work they produce rather than the quality of care delivered, face subtle pressure to increase profitability by ordering expensive diagnostic testing and seeing more patients in less time.

There seems to be little consensus in this debate and in a survey of 1200 physicians conducted earlier this year, sixty-one percent said PE investment could positively affect patient care through financial support while at the same time 78% also said PE investment could compromise patient care. Eighty-two percent felt PE investment may encourage over-testing or overtreatment simply for profit.

There is a growing national trend to limit PE's investment in healthcare. Oregon recently enacted legislation resembling the proposed federal bill. Connecticut is considering restrictions on private equity control of hospitals and expanded oversight of MSOs, while Illinois is weighing enhanced pre-merger notice requirements for private equity and hedge fund transactions. Massachusetts, New Mexico, Vermont, and Washington have likewise pursued expanded attorney general oversight and review of healthcare transactions.

Because federal bill may be vulnerable to constitutional challenge, these state laws may prove critical. The Tenth Amendment provides that powers not delegated to the federal government by the Constitution are generally reserved to the states and the authority to regulation of medicine is traditionally reserved for the states.

Legal challenges aside, the provisions of this bill are sufficiently hostile (as are those enacted or now actively considered by various states) that private equity may simply walk away and look for more lucrative investments that carry far less regulation, restriction, and risk of litigation. Without private funding, we will inevitably move toward some form of universal health care or a single payor "Medicare for All" system because there will be no other choices.

Mark Rieger, M.D., a physician leader with extensive experience in practice management and physician finance, " Ultimately, I agree that legislation should preserve clinical autonomy while allowing access to necessary resources. Where I differ is the suggestion that no meaningful alternative exists between private equity dependence and government financing of the entire system.

The alternative is physician leadership supported by professional management, workable financing, fair competition, and accountability. Congress should not merely restrict who may control a medical practice. It should make it economically realistic for physicians to retain that control. Patients benefit when the people responsible for their care have both the authority and the resources to deliver it well.

If the bill fails—and it may—it offers the opportunity to find a real way to strike a balance that preserves clinical autonomy while at the same time encouraging the private investment that healthcare desperately needs to survive. As simple as that sounds, we see nothing on the horizon.

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