

Banning Corporate Medicine: The Costs Congress Isn't Pricing In

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VIEWPOINT TOPICS

- Health Care

Senators Warren, Wyden, and Merkley, along with Representatives Hoyle, Ocasio-Cortez, and Subramanyam, have introduced the [Stop Corporate Takeovers of Physicians Act](#). The bill would establish the corporate practice of medicine doctrine, rooted in more than a century of law in about half of the states, as a federal baseline. The bill would require that licensed physicians be majority owners and controllers of medical practices and place limitations upon management services organizations. Its rationale is straightforward: a prior Senate bill titled the [Break Up Big Medicine Act](#) asserted that more than 75% of U.S. physicians now work for corporate employers, and the sponsors want clinical decisions made by doctors rather than shareholders.

While the goal may be laudable, the design isn't. The bill doesn't stop consolidation; it just changes who owns the practice. And it carries three costs its sponsors haven't priced in, all paid by patients and physicians.

1. ***It could accelerate the rural closures it aims to prevent.*** Rural and independent practices rely on management companies, staffing firms, outside capital, and lay entity ownership out of necessity. Many can't recruit specialists or fund billing, compliance, records systems, and state-of-the-art technology alone. Investor-backed groups already staff about a quarter of U.S. emergency departments, mostly where hospitals can't fill shifts any other way. Over 30% of rural hospitals are at risk of closing. Making these arrangements illegal, or merely uncertain, doesn't protect them. It cuts off the capital and staffing that keep them open.
2. ***It could raise prices by pushing practices into hospitals.*** Hospitals and nonprofits are exempt from the ban. A practice facing new compliance costs has one easy exit: sell to the hospital. Hospital employment is the biggest driver of higher prices, largely through facility fees. Where the hospital is the only other buyer, patients get higher costs and fewer choices.
3. ***It could freeze capital well beyond its target.*** The bill's private right of action, treble damages, and joint enforcement among the FTC, DOJ, and state attorneys general create exposure far beyond large investment firms. Hospital-affiliated management companies, academic physician groups, small physician practices, and telehealth platforms are all in range. Buyers will need to assess corporate-practice risk robustly. Lenders who count on management-fee cash flow face new uncertainty. Expect fewer buyers, costlier financing, and lower valuations, hitting small and rural practices hardest. For an owner near retirement with no successor, the sale as an exit may simply disappear.

The bill treats the symptom, not the cause.

Block the private buyer, and the practice sells to the hospital system. The physician is still an employee, now with a facility fee attached. The underlying pressures remain. For example, Section 6001 of the Affordable Care Act, which Senator Wyden and other backers of this bill supported, tightened the Stark Law (the Physician Self-Referral Law) by effectively eliminating the "whole hospital" exception for new facilities. In practice, Congress banned new physician-owned hospitals, barred new facilities from billing Medicare or Medicaid, and capped expansion of grandfathered ones. Those limits remain in effect.

Critics argue the provision pushed physicians into employment by large systems and fed the consolidation and price increases this bill now blames on investors. Leave that law alone, ban one kind of buyer, and you get a messaging bill, not a fix.

An alternative answer: let doctors own

The [Physician Led and Rural Access to Quality Care Act \(H.R. 2191 / S. 1390\)](#), backed by Senator Lankford and colleagues, and [endorsed by the GOP Doctors Caucus](#), would expand physician ownership instead of restricting outside ownership. It would allow physician ownership of rural hospitals more than a 35-mile drive (15 miles in extremely remote areas) from a main patient campus or critical access hospital, and lift restrictions on existing physician-owned hospitals. It does this by expanding Stark

Law flexibilities for physicians and physician-owned hospitals.

Same problem, different diagnosis. One bill bans a buyer. The other removes the federal barrier that kept doctors from owning the facilities where they practice. Only the second gives rural patients and physicians a new option instead of taking one away.

What to watch heading into the 120th Congress

The bill is dead for now, but the ground is moving. Seven things to track, and to act on before reintroduction, not after:

- **Midterm control.** The bill dies with this Congress. November decides whether reintroduction gets a hearing. Engage before the result, not after.
- **The reintroduced text.** Expect a rural or critical-access carve-out to answer this year's biggest criticism. Shape it while the text is open.
- **Committee venue.** Wyden's Finance seat controls Medicare, Medicaid, and the exclusion penalty. A Senate flip fast-tracks the bill there.
- **The Oregon precedent.** The [PeaceHealth case](#) settled after a judge found "ample evidence" of a violation. Courts are defining "control" now, with or without Congress. Track the rulings.
- **State activity in 2027.** Oregon-style bills are coming to statehouses regardless. Each one that passes strengthens the case for a federal floor. Track which states move first.
- **The Republican alternative.** H.R. 2191 / S. 1390 is the GOP's physician-ownership answer to consolidation. Watch whether Stark reform enters any bipartisan deal, and be ready to engage if it does.
- **FTC posture.** Agency leadership can move faster than any bill. Watch FTC enforcement now, whatever happens to this bill.

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