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Will Oregon's new law privately pitched as a ban on private equity in medicine, and legally structured as support for its already existing prohibition on the corporate practice of medicine, catch on across the country, impacting PE, physicians, and investors?

Certainly, Oregon is a small state in terms of medical practice, but what's happened in Oregon could, and some say will, spread across the country.

It poses issues for any physician desiring to sell his or her practice, whether it's small or mega size. And it's a burning question for private equity and other investor-owned medical groups who may be facing a world of hurt, not only in terms of having to divest ownership, but potentially, to fend off securities fraud lawsuits brought by investors.

Here's some background and the basic points that you need to know, no matter where you practice.

Background: Prohibition on the Corporate Practice of Medicine

Approximately 33 states have prohibitions on the corporate practice of medicine in one form or another.

In its pure form, these prohibitions, whether legislated or state court made, restrict who may own and control a medical practice, chiefly limiting those roles to physicians and, in some instances, to certain other healthcare professionals.

Disqualified "Owners" and the End-Run around the Prohibition

Because the front door to acquiring a medical practice was "locked" by the prohibition, lay investors such as private equity funds and other disqualified buyers found two open windows to climb through. Sometimes used alone and sometimes in tandem, those two end-runs are as follows:

1. Management Service Organization

The term "management service organization", or "MSO", is a broad descriptor of a business that provides some menu of items and services to a medical practice. It could include space, or supplies, or personnel, and so on.

In the common variant used as a proxy for medical practice ownership, the PE or other lay acquirer buys all of the target practice's assets other than the pure medical practice which remains owned by the target entity. Subsequently, it acts as an MSO, "renting" the benefit of the acquired assets plus attendant management support to the post-closing, stripped out target medical practice, which remains owned by the sellers, the physicians. [Note that the same structure could be used to create a new PE controlled medical group.]

The problem is that as opposed to a hands-off, business services relationship, the arrangements are generally structured, de facto or de jure, in a way in which the MSO exercises controlling influence over the purportedly independent, physician controlled medical practice.

2. The "Friendly Physician" Model

Often used in concert with the MSO structure, the second strategy is for the PE or other lay investor to identify a physician willing to cooperate, the so-called "friendly physician", who will him or herself "own" the shares in the medical practice entity.

The friendly physician's hands are tied by way of agreements that restrict the transfer of the physician's shares to anyone other than someone identified by the investor, i.e., a replacement friendly physician. In fact, the common set up involves the lay investor having right to instruct the current friendly physician to transfer ownership. Because the friendly physician is drawing compensation related to playing the role, he or she is likely to lend a very forgiving ear to the "suggestions" made by the non-owner PE "owner" lest he or she be fired.

Additionally, these end-run structures often include devices such as nondisclosure, noncompetition, and nondisparagement agreements to stifle reporting of and accountability for improper control of the medical practice.

Steelman

To be fair to those proponents of PE acquisition via one or both of those strategies, the steelman argument is that the purpose of the prohibition on the corporate practice of medicine is to preserve and restrict medical practice decision-making to those licensed to practice medicine.

Proponents assert that physician control remains in place because one or more physicians remain the legal owners of the medical practice and remain the licensed individuals charged with, and ultimately responsible for, patient care.

Additionally, both investors interested in purchasing and physicians desiring to sell their practices correctly assert that the presence of PE and other investors creates a larger pool of buyers, increasing purchase price multiples.

Oregon Senate Bill 951

The proponents of the new Oregon legislation, signed into law the second week of June 2025, disagree.

Although clearly aimed at blocking PE investment in medical practices, the law is framed as protecting end-runs around the state's judicially established prohibition on the corporate practice of medicine.

In simplified form, the law prohibits an MSO, or a shareholder, director, member, manager, officer, or employee of an MSO, from structuring an arrangement with a practice in the manner almost necessarily required by an PE buyer.

For example, the law places restrictions on controlling a majority of shares in a practice. It bars controlling or restricting the sale or transfer of a medical entity's shares. It prohibits a plethora of functions including, but not limited to, hiring or terminating or setting work schedules or compensation for medical licensees; making diagnostic

schedules or compensation for medical licensees; making diagnostic coding decisions, setting clinical standards or policies, setting prices, rates, or amounts the professional medical entity charges, among many others.

The law also imposes restrictions on medical practices in order to accomplish the same general ends. For example, a medical practice is prohibited from entering into an agreement that would permit anyone other than a majority of its own physician directors or shareholders from removing a director or an officer other than in certain specified instances of improper conduct.

Last, the new law places restrictions on noncompetition agreements and invalidates non-disparagement and non-disclosure agreement between a medical professional and an MSO (as well as with hospitals and certain other entities), except under certain limited circumstances.

Timing

Some restrictions, such as those applying to covenants not to compete, are void as to contracts entered into or renewed after the date of the law's enactment, June 9, 2025.

The law's application to MSOs and medical entities organized after the date of enactment do not go into effect until January 1, 2026.

And, for MSOs and practices in existence as of June 9, 2025, they must come into compliance by January 1, 2029. In other words, an existing, traditional end-run PE buyer has through 2028 to divest.

Additional Analysis

The law likely moots the business rationale for PE and other investor investment in medical practices located in Oregon.

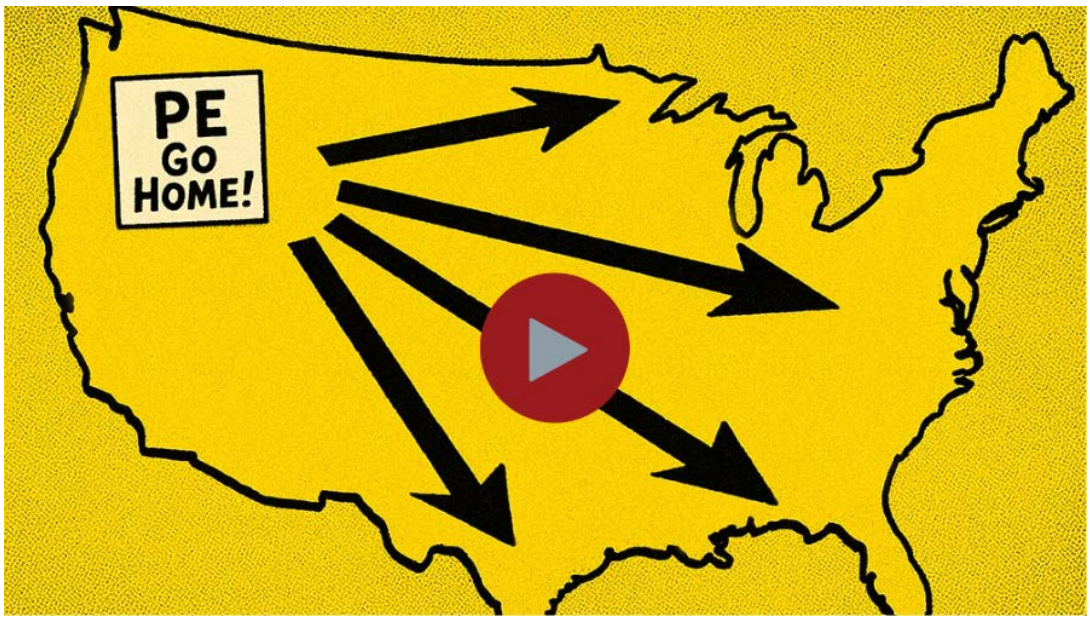
Those opposed to PE in healthcare will be happy. Those who wish to sell their practice will be faced with a smaller universe of potential buyers (and an increase in sellers due to PE divestment), which, in all probability translates to a significantly lower purchase price, in some cases, zero, because there will be no buyers for many practices.

But these issues impact both physicians and investors who have no interest in Oregon medical practice. That's because the push to pass the Oregon legislation, which previously died and then rose from the

dead, reinvigorated, was fueled by physician pushback against private equity's incursion into medical practice.

That same fuel is present in many states. Those states with existing prohibitions on the practice of medicine will likely see similar attempts to erect roadblocks to the MSO and friendly physician models. Those states without existing prohibitions might see physicians pushing for initial prohibitions.

Additionally, it's interesting to note that if PE firms did not disclose the risk of strict enforcement of prohibitions on corporate medicine when raising money from their investors, they face potential claims of securities fraud.



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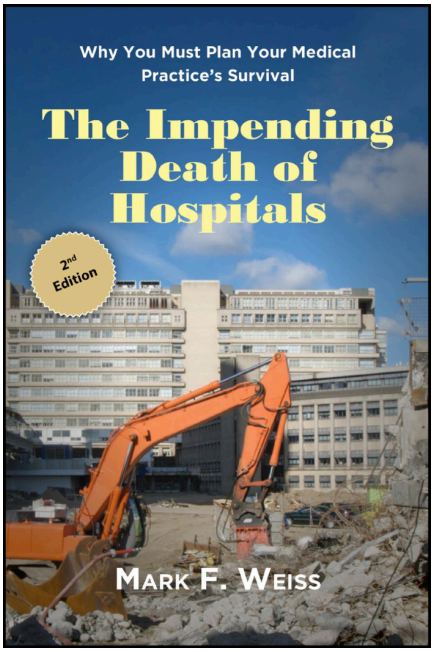

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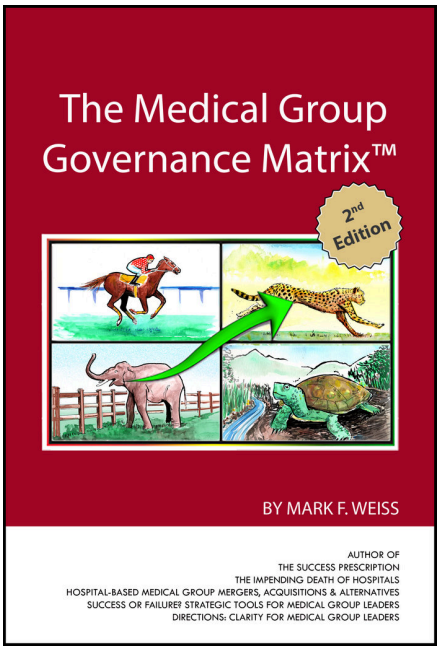

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