A reading sample from ***Structural Anatomy of MSO and DSO Arrangements****. This is the complete chapter as it appears in the book.*

Payer Ownership

8.1 The Structural Question: When the Payer and the Provider Are One Enterprise

Every arrangement read so far has had two sides: a professional entity that delivers care and a management organization that runs the business around it. Payer ownership adds a third. When the entity that pays for the care — an insurer, a health plan, or a risk-bearing entity — belongs to the same enterprise that delivers it, the structure acquires a boundary the earlier chapters did not have to read, and the questions change accordingly. The reading is no longer only who controls the practice and where its value goes; it becomes how value, risk, and control move across the line between the side that collects the premium and the side that delivers the care, when both sides are owned by one enterprise.

The change this works is best seen by contrast. In the ordinary world, the payer and the provider are adversaries across a contract. The payer wants to pay less; the provider wants to be paid more; the rate between them is set by a negotiation across an arm's-length line, and each side's regulator, incentives, and interests pull against the other's. Common ownership internalizes that adversarial line. What was a negotiation becomes an allocation: the enterprise that owns both sides decides what the payer pays the provider, how risk is divided between them, and where the margin is booked, and it decides all of it in its own interest rather than across a contest of interests. The premium dollar and the care it buys are now inside one enterprise, and the structural reading follows them across a boundary that has become internal.

Payer ownership is not new, and it is not, in itself, a defect — a point this chapter holds onto as firmly as the others held their neutrality, because the subject invites editorializing the structural reading must refuse. Integrated delivery, in which a single enterprise in-

sures and treats the same population, is a long-established model, and at its best it aligns the enterprise toward the total cost and quality of a population's care rather than toward the volume of services billed — an alignment many regard as the soundest in the system. What is new is that the consolidation this book examines is producing fresh instances of payer-provider integration: management platforms taking on insurance risk, and insurers acquiring provider platforms, assembling by transaction the integration the established model grew into over decades. Those new instances are read the same way the established model would be — for whether the integration genuinely aligns the enterprise toward the value of care, which is the sound form, or whether common ownership is used to capture value and shift risk across the internal boundary in ways the structure obscures, which is the fragile one. The form is the same; the question is which the structure actually serves.

8.2 The Boundary and the New Entity

The first move is to put the payer on the schematic. The entity set the control chapter drew — sponsor, management company, professional entity, friendly owner, real-estate entity, captive vendors — gains a payer or risk-bearing entity, commonly owned with the management side, and a line connecting the two that carries premium, payment, and risk. That line is the payer-provider boundary, and it is the new object of the reading.

Its structural significance is that what crosses an internal boundary is set rather than negotiated. Between unaffiliated parties, the payment rate, the risk terms, and the coverage rules that govern a provider's relationship with a plan are the product of opposing interests meeting in a contract; each is disciplined by the other side's resistance. Across a boundary inside one enterprise, that discipline is gone, and the terms are whatever the common owner sets them to be. This does not make the terms wrong — an enterprise may set an internal transfer at exactly the rate an arm's-length market would have reached — but it removes the adversarial check that ordinarily makes the rate trustworthy, and it means the reading cannot take the internal terms at face value the way it might take a negotiated one. The boundary has to be read for whether what crosses it reflects defensible value or simply reflects the owner's preference

about where, within its own enterprise, to place the money and the risk.

Figure 8.1 The Entity Schematic — Extended Across the Payer Boundary ENTERPRISE — COMMONLY OWNED (PAYER + PROVIDER) internal transfer price (pays for care) Management Company the DSO / MSO premium Payer / Members / Gov't Program Risk-Bearing Entity collects the premium MSA risk Professional Entities the PCs — deliver the care (+ affiliated vendors & real estate, as in Figs 4.3–5.1) the payer–provider boundary — set, not negotiated WHAT CHANGES WHEN THE PAYER IS INSIDE THE ENTERPRISE Transfer price & risk MLR & risk-adjustment floors Coverage / care conflict set internally, not negotiated not waivable by structure internalized in one enterprise The same schematic, extended: the adversarial payer–provider line becomes internal. What was a negotiation across a contract is now an allocation the common owner sets — which removes the adversarial check that ordinarily makes the rate trustworthy. Stylized composite.

8.3 Economics Across the Boundary

The economics chapter followed value out of the professional entity through a set of channels. Payer ownership adds the most consequential channel of all, and places it across the new boundary. The enterprise that owns both sides captures its margin where premium exceeds the cost of the care delivered, and that margin can be booked on either side of the internal line — taken at the payer level as underwriting profit, or moved to the provider level, or shifted between them — through the terms the common owner sets. Three features of the crossing have to be read.

The first is the internal transfer price: what the payer pays the provider for care. Between unaffiliated parties this is the negotiated rate; inside the enterprise it is a transfer price the owner sets, and it functions exactly as the affiliated-vendor and affiliated-rent channels did in the economics chapter, only larger, because it governs the whole flow of payment for care. Read on the defensible-to-extractive spectrum, a transfer price that approximates what an arm's-length market would pay is defensible; one set to move

margin to whichever side of the boundary is most advantageous — least visible, least regulated, or most favorable at a later sale — is the same value-shifting the earlier channels accomplished, now on the largest scale the arrangement offers. The second is the risk arrangement: capitation, shared savings, or shared risk, by which the provider side assumes from the payer side responsibility for the cost of a population's care. Between unaffiliated parties this transfers risk across a bargain; inside the enterprise it allocates risk between the owner's own pockets, and it is read for whether the allocation is a genuine alignment toward managing the cost of care or a placement of risk and reward chosen to flatter one side's reported results. The third is the regulatory floor: an insurer is generally subject to a medical-loss-ratio requirement obliging it to spend a minimum share of premium on care, and the internal transfer price and the affiliated arrangements determine how that ratio is computed — which costs count as care and which as administration — so the boundary is read for whether the integration meets the regulatory floor in substance or arranges the internal flows to meet it only in form. That classification, it should be said, is not the enterprise's to set at will: which costs count as care is defined and audited by the regulator, so the reading asks not what the enterprise has chosen to call care but whether its classification holds against the regulator's definitions.

Where the enterprise bears risk for a government program — Medicare Advantage being the principal arena — the crossing acquires a further dimension, because the premium the enterprise captures is set through a risk-adjustment mechanism that pays more for sicker populations, and the federal program-integrity and fraud-and-abuse frameworks read the arrangement for whether the risk it reports and the care it delivers actually match. This chapter reads that dimension structurally, through the documented terms and flows, and not through the claims-level behavior that belongs to a different kind of inquiry entirely; the structural question is whether the arrangement's documented design aligns reporting with care or creates a gap between them.

The fragile-to-sound reading follows. A sound payer-owned economics is one in which the internal transfer price is defensible, the risk arrangement genuinely aligns the enterprise toward the value

of care, the regulatory floors are met in substance, and the margin the enterprise earns is the margin of having managed cost and quality well. A fragile one uses the internal boundary to book margin where it is least visible, to shift risk to flatter results, or to arrange the flows so a regulatory floor is met in form while the substance escapes it — value moved across the boundary by an owner setting both sides, wearing the form of payment for care.

Payer ownership also carries the durability reading across the boundary, and adds questions to it the provider-only chapters could not reach because the payer was not yet on the schematic. A payer-owned structure's value depends not only on the durability of the control, value, and governance profiles the exit chapter tested, but on durability particular to the payer side: whether the insurance licenses transfer cleanly at a sale, whether the risk contracts and any government-program participation renew or lapse, and whether the regulatory regime the structure was built around — the medical-loss-ratio rules, the risk-adjustment mechanism — is itself stable or shifting. A risk-bearing integration assembled under one set of program rules can strain when those rules change, independent of anything the parties do, and a buyer inherits the licenses and the program participation only on the terms the regulators allow. These are the payer-side additions to the durability question the exit chapter framed, and they are read the same way: for whether the integration holds when it changes hands and when the regime around it moves.

8.4 Control and Governance Across the Boundary

The control reading extends across the boundary as readily as the economics did. The reserved powers now include the power over the payer entity — over the premium it sets, the coverage it grants, the claims it pays — and over the terms that govern the internal line, and in the common case the same owner holds the deciding power on both sides, so that the relationship between payer and provider is not a relationship

between parties at all but a set of decisions one owner makes. Reading control means recognizing that the boundary's terms are an exercise of the owner's reserved powers, not the output of two parties'

dealing.

Governance is where payer ownership introduces its most distinctive feature, because common ownership internalizes a conflict the separation of payer and provider was partly meant to keep apart. The same enterprise sets the premium and decides what care is covered, on the payer side, and delivers the care and decides what care is needed, on the provider side — and it earns its margin, in part, by spending less on care than it collects in premium. The structural conflict is plain and need not be moralized to be read: the enterprise that profits from spending less on care also decides, on the coverage side, what it will pay for, and influences, on the provider side, what is delivered. The corporate practice doctrine still fences the clinical layer, requiring that the treatment decision rest with the clinician; payer ownership adds a coverage-and-utilization layer alongside it, where the decisions about what is covered and what is authorized sit with the payer side of the same enterprise. The governance reading asks whether those decisions are insulated from the margin incentive — whether coverage and medical-necessity determinations are governed with genuine independence, and clinical decisions genuinely held by clinicians — or whether the margin incentive reaches across into the coverage and the care. A sound structure governs the internalized conflict with real insulation: coverage and clinical decisions made on their own terms, documented and defensible, with the margin earned downstream of decisions made honestly. What makes that insulation operative rather than recited is, as with governance generally, a set of structural marks a reader can look for: medical directors and utilization reviewers whose compensation does not turn on the denials they make; medical-necessity and coverage criteria tied to recognized external standards rather than set to the enterprise's internal target; an appeals process the enterprise cannot quietly override; and a clinical leadership whose authority over treatment the payer side cannot reach. These are the descriptive marks by which operative insulation is told from formal — not advice on repairing a given enterprise, but the features whose presence places the conflict's governance toward the sound end and whose absence places it toward the fragile. A fragile structure leaves the conflict ungoverned, so that the same incentive that sets the

premium reaches the authorization and the treatment, and the insulation the structure recites is, like a formal governance right, decoration over an enterprise deciding in its own interest at every step.

8.5 Reading Payer Ownership: Two Stylized Composites

The integration can be built from either side, and the reading runs the same way from both. Each composite is stylized — the structure is representative, not any particular enterprise.

Provider-led integration. Consider a management-organization platform of the kind the earlier chapters read, which adds a risk-bearing capability — a captive health plan, or risk contracts under which it accepts capitation for a population, including under a government program. The internal boundary now runs between the platform's risk-bearing side and its provider side. The reading extends the prior chapters across it: the transfer price between the plan and the practices is read on the defensible-to-extractive spectrum; the risk arrangement is read for genuine alignment versus result-flattering placement; the medical-loss-ratio and risk-adjustment dimensions are read structurally through the documented terms; and the governance is read for whether coverage and utilization decisions are insulated from the platform's margin incentive or absorbed by it. A sound version is an integration that genuinely manages the cost and quality of a population's care; a fragile one uses the captive plan to capture and relocate margin across a boundary the owner controls on both sides.

Payer-led integration. Consider the mirror: an insurer that acquires a provider platform — a management organization and the professional entities it manages. The same boundary appears, drawn from the other direction, and raises an additional control question, because the acquirer is now the payer, and the provider platform it has bought still sits under the corporate practice doctrine. The reading runs as before — transfer price, risk allocation, regulatory floors, the insulation of coverage and clinical decisions — with the doctrine's clinical-layer fence read on the provider side exactly as the control chapter read it, since an insurer owning a provider platform is as much a non-clinician owner as a private-equity sponsor

is. The sound and fragile cases are the same as in the provider-led version; only the direction of assembly differs.

8.6 Enforcement Context: A Second Regulator at the Boundary

Payer ownership brings the arrangement under a body of regulation the earlier chapters did not have to reach, because the payer entity is itself regulated. An insurer or risk-bearing entity is licensed and supervised — by state insurance regulators, and for government-program risk by federal program authorities — and is subject to solvency and reserve requirements and to the medical-loss-ratio floors described above. The structural reading therefore acquires a second regulator at the boundary: where the provider side answers to the corporate practice doc-

trine and the licensing boards, the payer side answers to insurance regulation, and the internal terms that cross the boundary are read against both.

The transaction-review regimes reach payer ownership directly, and in some respects were built for it: the notice and review frameworks that the enforcement chapter described as reaching providers and management organizations reach payers as well — payers are among the entities a regime like California's brings within its notice requirements — so that a transaction assembling a payer and a provider under common ownership is among the most likely to draw pre-closing review. The antitrust posture reaches it from the vertical direction: where the consolidation chapters' antitrust concern was horizontal — a roll-up concentrating a single market — payer-provider integration raises the vertical concern that an enterprise owning both a plan and the providers can foreclose competitors on either side, a concern the enforcement agencies read in vertical-merger terms. Payer ownership also has an enforcement dimension of its own, distinct from the antitrust angle in the way each earlier chapter's subject had its own line: where an enterprise both insures and provides, and steers its members toward the providers it owns, that steering is read not only for foreclosure but against the member-protection and network-adequacy rules that govern what a plan must offer its

members and how it may direct them — and, where the members are in a government program, against that program's own anti-steering and marketing rules. The vertical-foreclosure concern looks at competitors; the member-protection concern looks at the member, and a payer-owned structure is read against both. And where federal-program dollars are involved, the program-integrity and fraud-and-abuse frameworks apply to the risk and payment arrangements as they do to the fee arrangements of the economics chapter, with the same requirement that the arrangements rest on defensible value.

One feature distinguishes this chapter's exposures from the provider-side ones in kind, and it bears stating plainly: the payer-side regulator's requirements are not waivable by structure. A management fee can be tuned, a governance right made operative, a control profile rebuilt — but an enterprise cannot structure its way out of a medical-loss-ratio floor, a solvency requirement, or a risk-adjustment audit, because those are obligations the insurance and program regulators impose on the payer entity directly, whatever the surrounding structure. The structural reading locates how the internal flows meet those obligations in substance; it does not treat them as terms the structure can set.

Across all of it the substance-over-form discipline governs, as it has throughout. An enterprise does not establish that its internal transfer price is defensible by reciting that it is at market, or that its coverage decisions are insulated by charting an independent committee; the reading asks what the transfer price does to the margin and whether the insulation operates in fact, exactly as the economics and governance chapters asked of the fee and the governance rights. Payer ownership, read structurally, is the same reading the rest of the book performs — control, economics, and governance — extended across one more boundary, against one more regulator, with the conflicts one degree more internalized. This chapter, like those before it, locates the exposure rather than pricing it: it records where, across the payer-provider boundary, the integration aligns the enterprise toward the value of care, and where it uses the boundary to move value and risk in ways the structure conceals.

8.7 Closing Checklist: Reading Payer Ownership

Payer ownership is read by following value, risk, and control across the internal boundary, and by reading the conflict the boundary internalizes.

• Put the payer on the schematic. Is there a payer or risk-bearing entity commonly owned with the provider side, and what premium, payment, and risk cross the boundary between them? • Read the internal transfer price. What does the payer side pay the provider side for care, is it set as a defensible approximation of arm's-length value or as a lever to relocate margin, and toward which side of the boundary does it move the money? • Read the risk arrangement. How is risk for the cost of care allocated across the boundary — capitation, shared savings, shared risk — and does the allocation align the enterprise toward managing cost and quality, or place risk and reward to flatter one side's reported results? • Read the regulatory floors structurally. Do the internal flows satisfy the medical-loss-ratio and, where applicable, the risk-adjustment requirements in substance, or are they arranged to meet the floor in form? • Extend the reserved-powers reading. Who holds the power over the payer entity and over the terms that cross the boundary — and is the payer-provider relationship a dealing between parties or a set of decisions one owner makes? • Read the internalized conflict. Are coverage and medical-necessity decisions, on the payer side, and clinical decisions, on the provider side, insulated from the enterprise's margin incentive with genuine independence — reviewers not compensated on denials, criteria tied to external standards, an appeals process the enterprise cannot override, clinical authority the payer side cannot reach — or does that incentive reach the authorization and the treatment? • Read against the second regulator and the vertical and member-protection concerns. Does the payer entity meet its insurance-regulatory obligations, which structure cannot waive; does the integration raise the vertical-foreclosure concern toward competitors and the member-protection, network-adequacy, and anti-steering concerns toward members; and where a government program is involved, do the risk and payment arrangements rest on defensible value? • Test durability across the boundary. Beyond the control, value, and governance durability the exit reading tests, would the payer side hold a change of hands

and a shift in regime — do the insurance licenses transfer cleanly, do the risk contracts and program participation renew, and is the regulatory regime the structure was built around stable? • Locate the whole on the axis. Taking the integration as a whole, does it align the enterprise toward the value of a population's care — the sound form integration can take — or does it use the internal boundary to capture value and shift risk in ways the structure conceals?

8.8 Closing the Reading

The reading is now complete. An arrangement of this kind can be taken apart and read for who controls it, where its value goes, how its decisions are made, whether its answers hold when it changes hands, and — where a payer belongs to the same enterprise — how value, risk, and control move across

the boundary inside it. Read in sequence, those questions resolve a structure that is built, deliberately, to be difficult to read: they replace the cap table the structure defeats with a map of the reserved powers, the value channels, the governance machinery, the exit terms, and the payer boundary, and they locate every part of the arrangement on the single axis the book has used throughout — from the fragile, where the structure's substance departs from its form and depends on no one reading past the recital, to the sound, where substance and form agree and the arrangement does what it says.

That axis is the book's one persistent claim, and it is deliberately not a verdict. These structures are neither sound nor fragile as a class; they are built across the whole range, and the difference between a durable arrangement and a precarious one is not the model but the settings — how the primitives are tuned, where the powers sit, how the value flows, whether the protections are operative, what survives the change of hands, and how the conflicts of an internal payer boundary are governed. To read an arrangement well is to locate it on that range with enough precision that the reader — counsel testing their own structure, an investor weighing one, a litigator or a regulator examining one, a clinician deciding whether to enter one — can see exactly where it is sound and exactly where it is not, and act on the difference. The structural reading does not render

the legal judgment, price the exposure, or pronounce the arrangement healthy or doomed; it equips the reader to see the structure as it is. The instruments that turn each of these readings into a worked, repeatable examination are the subject of the companion volume; the understanding the instruments apply is the subject of this one.

End Matter

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