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THE OWNERSHIP OF HEALTH INSURERS

Peter Molk*

Spending by private health insurers exceeds \$800 billion and is expected to rise. The Affordable Care Act provides \$2 billion in subsidies to jump-start health insurers owned by their policyholders in an attempt to bring these costs under control. Firms with this corporate ownership structure have succeeded in other insurance markets, where Nationwide, Northwestern Mutual, and State Farm are just a few prominent examples. However, the potential of policyholder ownership in health insurance, which is dominated by investor and nonprofit ownership, is poorly understood. This Article applies theories of corporate ownership and control to analyze the strengths and weaknesses of investor, nonprofit, and policyholder health insurer ownership. Theory and an original empirical study of 1,000 individuals' projected healthcare consumption choices reveal policyholder ownership's ability to solve contracting failures, reduce overconsumption of medical services, and contribute to "bending the cost curve" of American health expenditures in ways unattainable by investor-owned or nonprofit insurers. The ACA's provisions for subsidizing policyholder ownership, however, force these firms to adopt restrictive policies that both exacerbate potential governance costs and keep them from maximizing policyholder ownership's advantages. In fact, the ACA's requirements force these firms into nonprofit/policyholder-owned hybrid organizations that capture the advantages of neither. Using additional empirical findings, this Article recommends ways that policyholder-owned health insurers could be promoted consistent with sound corporate governance principles.

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I. INTRODUCTION

The Affordable Care Act (“ACA”),¹ signed into law on March 23, 2010, and upheld by the Supreme Court as constitutional on June 28, 2012,² imposes significant change on the \$900 billion private health insurance industry.³ Proponents of reform perceived two problems: high healthcare spending that was projected to increase and a large number of individuals without adequate health insurance.

The ACA targeted this second problem through the headline-grabbing individual and employer mandates, insurance exchanges, and premium pricing restrictions.⁴ Significant attention was also directed at the first problem of controlling health spending, although it has received less coverage by the popular press. One of these provisions allocated \$6 billion in federal funds to subsidize “cooperative” health insurers, or insurers owned by their policyholders instead of investors.⁵ Termed Consumer Operated and Oriented Plans (“CO-OPs”), these insurers were envisioned by Congress as lowering costs by increasing competition and consumer choice, particularly in non-competitive markets.⁶ Although policyholder-owned cooperatives—also called “mutuals”—are common in other insurance markets, where prominent examples include New York Life (\$425 billion in assets), Northwestern Mutual (\$230 billion in assets), State Farm (\$225 billion in assets), and Nationwide (\$183 billion

1. Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 42 U.S.C.), amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111-152, 124 Stat. 1029 (2010). References in this Article to ACA indicate PPACA amended by HCERA as applicable.

2. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012). Although the Court held unconstitutional the ACA’s conditioning of continued levels of Medicare support on states’ willingness to expand Medicaid coverage, it upheld the broader regulation of the health insurance market and the individual mandate. *Id.*

3. *National Health Expenditures Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (July 28, 2015, 3:04 PM), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>.

4. See, e.g., Stacy Cowley, *Many Low-Income Workers Say No to Health Insurance*, N.Y. TIMES (Oct. 19, 2015), http://www.nytimes.com/2015/10/20/business/many-low-income-workers-say-no-to-health-insurance.html?_r=0; Sara Hansard, *State ACA Exchanges Financially Sustainable, Directors Say*, BLOOMBERG BNA (Sept. 30, 2015), <http://www.bna.com/state-aca-exchanges-n57982058902/>.

5. 42 U.S.C. § 18042 (2012).

6. Terry Gardiner, Roger Neece, & Michael Mendelevitz, *Realizing Health Reform’s Potential*, 8 COMMONWEALTH FUND, Apr. 2012, at 1, available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Apr/1591_Gardiner_innovative_strategies_help_coops.pdf; *Shining a Light on Health Insurance Rate Increases*, CENTERS FOR MEDICARE AND MEDICAID HEALTH SERVICES (Dec. 21, 2010), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ratereview.html>.

in assets),⁷ the decision to subsidize health insurance cooperatives drew irate opposition and was a topic of spirited Congressional debate.⁸ Those on the left viewed the cooperatives as a disappointing substitute for a robust public option,⁹ whereas those on the right feared the cooperatives would surely fail, taking taxpayer subsidies with them, while giving the federal government a foot in the door towards publicly provided health insurance.¹⁰

Despite these concerns, Congress ultimately committed \$2 billion to assist health insurance cooperatives' formation.¹¹ This is not the first time Congress has influenced the organizational structure of health insurers to try to control health spending. In the face of rising projected health costs of the 1970s,¹² President Richard Nixon signed the Health Maintenance Organization ("HMO") Act of 1973 to spur the creation of HMOs, insurers whose policyholders pay a fixed premium in exchange for covered treatment over the year at the insurer's facilities.¹³ The original HMO bill allocated \$375 million,¹⁴ comparable to the \$2 billion subsidy in current dollars,¹⁵ over a five-year period during which the legislation would, according to President Nixon, "enable the Federal Government to help

7. 2013 Annual Report, NATIONWIDE 8 (2013), available at <http://static.nationwide.com/static/NAC-292-2013-Annual-Report.pdf?r=42>; 2013 Annual Report, NEW YORK LIFE 2 (2013), available at <http://www.newyorklife.com/nyl-internet/file-types/2013-Annual-Report.pdf>; Facts for 2015, NORTHWESTERN MUTUAL (2015), available at http://www.northwesternmutual.com/about-northwestern-mutual/our-company/Documents/fact_sheet.pdf?win_type=pdf&form; State Farm Insurance Cos., FORTUNE, <http://fortune.com/fortune500/state-farm-insurance-cos-41/> (last visited Jan. 16, 2015).

8. See generally Mark A. Hall, *Evaluating the Affordable Care Act: The Eye of the Beholder*, 51 HOU. L. REV. 1029, 1029–30 (2014) (describing opposition to ACA).

9. Robert Pear & Gardiner Harris, *Alternate Plan as Health Option Muddies Debate*, N.Y. TIMES, Aug. 17, 2009, at A1, available at http://www.nytimes.com/2009/08/18/health/policy/18plan.html?_r=1 (quoting Nancy Pelosi as saying that in spite of the cooperatives, "[a] public option is the best option to lower costs, improve the quality of health care, ensure choice and expand coverage").

10. Press Release, U.S. House of Representatives, Energy & Commerce Comm., Energy and Commerce Leaders Seek Information on Potential Cost to Taxpayers in CO-OP Program (Apr. 24, 2012), <http://energycommerce.house.gov/press-release/energy-and-commerce-leaders-look-for-information-potential-cost-taxpayers-co-op-program> (identifying Representative Cliff Stearns's concerns of "[t]he potential losses to federal taxpayers" if the cooperatives fail); Sam Stein, *Kyl: Co-Ops a "Trojan Horse" for Public Option, GOP Won't Support*, HUFFINGTON POST (May 25, 2011), http://www.huffingtonpost.com/2009/08/18/kyl-co-ops-a-trojan-horse_n_262075.html (quoting Senator Jon Kyl as characterizing cooperatives as a "Trojan horse" aimed at implementing an eventual public plan).

11. Phil Galewitz, *Fiscal Deal Kills New Funding for Health Law's Co-Ops*, KAISER HEALTH NEWS (Jan. 2, 2013), <http://capsules.kaiserhealthnews.org/index.php/2013/01/fiscal-deal-kills-new-funding-for-health-laws-co-ops/>. In addition to the \$2 billion in funding, the ACA creates a special federal tax exemption for subsidized cooperatives, providing further (indirect) stimulus. 26 U.S.C. § 501(c)(29) (2012) (co-op exemption); PPACA Pub. L. No. 111-148, § 1322(h), 124 Stat. 119, 191–92 (2010) (creation of 26 U.S.C. § 501(c)(29)).

12. S. REP. NO. 93-129, at 1–2 (1973).

13. Health Maintenance Organization Act of 1973 ("HMO Act of 1973"), Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified at 42 U.S.C. § 300e (2012)).

14. HMO Act of 1973 §§ 2, 3, 87 Stat. at 930, 934–35.

15. Bureau of Labor Statistics, *CPI Inflation Calculator*, BUREAU OF LABOR STATISTICS, <http://data.bls.gov/cgi-bin/cpicalc.pl?cost1=375&year1=1973&year2=2014> (last visited Jan. 16, 2015).

demonstrate the feasibility of the HMO concept.”¹⁶ Forty years later, HMOs provide health insurance to a significant portion of Americans.¹⁷

Will policyholder-owned health insurers gain similar traction to HMOs and prove a viable vehicle for health insurance delivery? Will they do anything to curb the growth of national health expenditures? Is there a need for policyholder ownership in light of the investor-owned and nonprofit insurers that currently dominate private health insurance? Despite the importance of these questions, there was little reasoned discussion about the appropriateness of health insurance cooperatives before Congress appropriated \$2 billion for their benefit.¹⁸ Nor has anything changed in the time since the subsidies have been handed out.¹⁹

This Article considers explicitly whether there is a role for health insurance cooperatives owned by their policyholders in providing insurance and controlling costs. The Article applies theories of firm ownership and design to determine whether the cooperative ownership structure has advantages beyond what incumbent nonprofits and investor-owned insurers already provide. The Article also incorporates results from an experiment that assesses individuals’ projected behavior as policyholders under different models of health insurer ownership and uses these results to inform how the theory could play out in practice. This combined analysis demonstrates cooperative insurers’ real potential in addressing problems in modern health insurance. The analysis also reveals significant problems in their design and governance resulting from specific conditions that the ACA requires of subsidized cooperative insurers. In fact, these restrictive conditions mean that the ACA-subsidized firms are not really cooperatives at all and will be unable to capitalize on the benefits offered by policyholder ownership. Indeed, hampered by these restrictions, half of ACA-subsidized insurers have already failed.²⁰

Part II describes the current market for health insurance, focusing on important design elements of health insurance markets that make contracting between insurers and policyholders difficult and costly. It al-

16. President Richard Nixon, Statement on Signing the Health Maintenance Organization Act of 1973 (Dec. 29, 1973), available at <http://www.presidency.ucsb.edu/ws/?pid=4092>.

17. See, e.g., *Total HMO Enrollment*, KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/total-hmo-enrollment/> (last visited Jan. 16, 2015) (showing almost 86 million Americans as being insured through HMOs); see generally Lynn R. Gruber et al., *From Movement to Industry: The Growth of HMOs*, 7 HEALTH AFFAIRS 197 (1988) (describing rise of HMOs in response to federal stimulus).

18. See, e.g., Frank Paquale, *Jost on Cooperatives*, HEALTH REFORM WATCH (June 15, 2009), <http://www.healthreformwatch.com/2009/06/15/jost-on-cooperatives/> (reprinting Timothy S. Jost, *Are Cooperatives a Reasonable Alternative to a Public Plan?*); Anne Underwood, *So What’s a Health Insurance Co-op, Anyway?*, N.Y. TIMES (Aug. 17, 2009, 4:02 PM), <http://prescriptions.nytimes.com/2009/08/17/so-whats-a-health-insurance-coop-anyway/> (interview with Timothy S. Jost).

19. Cf., *Health Policy Brief*, HEALTH AFFAIRS, http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_107.pdf (last updated Jan. 23, 2014).

20. See Sean Williams, *More Than Half of Obamacare’s Co-Ops Have Now Failed – Here’s Why You Should Care*, THE MOTLEY FOOL (Nov. 15, 2015, 2:18 PM), <http://www.fool.com/investing/general/2015/11/15/more-than-half-of-obamacares-co-ops-have-failed-he.aspx>.

so outlines how key provisions from state and federal regulation, including the ACA affect this process.

Part III introduces the theory of cooperative firms, and uses this theory to develop how cooperative health insurers can reduce these contracting costs in ways that existing investor-owned and nonprofit insurers cannot. By making policyholders the owners of the insurer, cooperatives credibly commit to both high-quality coverage and policyholder-level reductions in healthcare consumption that other insurers cannot replicate. This Part augments the theoretical advantages with results from an original empirical study of 1,000 individuals' projected health decisions, which is the first systematic empirical investigation into cooperatives' potential to reduce member-owner moral hazard—in this case, policyholders' overconsumption of healthcare. The empirical evidence confirms that cooperative insurers could reduce policyholder overconsumption of healthcare, enhancing social welfare by controlling the rise in national health expenditures. The Article finds that in a situation representative of healthcare overconsumption, participants with a cooperative insurance company are significantly more likely to select a low-cost treatment option relative to those with an investor-owned insurer, doing so over twice as often, and thirty percent more likely to choose low-cost treatment than are those with a nonprofit insurer.

Part IV addresses why market forces have not already given rise to policyholder-owned health insurers. If cooperative health insurers could provide significant benefits, one would expect them already to be major players in the health insurance market, formed by savvy entrepreneurs. The key impediment is that cooperatives require a special entrepreneur who is willing to sacrifice personal gain for community benefit. Absent these individuals, cooperatives start only when specialized market conditions exist. I explore the differences between market conditions in the early 20th century—when some health insurance cooperatives organized successfully—and modern market conditions. I also compare health insurance to the evolution of property insurance, which shares similar market contracting failures that could be solved by policyholder ownership but which, unlike health insurance, has a significant cooperative market share.²¹

Part V addresses how subsidies could overcome existing market failures to facilitate the formation of cooperative health insurers. This

21. Cooperative insurers are referred to as “mutuals” in the property/liability and life insurance markets. Property/casualty insurance has a roughly twenty-five percent mutual market share, while health insurance has only a one percent cooperative market share. Peter Molk, *The Puzzling Lack of Cooperatives*, 88 TUL. L. REV. 899, 923, 940 (2014) (mutual market share). See also CARMEN DE NAVAS-WALT ET AL., U.S. DEP'T OF COMM., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, 23 (2011), available at <http://www.census.gov/prod/2011pubs/p60-239.pdf> (256 million Americans have health insurance.); Harris Meyer, *Feds Jump-Start Health Insurance Co-Ops with Loans*, KAISER HEALTH NEWS (Feb. 22, 2012, 1:25 PM), <http://www.kaiserhealthnews.org/stories/2012/february/21/health-coop-cooperatives-federal-loans.aspx> (noting that cooperative health insurers cover only approximately 2 million people before the ACA subsidies).

Part considers how both financial and nonfinancial subsidies could work in tandem with optimal governance and ownership provisions. To inform these provisions, this Part uses additional results from an empirical investigation into individuals' projected healthcare consumption decisions to show how these decisions are affected by how the insurer spends surpluses. These results are particularly important for cooperative design, as they show how different packages of policyholder-owner rights produce outcomes of varying desirability.

Finally, Part VI critically assesses provisions in the ACA and associated regulations developed by the Secretary of Health and Human Services that subsidize new health insurance cooperatives while imposing restrictions on their organization and operation. These requirements render the resulting organizations more fairly characterized as nonprofits rather than cooperatives. Unfortunately, these restrictions will undermine much of the cooperatives' potential benefit and, more disturbingly, could introduce dysfunction into these insurers' ownership and governance. I offer alternative guidelines that will provide policymakers with much needed guidance for designing effective cooperatives, while remaining consistent with the ACA's overarching goals.

A systematic appraisal of the ACA subsidies is warranted for several reasons. In a \$600 billion market, the rewards from these corrections can be particularly significant. Further, it is important to critique and reform the ACA's cooperative provisions because they present a large basin of attraction. New cooperatives will inevitably adopt the ACA's constraints in spite of their disadvantages because of the sizable subsidies that are attached, and therefore Congress has in essence co-opted the formation of new private health insurance cooperatives. Finally, the lessons drawn throughout this Article address broader issues of when a particular ownership structure offers advantages and how it should be subsidized. These lessons will prove useful for ongoing and future policy decisions that determine whether or how nonprofits, cooperatives, or investor-owned firms of a specified type offer advantages and should be subsidized.

II. CONTRACTING PROBLEMS IN THE HEALTH INSURANCE MARKET

This Part introduces features of the health insurance market that make it suited for the benefits of cooperative health insurers. Health insurance, even more than other types of insurance, is a product that few individuals fully understand.²² When combined with sophisticated, repeat-player insurers, this keeps the market for health insurance contracts from functioning perfectly. Market failures abound between insurer and policyholder. Regardless of whether individuals obtain insurance through the individual market or through their employer, six interrelated factors

22. See Omri Ben-Shahar & Carl E. Schneider, *The Failure of Mandated Disclosure*, 159 U. PA. L. REV. 647, 659 (2011).

drive these failures. First, individuals are comparatively unsophisticated and have difficulty valuing insurance contracts.²³ Second, policyholders have difficulty in comparison-shopping policies due to a lack of transparency.²⁴ Third, many markets have only one or two dominant insurers, giving them monopolistic market power over policyholders.²⁵ Fourth, there are information asymmetries: both insurers and policyholders possess information the other would like to know but cannot credibly learn,²⁶ which ultimately hurts policyholders. Fifth, moral hazard can lead policyholders to overconsume medical services.²⁷ And finally, relevant time horizons for policyholders and for insurers are very different.²⁸

As a consequence of these failures, federal and state governments have regulated various aspects of health insurance contracting, but this regulation is necessarily imperfect. In the following sections, the Article briefly discusses each of these contracting problems and the corresponding regulatory response. Cooperatives, by supplementing this contracting process with an ownership relationship, can offer significant welfare gains in each of these areas as I discuss in Part III.²⁹

A. *Imbalance in Sophistication*

First, policyholders are unsophisticated, lacking the training or expertise to effectively evaluate the convoluted language of modern health insurance contracts. They also participate in the insurance market only infrequently: the typical insurance policy remains in force for a year, and a policyholder usually has only infrequent and sporadic claims to file with her insurer.³⁰ Even a policyholder with an impressive understanding of her policy's terms will have difficulty in accurately assessing their value, because such a calculation requires knowing abstruse details such as of the insurer's negotiated rates for medical services, the probabilities of the policyholder requiring any particular medical service, and the selection of an appropriate discount rate—a calculation beyond the capability, ken, or interest level of most individuals.³¹ Insurers, on the other hand,

23. See *infra* Part II.A.

24. See *infra* Part II.B.

25. See *infra* Part II.C.

26. See *infra* Part II.D.

27. See *infra* Part II.E.

28. See *infra* Part II.F.

29. Because this Article is concerned with policyholder choice of health insurers, and particularly health insurance cooperatives, I do not address government run Medicare and Medicaid programs in which the insurance provider (the government) is fixed by statute.

30. See HEALTH CARE COST INST., HEALTH CARE COST AND UTILIZATION REPORT: 2010, 12 (2010), available at http://www.healthcostinstitute.org/files/HCCI_HCCUR2010.pdf (finding policyholders with three of the largest private insurance companies in 2010 visited a health professional about 3.3 times per year, and filled 9.3 drug prescriptions); see, e.g., Rhode Island BlueCross Blueshield, Subscriber Agreement: BlueSolutions for HAS Direct 5000/10000, at 10 available at https://www.bcsri.com/sites/default/files/BlueSolutions_HSA_Den_DP_5000_10000_00E_Bronze_v114.pdf (listing the length of the insurance policy as one “benefit year” which automatically renews annually every January 1st).

31. See, e.g., Ben-Shahar & Schneider, *supra* note 22, at 659.

are highly sophisticated enterprises and are, of course, repeat players in the health insurance market. They employ batteries of actuaries who use the insurer's wealth of prior experience to estimate costs associated with any individual's policy.³²

This dynamic creates the potential for the insurers to take advantage of customers. Policyholder unsophistication means most customers will not appropriately price the value of policies or individual policy terms,³³ giving insurers the potential to overcharge.³⁴ State and federal regulation restrict, but do not eliminate, the space of possible insurer opportunism through a series of consumer-protection regulations.³⁵

B. Difficulty in Comparison Shopping

Even if most policyholders are unsophisticated, a fluid, competitive market could arise if policies could be compared easily to one another.³⁶ With unregulated insurance markets, this does not happen.³⁷ Health insurance contracts are not commodities. The terms of policies can differ in

32. Approximately seventy percent of actuaries work in the insurance industry. BUREAU OF LABOR STAT., U.S. DEPT OF LABOR, ACTUARIES: WORK ENVIRONMENT, in OCCUPATIONAL OUTLOOK HANDBOOK (2014), available at <http://www.bls.gov/ooh/math/actuaries.htm#tab-3>. See generally BUREAU OF LABOR STAT., U.S. DEPT OF LABOR, ACTUARIES: WHAT THEY DO, in OCCUPATIONAL OUTLOOK HANDBOOK (2014), available at <http://www.bls.gov/ooh/math/actuaries.htm#tab-2> (describing actuaries working in health insurance as “help[ing] develop long-term car and health insurance policies by predicting expected costs of providing care” under a given contract).

33. See, e.g., Karen Pollitz & Larry Levitt, *Health Insurance Transparency Under the Affordable Care Act*, KAISER FAM. FOUND. (Mar. 8, 2012), <http://kff.org/health-reform/perspective/health-insurance-transparency-under-the-affordable-care-act/> (“[T]oo often, consumers don’t fully understand how coverage actually works until they get sick and try to use it, and then are surprised to learn their plan doesn’t pay as much, or at all, for care they thought would be covered.”).

34. See Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 644–45 (1979) (discussing conditions under which suppliers respond to a critical mass of informed customers by offering all customers a competitive price).

35. States and the ACA determine minimum levels of coverage that all plans sold to individuals, small employers, and certain large employers must provide. They also regulate the premiums that insurers can charge and cap insurers’ profit margins. PPACA, Pub. L. No. 111–148, § 1001, 124 Stat. 119, 131, 135, 137 (2010) (codified as amended in scattered sections of 42 U.S.C.); 45 C.F.R. § 158 (2014) (implementing minimum medical loss ratios); *State Approval of Health Insurance Rate Increases*, NAT’L CONFERENCE OF ST. LEGISLATURES (last updated Aug., 2015), <http://www.ncsl.org/issues-research/health/health-insurance-rate-approval-disapproval.aspx> (premiums). Large employers that self-insure can avoid much of this regulation, although fines enacted as part of the ACA encourage employers to meet these requirements. See 26 U.S.C. § 4980H(a)–(b) (2012) (requiring payment for large employers who fail to provide health insurance to employees); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 736 n.14 (1985) (exempting self-insured plans from state regulation); Suja A. Thomas & Peter Molk, *Employer Costs and Conflicts under the Affordable Care Act*, 99 CORNELL L. REV. ONLINE 56, 59–60 (2013) (discussing employers’ incentive to offer qualifying coverage because of these fines).

36. Comparison-shopping in a competitive market would push insurers to offer competitive prices even if policyholders could not accurately value the product, as long as insurers cannot easily price discriminate. Schwartz & Wilde, *supra* note 34.

37. *Id.* at 644–45, 651; see also D. Brad Wright, *Health Insurance and Free Market Competition*, HUFFINGTON POST, http://www.huffingtonpost.com/d-brad-wright/health-insurance-and-free_b_485112.html (last updated May 25, 2011, 3:45 PM) (attributing rising health insurance premiums to a “unregulated and non-competitive” health insurance market where consumers are not able to make substantive policy).

important respects from one another. Deductibles, copayments, physician networks, and covered procedures routinely vary from one health insurance policy to another.³⁸ For an individual policyholder to price the relative value of these differences beyond the roughest of estimates involves incurring costs that make doing so not worthwhile, or impossible.³⁹

Pricing the terms of the policy is not the only difficulty that policyholders face when comparison shopping. They must also evaluate the insurer's quality, which involves accessing and appraising the insurer's claims practices, such as how often it denies legitimate claims. Insurers typically do not make this information available unless required by regulators, so policyholders must rely on imperfect anecdotal experience or quasi-regulatory private bodies for rough substitutes,⁴⁰ again keeping them from accurately pricing policies regardless of sophistication.⁴¹ States and the federal government again, through various consumer protection regulations, restrict but do not eliminate the space for opportunism.⁴²

38. See CONSUMERS UNION, WHAT'S BEHIND THE DOOR: CONSUMERS' DIFFICULTIES SELECTING HEALTH PLANS (2012), available at <http://consumersunion.org/pub/pdf/Consumer%20Difficulties%20Selecting%20Health%20Plans%20Jan%202012.pdf> (discussing how this and other difficulties make comparison shopping difficult). The network of covered doctors in particular is subject to change without meaningful advanced notice to policyholders. See, e.g., Matthew Sturdevant & William Weir, *Children's Hospital and Insurer Settle Lengthy Contract Dispute*, HARTFORD COURANT (June 12, 2012), http://articles.courant.com/2012-06-12/health/hc-cmc-anthem-0613-20120612_1_david-r-fusco-anthem-blue-cross-care.

39. See Randall D. Cebul et al., *Unhealthy Insurance Markets: Search Frictions and the Cost and Quality of Health Insurance*, 101 AM. ECON. R. 1842, 1845 (2011) (predicting that "search frictions" allow insurers to charge supra-competitive prices).

40. Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Regulation*, 61 UCLA L. REV. 394, 418 (2014) ("[T]he vast majority of states did not make publicly available claims payment rates of health insurers' before the Patient Protection and Affordable Care Act (ACA).").

41. Ben-Shahar & Schneider, *supra* note 22, at 659–60.

42. The ACA requires that insurance for individuals and small employers be offered through "exchanges"—marketplaces where plans are sorted into four categories. The plans within each category are roughly similar, facilitating comparisons within and across categories. See 42 U.S.C. § 18022(d)(1) (2012); LARRY LEVITT & GARY CLAXTON, KAISER FAM. FOUND., FOCUS ON HEALTH REFORM: WHAT THE ACTUARIAL VALUES IN THE AFFORDABLE CARE ACT MEAN 4 (Apr. 2011), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf> (describing variation among plans within a single category); Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 139–40 (2011) ("An exchange is an entity that helps organize an underlying market and facilitate comparison shopping by buyers.").

Some state and federal law also require insurers to disclose certain claims payment information, allowing for critical evaluation by policyholders or other parties. Schwarcz, *supra* note 40. And the ACA requires individual- and group-market insurers to disclose key coverage information in an easily digestible four page uniform document. PPACA, Pub. L. No. 111–148, § 1001, 124 Stat. 119, 132–133 (2010) (codified as 42 U.S.C. § 300gg-15(b) (2012)); Blank Summary of Benefits and Coverage Form, CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 23, 2013), <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/sbc-template-accessible.pdf>. Taken as a whole, these laws restrict but do not eliminate insurer opportunism. For instance, the uniform document refers policyholders to their policy or plan document for complete coverage descriptions. See Blank Summary of Benefits and Coverage Form, *supra*. These policy and plan documents can easily be over one hundred pages long. See, e.g., Anthem BlueCross BlueShield, Subscriber Agreement for Anthem Silver DirectAccess Plan (Connecticut) (on file with author) (109 pages).

C. Market Power

Although on a national scale individual health insurers are relatively small, consumers do not shop nationally for their health insurance. Instead, the relevant markets for health insurance are local or regional areas within a particular state.⁴³ A study by the American Medical Association found that in sixty-four percent of the 313 metropolitan statistical areas examined, a single insurer had a market share of at least fifty percent, and in ninety-six percent of metropolitan statistical areas at least one insurer had a thirty percent market share.⁴⁴ The individuals and small businesses that buy insurance from health insurers have far less bargaining power than the insurers in these situations. Although large employers might be able to exert some leverage over large insurers,⁴⁵ large employers instead generally choose to self-insure and hire third-party administrators, a market which itself can have significant concentration.⁴⁶

When health insurers have large market shares and concomitant market power, they can extract monopoly profits from policyholders.⁴⁷ To combat market power, regulators can restrict firm size or firm behavior. The ACA adopts the second approach, requiring insurers to devote eighty-five percent of premiums from large group plans and eighty percent of premiums from small group and individual plans (called minimum medical loss ratios) to health-related expenses,⁴⁸ effectively capping profits at no more than fifteen to twenty percent of premiums.⁴⁹ The effect is to limit insurer market power to a restricted range, but not to eliminate it.⁵⁰

43. AM MED. ASS'N, COMPETITION IN HEALTH INSURANCE 2 (2007), available at file:///C:/Users/Citri_000/Downloads/amastudy.pdf.

44. *Id.* at 5.

45. Cf. Cebul et al., *supra* note 39, at 1855–56 (finding that employers who do not self-insure will still face supra-competitive prices because of search frictions in the health insurance market).

46. STATE OF N. H. INS. DEP'T, SUPPLEMENTAL REPORT OF THE 2010 HEALTH INSURANCE MARKET IN NEW HAMPSHIRE 20 (2012), available at http://www.nh.gov/insurance/lah/documents/suprep_10.pdf (showing high concentration of third party administrators in New Hampshire); Bulletin from Andrew Boron, Dir. of Ins., Ill. Dep't of Ins., to All Insurers, Registered Utilization Review Organizations, and Licensed Third Party Administrators in Illinois (Dec. 20, 2012), <http://www.iwcc.il.gov/CB2012-12.pdf> (requiring certain third party administrator-related activities to be conducted by companies located within the state of Illinois only).

47. Those markets with greater health insurer concentration are generally less competitive, measured along a variety of dimensions. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-864R, PRIVATE HEALTH INSURANCE: RESEARCH ON COMPETITION IN THE INSURANCE INDUSTRY 3-6 (2009), available at <http://www.gao.gov/new.items/d09864r.pdf> (collecting studies to this effect).

48. 42 U.S.C. § 300gg-18(b)(1)(A) (2012).

49. Because the premiums not spent on health expenses must cover administrative and other expenses, profits will be lower than this cap. The precise lines of what counts as health expenses versus administrative expenses were spiritedly debated, since the more expenses that insurers could shift to health expenses, the greater could be their potential profit margins. *Medical Loss Ratios*, HEALTH AFFAIRS (last updated Nov. 17, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=30.

50. Minimum loss ratios can have secondary effects as well, such as reducing premiums for healthy individuals relative to unhealthy individuals. Keith M. Marzilli Ericson & Amanda Starc, *Pric-*

D. Asymmetric Information

Asymmetric information—where one party to a contract has better information than the other party—exists on both sides of health insurance contracts. Both insurers and policyholders have superior information about certain characteristics the other would like to know. When this information is not or cannot be credibly communicated, the efficient market for health insurance is disrupted.

First, insurers have superior information about the quality and comprehensiveness of their health insurance products because of the factors discussed above.⁵¹ An imbalance in sophistication and the opacity of health insurance contracts and insurer performance mean insurers know better than prospective policyholders the treatments that will be covered, the costs of covered treatments, and the friendliness of the insurer's claims practices.⁵²

On the other side, individual policyholders also have superior information. They may have private knowledge about their susceptibility to costly medical expenses.⁵³ Or, they may have visible risk characteristics that the insurer is prohibited by regulation from incorporating into pricing decisions (anything other than age, tobacco use, family size, and geographic area in small employer and individual markets,⁵⁴ and any characteristic at all in large employer markets⁵⁵), which effectively amounts to the same result. Policyholders' superior knowledge would then lead high-risk policyholders to buy disproportionately more comprehensive insurance, an undesirable process known as adverse selection.⁵⁶

ing Regulation and Imperfect Competition on the Massachusetts Health Insurance Exchange 97 R. ECON. & STAT. 667, 684 (2015).

51. See *supra* Parts II.A–C.

52. See *supra* Parts II.A–B.

53. Objective factors are only imperfect predictors of future health expenses. See, e.g., Dimitris Bertsimas et al., *Algorithmic Prediction of Health-Care Costs*, 56 OPERATIONS RES. 1382 (2008); Yang Zhao et al., *Predicting Pharmacy Costs and Other Medical Costs Using Diagnoses and Drug Claims*, 43 MED. CARE 34 (2005). See generally *Hearing Before the Joint Economic Subcomm. Expanding Consumer Choice and Addressing Adverse Selection Concerns in Health Insurance*, 108th Cong. 49–57 (statement of Linda J. Blumberg, The Urban Institute), available at http://www.jec.senate.gov/republicans/public/?a=Files.Serve&File_id=4ad93d2a-5709-440f-bcf3-bfaed867fd41.

54. Premiums can vary based on age by a ratio of 3 to 1, by tobacco use by a ratio of 1.5 to 1, by geographic area, and by the number of family members obtaining coverage under a single policy. PPACA, Pub. L. No. 111–148, § 1201, 124 Stat. 119 (adding 42 U.S.C. § 300gg); 45 C.F.R. § 147.102 (market rules and rate review final rule implementing these ratios). States can further restrict these rating factors. See *State-Specific Rating Variations*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html> (last updated Aug. 30, 2015).

55. 29 U.S.C. § 1182(a)(1); see Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1602 (2011).

56. The consequences of adverse selection can be severe, and include the possibility that the insurance market enters a “death spiral” where insurers refuse to offer insurance. George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 493 (1970). When insurers offer different products, this worst-case scenario becomes less likely, but high risk individuals still can impose social costs by selecting more comprehensive insurance. See David M. Cutler & Richard J. Zeckhauser, *Adverse Selection in Health Insurance*, 1 FRONTIERS HEALTH POL'Y RES. 1 (1998) (finding adverse selection in health insurance plans offered by Harvard); Peter Siegel-

Because of asymmetric information, an efficient market breaks down. Insurers can cut back coverage or raise prices if policyholders cannot effectively compare policies.⁵⁷ Low-risk policyholders are charged premiums as if they were higher risk, leading to an under-provision of insurance. Policyholders may cost insurers more than anticipated if policyholders possess information relevant to future losses that insurers do not incorporate. The end result is higher-priced, lower-quality insurance.

E. Moral Hazard

In health insurance, moral hazard is the phenomenon where individuals consume more medical services when they are insured than when they are uninsured, because insurance reduces the policyholder's marginal cost of consuming healthcare.⁵⁸ Because policyholders bear only a fraction of the cost, they may consume healthcare even when its combined cost to the policyholder and insurer is less than its value to the policyholder. This socially-inefficient consumption raises the price of health insurance and contributes to the country's rising health costs.⁵⁹

Insurers combat moral hazard through various cost-sharing arrangements that force policyholders to internalize some of their costs of medical care. Insurers also routinely require preapproval of certain costly medical procedures where cheaper alternatives offering similar health outcomes exist.⁶⁰ Yet, these measures are necessarily incomplete.⁶¹

man, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1257–58 (2004) (concluding that adverse selection is more prominent when policyholders are offered a choice among multiple plans rather than merely a choice between insurance and no insurance).

57. Although the state insurance exchanges are designed to facilitate comparison-shopping, there is reason to believe that even here consumers will have difficulty comparing policies. See George Loewenstein et al., *Consumers' Misunderstanding of Health Insurance*, 32 J. HEALTH ECON. 850 (2013); Eric J. Johnson et al., *Can Consumers Make Affordable Care Affordable?*, PLOS (Dec. 18, 2013), <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0081521>.

58. Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 535 (1968); see also Mark V. Pauly, *More on Moral Hazard*, 2 J. HEALTH ECON. 81 (1983); see generally John A. Nyman, *Is "Moral Hazard" Inefficient?*, 23 HEALTH AFF. 194, 197 (2004) (identifying that in some circumstances, increased consumption of medical services may be desirable).

59. The presence of moral hazard in health insurance has been empirically identified. See, e.g., Liran Einav et al., *Selection on Moral Hazard in Health Insurance*, 103 AM. ECON. REV. 178 (2013) (finding that policyholders who are more likely to exhibit moral hazard disproportionately choose more generous health coverage); Willard G. Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 AM. ECON. REV. 251, 258–61 (1987) (finding that policyholders consume more health services when policyholders' expenses are lower).

60. Only rarely, however, do insurers completely refuse to cover health services that cost more than their expected benefits.

61. For health insurance to be actual insurance, the policyholder cannot bear the full cost of medical treatment, and whenever policyholders pay only a percentage of incurred costs, moral hazard can result. Further, administrative expenses keep insurers from implementing and enforcing preapproval (a process known as utilization review) in every circumstance where it could be effective. Insurers' inability to base policyholder rates on the policyholder's prior usage of insurance also encourages policyholder overindulgence in health services.

F. *Mismatched Time Horizons*

Policyholders and health insurers have divergent time horizons.⁶² Since health insurance contracts traditionally last for only a year,⁶³ with the policyholder able to switch insurers, insurers lack an incentive to undertake policyholder-specific investments with upfront costs that reduce future expected losses.

For instance, if at a cost of \$10,000 today the insurer could reduce a policyholder's annual expected losses by \$1,000, or improve the policyholder's future quality of life by a \$1,000 equivalent, annually, the rational insurer will not incur the cost because the policyholder could switch providers after the first year, once the insurer incurred the cost, and capture the \$1,000 annual benefit from a competitor insurer.⁶⁴ In health insurance, this situation emerges with preventative care and vaccinations, which promise future benefits in return for upfront investments. When these medical services are not required by statute or do not offer immediate payoffs to the insurer, the insurer has no reason to cover them.⁶⁵

III. THE ROLE OF POLICYHOLDER OWNERSHIP

The prior Part reviewed characteristics of the health insurance market that raise contracting costs between policyholders and insurers. This Part shows how cooperative health insurers could mitigate these contracting costs by augmenting the contractual relationship with an ownership relationship.

Firms adopt one of three basic ownership forms, where ownership entails the formal right to control the firm and to residual assets.⁶⁶ Most large firms are owned by investors, but ownership could also be held by the firm's suppliers, its workers, or its customers, in which case the firm is known as a cooperative.⁶⁷ Finally, the firm could be a nonprofit with no owners, since under nonprofit law no group has the right to receive distributions of profits and often no formal control right.⁶⁸ In each case,

62. See David A. Hyman, *Follow the Money: Money Matters in Health Care, Just Like in Everything Else*, 36 AM. J.L. & MED. 370, 372 (2010).

63. See, e.g., Rhode Island BlueCross Blueshield, Subscriber Agreement: BlueSolutions for HAS Direct 5000/10000, at 10 available at https://www.bcbsri.com/sites/default/files/BlueSolutions_HSA_Den_DP_5000_10000_00E_Bronze_v114.pdf (listing the length of the insurance policy as one "benefit year" which automatically renews annually every January 1st).

64. The insurer could contract around this result by, for example, forcing the policyholder to pay the \$10,000 if the policyholder switches companies. Rather than do so, insurers faced with this situation choose not cover the treatment unless required by statute, perhaps because convincing policyholders of the investment's future return, or policyholders' difficulty in covering sizable upfront investments, is too costly.

65. See generally Hyman, *supra* note 62, at 372 ("[D]elivering higher quality care and/or keeping one's patients healthier can actually make a provider financially worse off.").

66. See HENRY HANSMANN, *THE OWNERSHIP OF ENTERPRISE* 11 (1996).

67. See *id.* at 12.

68. Henry Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 838 (1980).

firms engage in market contracting for inputs and outputs beyond those provided by the ownership relationship.⁶⁹

Firms are generally run in a way that maximizes their owners' benefits.⁷⁰ Consequently, when policyholders own a health insurer, that insurer will be run differently from one owned by investors or from a nonprofit.⁷¹ These differences are particularly important when market contracting is costly, as in the ways described above.⁷² When the insurer interacts with policyholders through a market contract, as in the case of an investor-owned or nonprofit insurer, the contracting costs can be severe.⁷³ Having policyholders own the insurer can reduce these contracting costs, translating into lower-priced, higher-quality insurance. Since any profits the cooperative could earn from exploiting its policyholders are returned to those policyholders as owners, and since management is subject to policyholder control, cooperative ownership acts as a credible non-exploitation commitment mechanism, with the firm able to credibly guarantee to policyholders that they will not be exploited.⁷⁴ This commitment in turn reduces the contracting costs between policyholder and insurer, and it gives the cooperative insurer a competitive advantage over an investor-owned or nonprofit counterpart.

Altering the identity of the firm's owners therefore changes the group that is protected by ownership. When investors own the firm, managers tend to promote investors' interests and ensure their protection.⁷⁵ When customers own the firm, their interests are protected by the cooperative non-exploitation commitment.⁷⁶ And in the case of a nonprofit, all those who interact with the firm are protected to a degree: since profits do not belong to any one group, management ostensibly won't advance one set of interests to the detriment of another.⁷⁷

Figure 1 summarizes how these possible ownership structures protect various classes in the case of a health insurer. Parties enveloped within a dashed line are those potentially protected through that line's ownership structure. Those outside the dashed line are left to interact with the firm through market contracts and are not protected by the relevant ownership structure.

69. See HANSMANN, *supra* note 66; Hansmann, *Role of Nonprofit Enterprise supra* note 68.

70. See HANSMANN, *supra* note 66.

71. See *Id.* at 15; see generally LARRY E. RIBSTEIN, *THE RISE OF THE UNCORPORATION* (2010) (analyzing how different corporate forms will impact interactions among suppliers, workers, customers, investors, and management).

72. See *supra* Part II.

73. See *supra* Part II.A-F.

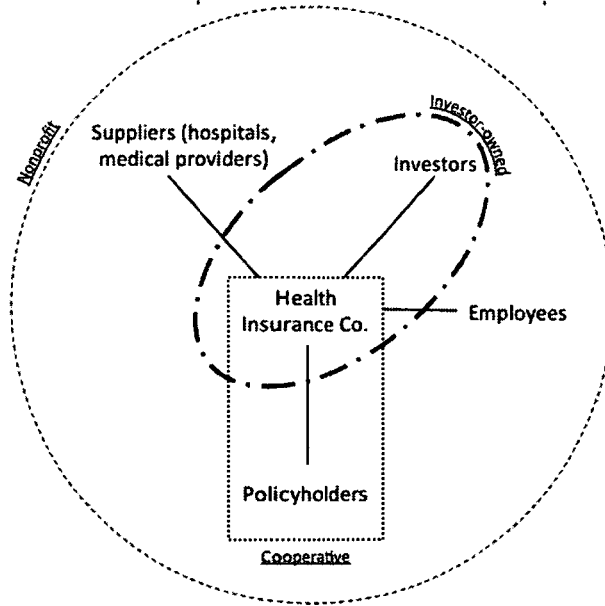
74. See generally Ryan Bubb & Alex Kaufman, *Consumer Biases and Mutual Ownership*, 105 J. PUB. ECON. 39 (2013) (finding lower exploitation of customer-owners by credit unions).

75. See Hansmann, *Role of Nonprofit Enterprise, supra* note 68, at 842.

76. See Bubb & Kaufman, *supra* note 74.

77. Hansmann, *Role of Nonprofit Enterprise supra* note 68, at 838-39. More will be said on this topic later in this Part.

FIGURE 1: POTENTIAL OWNERSHIP STRUCTURES OF HEALTH INSURANCE COMPANIES



Since the class that is protected varies by ownership type, a cooperative health insurer owned by its policyholders will have different comparative advantages and disadvantages relative to investor-owned or nonprofit health insurers. The following Section shows how cooperatives could reduce the contracting costs in health insurance markets relative to investor-owned insurers and then considers additional costs that the cooperative ownership structure incurs. The Article then undertakes the same analysis with respect to nonprofit insurers.

A. Benefits

Recall each of the costs that makes contracting for health insurance difficult for policyholders: sophistication imbalance, inability to comparison-shop, market power, asymmetric information (on the part of both insurers and policyholders), moral hazard, and mismatched time horizons. Cooperative ownership reduces each of these costs.

In a cooperative health insurer owned by its policyholders, the policyholders have the right to the insurer's profits and the formal right of control. In most circumstances, a policyholder's welfare as a customer and the value of the cooperative are inversely related—as the customer relationship grows more attractive to the policyholder, the value of the insurer decreases.⁷⁸ For example, as the insurer's coverage becomes more

78. *Id.*

comprehensive for a fixed premium, the policyholder derives more value from her customer relationship but her owner relationship suffers, as the cooperative's profits decrease. Policyholders, therefore, face a joint maximization problem over the combined value of their customer relationship and their owner relationship. By extension, management—responsive to policyholder-owners' interests because of their right to control management—likewise seeks to maximize policyholders' joint relationship.⁷⁹ Because of policyholders' joint relationship with the insurer and their right of control, cooperative ownership acts as a credible commitment that the insurer makes to refrain from exploiting its policyholders in a way that an investor-owned insurer might.⁸⁰ The commitment is credible because unlike other ownership structures, profits earned at policyholders' expense accrue to those same policyholders. This credible commitment reduces each of the health insurance contracting costs discussed previously.⁸¹

Consider first the imbalance in sophistication. As was shown earlier,⁸² when policyholders are less sophisticated than insurers, insurers are in an exploitative position to charge policyholders for coverage they mistakenly believe they will receive. When the profits from this exploitation accrue to investor-owners, management of the investor-owned insurer has a financial incentive to take advantage of the insurer's superior position—subject to regulatory restrictions and avoiding a bad reputation that harms future business. But, when the profits from this exploitation accrue to those who would be exploited, there is no longer a financial incentive for the insurer to exploit its position. Similar arguments show that cooperative insurers likewise have a diminished financial incentive to exploit comparison-shopping difficulties, market power, and asymmetric information relative to an investor-owned insurer.

Still to be examined are mismatched time horizons, policyholder asymmetric information, and moral hazard. Consider the mismatched time horizon problem: that investor-owned health insurers lack a reason to pay for services today that will benefit policyholders only later in the future, when the policyholder may have switched insurers.⁸³ When poli-

79. Management may diverge from policyholder-owners' interests and pursue its own agenda to the extent that doing so makes management better off, a process that produces "agency costs." This problem may be more severe with cooperatives than investor-owned firms, for reasons discussed *infra* Part III.B.

80. The strength of this commitment depends not just on management's responsiveness to policyholders' interests, but also on policyholders' entitlement to the cooperative's earnings being proportional to policyholders' relationship with the firm as a customer. See Molk, *supra* note 21, at 924 for an extended analysis of this requirement.

81. See *supra* Part II.A–F.

82. See *supra* Part II.A.

83. One example of these services would be preventative treatments that reduce policyholders' future health expenses by more than the cost of the preventative treatment. See, e.g., Joshua T. Cohen et al., *Does Preventative Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 662 (2008). A more typical example of these services would improve policyholders' future quality of life—but not necessarily reduce health expenses—by enough so that the policyholder would be willing to bear the expense today. *Id.* While policyholders with perfect information

cyholders own the insurer, this problem is reduced. The insurer has reason to cover expenses that pay back over the long term if those expenses improve policyholder welfare, because policyholder-owner welfare is one of the characteristics management seeks to maximize.⁸⁴ Further, policyholder-owned insurers may have more credibility when they recommend policyholders cover some of the cost of these treatments, as they have no ulterior profit motive—they have no external group of investors to whom profits are distributed.⁸⁵

Likewise, when policyholders own the firm, they have a diminished incentive to exploit informational advantages over the insurer or to run up health costs unnecessarily, and as a result, asymmetric information and moral hazard costs will be lower than for an investor-owned insurer. First, since policyholders have a stake in the firm's profits, they seek to avoid imposing unnecessary expenses on the insurer, because more insurer profits equals more policyholder profits. This effect is only attenuated, however. Because the policyholder gets only a fraction of any expense savings, she still has reason to seek care or exploit information when doing so benefits her more than her share of the cost.⁸⁶ Even though the effect is attenuated, it is still greater than any effect experienced under an investor-owned insurer where the policyholders have no interest in the insurer's earnings.⁸⁷ Further, to the extent policyholders care about the wellbeing of fellow policyholders in addition to their own welfare, such as when policyholders share a strong common bond, the effect can grow large enough so that some policyholders are willing to sacrifice small decreases in personal welfare for a broader welfare gain by all policyholders.⁸⁸ By forcing individual policyholders to factor in other policyholder-owners' welfare in this way, the cooperative structure makes it less likely that a policyholder will take advantage of asymmetric information or engage in moral hazard.⁸⁹

may be willing to pay upfront for such treatment, contracting difficulties—particularly the difficulty in accurately and credibly conveying to policyholders which treatments might sufficiently improve later welfare—prevent such agreements from being struck. As a result, investor-owned insurers tend not to cover these socially-desirable treatments unless required by statute. See *supra* note 65 and accompanying text.

84. See Avik Roy, *Health Care And The Profit Motive*, 3 NAT'L AFF. 35, 48 (2010).

85. Of note, however, covering such treatments might raise conflicts between long-term policyholder-owners and short-term policyholders who join just long enough to receive coverage for these treatments. This conflict is examined, *infra*, in Part VI.B.3.

86. Patricia Born et al., *Organization Form and Insurance Company Performance: Stocks versus Mutuals*, in THE ECONOMICS OF PROPERTY-CASUALTY INSURANCE 167, 177 (David F. Bradford ed., 1998).

87. *Id.* at 168.

88. Such sacrifices have been observed in industries ranging from property insurance to electricity consumption to banking. See HANSMANN, *supra* note 66, at 259 (enterprise generally); PATRICIA LLOYD WILLIAMS, THE CFC STORY: HOW AMERICA'S RURAL ELECTRIC COOPERATIVES INTRODUCED WALL STREET TO MAIN STREET 101 (1995) (electricity cooperatives); Molk, *supra* note 21, at 921 n.102 (property insurers).

89. Regarding moral hazard, there is a concern that policyholder ownership might push too strongly in the other direction and lead to healthcare *underconsumption*, rather than merely less overconsumption, as policyholders seek to reduce firm-level costs. While usually seen as less of a problem than overconsumption, underconsumption of healthcare is a legitimate concern, but one that policy-

Academics who emphasize cooperatives' potential to reduce advantageous use of asymmetric information or moral hazard in this way do so from a theoretical basis or, on occasion, introduce anecdotal evidence.⁹⁰ Yet, theoretical models and anecdotal evidence do not always accurately predict actual generalized behavior.⁹¹ To provide additional insight, I undertook an empirical test to obtain a better sense for how health insurance cooperatives might reduce moral hazard. I presented individuals with a hypothetical situation they might encounter as a policyholder. The scenario was designed to test cooperatives' potential at reducing moral hazard by reducing overconsumption of healthcare services. As with any study of this nature that relies on hypothetical situations, the external validity of the study's conclusions is constrained. Nevertheless, the study broadens what has to this point been largely a theoretical debate with a first pass at systemically and empirically predicting actual behavior.

1. *Empirical Study of Policyholder Moral Hazard*

a. Methodology

Study participants were presented with a scenario in which they were to imagine themselves with a mild knee discomfort and to consider two treatment options. The options promised the individual substantially similar expected outcomes and cost the policyholder nothing out-of-pocket, but differed in their costs to the insurer. The first option (self-treatment, followed by consulting a specialist if necessary) cost the insurer nothing while the second alternative (immediately consult a specialist) cost the insurer \$2,000.⁹² The scenario was designed to resemble a realistic situation that, under existing systems, contributes to healthcare overconsumption. For most individuals, the social welfare maximizing choice

holder-owned firms could address by, for instance, reducing policyholders' cost-sharing for these services or even reminding policyholders of the value—to themselves and other policyholders—from seeking at least these basic treatments. It is not unrealistic to think that policyholder-owned firms that maximize policyholder welfare would devise additional innovative methods to address this concern.

90. See, e.g., HANSMANN, *supra* note 66, at 259, 280. *But see* Bubb & Kaufman, *supra* note 74 (finding empirical evidence of credit unions' lower level of exploiting asymmetric information).

91. Cf. COLIN F. CAMERER, *BEHAVIORAL GAME THEORY: EXPERIMENTS IN STRATEGIC INTERACTION* 15 (2003) (positing that "pure reasoning" is insufficient to predict an outcome and that other less subtle factors influence the end result).

92. Such a situation would arise, for example, when the policyholder has no copay—perhaps because the annual out-of-pocket maximum has been reached—and has a choice between two or more covered medical procedures. It bears emphasizing that this scenario was one of relatively low stakes to the policyholder, approximating the case of routine or non-emergent care. In other situations requiring emergency treatment or where the expected outcomes have very different consequences to the policyholder, it could reasonably be expected that the insurer's ownership form will have a reduced impact.

The \$2,000 figure was based on the cost of obtaining an MRI on the knee. See, e.g., *Health Care Prices: MRI Scan, Knee* (2012), VIRGINIA HEALTH INFORMATION (Dec. 9, 2013), http://www.vhi.org/health_care_cost.asp?id=IS4 (finding average cost to be approximately \$2,500); *Outpatient Charge Data CY 2011*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Outpatient2011.html> (last updated June 1, 2015).

is the first option: to first self-treat the injury and, if that proves ineffective, to then consult a specialist.⁹³

Participants were recruited using Amazon.com's Mechanical Turk service and were paid \$0.50 for their participation. Participants were seventy-three percent male and ranged in age from eighteen to seventy-five, with an average age of thirty-three.⁹⁴ A total of 1,000 completed responses were collected. Across the entire sample, sixty-eight percent of respondents chose the less expensive option, while thirty-two percent opted for the more expensive choice.

Participants were randomly assigned to one of seven conditions that varied the ownership structure of participants' health insurer. The seven conditions were: (1) for-profit investor-owned with the ownership structure term undefined; (2) for-profit investor-owned with the term defined; (3) nonprofit undefined; (4) nonprofit defined; (5) cooperative undefined; (6) cooperative defined; and (7) ownership structure unspecified. These seven conditions and their relevant language are collected in Table 1.⁹⁵ In each condition, participants were presented with the above scenario and asked which treatment option they would choose and with what degree of confidence. Participants were then asked about their reactions to various aspects of the scenario. Participants were finally asked to respond to questions comprising an individualism-communitarianism index designed to capture their involvement in and dependence on groups,⁹⁶ and to provide demographic information. The order that items were presented was randomized across each section.

b. Results and Implications

Tables 2 and 2a⁹⁷ contain the results of logit regressions for the empirical model that predicts the likelihood of participants' choosing the less expensive treatment option.⁹⁸ Predictive independent variables

93. See *infra* Tables 2 & 2a.

94. Prior studies have found Mechanical Turk participants to be reasonably representative of the United States population for a variety of analyses. Adam J. Berinsky, Gregory A. Huber, & Gabriel S. Lenz, *Evaluating Online Labor Markets for Experimental Research: Amazon.com's Mechanical Turk*, 20 POL. ANALYSIS 351, 366 (2012). The sample recruited for this study appears skewed towards male respondents, but gender was not associated with a significant difference in responses except when interacted with those identifying with Asian ethnicity. *Id.*

95. See *infra* Table 1.

96. See Dan M. Kahan et al., *Culture and Identity-Protective Cognition: Explaining the White-Male Effect in Risk Perception*, 4 J. EMPIRICAL L. STUD. 465 (2007) (developing this index).

97. See *infra* Tables 2 & 2a.

98. The model was specified by $Choice_i = \beta_0 + \beta_1 X_i + \beta_2 Scenario_Type_i + \epsilon_i$ where i refers to an individual. Individuals' selections were first measured as a discrete variable derived from individuals' treatment choice and confidence in that choice, and ranged from -7 (extremely confident choice of self-treatment) to 7 (extremely confident choice of seeing a specialist). The distribution of this choice/confidence variable turned out to be bimodal, so it was transformed into the indicator variable *Choice*, with values -3 to -7 indicating self-treatment (1) and values 3 to 7 indicating specialist (0). The results do not qualitatively differ if the indicator variable is constructed using the values -4 to -7 / 4 to 7 or -1 to -7 / 1 to 7. X_i is a vector of individual characteristics variously including demographic information, degree of individualism continuous from 1 to 5, and reported political leanings discrete from 1

include: (1) demographic information; (2) the individualism-communitarianism index; (3) reported political leanings; and (4) an indicator for the type of health insurance company ownership.

Across all model specifications, participants who identified as “Asian” were significantly less likely to choose the cheaper treatment option. Older individuals were more likely to choose the cheaper option. Other demographic indicators were not significantly associated with choosing one treatment option over the other. Perhaps surprisingly, neither one’s political leanings nor one’s position along the individualism-communitarianism continuum were significantly associated with choosing one treatment option over another.

Along ownership dimensions, participants were not significantly more likely to choose the low-cost treatment option when presented with an undefined cooperative health insurer relative to the undefined investor-owned insurer baseline. This finding is consistent with a low public awareness of what it means for a firm to be a cooperative.⁹⁹ If individuals do not know what the cooperative ownership structure means, they may have no reason to alter their healthcare choices. However, when participants were given a sentence synopsis of the organizational form (“in a cooperative, the policyholders elect the company’s management and share the company’s profits”), the cooperative insurer was strongly associated with a more than doubled increased probability of choosing the low-cost treatment option, robust (at the one percent significance level) to various individual characteristics. This finding provides empirical support for the theoretical prediction that cooperatives could reduce member-owner moral hazard, and thereby address society’s overconsumption of medical services.

The undefined nonprofit health insurer is weakly associated with an increased probability of choosing the low-cost treatment option. This finding could result from a “warm glow” that many attach to nonprofits that may deter individuals from imposing costs on the nonprofit.¹⁰⁰ It could also be that a fraction—but not all—of the participants knew what the nonprofit ownership structure implies and were moderately willing to reduce their healthcare consumption. As discussed later in Section C.3, theory predicts that nonprofits, like cooperatives, could reduce policyholder moral hazard, although nonprofits will be less effective. When

(very liberal) to 5 (very conservative). *Scenario_Type_i* is a vector of indicator variables indicating the scenario presented (ownership type and whether a definition was provided).

99. See, e.g., Jerry Markon, *Health Co-Ops, Created to Foster Competition and Lower Insurance Costs, are Facing Danger*, WASH. POST (Oct. 22, 2013), http://www.washingtonpost.com/politics/health-co-ops-created-to-foster-competition-and-lower-insurance-costs-are-facing-danger/2013/10/22/e1c961fe-3809-11e3-ae46-e4248e75c8ea_story.html (describing efforts to inform potential policyholders about cooperatives). Participants’ responses in the undefined cooperative condition to what they thought it meant for a firm to be a cooperative confirm this result: “Where the insurance company cooperates with doctors;” “I honestly have no idea;” “Everybody pitches in;” “It is run by workers for workers.”

100. See Peter Molk, *Reforming Nonprofit Exemption Requirements*, 17 FORDHAM J. CORP & FIN. L. 475, 477, 535 (2012).

participants were given a sentence synopsis of the organizational form (“in a nonprofit, any earnings must be used to support the company’s mission and cannot be distributed to individuals”),¹⁰¹ the probability of participants’ choosing the low-cost treatment option increased, as did the significance of the relationship. The strength of the relationship, however, was not as great as that with the defined cooperative. This suggests—consistent with the theory discussed later in this Part—that cooperatives are better at reducing policyholder moral hazard than nonprofits.¹⁰²

Unsurprisingly, neither the defined investor-owned insurer (“investors elect the management and share the company’s profits”)¹⁰³ nor the unspecified ownership condition was associated with any changed tendency to choose the low-cost treatment, consistent with the idea that an investor-owned insurer gives policyholders no reason to reduce their healthcare expenditures.

Taken as a whole, the results suggest that respondents cared primarily about the personal financial implications from their choice—their expected health outcome and if they would capture the insurer’s savings from choosing the low-cost option. More community-oriented participants were no more likely to choose the low-cost option even if it saved the community (other owners) money. Additionally, only those ownership forms in which the insurer’s savings are captured by participants—the cooperative and the nonprofit—were associated with an increased likelihood of choosing the low-cost option.¹⁰⁴ This hypothesis is reinforced when considering respondents’ reactions to questions posing different uses of surplus by insurers, discussed in Part V, which show that promised direct distributions of surpluses to policyholders were the most effective method of promoting the low-cost treatment option.¹⁰⁵

The empirical results confirm the idea that cooperative insurers could provide the social benefit of reducing overconsumption of health expenditures, addressing policyholder moral hazard. Such behavior would both reduce the insurer’s expenses and constitute a meaningful step towards “bending the cost curve” of the United States’ health expenses, which many attribute to an existing incentive system that promotes overconsumption of health services.¹⁰⁶

101. *Id.*

102. *See infra* Part III.C.3 for additional discussion.

103. *See infra* Part III.C.3.

104. Policyholders have no formal or informal right to the insurer’s profits when the insurer is investor-owned. However, the insurer’s savings are directly capturable through the cooperative—policyholders are entitled to the firm’s surplus. And the insurer’s savings may be indirectly capturable through the nonprofit, which has no formal owners and therefore no group to which management might feel compelled to distribute earnings. *See infra* Part III.C for additional discussion on this nonprofit issue.

105. Additional experimentation that varied the treatment costs to the policyholder and the insurer and that varied participants’ ties to other cooperative owners would shed additional light on this issue.

106. *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 *AM. ECON. REV.* 941, 961–62 (1963).

B. Costs

The prior Section shows how cooperative insurers owned by their policyholders promise to reduce the contracting costs parties face compared to investor-owned insurers. These savings improve social welfare; as healthcare becomes more affordable and of better quality, more individuals obtain affordable coverage, and socially inefficient use of medical services is curbed.¹⁰⁷ Investor-owned insurers have some comparative advantages over cooperatives, however, which are the subject of this Subsection.

The comparative advantages of investor-owned companies are two: (1) their financing costs are lower, and (2) their ability to reach consensus among owners is easier, which reduces susceptibility to management agency costs. These advantages can be construed as costs of cooperatives. I discuss these in order, concluding that neither is insurmountable.

1. Costs of Capital

Although both investor-owned firms and cooperatives can use debt to finance some of their operations, investor-owned firms are in a better position to attract equity. While cooperative health insurers can draw equity only from the limited pool of their policyholders, investor-owned health insurers have the much broader pool of investors open to them.¹⁰⁸ A more expansive equity pool necessarily results in lower costs of equity, which in turn reduces the need for, and lowers the cost of, debt.¹⁰⁹ In addition, because investor-owners are better diversified than are cooperative owners (who risk both their equity investment and their policyholder relationship on the insurer's success), equity costs for investor-owned firms are lower still.

While it is true that financing costs will be higher for cooperative health insurers than for investor-owned health insurers, these costs are not particularly worrisome because health insurers require relatively little financing to carry out their operations.¹¹⁰ Health insurers act primarily as an intermediate party between policyholders and healthcare providers, and their primary functions involve spreading risk among the former

107. See generally PAUL MILGROM & JOHN ROBERTS, *ECONOMICS, ORGANIZATION AND MANAGEMENT* 24–25 (1992) (discussing the effect of organizational structures and processes on efficiency).

108. See Peter Molk, *The Puzzling Lack of Cooperatives*, 88 TUL. L. REV. 899, 907 (2014).

109. When equity is cheaper, firms will finance proportionately more of their operations with equity and less with debt. See generally Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure*, 3 J. FIN. ECON. 305 (1976) (analyzing the tradeoffs between debt and equity financing). As equity financing increases, the cost of debt financing falls because equity claims are subordinate to debt claims. See 11 U.S.C. § 1129(b)(2)(B) (2012) (bankruptcy priority rules); *N. Pac. Ry. Co. v. Boyd*, 228 U.S. 482, 504–05 (1913). The net result is that both equity and debt financing will be cheaper for the investor-owned firm.

110. *Id.*

and facilitating negotiated payments to the latter.¹¹¹ When these functions are combined with the fact that health insurance policies are binding only for a single year, health insurers do not need the significant financing reserves¹¹² that are required by liability and life insurers, who must cover uncertainty associated with liabilities that do not show up until many years after premiums are paid.¹¹³ Of course, some capital will still be required—health insurers must maintain a cushion to pay unexpectedly large claim years and meet state solvency requirements,¹¹⁴ plus accumulate a large enough policyholder and provider base to prove viable—but this requirement is relatively modest.

2. *Decisionmaking*

Owners must decide how the firm should be run, whether they run the firm themselves or, as invariably happens, whether they hire a management team to run the firm for them. Investor-owners generally seek to run the firm to maximize its financial value,¹¹⁵ since doing so in turn maximizes investors' returns. Because investor-owners are unified in achieving this goal, their management has relatively clear direction for how to run the firm.¹¹⁶ Transferable ownership interests and a market for corporate control keep management from straying too far from this path.¹¹⁷

Owners of cooperatives may not have as clear a consensus for running the firm, because their maximization function has more moving

111. See *The Role of Insurance Intermediaries*, COUNCIL OF INSURANCE AGENTS & BROKERS, <https://www.ciab.com/uploadedfiles/resources/roleofinsint.pdf> (last visited Jan. 16, 2015).

112. For example, the nonprofit Freelancers Insurance Company, started in 2009, has \$17 million in debt and accumulated surplus (an analogue of equity) compared to \$96 million in premiums. A.M. BEST, BEST'S INSURANCE REPORTS, LIFE/HEALTH (2011). On a smaller scale, Cuatro LLC commenced operations in 2011 using \$5 million in debt and capital financing. *Id.* See generally NAT'L ASS'N OF INS. COMM'RS, UNIFORM CERTIFICATE OF AUTHORITY APPLICATION: STATUTORY MINIMUM CAPITAL AND SURPLUS REQUIREMENTS (2014), available at http://www.naic.org/documents/industry_ucaa_chart_min_capital_surplus.pdf (identifying state minimum capital and surplus requirements for new insurers).

113. Notably, however, several established nonprofit insurers have accumulated large surpluses that they could use to subsidize current premiums, making themselves more competitive and potentially allowing them to undercut prices of new entrants. See, e.g., A.M. BEST, BEST'S INSURANCE REPORTS, LIFE/HEALTH (2011) (illustrating that Blue Cross & Blue Shield of Florida Group holds \$3 billion in unassigned surplus out of \$6 billion in total liabilities while Blue Shield of California Group holds \$3.5 billion in unassigned surplus out of \$6 billion in total liabilities). Much of these surpluses accumulated when nonprofit insurers were exempt from corporate income taxes. It would be troubling from a policy perspective if these accumulated surpluses were spent in such a difficult-to-detect anti-competitive fashion.

114. See *Financial Reporting*, INSURANCE INFORMATION INSTITUTE, <http://www.iii.org/publications/commercial-insurance/how-it-functions/financial-reporting> (last visited Jan. 16, 2015).

115. See HANSMANN, *supra* note 66, at 62–63.

116. *Id.* Note, however, that investor ownership may also involve some heterogeneity of preferences, particularly across investors with different time horizons or cash flow generation requirements, as with venture capital or private equity investors versus more traditional investors. Any heterogeneity among investors will undermine investor ownership's relative advantages.

117. Note that this threat only crudely bounds agency costs. Because of the effort involved in assembling a controlling interest, there remains a considerable range of agency costs that go unpunished by this market mechanism. *Id.* at 59.

parts—they seek to maximize the combination of the firm's value *and* the value of their relationship with the firm as a supplier, worker, or customer. This second relationship may vary across owners, so that what most benefits one cooperative owner may not maximize the welfare of others. When these conflicts result, owners either disagree over how the firm should be run—raising the costs of reaching consensus and freeing management from oversight to the extent a clear consensus is not reached¹¹⁸—or delegate more power to management to avoid raising conflict among owners, but raising agency cost concerns.

Applying this insight to the case of policyholder-owned health insurance cooperatives, one can immediately see that concerns over decision-making difficulties are legitimate. There will be significant variation in how different policyholders maximize their own welfare. Younger customers might want the insurer to focus coverage on preventive care to the exclusion of covering end-of-life care, while older customers would benefit financially from seeking the reverse. Preventing these conflicts from becoming insurmountable may require delegating substantial authority to management, trusting management to strike an appropriate balance but risking the firm's efficiency.¹¹⁹

Delegating this authority to management, however, does not necessarily mean agency costs will grow out of control. Similar conflicts among policyholder-owners arise with mutual property-casualty insurers, but the available evidence suggests that mutual insurers are no less efficient—and in some circumstances are more efficient—than investor-owned insurers.¹²⁰ Outside of insurance, the investment company Vanguard—owned by purchasers of its mutual funds—has achieved considerable success in spite of significant delegations of power to management to avoid the conflicts that would otherwise result among owners.¹²¹ Undoubtedly, the need to succeed in competitive markets bounds these firms' agency costs.

Just as with costs of capital, then, cooperatives' higher decisionmaking costs are not insurmountable. When combined with their ability to

118. See generally FRANK H. EASTERBROOK & DANIEL R. FISCHEL, *THE ECONOMIC STRUCTURE OF CORPORATE LAW* 37–38 (1991) (discussing how conflicts among different classes of owners could threaten a firm's operations); HANSMANN, *supra* note 66, at 44 (same).

119. See *infra* Part IV for thoughts on how to address this tradeoff.

120. See Born et al., *supra* note 86 at 191; Ulrike Birkmaier & David Laster, *Are Mutual Insurers an Endangered Species?*, 4 SWISS RE, SIGMA 3 (1999). Additionally, recent empirical work has confirmed that management turnover at mutual property-casualty insurers is positively associated with poor market performance (albeit less strongly than for investor-owned insurers), suggesting that policyholders still monitor management's performance and limit agency costs. See Enya He & David W. Sommer, *CEO Turnover and Ownership Structure: Evidence from the U.S. Property-Liability Insurance Industry*, 78 J. RISK & INS. 673 (2011); Jiang Cheng et al., *Organizational Form, Ownership Structure, and Top Executive Turnover: Evidence from the Property-Casualty Insurance Industry* (June 28, 2013), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2326797.

121. John Morley, *The Separation of Investments and Management: A Theory of Investment Fund Structure and Regulation*, 120 YALE L.J. 1228 (2014) (discussing the delegation of authority to Vanguard management); Bill McNabb on the Markets, the U.S. Debt Crisis, and Fee Wars, VANGUARD (Dec. 21, 2012), <https://www.vanguard.com.hk/portal/articles/research/markets-economy/bill-mcnabb-on-fee-wars-debt-crisis-trlv.htm> (identifying Vanguard's cooperative structure).

solve market contracting problems, cooperative health insurers promise significant potential welfare gains relative to investor-owned insurers. Next, I compare cooperatives to nonprofit health insurers, the other dominant method of health insurer ownership.

C. *Comparison to Nonprofits*

Nonprofits are firms that are barred from distributing earnings to private individuals.¹²² This non-distribution constraint serves a similar protectionist function as does the cooperative ownership structure, making the nonprofit form effective at solving contracting difficulties when the quality of the firm's output is difficult to gauge reliably.¹²³ At first blush, therefore, it might appear as if cooperatives have little to add to health insurance that the nonprofit structure could not already accomplish.

However, because the nondistribution constraint prohibits nonprofits from distributing earnings to *anyone*, the nonprofit form provides protection from exploitation to *all* parties interacting with the firm, as illustrated in Figure 1.¹²⁴ Suppliers, workers, customers, and lenders need not worry that profits are being funneled out to others. Further, although nonprofits, like other types of firms, have a duty to pursue their corporate purpose, nonprofits' purposes are generally a broadly defined social good that gives management the freedom to respect any party's interests while remaining true to their corporate purpose.¹²⁵ Nonprofit health insurers thus protect not just policyholders, as would cooperative health insurers, but also employees, suppliers, and lenders related to the pursuit of this purpose.¹²⁶ This critical distinction results in important differences between nonprofit and cooperative health insurers. Nonprofits have greater agency cost concerns; nonprofits' ability to solve policyholder contracting problems will be weaker; and nonprofits' policyholders will have a diminished incentive to curb overuse of healthcare services. Each is considered below.

I. *Agency Costs*

Management agency costs will be more severe for the nonprofit than the cooperative. Nonprofits' management is typically self-appointing without a vote by membership, leaving members without

122. Hansmann, *Role of Nonprofit Enterprise supra* note 68, at 838.

123. *Id.* at 843–44.

124. *See supra* Part III.

125. *See, e.g.*, ARTICLES OF CONSOLIDATION BETWEEN BLUE CROSS OF FLORIDA AND BLUE SHIELD OF FLORIDA 1–2 (July 1, 1980), <http://images.sunbiz.org/COR/2013/0822/50934770.Tif> (describing nonprofit insurer's general corporate purpose of maintaining health plan consistent with community needs, addressing economic and delivery problems in healthcare, and assisting other health-related nonprofit organizations). As discussed immediately below, this managerial freedom is heightened by low levels of member and regulatory oversight, as well as the lack of meaningful fiduciary duties owed to any particular group.

126. *See id.*

even a formal right to control management.¹²⁷ Self-appointment gives management less reason to be responsive to constituents' interest than the management of even a large cooperative with attenuated owner interests, which raises the severity of potential agency costs.

The states' attorneys' general are a hypothetical check on agency costs unique to nonprofits. They are responsible for making sure nonprofits pursue their mission and for enforcing nonprofits' nondistribution constraint, which generally requires that management's compensation be "reasonable" and which might deter extreme cases of agency costs.¹²⁸ Unfortunately, this enforcement is spotty at best and can be detrimental to constituents' interests at worst.¹²⁹

2. Policyholder Contracting Problems

Nonprofits are not as well situated as are cooperatives to address the contracting problems in health insurance markets. Although the nondistribution constraint prohibits nonprofits from explicitly distributing earnings to any individual or group, these earnings can still be distributed indirectly and be consistent with the nonprofit's corporate purposes. They might, for example, be distributed to suppliers by paying a bit more for medical treatments, to employees by making working conditions more favorable or increasing wages, or to policyholders by reducing future premiums or increasing the quality of care. Or they might not be distributed at all. The nonprofit might retain earnings and amass a substantial endowment.¹³⁰ Nor does management of a nonprofit owe fiduci-

127. MARION R. FREMONT-SMITH, *GOVERNING NONPROFIT ORGANIZATIONS: FEDERAL AND STATE LAW AND REGULATION* 159 (2004). For those few nonprofits where members have voting rights, the diverse membership base and the lack of a profit interest produces voter apathy and an effectively self-appointed management. An example of the risks that result from this situation emerged when anti-immigration activists attempted to take over the Sierra Club—a nonprofit with an elected board—by allegedly recruiting new members solely to elect the activists. Joey Bunch, *Sierra Club Vote Rejects Lamm, Allies*, DENVER POST, Apr. 22, 2004, at A1.

128. MODEL NONPROFIT CORP. ACT § 6.41(a) (2008). Public disclosure can also be a check on agency costs. See generally Brian D. Galle & David I. Walker, *Nonprofit Executive Pay as an Agency Problem: Evidence from U.S. Colleges and Universities* (Aug. 1, 2013), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2187979 (finding that disclosure of high university president salaries provokes sanction by donors); Brian D. Galle & David I. Walker, *Sunshine, Stakeholders, and Executive Pay: A Regression-Discontinuity Approach* (Dec. 17, 2013), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2363013 (same).

129. Laura B. Chisolm, *Accountability of Nonprofit Organizations and Those Who Control Them: The Legal Framework*, 6 NONPROFIT MGMT. & LEADERSHIP 141 (1995) (arguing for low enforcement in the charitable sector); Jonathan Klick & Robert H. Sitkoff, *Agency Costs, Charitable Trusts, and Corporate Control: Evidence from Hershey's Kiss-Off*, 108 COLUM. L. REV. 749 (2008) (explaining value-destroying enforcement). The I.R.S. provides additional scrutiny of charitable exempt nonprofits, but this oversight, too, is often superficial and, in any event, no longer applies to nonprofit health insurers, which lost their tax exemption in 1986. 26 U.S.C. §§ 501(m), 833 (2012) (exemption revocation). See JAMES J. FISHMAN & STEPHEN SCHWARZ, *TAXATION OF NONPROFIT ORGANIZATIONS* 9 (2d ed. 2006) (citing GILBERT M. GAUL & NEILL A. BOROWSKI, *FREE RIDE: THE TAX-EXEMPT ECONOMY* (1993)).

130. Ultimately, when the nonprofit dissolves, these profits are distributed according to the organization's plan of distribution. For a representative example, compare 805 ILCS 105/109.10 (2015) (broadly prohibiting distributions prior to dissolution) with 805 ILCS 105/112.17 (2015) (distribution

ary duties to act in the interests of any particular group of patrons.¹³¹ Nonprofits therefore fail to offer a credible commitment against exploiting policyholders, since gains from doing so need not inure to policyholders' benefit.

When this is combined with the self-perpetuating management that many nonprofits feature, policyholders cannot trust that the nonprofit insurer's earnings will ultimately inure to their benefit, as they do with a cooperative. The protection policyholders gain from the nondistribution constraint is therefore nowhere near the protection that cooperatives offer, making nonprofits less effective at reducing the insurer-policyholder contracting costs discussed in Part II.¹³² The enhanced protection that cooperatives offer policyholders comes at the expense of less credibility to refrain from exploiting other classes—suppliers or workers, for instance—but as these relationships do not appear to exhibit any particularly egregious exploitative opportunities in health insurance; a favorable tradeoff.

3. *Policyholder Moral Hazard*

Cooperative health insurers stand to reduce policyholder moral hazard—the overconsumption of healthcare—because policyholder-owners of a cooperative health insurer have a stake in the insurer's profits. Policyholders of the nonprofit insurer, however, have no direct interest in the insurer's profits. Although the insurer's earnings can be distributed indirectly to policyholders, management can just as easily decide to distribute those earnings to other groups instead, because policyholders have no superior entitlement to any share of the savings from reduced healthcare consumption. Therefore, policyholders of nonprofit insurers have less reason to minimize health expenses than do cooperative policyholders, and cooperative insurers have superior potential for managing policyholder moral hazard.

upon dissolution). See generally MODEL NONPROFIT CORP. ACT §§ 6.40, 6.41(c) (2008) (prohibiting distributions except upon dissolution).

131. Natalie Brown, Note, *The Principal Problem: Towards a More Limited Role for Fiduciary Law in the Nonprofit Sector*, 99 VA. L. REV. 879, 894–98 (2013). Even in the particular case of mutual benefit nonprofits—nonprofits organized for the benefit of their members—there is no fiduciary duty exclusively to members. See Evelyn Brody, *The Board of Nonprofit Organizations: Puzzling Through the Gaps Between Law and Practice*, 76 FORD. L. REV. 521, 525 (2007).

132. Although the management of a cooperative could also indirectly distribute profits to a class other than policyholders in the same way as could a nonprofit, fiduciary duties owed to policyholder-owners, and the fact that management is responsible exclusively to policyholders via policyholder vote, both constrain this activity.

IV. WHY ARE THERE SO FEW POLICYHOLDER-OWNED HEALTH INSURERS?

Cooperative health insurers offer the prospect of mitigating several of the concerns plaguing policyholders in health insurance markets in ways that investor-owned and nonprofit insurers cannot. Their relative costs—higher capital costs and governance costs—also are solvable. Why, then, do cooperative insurers have no meaningful presence in modern health insurance markets if they offer compelling welfare gains? This Part answers this question.

In other work, I have identified and analyzed the market situations necessary for entrepreneurs to choose the cooperative model over its competitors.¹³³ Briefly put, entrepreneurs are unlikely to start new firms as cooperatives, because the entrepreneur must share most of the firm's surplus with other owners for the cooperative to offer a credible non-exploitation commitment to its policyholders and attain its comparative advantages.¹³⁴ Further, brokers are unlikely to convert existing firms to cooperatives, because the costs of coordinating an existing group of the firm's patrons to buy out the firm and make it a cooperative typically make such a transfer unprofitable.¹³⁵ Neither problem plagues investor-owned firms, and nonprofit health insurers, until recently, benefited from federal and state tax subsidies to aid their formation.¹³⁶

Despite these difficulties, two situations emerge where cooperatives will appear. First, certain altruistic entrepreneurs might value other owners' welfare in addition to their own. These entrepreneurs would start a cooperative if the cooperative offers more total surplus to owners, even if the entrepreneur's personal share of that surplus is lower for the cooperative. And second, the cooperative structure may offer such compelling efficiencies over an investor-owned or nonprofit counterpart that the entrepreneur's small personal share of the cooperative's greater welfare gains makes the entrepreneur better off than the entrepreneur's larger personal share of an investor-owned firm's lower welfare gains or the gains from starting a subsidized nonprofit.¹³⁷

These two situations are uncommon, but they explain both why some health insurance cooperatives originally formed as well as why so few overall have organized. Modern health insurance started comparatively late, beginning with the founding of the first Blue Cross plan in

133. Molk, *supra* note 21, at 929–45.

134. *Id.* at 930–35.

135. *Id.* at 935–39.

136. *Id.* at 931–32, 946–47.

137. *Id.* at 933–35. This second circumstance, while often favoring investor-owned insurers over cooperatives, would more often appear to favor cooperatives over nonprofit insurers because nonprofits cannot distribute profit shares to entrepreneurs, yet many nonprofit insurers were organized. As will be discussed shortly, physician resistance greatly raised the costs of starting cooperatives but not nonprofits, because the medical industry was routinely able to dominate the boards of nonprofit insurers. See *infra* note 152 and accompanying text.

1929.¹³⁸ Medical technology had been fairly limited, keeping down medical expenses and any need for insurance.¹³⁹ As medical expenses rose and incomes plummeted from the Great Depression, the idea of medical insurance grew more attractive to consumers and the industry grew.¹⁴⁰

Health insurance was slow to develop even after the first Blue Cross plan started because of moral hazard concerns that those covered by insurance would seek more medical attention and increase medical expenses, driving the insurer into insolvency.¹⁴¹ Consequently, early insurers like the Blue Cross plans focused on covering surgeries and other non-elective expenses not subject to policyholder moral hazard.¹⁴² Notably, this left entire swaths of medical expenses without insurance,¹⁴³ which did not begin to be covered until the 1940s, when tax deductions for insurance benefits and the threat of a national insurance program stimulated private provision of this insurance.¹⁴⁴

The 1930s through 1940s was the most active time of spontaneous cooperative health insurer formation.¹⁴⁵ Cooperatives organized primarily in rural areas and other locations where existing health insurers had

138. ROBERT CUNNINGHAM III & ROBERT M. CUNNINGHAM JR., *THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM* 5–6 (1997); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 294–95 (1982). Company doctors—salaried doctors who treated employees for a particular employer—had also achieved modest success during the prior decade but were soon eclipsed by Blue Cross and its successors. CUNNINGHAM III & CUNNINGHAM JR., *supra* at 8; STARR, *supra* at 294.

139. See, e.g., David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 *HEALTH AFFAIRS* 11, 11 (2001) (“It is widely accepted that technological change has accounted for the bulk of medical care cost increases over time.”).

140. For data on medical expenses’ share of GNP, see Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, 6 *J. ECON. PERSPECTIVES* 3, 4 (1992).

141. STARR, *supra* note 138, at 291–92. While adverse selection—sick people disproportionately buying insurance—was also a concern, one way companies could manage it was by insisting that a minimum percentage of a relevant population (workforce or community, for example) commit to buying insurance before anyone could obtain insurance. Requiring that a minimum portion of the population buy insurance ensures that the policyholder pool contains at least a certain percentage less-risky individuals. See, e.g., CUNNINGHAM III & CUNNINGHAM JR., *supra* note 138, at 5 (early plan that required participation by seventy-five percent of teachers); MICHAEL A. SHADID, *CRUSADING DOCTOR: MY FIGHT FOR COOPERATIVE MEDICINE* 89 (1992) (recounting plan to start insurer only if approximately eighty-five percent of the relevant population joined). Although later insurers adopted the more effective approach of varying premiums to reflect risks, early insurers typically charged everyone an identical amount owing to the lack of historical data upon which to base premium variations. See CUNNINGHAM III & CUNNINGHAM JR., *supra* note 138, at 5.

142. CUNNINGHAM III & CUNNINGHAM JR., *supra* note 138, at 101.

143. For instance, the Blue Cross plans covered only some hospital-related expenses, leaving other hospital-related expenses as well as all physician services uninsured. See *id.* at 6.

144. *Id.* at 56–57, 60–61.

145. STARR, *supra* note 138, at 320–22. I ignore “cooperative” health plans promoted by the federal government as part of its New Deal Farm Security Administration. For in-depth treatment of these plans, see MICHAEL R. GREY, *NEW DEAL MEDICINE: THE RURAL HEALTH PROGRAMS OF THE FARM SECURITY ADMINISTRATION* (2002). Many of the key features of these plans were determined by the federal government, making them poor indicators of the potential viability of private cooperative health plans. These plans were back-stopped by the federal government, required that doctors treat according to a reduced fee schedule, reimbursed doctors a pro-rated amount of their billings depending on how much all doctor billings in a community exceeded a fixed pot of money set by the farm security administration, and generally had no policyholder governance or ownership rights. *Id.* at 59, 62.

not yet penetrated.¹⁴⁶ They also covered expenses that other insurers were unwilling to touch.¹⁴⁷ The more ambitious of these were pre-paid medical service plans, where the plan employed salaried doctors and offered policyholders a range of medical services for no or low incremental cost in exchange for premiums, approximating pure HMOs of today.¹⁴⁸ Others operated as more traditional insurers, being owned by policyholders but not employing salaried doctors or owning medical facilities directly.¹⁴⁹

Several of these plans were started by altruistic, idealistic entrepreneurs, fitting the first situation of when cooperatives will form spontaneously.¹⁵⁰ These entrepreneurs preferred to maximize total stakeholder welfare with the cooperative over greater personal financial returns (but lower overall total welfare) from organizing as an investor-owned insurer.¹⁵¹ Some cooperative entrepreneurs also fell into the second category: for them, the smaller share of larger cooperative profits could have been more remunerative than an alternative organizational form.¹⁵²

The initial success of these early cooperative plans, however, was promptly quashed by organized and vociferous physician resistance, greatly deterring any additional spontaneous formation.¹⁵³ Organized medicine resented any introduction of outside forces that might have a say in determining their pay or compromising their independence.¹⁵⁴ Entrepreneurs of cooperative insurance plans and physicians involved in

146. STARR, *supra* note 138, at 320–21.

147. *Id.* at 322.

148. *Id.* at 321–23; SHADID, *supra* note 141, at 96.

149. STARR, *supra* note 138, at 328.

150. *Id.* at 322.

151. *See, e.g., id.* at 303 (describing doctor who idealistically started cooperative plan after first securing financial future in prior career); *id.* at 322 (describing other plans); *see* SHADID, *supra* note 141, at 87, 147. In many cases, altruistic entrepreneurs may also have preferred the nonprofit form and its tax subsidies over the cooperative form. *See* Edward L. Glaeser & Andrei Shleifer, *Not-For-Profit Entrepreneurs*, 81 J. PUB. ECON. 99 (2001).

152. The credible commitment to a high-quality product that the cooperative structure offered helped particularly with marketing to farmers, who were generally distrustful of investor-owned insurers. JOHN BAINBRIDGE, *BIOGRAPHY OF AN IDEA: THE STORY OF MUTUAL FIRE AND CASUALTY INSURANCE* 154, 169–70 (1952) (general distrust of investor-owned insurers); SHADID, *supra* note 141, at 97 (promoting high-quality component of plan, which requires credible commitment to be effective); STARR, *supra* note 138, at 323 (higher quality care in these plans). In some cases, entrepreneurs took a fixed salary to partially compensate for their entrepreneurial activity, which unlike a profit share does not defeat the cooperative's commitment mechanism. *See, e.g.,* SHADID, *supra* note 141, at 98 (entrepreneur appointing himself medical director for guaranteed five-year term). For further discussion of this issue, *see* Molk, *supra* note 21, at 931 n.133 (difficulties of fixed wage vs. share).

153. STARR, *supra* note 138, at 324–26.

154. The position adopted by the American Medical Association is illustrative of the attitude at the time. It stated: "Voluntary insurance systems are now in operation in many parts of the United States and are increasing in number and size Wherever they are established there is solicitation of patients, destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the professions. It is clear that all such schemes are contrary to sound public policy" CUNNINGHAM III & CUNNINGHAM JR., *supra* note 138, at 38. *See also* STARR, *supra* note 138, at 299–300 (summarizing ten principles promulgated by the AMA for supporting private health plans, including that "[a]ll features of medical service in any method of medical practice should be under the control of the medical profession" and that "[t]here should be no restrictions of treatment not formulated and enforced by the organized medical profession.").

helping the plans start were expelled by their local medical societies, who also boycotted medical facilities accepting the plans.¹⁵⁵ With these headwinds pushing against the formation of cooperative health insurance plans, unsurprisingly their rate of formation dwindled to a trickle.¹⁵⁶

Although the Supreme Court upheld the AMA's conviction for antitrust conspiracy in 1943, the AMA, through a combination of state lobbying and informal norms, was able to effectively bar cooperative health insurance plans in a majority of states despite this ruling.¹⁵⁷ What developed in the aftermath, and which continued until the 1970s' push for managed care, was a series of physician-controlled Blue Shield plans—nonprofit plans controlled by physicians that covered provider-related medical expenses¹⁵⁸—and fee-for-service plans that reimbursed policyholders for health expenses without significant control over medical utilization or physician behavior.¹⁵⁹

The backlash against rising health expenditures finally broke this resistance in the 1970s,¹⁶⁰ and cooperative health insurance plans have again begun to form spontaneously, although they have been more limited in scope. In several states, health insurance purchasing cooperatives have organized.¹⁶¹ The entrepreneurs of these plans coordinate a group of individuals or businesses together to buy insurance collectively from an existing investor-owned or nonprofit insurer, potentially addressing situations of market power and adverse selection. But as medical expenditures have continued to rise, so too have the potential rewards offered by more comprehensive cooperative insurers that could address the full spectrum of market contracting costs discussed in Part II.

The absence of a meaningful cooperative health insurer market share today therefore seems due largely to historical path dependence, rather than inherent disadvantages of the organizational form. Cooperative health insurers formed spontaneously during a window in which returns were high enough to overcome their barriers to formation, but medical provider resistance quickly slammed it shut. Now that the window has opened again, cooperatives have begun to form once more, but

155. STARR, *supra* note 138, at 304–05. The personal impact to physicians from being refused membership in the local medical society included being refused malpractice insurance, being prohibited from being recognized as a specialist, and being denied the chance to consult with other physicians. SHADID, *supra* note 141, at 225; *see also* STARR, *supra* note 138, at 229 (noting how a doctor's "need for referrals and hospital privileges" produced a dependence on physician colleagues that would be undermined by expulsion from the local medical society).

156. STARR, *supra* note 138, at 320–21.

157. *Am. Med. Ass'n v. United States*, 317 U.S. 519 (1943); STARR, *supra* note 138, at 305–06.

158. STARR, *supra* note 138, at 306–07.

159. *Id.* at 327, 331, 381.

160. *Id.* at 381.

161. *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO/HEHS-00-49, PRIVATE HEALTH INSURANCE: COOPERATIVES OFFER SMALL EMPLOYERS PLAN CHOICE AND MARKET PRICES 9 (2000) (describing several such cooperatives); *About Us*, FARMERS' HEALTH COOPERATIVE OF WISCONSIN, <http://www.farmershealthcooperative.com/aboutus.asp> (last visited Jan. 16, 2015) (a recently-formed health insurance purchasing cooperative).

the inherent difficulty in starting a cooperative,¹⁶² and the unfamiliarity of the form to most,¹⁶³ implies that an external boost may be necessary.

Notably, mutual property insurers solve similar contracting failures as do cooperative health insurers, and therefore offer similar advantages. The credible commitment structure of mutual property insurers solves problems from disparities in sophistication and difficulty in comparison shopping;¹⁶⁴ and property insurance has similar problems of asymmetric information (the insurer might opportunistically deny paying claims, or the policyholder might know she is lower risk than the insurer believes), moral hazard (the policyholder might not take sufficient steps to avoid a loss if her home is insured), and mismatched time horizons (the advantage of renovation that permanently reduces the likelihood of future losses does not completely inure to the insurer).¹⁶⁵ Unlike with health insurance, however, the evolution of property insurance markets did not experience coordinated resistance that undermined spontaneous cooperative formation, and mutual property insurers consequently have significant market share today.¹⁶⁶

V. SUBSIDIES AND GOVERNANCE

Cooperative health insurers solve many of the same market failures as do mutual property insurers. Thus, cooperatives' success in the property insurance market suggests cooperatives could offer efficiencies in the health insurance market as well. Absent extended resistance by medical providers that disproportionately raised the costs of starting one, cooperative health insurers might already have arisen organically as they have in property insurance. Because health insurance cooperatives still face barriers to formation, cooperative health insurers require an external stimulus to reach their full potential. This Part makes the case for subsidies and then develops optimal subsidization and governance best practices for health insurance cooperatives.

Any financial subsidy that is given to health insurance cooperatives will make them comparatively more attractive and increase their probability of forming. Not all subsidies are equivalent, however; careful tailoring can encourage maximum welfare gains per dollar of subsidy while ensuring that unanticipated adverse consequences from subsidization are minimized. These lessons will be used in the final Part to assess the need

162. See Underwood, *supra* note 18.

163. See *id.*

164. Daniel Schwarcz, *Reevaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263, 1318 (2011).

165. For more extended treatment of mutual property insurers' relative advantages, see Henry Hansmann, *The Organization of Insurance Companies: Mutual Versus Stock*, 1 J.L. ECON. & ORG. 125, 128 (1985); Molk, *supra* note 21, at 920–21, 941 n.174.

166. For comprehensive treatment of the mutual property insurance industry, see BAINBRIDGE, *supra* note 152; RICHARD B. HEFLEBOWER, *COOPERATIVES AND MUTUALS IN THE MARKET SYSTEM* 162–76 (1980); HAROLD W. WALTERS, *A CENTURY OF COMMITMENT: A HISTORY OF THE NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES, 1895–1995* (1994).

for the ACA's subsidization of cooperative health insurers, the manner in which the ACA subsidizes them, and the restraints the ACA places upon their organization.

A. *Why Subsidize*

Before discussing optimal subsidization strategies, the case must first be made for why a subsidy is required—something that was largely ignored in the health reform debate. The answer to this question depends both on whether cooperative insurers promise any welfare gains and whether cooperatives will form in adequate numbers absent subsidy.

Part III has shown how cooperative health insurers could provide benefits unobtainable by other methods of health insurer ownership. In other work, I have also shown why the private marketplace is unlikely to provide an adequate number of cooperatives absent a subsidy, because entrepreneurs cannot capture most of the welfare gains that their efforts generate.¹⁶⁷ Further, because cooperatives are an unfamiliar sight to most potential health insurance customers outside of, perhaps, the grocery store market, early entrants face the additional hurdle of convincing potential policyholders both that cooperative insurers are viable and that they offer unique advantages.¹⁶⁸ These factors push towards supporting cooperative health insurers.

B. *How to Subsidize*

Different subsidies can have different impacts on potential cooperative health insurer success. Below I consider financial and nonfinancial possibilities.¹⁶⁹

1. *Financial Subsidy*

Financial subsidies that increase the comparative attractiveness of cooperatives could be effective at promoting them. The primary barriers that impede cooperative health insurers relate to their formation: entrepreneurs are unlikely to start new firms as cooperatives,¹⁷⁰ and the lack of a meaningful presence of cooperative health insurers drives consumer unfamiliarity with them, raising the costs of getting new customers on board.¹⁷¹ Therefore, financial subsidies that target only the formation of new health insurance cooperatives are likely to be more effective per dollar of subsidy in comparison to subsidies that continue past startup.

167. See Molk, *supra* note 21, at 945–47.

168. Markon, *supra* note 99.

169. For more in-depth treatment of subsidies as a tool for solving the general lack of cooperative starts, see Molk, *supra* note 21, at 945–57.

170. *Id.* at 930–35.

171. *Id.* at 937–38.

Additionally, unlike long-term subsidies, financial subsidies that target only formation do not risk long-term costs if the subsidies end up over-promoting cooperatives at the expense of other forms.¹⁷² Nor can a compelling case be made for subsidizing cooperative health insurers over the long term. Although starting a new cooperative insurer could be subsidized to compensate for the externalities the entrepreneur's activity has on other members, the surpluses created by cooperative health insurers' ongoing operations are largely captured by its membership and need no stimulus to be provided at efficient levels.¹⁷³

Financial subsidies could take a variety of forms, two of which I consider here. The first would pay entrepreneurs directly for forming cooperatives. Such a subsidy could be effective at maximizing cooperative starts per dollar of subsidy, as it directly targets the deterrent to entrepreneurs of being undercompensated when selecting the cooperative form. Tying the subsidy's amount to the cooperative's success could ensure entrepreneurs exert effort in structuring and managing the firm to its full potential.¹⁷⁴

The second method would provide loans or grants that entrepreneurs could use to help finance the cooperative's early operations. Because cooperatives' equity must come exclusively from its policyholder-owners, their cost of capital is relatively high.¹⁷⁵ Low-interest loans or grants could bring these borrowing costs back down. While this policy would encourage formation of cooperative health insurers, it would yield a lower formation rate per dollar of subsidy than an alternative that rewards entrepreneurs directly. If a major deterrent to cooperative formation is entrepreneurs' comparatively lower personal return, then assisting cooperatives' financing is a less cost-effective strategy, because much of the subsidy's benefit is not captured by the entrepreneur but instead goes to the other owners. Such a policy may be more politically expedient, however, than a bounty for new cooperatives.

2. *Nonfinancial Subsidy*

Nonfinancial initiatives could also encourage formation of cooperative health insurers. I consider here education and regulatory standards as two of several viable strategies.

172. *Id.* at 951.

173. The ongoing presence of cooperative health insurers may have some positive spillovers such as promoting competitive prices in otherwise non-competitive markets or reducing the number of uninsured individuals who would otherwise seek uncompensated emergency room treatment. *See supra* note 6 and accompanying text. These advantages, however, are not unique to cooperative health insurers and instead are a consequence of *any* new entrant, giving no reason to subsidize cooperative health insurers in particular.

174. Because many of the cooperative's benefits could not be accurately gauged by the firm's financials, developing such a metric could require some creativity. One method might tie the subsidy to the membership's annual approval rating of the insurer, which would encourage the entrepreneur to design a firm that continues to maximize the membership's welfare.

175. Molk, *supra* note 21, at 927.

a. Education

When policyholders are wholly unfamiliar with cooperatives as health insurers, the difficulty in attracting policyholders grows because they must be first convinced that the unfamiliar form of ownership is a viable possibility. This difficulty increases the costs of forming a cooperative and makes initial formation less likely.¹⁷⁶ Once cooperatives penetrate the market and become a familiar feature to policyholders, this cost dissipates and forming future cooperatives becomes easier, as has happened with mutual insurers in the property and life insurance markets.¹⁷⁷ Early entrants, therefore, bear a disproportionate cost that may keep them from entering in the first place.¹⁷⁸

Additionally, as Table 2 shows,¹⁷⁹ cooperatives are effective at reducing overconsumption of healthcare only if policyholders are first informed about what the cooperative ownership structure means. When participants were simply presented with a cooperative health insurer, they were no more likely to choose the low-cost treatment option than when presented with any other type of health insurer. Increasing the public's knowledge about cooperative ownership could therefore be just as important as increasing the public's receptiveness to the organizational form.

A policy that publicized cooperatives' potential as health insurers or that provided financial support for cooperatives to undertake outreach could both reduce the initial hurdle faced by early cooperative entrants and make those cooperatives more effective at reducing inefficient healthcare consumption. Because the benefits from an educational campaign accrue to all cooperative health insurers and are a method of solving an initial coordination problem, financing this policy with an assessment on cooperative health insurers' future profits could be a sensible approach.

b. Regulatory Standards

The protection offered by the cooperative ownership structure presents the possibility that regulatory requirements could be relaxed, making it easier for cooperative health insurers to do business. Insurance is a highly regulated industry: insurers are generally subject to solvency requirements, price constraints, restrictions on market conduct, and limitations on the types of policies they can sell.¹⁸⁰ This regulation can be burdensome to comply with, but it is commonly justified as an essential

176. *Id.*

177. *Id.* at 942–43.

178. To be sure, initial entrants may enjoy a period of super competitive profits, if new cooperative insurers offer efficiency gains. But potential cooperative entrepreneurs may prefer to forego some of these profits if entry costs drop sufficiently by waiting.

179. See *infra* Table 2.

180. See *Molk, supra* note 21, at 952–53, n.217.

consumer-protection device, since insurers may exploit market positions over policyholders when policyholders do not own the firm.¹⁸¹

If policyholders own the firm, however, management becomes more responsive to policyholder interests and the insurer's reason to exploit policyholders will be reduced. In that case, the ownership structure replicates the goals of regulation, and ratcheting back regulatory oversight of these insurers frees regulatory resources to be focused on higher-gains areas and reduces the cooperative insurer's operational costs.¹⁸²

Crucially, the decision to cut back on regulation rests on how responsive management is to policyholders. In other markets, some cooperatives adopt policies that dissuade owners from exercising oversight, and for these cooperatives there is little reason to reduce regulation.¹⁸³ For cooperatives with active policyholder involvement, however, a better argument could be made for reducing regulation. The line need not be drawn on a case-by-case basis. Instead, observable proxies for policyholder involvement could be used to determine when regulatory requirements could be reduced. For example, cooperatives with greater than, say, fifty percent policyholder participation in voting or that have adopted participatory-enhancing measures like conditioning annual dividends on attending an annual meeting could reasonably be assumed to have the type of policyholder involvement necessary for reducing regulatory oversight.

C. *Optimal Design and Governance*

Any subsidization policy should concentrate not just on forming new cooperative health insurers but also on facilitating (and certainly not impeding) those cooperatives' solving the contracting difficulties discussed in Part II, thus maximizing their potential welfare gains.¹⁸⁴ To aid this endeavor, I describe several important aspects below.

1. *Distributing Surpluses*

Cooperative health insurers can adopt the same initial package of techniques to reduce healthcare overconsumption as other insurers. Deductibles and coinsurance, pre-approval, and disallowing coverage for certain procedures form an effective baseline. Yet, cooperatives are in a unique position to go beyond these traditional methods, because policyholders are the owners and are therefore entitled to the insurer's surplus.

181. See Schwarcz, *supra* note 40, at 436.

182. For analysis of the difficulties involved in changing regulatory policy, see Peter Molk & Arden Rowell, *Reregulation and the Regulatory Timeline*, 101 IOWA L. REV. __ (forthcoming 2016).

183. See, e.g., J. A. C. Hetherington, *Fact v. Fiction: Who Owns Mutual Insurance Companies*, 4 WIS. L. REV. 1068, 1069 (1969) (describing policyholder apathy towards many large mutual insurers).

184. See *supra* Part II.A.

As shown in Table 2,¹⁸⁵ this attribute of ownership is associated with reduced consumption of socially inefficient medical care.

As behavioral economics has demonstrated in a variety of contexts, framing and context can greatly impact individuals' behavior.¹⁸⁶ Characteristics such as whether changes in welfare are seen as gains or losses, or whether those changes are salient, will impact the direction and magnitude of individuals' responses. It is therefore reasonable to suppose that the way in which the cooperative insurers' surpluses are returned to policyholder-owners may impact their behavior. Surpluses that are distributed at the end of the year as highly salient dividends may more effectively deter policyholders from over consuming healthcare than surpluses that are used in a less salient manner to promote policyholder health and wellness, for example.

To understand the relationship between different uses of surpluses and policyholder behavior, as part of the experiment, discussed in Part III,¹⁸⁷ participants were asked whether their selection of high versus low cost treatment would be affected by how the insurer used year-end surpluses. Participants were given five ways the insurer could distribute surpluses, including direct distributions to policyholders, indirect distributions to policyholders, and distributions to non-policyholders (investors, or the public). The precise possibilities are reproduced in Table 3.¹⁸⁸

For each of the insurer's potential use of surpluses, participants selected along a scale ranging from significantly more likely to choose the socially efficient, low-cost ice/rest option (assigned a score of -3) to significantly more likely to choose the high-cost specialist option (assigned a score of 3). For each type of insurer ownership, the results of t-tests that the particular use of surplus would have no effect are presented in Table 3.¹⁸⁹

As the table shows,¹⁹⁰ the way the insurer uses operating surpluses can have significantly different effects on policyholder behavior. Generally, if policyholders ultimately benefit from the surplus, policyholders are more likely to choose the low-cost treatment option. Across all ownership types, and irrespective of whether an explanation of the ownership form was provided, participants were more likely to choose the low-cost treatment option when surpluses were distributed to them directly by reducing future premiums or (for the cooperative) distributed to policyholders. Likewise, across all ownership types policyholders were more likely to choose the low-cost treatment option when surpluses were distributed to them indirectly by promoting policyholder health and wellness or being donated to charities focused on improving public health.

185. See *infra* Table 2.

186. See Molk, *supra* note 21, at 912–13, n.55.

187. See *supra* Part III.

188. See *infra* Table 3.

189. See *id.*

190. See *id.*

On the other hand, when surpluses were neither directly nor indirectly distributed to policyholders, participants were not more likely to choose the low-cost option and, in some cases, were significantly more likely to choose the *high-cost* treatment option. These surplus distributions included distributions to investor-owners, spending to expand the membership base (empire building), or increasing the insurer's employees' salaries. These results generally suggest a primary motive of policyholder self-interest. Policyholders might be more inclined to reduce the insurer's expenses, but only if policyholders benefit from doing so.

When surpluses are distributed to policyholders, the manner of this distribution can also differentially impact behavior. For all but the cooperative health insurer, surpluses that are used to reduce future premiums consistently had the largest influence in pushing policyholders towards the low-cost treatment. For the cooperative insurer, surpluses that are distributed as either dividends or used to reduce future premiums had equivalently large effects on promoting the low-cost option. Across all ownership types, these salient, direct distributions to policyholders were more effective at promoting the low-cost treatment choice than indirect distributions.

This effect could arise because policyholders perceive direct distributions to provide the most self-benefit per dollar of distribution—some benefits from indirect distributions escape to non-policyholders due to the indirect nature. It could also be that direct distributions are more salient to policyholders and, as behavioral economics would predict, thereby have a greater effect on behavior than indirect distributions of lower salience. Additional experimentation could further disentangle this relationship.

As before, the generalizability of these results to real world situations is unlikely to be perfect. For instance, policyholders may not know ahead of time how insurers will spend operating surpluses, either because they remain ignorant or because an insurer may simply be engaging in non-binding "cheap talk."¹⁹¹ Nor will real world situations usually be as simple as the scenario presented. Insurers likely will spend surpluses in a variety of ways, rather than a single one. Participants' responses show, however, that cooperative insurers should carefully consider how they dispose of operating surpluses. While using surpluses to promote policyholder health and wellness may improve policyholder welfare, it could be relatively less effective at reducing overconsumption of healthcare and maximizing the insurer's financial value. Or, increasing employee salaries may improve employee morale, but it could also increase the insurer's health expenses if policyholders find out about it. There certainly may be circumstances when it is appropriate to sacrifice financial value for other

191. This factor could be more readily overcome by cooperatives; cooperatives can make credible prospective commitments to policyholders when policyholders elect the management, and insurer outreach and publicity could address the contention that policyholders generally do not know how insurers dispose of surpluses.

welfare gains, but management must be attuned to this requisite balancing.

2. *Emphasizing a Common Bond*

Effective cooperative design involves not just considering how to dispose of earnings. The bond among policyholder-owners is also important. When policyholders prioritize the insurer's interest over their own, the insurer's returns are maximized which in turn maximizes the combined welfare of all policyholder-owners. The problem, of course, is that individual policyholders typically have little reason to place the insurer's welfare above their own, since individual policyholders capture only a small portion of any savings they generate from reducing healthcare expenses. Thus, policyholders face a classic coordination problem.¹⁹² If individual policyholders care about the welfare of other policyholders in addition to their own, however, then they move closer to the desired outcome of maximizing total welfare rather than their individual wellbeing and solve the coordination problem.¹⁹³

Cultivating this behavior justifies the traditional "common bond" requirement imposed on credit unions, wherein members must be "groups having a common bond of occupation or association, [or be within] a well-defined neighborhood or rural district."¹⁹⁴ Members of a credit union who share a common bond will typically care about the welfare of other members and be better situated to monitor one another, resulting in being less likely to exploit the bank and instead act in line with all members' interests.¹⁹⁵ Beyond credit unions, sharing a common bond can be a powerful motivator that induces individuals to maximize group rather than individual welfare, achieving outcomes ranging from driving

192. The insurer can take some steps to alleviate this problem by, for example, refusing to cover treatments that most policyholders would *ex ante* identify as not wanting to pay for. Because of the range of treatments and policyholder preferences, however, this problem cannot by any means be eliminated completely—contributing to the overconsumption of medical services, among other problems.

193. A common bond, while typically associated with cooperatives, could arise with other types of ownership. For example, one could think of an investor-owned firm with a loyal customer base that might make sacrifices for the firm's benefit. Charitable donative nonprofits have also been associated with a bond among donors. Usha Rodrigues, *Entity and Identity*, 60 EMORY L.J. 1257, 1292 (2011). The prospects of a common bond are particularly promising in the case where the bonded members also share ownership, explaining its common association with cooperatives.

194. 12 U.S.C. § 1759(b) (2012); Nat'l Credit Union Admin. v. First Nat'l Bank & Trust Co., 522 U.S. 479, 482–83 (1998). In recent times, the requirements for credit unions' common bond has been relaxed, leading some to argue that it has lost much of its force. Mehrsa Baradaran, *How the Poor Got Cut out of Banking*, 62 EMORY L.J. 483, 505–09 (2013). Interestingly, while this weakening of the common bond may undermine customer-owner moral hazard reductions and their monitoring incentives, it has not resulted in an elimination of the banks' non-exploitation commitment. Bubb & Kaufman, *supra* note 74, at 33.

195. HANSMANN, *supra* note 66, at 259. Some evidence suggests credit unions may be more efficient than competing methods of ownership. Molk, *supra* note 21, at 941 n.174.

the industry of microfinance.¹⁹⁶ to encouraging kidney transplants,¹⁹⁷ to running an effective military.¹⁹⁸ Given cooperative health insurers' potential to reduce overconsumption of medical services by generating insurer-level savings to which policyholders are entitled, encouraging a common bond among policyholders could greatly assist achieving this goal.¹⁹⁹

Cooperative health insurers should, at a minimum, require a similar common bond as credit unions, ensuring at least a basic level of similarity among members. Bonds will vary in their strength, and early cooperatives could concentrate on the strongest ones, such as organizing around service in a particular branch of the military, or graduating from a large football university, or working for the same employer. They could further encourage the common bond by, for example, publicizing the existence of the common bond among its membership, or developing an affinity credit card that donates a percentage of all purchases to a program related to the common bond.

A strong common bond would reduce policyholder moral hazard. It could also make governance conflicts among policyholders easier to solve—the major cost of cooperative ownership. I address this next.

3. *Managing Governance Conflicts*

One of the most significant potential problems faced by cooperative health insurers is the prospect of governance conflicts. Policyholders will have a range of treatments they will prefer to have covered comprehensively, varying by their age, genetic predispositions, lifestyles, and other individualized characteristics. If these policyholders become actively involved in the insurer's management, they run the risk of tearing the firm apart as they pursue their personal agendas at other policyholders' expense.²⁰⁰

Clearly, then, policyholders should not manage the insurer's day-to-day operations, instead leaving most ordinary business decisions to an elected management. The question remains, however, whether it would be better to promote active or minimal policyholder-owner oversight of

196. See, e.g., Mamiza Haq, Michael Skully, & Shams Pathan, *Efficiency of Microfinance Institutions: A Data Envelopment Analysis*, 17 ASIA-PACIFIC FIN. MKTS. 63, 64 (2010) (explaining the effect of a common bond on microfinance institutions).

197. Kieran Healy & Kimberly D. Krawiec, *Custom, Contract, and Kidney Exchange*, 62 DUKE L.J. 645, 649 (2012).

198. Techniques such as emphasizing a common sense of duty or a common military unit name and insignia help form a strong sense of cohesion among military members. See Mikhael Weitzel, *Military Customs and Traditions Inspire Unit Cohesion*, U.S. ARMY (July 31, 2014), http://www.army.mil/article/130931/Military_customs_and_traditions_inspire_unit_cohesion/.

199. A common bond could be usefully augmented with dynamic measures that emphasize the common bond or magnify the cooperative contributions of other members. See generally Lior Jacob Strahilevitz, *Charismatic Code, Social Norms, and the Emergence of Cooperation on the File-Sharing Networks*, 89 VA. L. REV. 505, 547–75 (2003) (examining how these tools promoted file-sharing networks).

200. Indeed, heterogeneity among owner preferences has been identified as a significant cost that deters cooperative ownership in many circumstances. See HANSMANN, *supra* note 66.

management. Most mutual property and life insurers provide contractual ownership rights that give policyholders very little reason to monitor management, resulting in these firms effectively being run by an autonomous, self-appointed management.²⁰¹ This strategy has also been employed in other large cooperatives, such as the financial firm Vanguard.²⁰² The advantage of this delegation to management is that inter-owner conflicts are minimized. However, this advantage carries a price. Agency costs rise as management grows more autonomous and less responsive to policyholder-owner interests. The cooperative's ability to solve market contracting problems consequently may decrease, as management pursues its own agenda over owners' and protection promised by the ownership structure becomes non-credible. Policyholders care less about increasing the insurer's profits by reducing their own healthcare consumption, both if the benefits from doing so are captured by management instead of policyholders as well as if policyholders feel little connection to the insurer and one another stemming from delegated authority.

Regardless of how the balance between empowering owners and empowering management is ultimately struck, effective governance will take steps to minimize remaining owner conflicts. One method would be again to emphasize owners' common bond, which could align owner interests and reduce conflicts in spite of heterogeneity. Additional techniques can be drawn from the success of other cooperatives with owner heterogeneity: agricultural cooperatives often do a remarkable job of franchising farmer-owners without suffering undue conflicts.²⁰³

VI. THE ACA'S SOLUTION

There are a variety of ways to encourage cooperative health insurers, and a number of design and governance principles to bear in mind when doing so. The ACA subsidizes "nonprofit cooperatives" by giving them low interest loans and a perpetual income tax exemption.²⁰⁴ This Part assesses this subsidization in light of the principles just discussed, pointing out its strengths and weaknesses. A richer understanding of the ACA's subsidization is essential both for future rounds of cooperative health insurer subsidy as well as for designing effective stimulus plans

201. Hetherington, *supra* note 183. Because policyholders typically have no right to accrued surpluses, and because the purchase of insurance constitutes only a small part of individuals' consumption bundles, it is almost never worthwhile for individuals to incur the costs involved in monitoring their insurer or attempting to reform their insurer's operations. *Id.* at 1074–78.

202. Morley, *supra* note 121, at 1276–79.

203. Henry Hansmann, *Cooperative Firms in Theory and Practice*, 4 FINNISH J. BUS. ECON. 387, 397–98 (1999).

204. Original plans had earmarked \$6 billion in government funds to be provided as grants and loans, but the subsidy was twice reduced in response to political pressure and intense lobbying by existing health insurers. Rick Cohen, *The Affordable Care Act, Three Years Later: Where Do Nonprofits Stand?*, NONPROFIT Q. (Apr. 4, 2013), <http://nonprofitquarterly.org/2013/04/04/the-affordable-care-act-three-years-later-where-do-nonprofits-stand/>.

more broadly. Some terms of the existing subsidies could also be modified to comport with these principles and achieve a more effective outcome from the \$2 billion already distributed.²⁰⁵

A. Strengths

1. Definitional Line-Drawing

A challenge with any subsidy is to draw the lines neither too narrowly nor too broadly so that a broad class of only intended recipients is receiving the subsidy.²⁰⁶ The ACA addresses this challenge admirably.

The ACA's subsidies apply only to new organizations that are not sponsored by a state or local government.²⁰⁷ Both these limitations on the subsidy are sensible. Because the market failure that must be overcome is entrepreneurs' disincentive to start cooperative insurers, subsidizing only *new* insurers is appropriate. Further, cooperative insurers that might receive backing from state or local governments may not require additional federal stimulus and are properly excluded.

The ACA also requires that subsidized health insurers' governance is subject to a majority vote of its members²⁰⁸ and that profits inure to the members' benefit.²⁰⁹ These requirements are the essence of a cooperative: members have the formal right to control and to residual assets.²¹⁰ By requiring that subsidized firms adopt these principles, the ACA ensures that subsidies are given only to true cooperatives rather than firms masquerading as cooperatives solely to get a subsidy.

2. Subsidies as Loans

The ACA provides \$2 billion in financial subsidies as low interest loans that must be repaid by recipients. Two types are available: (1) five-year startup loans for financing initial startup costs, and (2) fifteen-year solvency loans to be used for meeting state reserve requirements.²¹¹ Startup loans carry an interest rate of one percent below five-year Treas-

205. See Louis Kaplow, *An Economic Analysis of Legal Transitions*, 99 HARV. L. REV. 509, 511 (1986) (discussing whether to compensate for these disruptive costs policy); Molk & Rowell, *supra* note 182 (analyzing costs involved in disrupting regulatory policy).

206. See generally Molk, *supra* note 21, at 950 (grappling with this problem in the general cooperative case).

207. 42 U.S.C. § 18042(c)(2) (2012).

208. *Id.* § 18042(c)(3)(A).

209. *Id.* § 18042(c)(4). The precise requirement is that profits are "used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members." *Id.*

210. See HANSMANN, *supra* note 66.

211. See 45 C.F.R. §§ 156.520(a)–(b) (2015); DEP'T OF HEALTH AND HUMAN SERV.'S ET AL., CONSUMER OPERATED AND ORIENTED PLAN [CO-OP] PROGRAM INVITATION TO APPLY 10–13 (Sept. 10, 2012), available at <http://www.grants.gov/search/search.do?sessionId=TmwjPHDZ18nIDH9QJLQvGyW8nhynGmQT3LCL2PDlq2R10W2L49jG!-62778654?oppId=136873&mode=VIEW> (click "Related Documents" tab and select "Revised Full Announcement" with the description: "CO-OP FOA (Revised Project Officers 9/19/12)") [hereinafter FOA].

uries, while solvency loans have interest rates of two percent below fifteen-year Treasuries (both with a floor of zero percent).²¹² Such financial support fits nicely with the type of financial subsidy that could facilitate formation of new cooperatives.²¹³

Ordinarily, the fact that loan rates are tied to Treasuries rates rather than the individual cooperative's riskiness would be cause for concern.²¹⁴ Linking the cooperative's financing to its riskiness ensures that market forces would keep inefficient cooperatives from organizing, as the inefficiency manifests in high borrowing rates. Federally subsidized loans, however, cannot be used to completely finance cooperatives' operations. Various ongoing expenses,²¹⁵ particularly marketing expenses, are explicitly excluded from these loans, which has been decried by cooperative health insurer advocates.²¹⁶ But requiring cooperatives to fund a meaningful portion of their expenses with market-based debt or more earnings brings market discipline back into the picture, allowing market forces to continue to deter the nonviable cooperatives from starting.

3. Governance

Given that most policyholder-owners have little understanding that would be useful for the day-to-day operations of a health insurer, the ACA explicitly sets up managing boards to handle these operations.²¹⁷ The ACA requires that subsidized health insurers "operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members."²¹⁸ Regulations have expanded this provision to include requirements that explicitly align management and member interests.²¹⁹ The board must be elected by a majority vote of members; a majority of the board must also be members of the health insurer; and each member is given one vote.²²⁰ These provisions constrain agency costs that could arise if the firm's members delegate most decisions to management and engage in little or no monitoring of their own.

Other provisions are aimed at guaranteeing a minimum level of policyholder involvement in the cooperative. A quorum of member-owners must vote for new directors to be successfully elected, and the elections must be contested with more potential directors than available seats.²²¹ These requirements deter the member-owner apathy present in most modern property-liability insurance cooperatives that may largely give

212. 45 C.F.R. §§ 156.520(c)(1)–(2).

213. See *supra* Part III.B.1.

214. Molk, *supra* note 21, at 949.

215. FOA *supra* 211 at 10–13, 40.

216. Markon, *supra* note 99.

217. 42 U.S.C. § 18042(b)(4).

218. *Id.* § 18042(c)(3)(C).

219. 45 C.F.R. § 156.515.

220. *Id.* § 156.515(b).

221. *Id.* §§ 156.515(b)(1)(i), (v).

rise to a self-perpetuating management.²²² If member-owners must regularly participate in electing management, there is a greater likelihood they will become involved in other governance aspects, such as monitoring management.²²³ A requirement that most of the insurer's business comes from the individual and small employer markets—those markets that individuals will most care about—further increases this likelihood.²²⁴

No provisions are aimed at deterring too much policyholder involvement, however. Policyholders with heterogeneous preferences could tear the insurer apart if they become heavily involved in governance.²²⁵ This is particularly worrisome given the absence of a common bond requirement, discussed next.

B. Weaknesses

I. No Common Bond

A common bond among policyholders could mitigate governance conflicts and promote the efficient consumption of health services. Yet, the ACA not only fails to impose such a requirement, but also renders voluntary adoption of a common bond all but impossible.²²⁶ Cooperative health insurers, like all other health insurers, are subject to the ACA's "guaranteed issue" provision.²²⁷ Under this provision, insurers must accept as policyholders any individual or employer applying for coverage if the insurer writes individual or group coverage, respectively.²²⁸ These individuals or employers need not have any connection among one another. Insured individuals and employers are subsequently entitled to renew coverage at their option.²²⁹

The guaranteed issue requirement makes sure that insurers do not circumvent the ACA's restrictions on price discrimination by insuring only healthy risks and leaving riskier individuals unable to buy coverage. But, other provisions in the ACA further the same goal, making the guaranteed issue requirement something of a safety net. The ACA's risk adjustment mechanism, for instance, assesses a charge on insurers that cover a comparatively healthy risk pool and provides payments to insurers that insure a comparatively unhealthy pool.²³⁰ If this risk adjustment process works as intended, then the value from a guaranteed issue re-

222. Hetherington, *supra* note 183.

223. *Id.*

224. 45 C.F.R. § 156.515(c)(1).

225. *See supra* note 116 and accompanying text.

226. *See* 42 U.S.C. § 300gg-2 (2012).

227. *Id.* §§ 300gg-1 (outlining guaranteed issue requirement), 18042(c)(5) (discussing the formation of cooperative insurers), 18044(b) (applying requirement to cooperative insurers).

228. *Id.* § 300gg-1.

229. *Id.* § 300gg-2.

230. PPACA, Pub. L. No. 111-148, § 1343, 124 Stat. 119, 212–13 (2010) (enacting 42 U.S.C. § 18063).

quirement is reduced.²³¹ In that case, a limited exemption for cooperatives from the guaranteed issue requirement in favor of a common bond would be a good idea.

There is a legitimate concern, however, that despite the benefits of a common bond, if cooperative insurers are relieved from the guaranteed issue requirement, they could manipulate their common bond to cover only healthy risks not captured by the risk adjustment mechanism. This would undermine the ACA's purposes of spreading health insurance costs across both healthy and unhealthy individuals. Luckily, this problem is not without an antidote. An effective solution would couple guaranteed issue and the common bond, allowing cooperative insurers to organize around a common bond while applying the guaranteed issue provision to individuals who satisfy that common bond. These common bonds could be chosen from a predetermined menu of common bonds that are not closely correlated with health status—or more precisely, in ways not closely correlated with those aspects of health status not already captured through the risk adjustment process. Candidate common bonds might, for instance, include places of employment with 100 or more employees and retirees, or colleges and universities with a minimum number of graduates. The guaranteed issue provision would then require that these insurers offer policies to any individual who wants one who also satisfies the common bond. This solution allows for strong common bonds, which promotes efficient healthcare consumption decisions and facilitates governance, while assuaging concerns about using a common bond to undermine the ACA's purposes by insuring only healthy risks not captured by the risk adjustment mechanism.

2. *Perpetual Subsidy Through Tax Exemption*

The ACA amends the tax code to introduce a federal income tax exemption for health insurance cooperatives formed within the ACA's requirements.²³² A federal tax exemption is a perpetual subsidy that encourages capital accumulation.²³³ This is inappropriate for three reasons. First, cooperative health insurers are not in need of a perpetual subsidy. Ongoing operations do not need to be subsidized, because welfare gains are fully captured by policyholder-owners and thus will not be underprovided.²³⁴ A perpetual subsidy therefore amounts to an unneeded outlay of federal funds. Second, perpetual subsidies risk long-term costs from what may turn out to be inappropriate subsidization of some cooperative insurers. Inefficient firms may persist over the long term solely because of

231. Note that prior implementations of risk adjustment have been imperfect. See Jason Brown et al., *How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program*, 104 AM. ECON. REV. 3335, 3340–42, 3355–58 (2014) (finding that imperfections in Medicare Advantage risk adjustment mechanism lead insurers to target profitable policyholders).

232. 26 U.S.C. § 501(c)(29) (2012).

233. See Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 74 (1981); *supra* note 204 and accompanying text.

234. See *supra* notes 173 and accompanying text.

the subsidy, tying up valuable resources.²³⁵ Finally, because the tax exemption encourages capital accumulation, this subsidization risks empire-building (and concomitant reduced policyholder monitoring as operations expand) as well as accumulating inefficiently large retained surpluses.²³⁶

3. Requirement to Organize as a Nonprofit

This Article has focused on health insurers' potential as cooperative firms. The ACA, however, requires them to be organized not as traditional cooperatives, but instead as nonprofits with cooperative features.²³⁷ Whether this requirement proves problematic will depend on how future health insurance markets develop.

The essential characteristic of a nonprofit is that excess earnings cannot be distributed to private individuals. Nonprofits therefore have no equity investors in the traditional sense and are generally barred from distributing dividends.²³⁸ While the ACA insurers must have these attributes, they also have the essential features of a cooperative: member-policyholders have the exclusive right to control, and they also have the right to the organization's surpluses which, by statute, must be used to improve member-policyholders' welfare.²³⁹ The organizations required by the ACA, therefore, are cooperatives without either equity that could appreciate or the ability to distribute dividends.²⁴⁰

The lack of appreciable equity may not be particularly problematic, since surpluses can be distributed to policyholders other ways, notably by reducing future premiums. It does mean, however, that the insurer might accumulate sizable surpluses over time and never use them for the benefit of those policyholders whose premiums were used to accumulate those surpluses. This reduces the insurer's ability to solve the market contracting problems described in Part III; such an insurer loses its credible commitment not to expropriate funds from existing policyholders, because those funds need not be returned to those policyholders and instead could be held for the benefit of future policyholders. As long as existing policyholders are diligent in monitoring management and refusing to allow the buildup of sizable endowments, this should not be a problem. But if policyholders fail to do so, another monitor should be substi-

235. This problem is particularly severe when combined with the prohibition against conversions, discussed *infra* notes 249–253 and accompanying text.

236. This latter concern has been flagged with electric cooperatives, which receive a federal tax exemption under 26 U.S.C. § 501(c)(12). See generally Jim Cooper, *Electric Co-Operatives: From New Deal to Bad Deal?*, 45 HARV. J. ON LEGIS. 335 (2008) (discussing the federal tax exemption under 26 U.S.C. § 501(c)(12) as applied to electrical cooperatives).

237. 42 U.S.C. § 18042(c)(1)(A) (2012).

238. Hansmann, *Role of Nonprofit Enterprise supra* note 68, at 838.

239. 42 U.S.C. § 18042(c)(4).

240. More accurately, they may be analogized to mutual benefit nonprofits, like social clubs. See Molk, *supra* note 21, at 910 n.46 (discussing the various state statutes under which cooperatives incorporate, including nonprofit statutes).

tuted—such as scrutiny by insurance regulators, or a statutory prohibition against outsized endowments.²⁴¹

The most troubling implications of the prohibition against appreciable equity are that it may reduce both members' oversight of insurers as well as the insurer's investment in long-term profitability. If policyholders have no transferable ownership interest in the insurer's value, they are much more inclined to express dissatisfaction with the insurer through exit—that is, switching insurers—than through exercising voting rights, a problem that plagues other large insurers and mutual funds and raises the specter of severe management agency problems.²⁴² Additionally, if policyholders have no equity stake, short-term policyholders are made financially worse off when the insurer spends current earnings to invest in long-term improvements, reducing the insurer's likelihood of undertaking these investments.²⁴³ Cooperatives in other markets address this problem with sophisticated equity redemption practices that are prohibited under nonprofit law.²⁴⁴

The virtue of no appreciable equity is that it reduces owner conflict by encouraging delegation to management, since owners have little incentive to spend effort on exercising their ownership rights. Without empirical evidence, it is difficult to say whether the tradeoff struck by the ACA in favor of management delegation is the correct choice.

Nonprofits' inability to distribute surpluses as dividends is also problematic, and it forms the topic of the next Section.

4. *Inability to Issue Dividends*

Table 3²⁴⁵ shows that distributing surpluses as dividends could be the most effective method of addressing policyholder moral hazard and inducing more efficient consumption of health services by policyholders. It is unclear, however, whether subsidized cooperative health insurers are allowed under nonprofit law to issue dividends. The ACA requires that

241. Others have argued that this member-owner indifference has allowed mutual insurers and electric cooperatives to accumulate inefficiently large surpluses. HANSMANN, *supra* note 66, at 274; Cooper, *supra* note 236, at 363–64. Unlike with these other organizations, the voting requirements discussed above ensure that current policyholders remain involved with the insurer, which will tend to mediate against accumulating large surpluses at current policyholders' expense.

There are additional potential problems with this arrangement. The fact that accumulated surpluses do not belong to the policyholders that earned them deters policyholders from incurring monitoring expenses, making external enforcement more necessary. There is also the issue of what policyholders could do even if they *did* monitor. Absent voting out management, policyholders may have few legal rights if the firm is organized as a nonprofit. See Thomas L. Greaney & Kathleen M. Boozang, *Mission, Margin, and Trust in the Nonprofit Health Care Enterprise*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 1, 55–56 (2005) (noting that statutes and courts fail to distinguish fiduciary duties by nonprofit purpose); Hansmann, *Role of Nonprofit Enterprise* *supra* note 68, at 873–74 (noting lack of enforcement by public actors); *supra* notes 127–28 and accompanying text (discussing enforcement of nondistribution constraint).

242. Hansmann, *Cooperative Firms* *supra* note 203, at 398–99.

243. *Id.* at 400.

244. *Id.* at 398–401.

245. See *infra* Table 3.

any surpluses be used “to lower premiums, to improve benefits, or . . . to improve the quality of health care delivered to its members.”²⁴⁶ Missing from this list is returning surpluses as dividends, and even if the ACA allowed dividends, distributing dividends is prohibited under most states’ nonprofit law.²⁴⁷

From a regulatory perspective, using surpluses to lower future premiums has an equivalent effect to distributing surpluses as dividends, so a prohibition on only dividends accomplishes little. From a behavioral perspective, however, dividends could be the superior method to reduce healthcare overconsumption.²⁴⁸ Unambiguously allowing cooperative insurers to distribute dividends could help.

5. *Conversion Prohibited*

Regulations promulgated pursuant to the ACA prohibit subsidized cooperative health insurers from ever converting or selling to a non-cooperative insurer.²⁴⁹ Their only options are to either operate as cooperatives or close down.²⁵⁰ While this prohibition makes sure that subsidies are not ultimately used to further the interests of other existing insurers—which do not have an analogous formation difficulty to cooperatives—it carries the danger that capital will become permanently locked up in inefficient cooperatives, either because the firm is run poorly or because future changes in markets and regulation render cooperatives’ commitment mechanism less valuable.²⁵¹ A prohibition against conversions or selling assets means cooperatives will continue to operate as long as they at least break even, even if greater surpluses could be created from an investor-owned or nonprofit insurer. Allowing cooperatives to convert provides flexibility in the event of these future unanticipated situations.²⁵²

Permitting conversions, while requiring that the non-cooperative purchasing insurer pay a retroactive market rate on any subsidized loans, could address most concerns that conversion might allow the benefit

246. 42 U.S.C. § 18042(c)(4) (2012).

247. MODEL NONPROFIT CORP. ACT § 6.40 (2008); REVISED MODEL NONPROFIT CORP. ACT §§ 1.40(10), 13.01 (1986). Nonprofit credit unions, however, have received special statutory authority to issue dividends, despite what would ordinarily be prohibited by the nonprofit organizational form. 12 U.S.C. § 1763; *Dividends*, CREDIT UNION TIMES, <http://www.cutimes.com/tag/dividends> (last visited Jan. 16, 2015) (listing dividend-paying events).

248. See *supra* notes 104–06 and accompanying text.

249. 45 C.F.R. § 156.520(f) (2015).

250. See *id.*; Molk, *supra* note 21, at 942–43.

251. This latter phenomenon has occurred with property and life insurance, slowing the formation rate of new mutual insurers in those industries and leading some existing mutuals to convert to investor ownership. See Molk, *supra* note 21, at 942–43.

252. See *id.* at 949–50 (recommending short-term subsidies that later permit market forces to winnow out inefficient cooperatives); Molk & Rowell, *supra* note 182, at 32–34 (identifying the attraction of allowing flexibility in regulatory policy).

from federal subsidies to accrue to non-cooperative insurers.²⁵³ Some other fee-based mechanism that depends on the amount of subsidized loans and how long ago those loans were received and paid back would also work. But a complete prohibition against conversion at any time, while admirably easy to implement, is too broad.

6. *Regulatory Scrutiny Cannot Be Lessened*

The ACA explicitly provides that cooperative health insurers be subject to at least the same regulatory scrutiny as other health insurers.²⁵⁴ As discussed in Section V.B., it may be appropriate to reduce regulation of cooperative insurers, because the cooperative ownership structure promises the same policyholder protection that regulation seeks to replicate. Allowing for the possibility to reduce regulatory oversight over cooperative insurers if policyholders are already doing so could free cooperative insurers to pursue their business while liberating regulatory capital to be spent where it would be more effective.

7. *No Education Requirement*

As discussed above,²⁵⁵ educating potential policyholders about cooperative ownership and cooperatives' presence in everyday markets could reduce cooperatives' formation costs and make those cooperatives more effective at managing healthcare overconsumption. While savvy cooperative insurer management will educate policyholders voluntarily, there is no requirement that insurer management be savvy.²⁵⁶ Thus, a requirement that subsidized cooperatives spend a meaningful portion of their funding on outreach that educates the public and prospective policyholders about cooperative ownership could be sensible.

Yet, not only is there no such requirement, but also there was a prohibition against spending any subsidy dollars on marketing that was interpreted to include spending on general education, until later regulations were issued by the Department of Health and Human Services.²⁵⁷

253. It bears noting that in a competitive market, when the insurer is sold or converts, any effects from the subsidy will accrue to the cooperative's policyholder-owners (the original intended audience), rather than the purchaser.

254. 42 U.S.C. §§ 18042, 18044 (2012) (holding that private insurers are not subject to certain regulation unless cooperative insurers are also subject to that regulation). The dimensions regulated include price, market conduct, and solvency regulation. *Id.* § 18044(b).

255. See *supra* Part V.B.2.a.

256. See, e.g., Application by the Proposed Vt. Health CO-OP For a Certificate of Pub. Good and Certificate of Auth. to Commence Bus. as a Domestic Mut. Ins. Co., Docket No. 12-041-I (Vt. Dep't of Financial Regulation May 22, 2013), available at <http://www.dfr.vermont.gov/sites/default/files/CO-OP-Order-Full%20Text.pdf> (raising solvency concerns, governance concerns, and conflicts of interest between the president of the insurer's board and policyholders in denying Vermont health insurance cooperative a license to sell insurance in Vermont).

257. Patient Protection and Affordable Care Act: Establishment of Consumer Operated and Oriented Plan (CO-OP) Program, 76 Fed. Reg. 77,392, 77,396 (Dec. 13, 2011) (to be codified at 45 C.F.R. pt. 156); FOA, *supra* note 211, at 40; Markon, *supra* note 99.

Nor did governments step in to provide outreach in the insurers' stead.²⁵⁸ While insurers were free to spend non-subsidy dollars on outreach, a prohibition on using federal dollars appears of little value, and the failure to require or recommend this type of outreach was a missed opportunity.

VII. CONCLUSION

Policyholder-owned cooperative health insurers have significant potential in modern health insurance markets. Through the commitment to policyholder interests offered by policyholder ownership, these insurers promise potential welfare gains by credibly providing high quality insurance at reasonable prices. They also may further the social goal of reducing healthcare overconsumption. Competing investor-owned and non-profit health insurers, with their alternative incentives, ownership structures, and resultant governance differences, cannot match this potential.

Because of the unique barriers to starting cooperatives, a compensating subsidy such as that contained in the ACA is an appropriate reaction to jumpstart these organizations. Some aspects of the subsidy are well designed, but others appear poised to exacerbate governance difficulties inherent in the cooperative form while preventing the structure's commitment mechanism from realizing its full potential. Indeed, given these disadvantages, it may not be surprising that half the subsidized insurers have already failed. While future performance will show whether remaining insurers will be sufficiently nimble and creative to compensate for these handicaps, my hope is that the lessons drawn from this Article will be useful in avoiding the imposition of these roadblocks in the future.

258. See Markon, *supra* note 99.

TABLE 1: SEVEN HEALTH INSURER OWNERSHIP CONDITIONS

Condition	Language
Investor-owned (undefined)	You are a customer of an investor-owned for-profit health insurance company.
Investor-owned (defined)	You are a customer of an investor-owned for-profit health insurance company. In an investor-owned for-profit company, the investors elect the company's management and share the company's profits.
Nonprofit (undefined)	You are a customer of a nonprofit health insurance company.
Nonprofit (defined)	You are a customer of a nonprofit health insurance company. In a nonprofit company, any earnings must be used to support the company's mission and cannot be distributed to individuals.
Cooperative (undefined)	You are a member-owner of a cooperative health insurance company.
Cooperative (defined)	You are a member-owner of a cooperative health insurance company. In a cooperative, the policyholders elect the company's management and share the company's profits.
Ownership unspecified	(no language)

TABLE 2: PROBABILITY OF CHOOSING LOW-COST TREATMENT
(ODDS RATIOS)

Age	1.029*** [1.010, 1.048]	1.029*** [1.010, 1.048]
Asian Male	0.507** [0.277, 0.929]	0.500** [0.274, 0.915]
Asian Female	0.318*** [0.140, 0.724]	0.319*** [0.138, 0.736]
For-Profit Insurer (defined)	1.501 [0.831, 2.708]	1.492 [0.824, 2.701]
Nonprofit Insurer (undefined)	1.672* [0.914, 3.060]	1.691* [0.923, 3.099]
Nonprofit Insurer (defined)	1.753** [1.019, 3.017]	1.758** [1.017, 3.038]
Cooperative Insurer (undefined)	1.068 [0.578, 1.972]	1.060 [0.570, 1.969]
Cooperative Insurer (defined)	2.372*** [1.313, 4.284]	2.375*** [1.308, 4.313]
Unspecified Insurer	1.256 [0.748, 2.110]	1.275 [0.756, 2.149]
Individualism		0.964 [0.748, 1.242]
Political Party		0.942 [0.830, 1.069]
<i>N</i>	936	936

* signifies p-value less than 0.10; ** 0.05; *** 0.01. All estimates are odds ratios. Estimates are reported with 95% confidence intervals in brackets.

Other explanatory variables included in the regressions but not shown are: white female, black male/female, Hispanic male/female, "other" race male/female, education attained, whether currently enrolled in school, employment status, household income, household size, number of household members under 18, marital status, and years living in the U.S.

TABLE 2A: PROBABILITY OF CHOOSING LOW-COST TREATMENT
(LOGIT COEFFICIENTS)

Age	0.028***	0.029***
	[0.010, 0.047]	[0.010, 0.047]
Asian Male	-0.678**	-0.692**
	[-1.283, -0.074]	[-1.296, -0.089]
Asian Female	-1.146***	-1.144***
	[-1.969, -0.322]	[-1.982, -0.306]
For-Profit Insurer (defined)	0.406	0.400
	[-0.185, 0.996]	[-0.194, 0.993]
Nonprofit Insurer (undefined)	0.514*	0.525*
	[-0.090, 1.119]	[-0.080, 1.131]
Nonprofit Insurer (defined)	0.561**	0.564**
	[0.019, 1.104]	[0.017, 1.111]
Cooperative Insurer (undefined)	0.065	0.058
	[-0.548, 0.679]	[-0.562, 0.678]
Cooperative Insurer (defined)	0.864***	0.865***
	[0.272, 1.455]	[0.269, 1.462]
Unspecified Insurer	0.228	0.243
	[-0.290, 0.747]	[-0.280, 0.765]
Individualism		-0.037
		[-0.290, 0.217]
Political Party		-0.060
		[-0.187, 0.067]
Constant	-1.918	-1.663
	[-4.882, 1.046]	[-4.672, 1.345]
<i>N</i>	936	936

* signifies p-value less than 0.10; ** 0.05; *** 0.01. Estimates are reported with 95% confidence intervals in brackets.

Other explanatory variables included in the regressions but not shown are: white female, black male/female, Hispanic male/female, "other" race male/female, education attained, whether currently enrolled in school, employment status, household income, household size, number of household members under 18, marital status, and years living in the U.S.

Table 3: T-Tests on Propensity to Choose Low-Cost (Negative) vs. High-Cost (Positive) Treatment

	Investor-owned		Nonprofit		Cooperative		Unspecified
	Undefined	Defined	Undefined	Defined	Undefined	Defined	
Most of the insurer's profits are distributed to its investor-owners	0.0526 (0.151)	-0.188 (0.131)					--
Most of the insurer's profits are spent on promoting policyholder health and wellness	-0.132 (0.140)	-0.293** (0.123)	-0.133 (0.147)	-0.290** (0.126)	-0.440*** (0.146)	-0.252* (0.132)	-0.281*** (0.0907)
Most of the insurer's profits are spent on increasing salaries for its employees	0.0877 (0.143)	0.0226 (0.122)	0.0250 (0.153)	0.265** (0.130)	0.130 (0.168)	0.238* (0.142)	0.129 (0.101)
Most of the insurer's profits are donated to various charities focused on improving public health	-0.149 (0.144)	-0.256* (0.131)	-0.583*** (0.145)	-0.469*** (0.122)	-0.360** (0.159)	-0.415*** (0.125)	-0.228** (0.0996)
Most of the insurer's profits are used to reduce future premiums	-0.351** (0.170)	-0.383** (0.153)	-0.575*** (0.159)	-0.691*** (0.134)	-0.950*** (0.162)	-0.721*** (0.143)	-0.464*** (0.115)
Most of the insurer's profits are used to expand membership base			0.350*** (0.127)	0.198* (0.105)			
Most of the insurer's profits are distributed to the member-owners at the end of the year as a dividend					-1.010*** (0.180)	-0.769*** (0.142)	
Most of the insurer's profits are distributed to its owners							0.384*** (0.117)
N	114	133	120	162	100	147	224

* signifies p-value less than 0.10; ** 0.05; *** 0.01. Robust standard errors in parentheses.

